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:	Hillview Private Nursing & Retirement Residence
Centre ID:	OSV-0000141
Centre address:	Rathfeigh, Tara, Meath.
Telephone number:	041 982 5698
Email address:	jjcahill@hillviewcare.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Hillview Private Nursing & Retirement Residence Partnership
Provider Nominee:	John James Cahill
Lead inspector:	Catherine Rose Connolly Gargan
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	19
Number of vacancies on the date of inspection:	7

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:
28 August 2017 10:15	28 August 2017 18:00
29 August 2017 09:00	29 August 2017 15:30

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

Outcome	Our Judgment
Outcome 01: Statement of Purpose	Compliant
Outcome 02: Governance and Management	Non Compliant - Major
Outcome 04: Suitable Person in Charge	Compliant
Outcome 07: Safeguarding and Safety	Compliant
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 09: Medication Management	Compliant
Outcome 10: Notification of Incidents	Compliant
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 14: End of Life Care	Compliant
Outcome 15: Food and Nutrition	Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Non Compliant - Moderate
Outcome 18: Suitable Staffing	Compliant

Summary of findings from this inspection

This inspection report sets out the findings of an announced inspection completed in response to an application made by the provider for renewal of registration for the centre. All required documentation as prescribed under Regulation 4 of the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 was not submitted to the Health Information and Quality Authority for application to renew the centre's registration of the centre.

The last inspection of the centre by the Health Information and Quality Authority (HIQA) was a thematic inspection completed on 02 November 2016 to assess compliance with the regulations regarding the service provided for residents with dementia living in the centre. The inspector followed up on progress with completion of the action plan from the last inspection and found that seven of the 10 actions in the action plan were satisfactorily completed. The inspector found that the three remaining actions were partially completed and are restated in the action plan with

this inspection. The inspector also reviewed the details of unsolicited information received by HIQA in August 2017 and found that the issues raised were largely unsubstantiated. However some areas for improvement were identified and are detailed in the report and action plan.

Residents spoken with during this inspection and feedback from pre-inspection questionnaires completed by nine residents and five residents' relatives referenced good levels of satisfaction with the service provided, care received and the staff in the centre. Residents confirmed that they felt safe and had choice in their daily routine. A summary of the feedback received from residents and their relatives was also communicated to the provider and person in charge during the course of the inspection.

The inspector met with the provider, person in charge, deputy person in charge, members of the staff team, residents and their relatives during the course of the inspection. Documentation records such as the centre's policies, risk management (including fire safety) procedures and records, audits, staff training records and residents' records were reviewed among other documentation.

Residents were appropriately safeguarded and the inspector observed that all interactions by staff with residents were courteous, respectful and kind. Procedures were in place and implemented to ensure that residents were protected from abuse. There was evidence that the views of residents were valued and actively sought. Feedback from residents and their relatives and used to improve the service provided to meet residents' needs.

There were appropriate systems in place to manage and govern the service. The provider and person in charge held responsibility for the governance, operational management and administration of services and provision of sufficient resources to meet residents' needs. They demonstrated sufficient knowledge and an ability to meet regulatory requirements. The centre was a single-storey, purpose-built premises and was in a good state of repair. While residents were protected from risk of injury and fire, the documentation to inform risk management and to provide assurances that fire safety equipment was functioning required improvement.

Residents' healthcare needs were met to a good standard. However, improvements was required in relation to some residents' care records and documentation. While the activities provided for residents were interesting, varied and meaningful, improvement was required to ensure a small number of less able residents were facilitated to engage in activities that met their needs. Staff were knowledgeable regarding residents needs and were facilitated to attend training to meet mandatory requirements and their professional knowledge and skill needs.

The Action Plan at the end of this report identifies improvements that must be made to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland 2016.

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:
A written statement of purpose document dated May 2017 was forwarded to HIQA. It contained all information required by Schedule 1 of the Regulations and detailed the changes in service provision to meet the needs of 26 residents. The statement of purpose and function accurately described the range of needs that the designated centre meets, the services provided and was demonstrated in practice.

Judgment:
Compliant

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

Theme:
Governance, Leadership and Management

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

Findings:
The inspector found that there was a clearly defined governance and management structure in place. Lines of authority and accountability were defined. All members of the team were aware of their roles, responsibilities and reporting arrangements. The provider representative worked from an office based in the centre. The provider

representative was known to residents. A monthly management meeting schedule was in place and was attended by the provider nominee and person in charge. Minutes of these meetings were made available to the inspector and they indicated that key indicators of the quality and safety of the service was discussed. Evidence was available of completion of actions from meetings. Inter-team communication was promoted by regular staff meetings chaired by the person in charge.

There was a system in place to ensure that the service provided was consistent. safe, regularly monitored and appropriate to meet residents' needs. There was evidence that key areas of clinical care, the environment and feedback from residents and their relatives was reviewed to ensure the service provided was safe and effective. There was evidence that the information collated in audits and in feedback from residents and their relatives was analyzed and areas identified as requiring improvement were actioned. An annual report detailing a review of the quality and safety of care delivered to residents in accordance with the National Standards was completed for 2016 and was made available to the inspector.

Residents and their relatives who talked with the inspector were familiar with the management structure and arrangements in the centre. Residents knew the person in charge well. Residents and relatives spoke positively about the service provided and the staff caring for them. There was evidence that residents were given opportunity to express their views and their feedback on the service they received was welcomed.

There were sufficient resources provided to ensure the effective delivery of care and service as described in the centre's statement of purpose document.

A major non compliance was merited as the provider's application to renew the registration of the centre was incomplete. All required documentation as prescribed under Regulation 4 of the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 was not submitted to the Health Information and Quality Authority. The partnership authorization declaration document was not signed by all the partners and Garda Siochana vetting was also outstanding, despite repeated reminders to submit the required documentation.

Judgment:
Non Compliant - Major

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

Theme:
Governance, Leadership and Management

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

Findings:
The centre was being managed by a suitably qualified and experienced nurse in care of older people. The person in charge demonstrated that she had authority and was accountable and responsible for provision of the service to residents. The person in charge demonstrated that she was engaged in the governance, operational management and administration of the centre on an on-going. She works full-time in the centre and has sufficient knowledge and expertise to meet the needs of residents in the centre. The person in charge is supported in her role by a deputy nurse manager, nursing, care assistant, administration, maintenance, catering and housekeeping staff who report directly to her.

The person in charge is a registered nurse with An Bord Altranais agus Cnáimhseachais Na hÉireann. The person in charge has a postgraduate qualification in gerontology nursing and has completed courses in dementia care and acquired brain injury. She demonstrated that she had knowledge of the Regulations and Standards pertaining to the care and welfare of residents in the centre and the responsibilities of her statutory role as person in charge.

The person in charge had a detailed knowledge of each resident's life history, condition and care needs. Staff confirmed that there was good inter-team communications. The person in charge had effective systems in place to ensure the quality and safety of clinical care was maintained to a good standard. Information required was easily accessed and was well organized. Residents and relatives spoken with knew the person in charge and spoke positively regarding her kindness and concern for them.

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:
There were measures in place to protect residents from being harmed or from suffering abuse, and to ensure that appropriate action would be taken in response to allegations, disclosures or suspected abuse. A policy was in place to inform safeguarding residents from abuse. Staff spoken with by the inspector were knowledgeable about the various types of abuse and the actions they should take including their responsibility to report. Residents spoken with during the inspection and residents who completed pre-inspection questionnaires confirmed that they felt safe in the centre.

The inspector's findings indicated that a restraint-free environment was promoted in the centre. Bedrails were in use for three residents on the day of inspection. Safe use of bedrails was informed by completed risk assessments and checking procedures. Procedures were also in place to ensure any restriction to residents' free mobility was minimized. Procedures were in place to ensure bedrail safety checks and the periods when bedrails were reduced was indicated and recorded on completion. Less restrictive alternatives to full-length bedrails were tried and used where possible to ensure residents' safety and to support them to change their position in bed independently if they wished. No residents received psychotropic medications on a PRN (a medicine only taken as the need arises) basis at the time of this inspection. Arrangements were in place for review of any administration of PRN psychotropic medicines for management of responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). While access through the main exit doors to the centre was controlled to safeguard residents, they could freely access two safe enclosed garden/courtyards as they wished. Use of restraint was recorded in the restraint register and reported to the Health Information and Quality Authority (HIQA) as required.

A policy was available to inform staff on supporting residents who were predisposed to responsive behaviours. The inspector was told that a low number of residents experienced occasional responsive behaviours. The inspector observed that there no residents experiencing responsive behaviours on the day of inspection. Staff spoken with by the inspector could describe the person-centred de-escalation techniques they used to support and de-escalate individual resident's responsive behaviours. Each resident predisposed to responsive behaviours had a behaviour support care plan in place that described the triggers to the behaviour and the most effective person-centred strategies to de-escalate the behaviour for each person. The inspector observed that staff responded to residents with a history of responsive behaviours in a sensitive, person-centred and compassionate way and residents responded positively to the techniques they used. Residents with responsive behaviours were referred appropriately to community psychiatry services. The psychiatry services attended the centre to review residents and some residents attended this service on an out-patient basis. Residents were supported to attend these out-patient appointments.

A system was in place to safeguard small amounts of residents' money kept in safekeeping on their behalf by the centre which they could access as they wished. A sample of records and balances of residents' money kept in safekeeping by the provider were checked by the inspector and found to be transparent and accurate. All transactions were recorded and dual-signed by a staff member and the resident or their relative or two staff members. The provider representative confirmed to inspectors that at the provider did not function as a pension agent for any of the residents.

Judgment:
Compliant

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

Theme:
Safe care and support

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

Findings:
Findings on this inspection demonstrated that the health and safety of residents, staff and visitors was protected and promoted however documentation to support and inform this process required improvement. The inspector found that fire safety checking records were incomplete.

There was a safety statement available for the centre and was updated for 2017. Risk management procedures for areas specified by Regulation 26 (c) were in place to protect vulnerable residents. Clinical risk assessment was completed for individual residents who smoked. Hazardous areas such as sluice rooms were secured at all times to prevent unauthorized access. A health and safety committee met every quarter and risk management was discussed at weekly management meetings. Risks identified on the last inspection were addressed. Hot water and radiator were maintained at a temperature that did not pose a risk of scald/burn to vulnerable residents. Procedures were put in place to ensure vulnerable residents could not access chemicals such as bleach and detergents in the laundry room. Open fencing in part of the garden beside a steep incline had been addressed and no longer posed a risk to vulnerable residents. While centre-specific internal and external hazards, including hazards found on the last inspection in November 2016 were satisfactorily mitigated, these hazard and the concomitant controls implemented were not recorded in the risk management policy documentation. This finding did not ensure that risks identified could be reassessed or that controls implemented could be referenced by all members of the staff team.

All incidents and accidents involving residents, staff and visitors were recorded. They were reviewed and actions were documented and implemented to mitigate risk of recurrence. Data on resident falls was collated, analyzed and used to inform risk management strategies and staffing resources. There was a low incidence of resident falls necessitating hospital care in the centre. Each resident has a risk of fall assessment completed on admission and was regularly reviewed thereafter, including after a fall incident. Hip protection equipment, low level beds, foam floor mats, hand rails in corridors, toilets and showers, staff supervision and sensor equipment were used to reduce risk of fall or injury to vulnerable residents.

Residents were protected against risk of fire in the centre. All residents had evacuation risk assessments completed and documented. This information was improved since the last inspection to include residents' cognitive status and behaviours that required consideration should an emergency evacuation be required. Fire safety management checking procedures were in place but required improvement. The inspector found that the centre's fire alarm, emergency lighting, directional signage and function of fire exit doors were checked and serviced by an external contractor on a quarterly basis but local

weekly checking procedures for this fire safety equipment were not in place. Fire evacuation drills were completed and while they reflected testing of day time resources and conditions to ensure residents could be safely evacuated in an emergency, a simulated night-time scenario had not been completed. Staff training records referenced that all staff had completed fire safety training and had participated in a fire evacuation drill. Staff spoken with by the inspector were aware of the emergency procedures in the event of a fire in the centre.

An infection control policy informed procedures for management of communicable infection and infection outbreak to guide and inform staff. The centre was visibly clean. Hand hygiene facilities were located throughout the premises. Environmental cleaning procedures reflected best practice in infection prevention and control standards. Most staff, including cleaning and laundry staff had attended training on infection prevention and control. Hand hygiene practice by staff and compliance with infection control and prevention standards were audited by the person in charge as part of the centre's quality and safety monitoring system.

Judgment:
Non Compliant - Moderate

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

Theme:
Safe care and support

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

Findings:
Residents were protected by safe medication management practices in the centre. There was a written operational policy in place informing prescribing, storing and administration of medicines to residents. This policy was demonstrated in practice. Medication administration sheets were completed in line with professional guidance and legislative requirements. Medicines to be administered in a crushed format were individually prescribed. Since the last inspection procedures were put in place to ensure the maximum dose of PRN medicines (a medicine only taken as the need arises) permissible over a 24 hour period was indicated in each case.

A register of medicines that required strict control measures under misuse of drugs legislation was maintained in the centre. The medicines were carefully managed and held in secure storage as required. Appropriate recording and checking procedures were in place and the amount of medications held matched the balances recorded in a sample examined by the inspector. Medicines to be stored at room temperature were stored securely in a locked cupboard or in the locked medicine trolley which was secured at all times. Medicines requiring refrigeration were stored appropriately and the temperature

of the refrigerator was monitored and recorded. There was appropriate procedures in place for the handling and disposal of unused and out of date medicines.

The pharmacist dispensing residents' medicines was facilitated to meet their obligations to residents and was also involved in providing medicine updates for nurses in the centre. The pharmacist audited the medicines and was available to residents to discuss their medicines. An auditing system was also in place as part of the centre's quality and safety monitoring system. Procedures were in place for recording and managing medicine errors.

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 incidents and accidents to residents that occurred in the centre was maintained and were reviewed by the inspector. The person in charge was aware of the legal requirement to notify the Chief Inspector of specified accidents and incidents occurring in the centre. To date and to the knowledge of the inspector, all relevant incidents have been notified to the Chief Inspector by the provider and person in charge.

A quarterly notification report was forwarded to HIQA referencing details of required information up to the end of quarter 2, 2017

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:
The inspector found that residents' health care needs were met to a good standard on this inspection. Some improvements were required in pain assessment procedures and procedures to ensure recommendations by some allied health professionals were consistently recorded in residents' care plan interventions to ensure they are effectively implemented. There were 18 residents in the centre and one resident in hospital on the days of this inspection.

Residents had a good access to general practitioner (GP) services including an out of hours GP on-call service. Residents' healthcare records confirmed had timely access to medical care. Residents had access to allied health professional care. Dietetic, speech and language therapy, physiotherapy, occupational therapy, dental, chiropody and the services of an optician were available to residents as necessary. Residents with natural teeth were supported to access routine dental checkups. Residents also had access to specialist medical and nursing services including psychiatry of older age, palliative care and tissue viability nursing services. Residents were supported to attend outpatient appointments as necessary. There was evidence that residents' health and wellbeing was optimised with regular exercise as part of their activation programme, vital sign monitoring, blood profiling and an annual influenza vaccination programme. Residents who required regular monitoring of their blood to ensure serum levels of medicines were within therapeutic parameters were supported to attend external clinics as necessary.

Residents had a comprehensive nursing assessment completed within 48 hours of their admission to the centre. The assessment process involved the use of validated tools to determine each resident's risk of malnutrition, falls, their level of cognitive health and skin integrity among others. This information informed person-centred care plans to meet each resident's care needs. While recommendations made by allied health professionals were mostly documented in relevant care plans, dental hygiene needs as recommended by the dentist was not documented in one resident's oral care plan. Although one resident recently reviewed by the speech and language therapist was receiving the recommended diet, this information was not updated in their care plan. Care plans were reviewed on a three to four-monthly basis or more often to reflect residents' changing care needs. An action from the last inspection in November 2016 requiring improvement in the detail provided in daily progress notes to comprehensively inform care plan implementation was completed. The inspector found that the daily progress information examined described the care given to residents in sufficient detail. Residents spoken with during the inspection and feedback in residents' completed pre-inspection questionnaires confirmed their satisfaction with the level of care they received. Care plans in the sample reviewed were updated to reflect all safety measures put in place to safeguard residents at risk of falling. A pain assessment was completed for residents who experienced pain which informed their plan of care. Staff told the inspector they also assessed residents' pain levels prior to administering analgesia which

included interpretation of body language to identify if residents who was non-verbal were in pain. A pain assessment and monitoring tool was not used to measure and record the level of residents' pain on an on-going basis to determine if the analgesia administered was effective. This finding was an action required from the last inspection. There was evidence that staff consulted with residents or their relatives on their behalf as appropriate regarding care plan development and subsequent reviews. However, the detail of the information in records of care plan consultations required improvement.

There were no residents in the centre with pressure related skin injuries. There was evidence where residents admitted with wounds improved with the care given to them in the centre. All residents were assessed on admission and regularly thereafter for risk of developing pressure related skin injury. Arrangements were in place for care plan development to inform interventions to be completed to mitigate any risk identified. Pressure relieving mattresses were available and in use. Repositioning schedules were also in place for residents at risk and unable to independently change their position. The dietician reviewed the nutritional needs of residents to ensure their nutritional intake was optimised to promote their skin integrity. Wound management procedures in the centre for residents with chronic wounds were examined and found to reflect best practice procedures. A treatment plan was developed in each case and close monitoring of progress with healing was evident. Wound dressing requirements were described.

Judgment:
Non Compliant - Moderate

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

Theme:
Person-centred care and support

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

Findings:
Staff provided end of life care to residents with the support of their medical practitioner and the community palliative care services if required. Single rooms were available for residents' end-of-life care. Residents' relatives were accommodated to stay with them when they were unwell.

Since the last inspection in November 2016, practices had been reviewed to ensure each resident's wishes for their future care, including their end of life care was discussed with them where possible. Where residents required support from family members, these discussions were convened in their presence. One resident's end-of-life care wishes were being provided during the days of inspection. As this resident was unable to speak with the inspector, family members spoken with expressed their satisfaction with the

physical, psychological and spiritual care their relative was provided with in the centre. They confirmed that the care provided reflected the resident's wishes. They also commented positively on the support, flexibility and kindness of staff towards them.

Residents had access to clergy to meet their faith needs. There was a small oratory in the centre which was available to residents. An annual remembrance service was held in the centre.

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:
There were systems in place to ensure residents' nutritional needs were met, and that they did not experience dehydration. A policy was in place to guide staff on monitoring and recording of weights, nutritional intake and risk of malnutrition. Access to a dietician and speech and language therapist was available to residents on a referral basis. Residents' feedback on the catering service provided was sought at residents' committee meetings and in an annual satisfaction survey completed by them. Feedback in one pre-inspection questionnaire indicated there was opportunity for improvement in choice of menu and the minutes of the two most recent residents' committee meetings referenced suggestions for an alternative fish and potato menu. The chef confirmed to the inspector that these suggestions were used to inform a change in the menu. Residents spoken with on the day of inspection and feedback in pre-inspection questionnaires confirmed their satisfaction with the quality of the food and menu choices provided for them. The inspector found that residents were provided with food and drink at times and in quantities to meet their needs and wishes.

Residents were screened for nutritional risk on admission and were reviewed regularly thereafter to identify any unintentional weight loss or gain at an early stage. Residents' weights were closely monitored and checked routinely on a monthly basis or more frequently when indicated. Since the last inspection in November 2016, a weighing module that could be fitted to a hoist was provided to monitor weights of residents who were unable to sit on the chair scales. A Nutritional care plan in place for each resident that detailed their individual food preferences and needs. The daily menu was displayed on a white board in the dining room. Staff also reminded residents of the menu options

available at each mealtime. These combined actions supported residents to make an informed choice regarding the food they ate. Snacks and refreshments were provided throughout the day and were available at night if residents wanted them. The inspector observed that residents with special dietary and fluid consistency requirements recommended by the dietician and speech and language therapist received the diets and thickened fluids as recommended to meet their needs.

There were sufficient numbers of staff available to support residents at mealtimes. Staff sat with residents and provided them with encouragement and discreet assistance with their meals as necessary. Residents' dietary and fluid intake was monitored by staff in the dining room to ensure all residents including residents who did not require assistance were eating and drinking sufficient amounts to meet their needs. Residents had a choice of hot meal for their lunch and tea each day. Food was served and presented in an appetizing way and the meal courses were paced to allow residents sufficient time to complete each course on this inspection. Extra portions or alternatives to the menu choices were available to residents as they wished. The chef prepared sausages for one resident who requested them as an alternative to the menu available.

Judgment:
Compliant

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

Theme:
Person-centred care and support

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

Findings:
Residents were consulted and involved in organization and planning in the centre. Examples of this were observed in weekly bus outings and vegetable and flower planting in the garden. Raised flower and vegetable beds were in place along garden pathways to support residents with accessing them. Plans were underway for harvesting of peas grown by interested residents. There was evidence that feedback was sought and welcomed from residents on an ongoing basis. Findings from review of the residents' forum meeting minutes indicated that issues raised by residents were actioned. The person in charge was involved in the day-to-day care of residents and met with them on a daily basis. An annual survey circulated to residents and their relatives indicated a high level of satisfaction and areas identified for improvement were actioned. Some residents

had personal mobile phones and Wifi was also available to support them with keeping in contact with their family and friends. The centre had a bus and residents had regular trips to venues that were decided by them.

Improvements had been made since the last inspection in November 2016 to ensure that the activities available to meet residents' capabilities and interests were not dictated by the centre's routine and resources. Many residents were observed chatting with each other and staff during mealtimes. Meal courses were paced to give residents time and opportunity to eat and enjoy them. Three residents remained in the dining after the lunchtime meal was finished to enjoy a cup of tea and biscuits together.

There was a good variety of interesting and meaningful activities available to suit residents' varying capabilities. Each resident's activation needs were assessed. The assessment process included a review of residents' likes, dislikes and previous interests and hobbies. Residents' activities were coordinated each day and many residents participated in and enjoyed the group based activities. Some residents were facilitated to engage in interests they liked to pursue alone. For example, one resident liked to sweep up the leaves in the garden and another resident liked to care for a number of rose shrubs. A facility located at the back of the centre called 'Teach Brid' was used for small groups of residents to engage in arts and crafts, baking and other activities two days each week. Access to this facility was external to the centre and facilitated residents with a change of environment which they enjoyed. However, the inspector's findings indicated that further work was necessary to ensure the needs of a small number of residents who were unable to participate in meaningful activities due to their medical diagnosis were met. For example, some residents who remained in their bedrooms had only one session of a one-to-one activity each day and some other residents with poor concentration or restlessness due to their diagnosis did not have a specific activity programme developed to meet their needs for meaningful activation. For example, one resident was assessed as needing day service based activation was not sufficiently supported with placement in a suitable service. The detail of records used to provide the team with assurances that the activities provided and participated in by residents met their individual interests and capabilities required improvement. Records examined by the inspector recorded residents' level of engagement in one activity each day which was not accurate for some residents who were observed to participate in more than one activity on each day of the inspection. The records also did not detail the activity each resident engaged in.

Staff worked to ensure that each resident received care in a way that respected their individual preferences, privacy and dignity. Staff were observed knocking on bedroom and bathroom doors. Adequate bed screening was available in twin bedrooms. Bedroom, toilet and bathroom doors were closed during personal care activities. All interaction by staff with residents were observed to be respectful manner, supportive and kind. Staff and residents knew each other well and residents spoken with by the inspector expressed their high satisfaction with the care and service they received from the provider and staff team.

An independent advocacy service was available to assist residents and their contact details were display in the reception area. There were no residents using this service on the days of inspection. However, there was an absence of evidence that some residents

who could benefit from this independent support were supported to avail of it. Residents were facilitated to exercise their civil, political and religious rights and residents confirmed in pre-inspection questionnaires that their rights were upheld.

There was an open visiting policy and family were encouraged to be involved in aspects of residents' lives. There were a number of quieter communal sitting rooms and a seated area to the side of the dining area in the conservatory where residents could meet their visitors in private if they wished. The inspector observed that some residents availed of these quieter areas for rest and relaxation at times during the inspection.

Judgment:
Non Compliant - Moderate

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:
The number and skill-mix of staff was appropriate to meet the assessed needs of residents. There was evidence that the allocation and responsibilities of staff had been revised to ensure residents' were appropriately supervised and supported to engage in activities to meet their needs. Two staff were responsible for coordinating residents' activities and healthcare assistant staff were observed to support them with facilitating arranged group and one-to-one activities. There was a planned staff roster in place, with any changes clearly indicated. The staffing in place on the days of inspection was reflected in this roster.

Staffing levels were based on residents' dependencies determined by use of a validated assessment tool. Residents, relatives and staff agreed that there were adequate staff on duty during the day and at night. Recruitment procedures in place met regulatory requirements, and included completed An Garda Siochana vetting. Three volunteers regularly visited residents in the centre. Garda clearance was sought for these volunteers and they had signed an agreement which outlined the their roles and responsibilities. An induction programme was available to support new staff to the centre in their roles with caring for residents. All nursing staff had up-to-date registration with An Bord Altranais agus Cnáimhseachais na HÉireann Staff were

supervised appropriate to their role and the person in charge completed annual staff performance appraisals.

There was an effective system to ensure that all staff attended mandatory training and refresher training. Staff spoken with on the days of inspection and the centre's training records confirmed that staff had attended up-to-date mandatory training. Training in safe moving and handling procedures was scheduled for a small number of staff in the weeks following the inspection. Staff were facilitated to attend training to maintain their skills and competencies and to support them with caring for residents with diverse care needs in the centre. Since the last inspection, the person in charge had placed increased emphasis on a person-centred approach to care of residents by staff. This was evident on the days of inspection in staff interactions with residents and in the documentation informing their care needs.

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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Regulation Directorate
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Regulation Directorate

Action Plan

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

Provider's response to inspection report[1]

Centre name:	Hillview Private Nursing & Retirement Residence
Centre ID:	OSV-0000141
Date of inspection:	28/08/2017
Date of response:	22/09/2017

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:
All required documentation as prescribed under Regulation 4 of the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 was not submitted to the Health Information and Quality Authority for application to renew registration of the centre.

1. Action Required:

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

Under Regulation 4 of the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 you are required to: Provide all documentation prescribed under Regulation 4 of the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015.

Please state the actions you have taken or are planning to take:
I fully appreciate and understand the seriousness of this major noncompliance. I am currently pursuing the completion of this documentation and Garda Siochana Vetting to comply with requirements for renewal of registration. I am prioritized this a matter of great urgency.

Proposed Timescale: I am relentless in pursuit of this outstanding documentation and would expect to be in a position very shortly to conclusion and compliance.

Proposed Timescale:

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:
While centre-specific internal and external hazards, including hazards found on the last inspection in November 2016 were satisfactorily mitigated, these and other areas of hazard and the concomitant controls implemented were not recorded in the risk management documentation.

2. Action Required:
Under Regulation 26(1)(a) you are required to: Ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.

Please state the actions you have taken or are planning to take:
Hazards found on the last inspection and satisfactorily mitigated will be added to the current risk management documentation.
Any areas of risk identified following assessment will be managed accordingly and recorded in the risk management documentation.

Proposed Timescale: 30/09/17 & ONGOING

Proposed Timescale: 30/09/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The inspector found that the centre's fire alarm, emergency lighting, directional signage and function of fire exit doors were checked and serviced by an external contractor on a quarterly basis but local weekly checking procedures for this fire safety equipment were

not in place.

3. Action Required:
Under Regulation 28(1)(c)(iii) you are required to: Make adequate arrangements for testing fire equipment.

Please state the actions you have taken or are planning to take:
As of day of inspection, in addition to quarterly checks and servicing, weekly checks of our fire alarm, emergency lighting, directional signage and function of the fire exit doors are undertaken and documented in the fire safety documentation with any adverse findings attended to immediately.

Proposed Timescale: 22/09/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Fire evacuation drills were completed and while they reflected testing of day time resources and conditions to ensure residents could be safely evacuated in an emergency, a simulated night-time scenario had not been completed.

4. Action Required:
Under Regulation 28(1)(c)(ii) you are required to: Make adequate arrangements for reviewing fire precautions.

Please state the actions you have taken or are planning to take:
A simulated night - time scenario fire drill has been completed (11/09/17) and findings documented in fire safety documentation showing a satisfactory outcome. Night-time scenario fire drills will be repeated at 6 monthly intervals or earlier if necessary.

Proposed Timescale: 22/09/2017

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:
While recommendations made by allied health professionals were mostly documented in relevant care plans, dental hygiene needs as identified by the dentist was not documented in one resident's oral care plan. Although one resident recently reviewed by the speech and language therapist was receiving the recommended diet, this information was not updated in their care plan.

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:
• This resident's care plan has been updated to reflect the dental hygiene needs of the resident, as identified by the visiting dentist, and actioned accordingly.
• This resident's care plan has now been updated to include the actioned recommendations as made by the speech and language therapist.

Proposed Timescale: 22/09/2017

Theme:
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The records of care plan consultations with residents or their relatives lacked sufficient detail.

6. 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:
A review of the recording of consultations that currently take place, with residents and / or their relatives in regards to care planning will be undertaken, to improve the detail of information gathered during consultation.

Proposed Timescale: 31/10/2017

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A pain assessment and monitoring tool was not used to measure and record the level of residents' pain on an on-going basis to determine if the analgesia administered was effective.

7. 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:
The Pain assessment and monitoring tool in use will be incorporated into the residents individual care plan/medication documentation to ensure effective use and and allow for effective review of the effect of the analgesia given.

Proposed Timescale: 31/10/2017

Outcome 16: Residents' Rights, Dignity and Consultation

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some residents who remained in their bedrooms were supported with a single one-to-one activity each day and other residents with poor concentration or restlessness did not have a specific activity programme developed to meet their social and emotional needs.

The records used to provide the team with assurances that the activities provided and participated in by residents met their individual interests and capabilities lacked sufficient detail.

8. 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:
While there is a comprehensive activity programme in place to meet the needs of all residents, the documentation and recording of same is to be reviewed to accurately reflect the programme in place and its effectiveness for all residents.

Proposed Timescale: 31/12/2017

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 evidence that some residents who could benefit from independent advocacy support were supported to avail of it.

9. Action Required:
Under Regulation 09(3)(f) you are required to: Ensure that each resident has access to independent advocacy services.

Please state the actions you have taken or are planning to take:
Advocacy details and how to avail of same are given to all residents on admission to our home, and are on display on the information board, however, nursing documentation

will be reviewed to provide evidence of this and those residents who wish to avail of advocacy support will be supported to do so.
Proposed Timescale: 31/10/2017