Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	Blackrock Abbey Nursing Home
Centre ID:	OSV-0000118
Centre address:	Cockle Hill, Blackrock, Dundalk, Louth.
Telephone number:	042 932 1258
Email address:	seamus@talbotgroup.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Orkcalb Unlimited Company
Provider Nominee:	Seamus O'Shea
Lead inspector:	Catherine Rose Connolly Gargan
Support inspector(s):	Sheila Doyle
Type of inspection	Announced
Number of residents on the date of inspection:	55
Number of vacancies on the date of inspection:	5

About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

▪ Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
▪ Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

▪ to monitor compliance with regulations and standards
▪ to carry out thematic inspections in respect of specific outcomes
▪ following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
▪ arising from a number of events including information affecting the safety or wellbeing of residents.

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.

Please note the definition of the following term used in reports:
responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration renewal decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
13 February 2017 09:15	13 February 2017 18:00
14 February 2017 09:00	14 February 2017 14:00

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

Outcome	Our Judgment
Outcome 01: Statement of Purpose	Compliant
Outcome 02: Governance and Management	Substantially Compliant
Outcome 03: Information for residents	Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Compliant
Outcome 06: Absence of the Person in charge	Compliant
Outcome 07: Safeguarding and Safety	Non Compliant - Moderate
Outcome 08: Health and Safety and Risk Management	Substantially Compliant
Outcome 09: Medication Management	Compliant
Outcome 10: Notification of Incidents	Compliant
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 12: Safe and Suitable Premises	Non Compliant - Moderate
Outcome 13: Complaints procedures	Substantially Compliant
Outcome 14: End of Life Care	Compliant
Outcome 15: Food and Nutrition	Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Compliant
Outcome 17: Residents' clothing and personal property and possessions	Compliant
Outcome 18: Suitable Staffing	Compliant

Summary of findings from this inspection

This was an announced inspection completed in response to an application made by the provider for renewal of registration of the centre. Inspectors reviewed progress with their completion of action plans following the previous inspection in September 2016 and found that 23 of the 25 action plans were satisfactorily completed. The remaining two action plans referencing quality and safety monitoring systems and developmment of behavioural support care plans were partially completed and are

restated in the action plan with this inspection. Inspectors also reviewed two items of unsolicited information received by HIQA (Health Information and Quality Authority) in relation to pre-admission assessment, care of residents with swallowing difficulties, preventative pressure area management and end of life care procedures. While this information was substantiated by the findings of the last inspection in September 2016, there was evidence of improvement in all areas referenced in the information received on this inspection.

Inspectors found that systems and appropriate measures were in place to manage and govern this service. The provider nominee, person in charge and staff team responsible for the governance, operational management and administration of services demonstrated sufficient knowledge and commitment to meet regulatory requirements. The management and staff in the centre were striving to improve the quality of the service and the outcomes for residents.

Inspectors spoke with residents, relatives of residents and staff members. In addition pre- inspection questionnaires completed by one resident and two relatives were reviewed. Residents and relatives spoken with and who completed pre-inspection questionnaires were generally positive in their feedback and expressed satisfaction about the facilities, services and care provided. Residents appeared well cared for and confirmed to inspectors that they felt safe and had a choice in their daily routine. Inspectors observed that all interactions by staff with residents were courteous, respectful and kind.

Inspectors observed practices and reviewed documentation such as care plans, accident and incident records, medical and nursing records, policies and procedures and staff files. Inspectors found that overall residents' health care needs were well supported with good access to medical services and allied health professionals. Activities provided were found to be meaningful, varied and most residents were engaged in the activities provided. Residents told the inspectors they enjoyed the activities.

Staff were knowledgeable with regard to the care to be provided to residents and described person-centred care provision. Areas for review from this inspection included ensuring that all incidents were appropriately investigated, clarity in behaviour support care plan documentation, storage facilities, access to an external area for residents on the first floor, improvement in documentation to guide the management of falls and wound care, suitability of and safety in the smoking facility and improvement in the system for monitoring the quality and safety of care.

The areas for improvement are discussed throughout the report. The action plans at the end of the report contains actions that must be completed 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.

Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

Outcome 01: Statement of Purpose
There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:
Governance, Leadership and Management

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

Findings:
There was a written statement of purpose document available which was recently updated and a copy was forwarded to the Chief Inspector as required. It contained all information required by schedule 1 of the Regulations. The statement of purpose and function accurately described the range of needs that the designated centre meets and the services provided. The services and facilities outlined in the statement of purpose and how care is provided reflects the diverse needs of residents in the centre

Judgment:
Compliant

Outcome 02: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.

Theme:
Governance, Leadership and Management

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

Findings:
The findings on this inspection evidenced a comprehensive review of the governance and management of the service had taken place since the last inspection in September

2016. There was evidence of actions progressed to ensure safe care and improved quality of life for residents.

The management structure was revised in December 2016 to reference assignment of the role of provider representative to the general manager. This revision enabled the person in charge to fulfil her regulatory responsibilities. Inspectors found that the roles of responsibilities of all staff were identified and lines of authority and accountability were clearly defined.

Systems for effective monitoring of the standard and safety of care, the service provided and the quality of life for residents in the centre were significantly improved. Key aspects of the service and clinical care parameters had been reviewed. Although there was clear evidence that improvements had been made in response to reviews done, this process was not informed by comprehensive analysis of the data collated, development of action plans and trending of findings. The provider had recognised that this shortcoming did not support a proactive approach to quality improvement. In response, the provider had progressed the implementation of a computerised software programme to assist them with monitoring the quality and safety of key aspects of the service and to inform proactive quality assurance in the centre.

There was evidence of improved consultation with residents and their families. Sufficient resources were provided to ensure the effective delivery of care in line with the centre's statement of purpose.

Judgment:
Substantially Compliant

Outcome 03: Information for residents
A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

Theme:
Governance, Leadership and Management

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

Findings:
The residents' guide was reviewed and found to contain all the information as required by the Regulations. A copy of this guide was available to all residents.

Contracts for the provision of services were noted to contain the necessary details such as the services to be provided and the fees to be charged. These contracts had been agreed to by residents or their representatives.

Judgment:

Compliant

Outcome 04: Suitable Person in Charge
The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:
Governance, Leadership and Management

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

Findings:
The centre is managed by a suitably qualified and experienced person in charge. The person in charge is a registered nurse, has completed a postgraduate management course and has worked in a management capacity in the centre since 2003. She demonstrated that she was involved in the governance, operational management and administration of the centre on a regular and consistent basis. She reports to the general manager who is the representative for the provider.

The person in charge is supported in her role by a clinical nurse manager not included in the staff compliment providing direct care to residents, a clinical nurse manager on each floor, staff nurses, care staff, activity coordinators, catering, household, administration and maintenance staff.

The person in charge demonstrated that she knew residents well and was aware of their individual needs. Inspectors saw that residents knew the person in charge. Since the last inspection in September 2016, the person in charge demonstrated that she had improved oversight of residents' needs and the standard of care and service provided to them. The person in charge advised inspectors at the inspection feedback meeting that she was progressing arrangements so she or her deputy would attend the handover meeting from night to day staff each morning.

Judgment:
Compliant

Outcome 05: Documentation to be kept at a designated centre
The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:
Governance, Leadership and Management

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

Findings:
Inspectors were satisfied that the records listed in Part 6 of the Regulations were maintained in a manner so as to ensure completeness, accuracy and ease of retrieval as required by the Regulations.

The provider was aware of the periods of retention for the records which were securely stored.

The designated centre had the written operational policies required by Schedule 5 of the Regulations in place. It was noted at the previous inspection that the communication policy required improvement to inform practice in relation to residents with specific communication needs. Inspectors found that this had been addressed. A comprehensive policy was now in place.

Insurance cover was in place.

All information requested by inspectors was readily available.

Judgment:
Compliant

Outcome 06: Absence of the Person in charge
The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:
Governance, Leadership and Management

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

Findings:
The provider and person in charge demonstrated they were aware of the responsibility to notify the Chief Inspector of any proposed absence of the person in charge greater than 28 days from the designated centre and the arrangements in place for the management of the designated centre during her absence.

Deputising arrangements were in place if required.

Judgment:

Compliant

Outcome 07: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe care and support

Outstanding requirement(s) from previous inspection(s):
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. However the use of restraint was not in line with national guidelines and required improvement to safeguard residents. Although peer-to-peer incidents and incidents of bruising of unknown origin to residents' skin occurred infrequently, review of these incidents required improvement to outrule any evidence of abusive behaviours.

Improvement was required around the use of bedrails and usage remained high. Comprehensive assessments had been completed and this had been identified as an area for improvement at the last inspection in September 2016. However there was no documented evidence that safety checks were completed when bedrails were in use. In addition, care plans did not contain sufficient information to guide practice. They did not outline if these checks were to be carried out or how often. A similar issue was noted with the policy in use. Inspectors noted that safety checks were completed and documented when lapbelts were in use.

Additional equipment such as low beds had been purchased to reduce the need for bedrails.

Staff had received training on identifying and responding to elder abuse. There was a policy in place which gave guidance to staff on the assessment, reporting and investigation of any allegation of abuse. The person in charge and staff spoken to displayed sufficient knowledge of the different forms of elder abuse and all were clear on reporting procedures.

Because of their medical condition some residents had episodes of responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). Residents presenting with responsive behaviours were appropriately referred and reviewed by specialist medical services such as psychiatry and psychology. Behavioural support care plans were developed for residents in each case. The behavioural support care plans

reviewed informed proactive and reactive strategies which were person-centred. However, they did not describe the behaviours for which the care plan was developed. This finding is actioned in outcome 11.

Inspectors reviewed the system for the management of residents' monies. This was found to be robust and transparent. All transactions were lodged and receipts maintained.

Judgment:
Non Compliant - Moderate

Outcome 08: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Safe care and support

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

Findings:
Inspectors were satisfied that the health and safety of residents, visitors and staff was sufficiently promoted and protected.

There was a health and safety statement in place. Environmental risk was addressed with health and safety policies implemented which included risk assessments on such areas as waste management. The risk management policy met the requirements of the regulations. Inspectors noted other risk measures were also completed such as random temperature recording to ensure that hot and cold water temperatures were within acceptable limits. Hazards were identified throughout the centre and controls to minimise risk of occurrence were stated.

The environment was kept clean and was well maintained and there were measures in place to control and prevent infection. Audits were carried out to ensure compliance with infection control procedures. Areas for improvement to prevent any risk of cross infection included open shelf storage of utilities such as hand towels in the cleaning room and uncovered toilet rolls in communal toilets.

Robust procedures for fire detection and prevention were in place. Service records indicated that the emergency lighting and fire alarm system were serviced three-monthly and fire equipment was serviced annually. Inspectors noted that the fire panels were in order and fire exits, which had regular checks, were unobstructed. The fire alarm system was in working order. There was evidence of frequent fire drills taking place and all staff had attended training. Staff spoken with were clear on the procedure they would follow in the event of a fire. A wooden shelter was recently erected for residents who smoked on a balcony on the first floor. While a fire blanket was provided, a fire extinguisher or a specialised apron to protect vulnerable residents was not

provided. Risk assessments were completed for residents who smoked to ensure their safety needs were met.

Personal emergency evacuation plans (PEEP) were in place for each resident and these included detailed information on each resident's mobility levels and requirements for assistance in the event of an emergency evacuation.

An emergency plan was in place which outlined the procedure to follow in the event of an emergency such as flooding or chemical explosion. Alternative accommodation was also available should evacuation be necessary.

Moving and handling assessments were completed for residents. Inspectors observed that safe procedures were carried out by staff. Training records confirmed that all staff had attended mandatory training in safe moving and handling procedures.

Judgment:
Substantially Compliant

Outcome 09: Medication Management
Each resident is protected by the designated centre's policies and procedures for medication management.

Theme:
Safe care and support

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

Findings:
A medicine management policy was in place to inform safe practices. The inspector observed that residents' medicines were stored appropriately including medicines controlled under Misuse of Drugs legislation and medicines requiring refrigeration. Balance checking of stock of controlled medicines and refrigerator temperatures was consistently completed. Residents' prescribed medicines were reviewed at least on a three-monthly basis. Administration of specified medicines such as antibiotics and psychotropic medicines was tracked as part of clinical information collated and reviewed by the person in charge.

An action required from the last inspection in September 2016 regarding PRN (a medicine only taken as the need arises) psychotropic medicine administration procedures was completed. A monitoring and reviewing system was in place to ensure safe medication management practices.

Procedures were in place to record the date of opening of residents' topical creams/ointments and oral liquid medicines to ensure they were not used beyond the timescales recommended by the manufacturer. Procedures were also in place to ensure medicines no longer used by residents in the centre were removed from the medicines

trolley and discarded appropriately.

The pharmacist dispensing residents' medications was facilitated to fulfil their obligation. Residents had access to a local pharmacist and the pharmacist was available to meet with residents as they wished. The pharmacist undertook regular audits of medicine management procedures in the centre.

Judgment:
Compliant

Outcome 10: Notification of Incidents
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:
Safe care and support

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

Findings:
A record of all accidents and incidents was maintained. The person in charge had notified HIQA of all incidents and quarterly returns as required by the regulations.

Judgment:
Compliant

Outcome 11: Health and Social Care Needs
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

Theme:
Effective care and support

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

Findings:
There was evidence that a comprehensive review of how residents' healthcare needs were met was undertaken and robust action was taken to improve the standard of

healthcare provision since the last inspection in September 2016. Actions required from the last inspection referenced substandard findings in relation to care planning to meet residents' needs, procedure for prevention of pressure related skin injury and limitations in access for residents to additional healthcare professional expertise.

The process of moving all residents' care documentation to a computerised data management system was complete. The system was also password protected to protect residents' personal information. Inspectors found that residents' needs were assessed by use of a suite of assessment tools. Residents' behavioural support care plans did not identify the responsive behaviours for which the care plan was developed. All residents' other needs were addressed with person-centred care plans that clearly detailed their needs and the interventions that must be completed in each case in the sample of residents' records reviewed by inspectors. There was evidence of improved consultation with residents or their families, where appropriate regarding care plan development and reviews thereafter. Improvements were implemented to ensure residents had timely access to additional healthcare expertise as required. Care plans were updated to include recommendations made by the multidisciplinary team.

There were three residents with pressure related skin injuries that developed in the centre. Prevention management procedures were reviewed since the last inspection. Improvements made included the implementation of a new assessment tool, staff training, purchasing of new pressure relieving mattresses and cushions and strict repositioning schedules. The improvements made had a positive impact on residents' care and inspectors saw where pressure ulcers were improved or healed. While a policy was available to inform assessment and management of pressure ulcers, there was no policy available to inform staff on evidence-based management of other wounds. This was evidenced in findings of inconsistent wound monitoring procedures.

Improvement was required in relation to falls management. Inspectors saw that a resident had fallen and sustained a head injury. However neurological observations were not completed. This was discussed with staff at the time and inspectors saw it was addressed. The care plan was also updated and the falls risk assessment was completed. Inspectors read the policy in place and saw that it was not detailed enough to guide practice. For example, while it stated that neurological observations were to be recorded, it did not specify frequency and duration.

Inspectors also noted that although each fall was reviewed, no overall review was undertaken to see if any pattern or trend was evident. One clinical nurse manager (CNM) discussed plans to review their current falls management system and introduce additional safety measures for residents such as an alert system for staff.

Judgment:
Non Compliant - Moderate

Outcome 12: Safe and Suitable Premises
The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents,

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

Theme:
Effective care and support

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

Findings:
The centre is purpose-built and accommodates a maximum of 60 residents in 44 single (14 of which had en-suite toilet, shower and wash-basin facilities) and eight twin en-suite bedrooms over two floors. The size and layout of bedrooms was suitable to meet the needs of residents and there was sufficient toilet and washing facilities located at convenient intervals and within close proximity to communal areas. The centre was clean, bright, well ventilated and warm. Since the last inspection, the provider had completed an extensive refurbishment to the internal fabric of the centre that included repainting, repairs and replacement of furniture and some floor coverings. There was a variety of communal areas provided on each floor to meet residents' collective needs. The layout of furniture in the communal dining room on the first floor had been reviewed to improve the circulation space available to residents. Although improved, this dining room remained overcrowded. For example, one of two exit doors from the dining room to the corridor was obstructed while residents were seated during mealtimes.

A lift was available and residents were seen by inspectors using it at will. The first floor was accessible from a roadway located at the same level at the back of the centre. An internal secure and safe garden area was freely accessible from the ground floor. As discussed in outcome 6, access to external balcony areas from the first floor was restricted. A shelter provided for residents who smoked was provided on a balcony on the first floor required review to ensure it adequately protected residents who used it from inclement weather conditions.

The provider/person in charge and staff demonstrated resourcefulness and creativity with work done in refurbishing communal areas on both floors to provide a comfortable and therapeutic environment for residents. Furniture, fittings and fixtures supported residents' accessibility and comfort in the centre. Grab-rail fittings were in place in toilets and showers. Handrails were fitted on corridors. Residents had access to appropriate assistive equipment to promote their mobility, independence, personal and seating needs.

There was a process for ensuring all equipment was properly installed, used, maintained, serviced and replaced. Equipment service records were available. While some storage areas were available for equipment, a storage room on the first floor was inaccessible and equipment such as hoists, assistive chairs and laundry trolleys were stored in annexed areas on corridors on the first floor.

While curtains provided privacy for residents sharing twin bedrooms, the layout of these

rooms did not allow one resident in each room to engage in watching television due to the location of their personal television. This was also a finding on a previous inspection in 2016.

Judgment:
Non Compliant - Moderate

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

Theme:
Person-centred care and support

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

Findings:
Since the last inspection in September 2016, revisions made to the management of complaints received in the centre from residents and their families provided assurances that a record of complaints was maintained. The complaints procedure was displayed and since the last inspection, was also set out in an accessible format to meet the needs of some residents.

There was a designated complaints officer. There was evidence of timely and appropriate investigation and communication of outcomes to the complainants concerned. An appeals process was in place. However, the effectiveness of the appeals process could not be assessed in the absence of a consistent record of the satisfaction of complainants with the outcome of investigations completed. The provider and person in charge had identified this omission and had commenced actions to address it.

Residents spoken with told inspectors that they could freely express any dissatisfaction they had with the service provided and they believed they would be listened to.

Judgment:
Substantially Compliant

Outcome 14: End of Life Care
Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.

Theme:
Person-centred care and support

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

Findings:
Inspectors were satisfied that caring for a resident at end of life was regarded as an integral part of the care service provided.

Inspectors found on the last inspection in September 2016 that residents had not been offered the opportunity to discuss their preferred priorities of care. This had been addressed. Inspectors read where residents or their representatives had been offered this opportunity and specific information was recorded when available in the residents' records reviewed.

The end-of-life policy was comprehensive, evidence-based and inspectors were satisfied that it guided practice. The person in charge stated that the centre received support from the local palliative care team if required. In addition the person in charge discussed plans underway for additional training to be provided to staff.

There was a procedure in place for the return of possessions and specific handover bags were in use.

Inspectors saw that in November last, a remembrance mass was organised by staff for residents and bereaved relatives. Staff spoken with described how beneficial this was and how it is planned to have this as an annual event.

Judgment:
Compliant

Outcome 15: Food and Nutrition
Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.

Theme:
Person-centred care and support

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

Findings:
Inspectors were satisfied that each resident was provided with food and drinks at times and in quantities adequate for his/her needs. Food was properly prepared, cooked and served, and was wholesome and nutritious. Assistance was offered to residents in a discreet and sensitive manner.

An action required from the last inspection in September 2016 related to choice being offered to residents at meal times. It was also noted at that time that meals appeared rushed when assistance was required. Inspectors saw that both of these actions had been satisfactorily addressed.

An extensive menu was now available and offered to each resident. A questionnaire had been completed regarding residents' preferences and inspectors noted that this was also available in pictorial format if this was more suitable for some residents. Inspectors also saw that the results were discussed at the residents' committee meetings to check if any additional choices were required. Residents who required modified consistency diets had the same menu choices available to them.

In general improvements were noted across the whole dining experience. The dining rooms had been redecorated, pretty table cloths were in use and pictorial menus were on display at each table.

Inspectors saw staff sitting with residents while assisting with meals. Inspectors heard the various menu choices being offered to the residents.

Inspectors also saw that recommendations by residents at their committee meeting had been taken on board. This included having sauces and condiments available in sachets. A dietician had reviewed the menu provided on a three-week cycle for residents to ensure the nutritional content met residents' needs.

Inspectors noted that plans were underway for St. Valentines' day celebrations. Specific heart shaped cakes and desserts were prepared and residents were involved with the preparations.

Judgment:
Compliant

Outcome 16: Residents' Rights, Dignity and Consultation
Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

Theme:
Person-centred care and support

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

Findings:
Several actions were required from the last inspection in September 2016. At that time

there was limited evidence that residents with specialist communication needs were consulted with or facilitated to meaningfully participate in the organisation of the centre. In so far as was possible this was now addressed. Advocacy services were available and inspectors also noted that additional support was provided by fellow residents.

It was noted at the last inspection that a consultation process had not commenced with residents who would be impacted by plans underway to change the resident profile of the centre to an exclusively older person service. Inspectors saw that this was underway with input from all relevant stakeholders.

Inspectors previously had reservations regarding a small minority of staff using language that was not age-appropriate when speaking with some residents. Additional training had been provided to staff and there was no evidence of this at this inspection.

Extensive work was undertaken to ensure that all residents were consulted with regarding activity choices and provision of activities to meet their interests and capabilities. These areas were identified for improvement on the last inspection in the centre. A survey in pictorial and word format had been completed and inspectors saw that the results were used to inform the activity programme. New group and individual activities were taking place. For example inspectors saw a resident enjoying a foot spa while another sang to specific music. 'A key to me' was completed for residents and staff discussed plans to make this more resident specific. Staff also discussed plans to introduce life stories to ensure that all relevant information was available. Inspectors saw that staff other than the activity coordinators also undertook activities with residents in the day rooms.

The issue previously identified relating to some residents' privacy and dignity had been addressed. Inspectors saw that at breakfast time, some residents were in the dining room in new dressing gowns and were enjoying their breakfast while others had opted to get fully dressed. Residents could meet their visitors in private if they wished in communal areas other than the main sitting rooms on each floor and their bedrooms.

Inspectors saw that the residents' committee met on a regular basis. Inspectors saw that recommendations from this were taken on board. For example recommendations regarding activity and menu choices had been acted upon.

Judgment:
Compliant

Outcome 17: Residents' clothing and personal property and possessions Adequate space is provided for residents' personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.

Theme:
Person-centred care and support

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

Findings:
An action from the last inspection regarding insufficient record keeping for residents' clothing was found to be satisfactorily addressed on this inspection. Since the last inspection the laundry service had been outsourced to an external contractor. Arrangements were in place to ensure the service met residents' needs and that they were satisfied with how their clothes were laundered. Inspectors saw where the provider had responded to residents' feedback and had taken action to ensure that the changeover in the laundering arrangements did not negatively impact on them.

Records of residents' clothing and possessions were maintained and arrangements were in place to keep these records up-to-date. Adequate space was provided for storage of residents' personal possessions and clothing in their bedrooms. Residents had control over and could freely access their clothing and possessions. There was a policy in place to inform staff on management of residents' personal property.

Judgment:
Compliant

Outcome 18: Suitable Staffing
There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

Theme:
Workforce

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

Findings:
Inspectors found that there were appropriate numbers of staff on duty with the required skill mix to meet the needs of residents.

Inspectors reviewed staff rosters and found that these indicated that there were sufficient numbers of staff on duty to provide for residents. There was a recruitment policy in place which met the requirements of the regulations. Inspectors examined a sample of staff files and found that all contained required information including An Garda Siochana vetting. The provider gave assurances that all staff were appropriately

vetted prior to working in the centre

Inspectors confirmed that up to date An Bord Altranais agus Cnáimhseachais na hÉireann registration numbers were in place for nursing staff. Resident dependency was assessed using a recognised dependency tool and the staffing rotas were adjusted accordingly.

Systems were in place around induction and appraisals for staff.

Actions required from the previous inspection related to supervision of staff and mandatory training. In addition, action was required to ensure that staff had sufficient knowledge and training to meet the needs of all residents including those with an intellectual disability. Inspectors found that these had been addressed. There was evidence of extensive professional development training for staff being undertaken recently and a plan was in place for the remainder of the year. All staff had attended mandatory training.

Additional clinical supervision was in place. For example clinical nurse managers (CNMs) were now on duty on both floors and were rostered over seven days. External consultants had been brought in to assist with supervision and coaching. A management programme was being developed for the CNMs. All staff spoken with said they felt supported in their role.

Judgment:
Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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Action Plan

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

Provider's response to inspection report[1]

Centre name:	Blackrock Abbey Nursing Home
Centre ID:	OSV-0000118
Date of inspection:	13/02/2017
Date of response:	22/03/2017

Requirements

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

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

Outcome 02: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Although there was clear evidence that improvements had been made in response to reviews done, this process was not informed by comprehensive analysis of the data collated, development of action plans and trending of findings.

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

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

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

Please state the actions you have taken or are planning to take:
A computerised audit system (ViClarity) has been purchased. Currently work is ongoing with the supplier to finalise the audit tools to be used. When operational this system will facilitate comprehensive analysis of the data collated, development of action plans and trending of findings.

A senior manager has been assigned the role of System Administrator. This role involves the following responsibilities:

- Champion/Super User of the system in Talbot Group Nursing Homes..
- Train staff on how to use the system.
- Educate staff on the benefits of the system.
- Safeguard the integrity of how the system is used.
- Support Clinical & Support Services Managers to use the system to maximise compliance so as to provide assurance to senior management.

Pending the implementation of the computerised audit system (ViClarity), audits will continue to be carried out. The results of audits will be reviewed by the PIC and discussed at team meetings. Agreed actions arising from audit results will be implemented and monitored by PIC to ensure improvements are achieved where required.

Proposed Timescale: 31/05/2017

Outcome 07: Safeguarding and Safety

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no documented evidence that safety checks were completed when bedrails were in use.

Care plans did not contain sufficient detail to guide practice.

The policy around the use of restraint was not in line with national policy.

Review of peer-to-peer incidents and bruising of unknown origin, required improvement to out rule any evidence of abusive behaviours.

2. 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:
1. The completion of safety checks when bedrails are in use is now recorded on "epicCare touch" system. This action was completed when the issue was highlighted during inspection.

2. A review of Restraint care plans has commenced and will be completed by 31/03/2017, to ensure they contain sufficient detail to guide practice.

3. The policy on restraint will be reviewed to bring it in line with national policy.

4. Our "Review of Care" document will be amended so as to ensure when reviewing peer to peer incidents or bruising of unknown origin to include investigations that will out-rule any evidence of abusive behaviours.

Proposed Timescale: 30/04/2017

Outcome 08: Health and Safety and Risk Management

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Areas for improvement to prevent any risk of cross infection included open shelf storage of utilities such as hand towels in the cleaning room and uncovered toilet rolls in communal toilets.

3. 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:
1. Adequate storage presses will be installed for storage of utilities.
2. Uncovered toilet rolls in communal toilets will be replaced with covered toiled roll holders.

Proposed Timescale: 31/03/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A fire extinguisher or a specialised apron to protect vulnerable residents was not provided in a shelter for residents who smoked.

4. Action Required:
Under Regulation 28(1)(a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.

Please state the actions you have taken or are planning to take:
Risk assessments have been completed for residents who smoke.

Fire extinguisher and smoking safety apron are now in place in the smoking shelter.

Proposed Timescale: 22/03/2017

Outcome 11: Health and Social Care Needs

Theme:
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Residents' behavioural support care plans did not identify the responsive behaviours for which the care plan was developed.

5. 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:
Behaviour support plans are under review to ensure they include the responsive behaviours for which they were developed.

Proposed Timescale: 31/03/2017

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Falls management was not in line with evidence based care. The policy in place was not detailed enough to guide practice.

There was no policy available to inform staff on evidence-based wound care management.

6. 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:
1. The Falls Management Policy is under review. The revised policy when finalised will give sufficient detail to guide practice.
2. A new Wound Care Management Policy is being developed and will be implemented no later than 30/04/17.

Proposed Timescale: 30/04/2017

Outcome 12: Safe and Suitable Premises

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The dining room on the first floor was overcrowded.

A storage room on the first floor was inaccessible and equipment such as hoists, assistive chairs and laundry trolleys were stored in annexed areas on corridors on the first floor.

The layout of twin bedrooms did not allow one resident in each room to engage in watching television due to placement of their personal television.

A residents' smoking shelter required review to ensure it adequately protected residents who used it from inclement weather conditions.

7. 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:
1. When the transition of residents on the ground floor to community houses takes place, the number of residents using the dining room on the first floor will be reduced. Proposed Timescale: 31/08/17. In the meantime two dining tables have been moved to the room adjacent to the dining room.

2. Storage facilities on the first floor have been reviewed. Assistive chairs no longer required have been removed. The annexed areas will only be used to store equipment that needs to be conveniently located near residents for their benefit. Proposed Timescale: Completed.

3. Where necessary televisions will be repositioned to ensure residents have an

unobstructed view of their television. Proposed Timescale: 31/05/17.

4. Smoking facilities will be upgraded to adequately protect residents from inclement weather conditions. Proposed Timescale: 31/05/17.

Proposed Timescale: 31/08/2017

Outcome 13: Complaints procedures

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Satisfaction of complainants with the outcome of investigations was not consistently recorded.

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

Please state the actions you have taken or are planning to take:
In future the satisfaction of complainants with the outcome of investigations will be consistently recorded.

Proposed Timescale: 22/03/2017