

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Boyne Valley Nursing Home
Centre ID:	OSV-0000119
Centre address:	Dowth, Drogheda, Meath.
Telephone number:	041 983 6130
Email address:	niamhbvnh@eircom.net
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Nemeco Limited
Provider Nominee:	Niamh Darcy
Lead inspector:	Catherine Rose Connolly Gargan
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	18
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

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

The inspection took place over the following dates and times

From:	To:
28 July 2014 10:00	28 July 2014 17:00
29 July 2014 09:00	29 July 2014 17:00

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

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

Summary of findings from this inspection

This was the seventh inspection and was an eighteen outcome, announced inspection of the centre by the Health Information and Quality Authority (the Authority) in response to an application by the provider to the (the Authority) to renew registration of this centre. The inspector also completed a follow-up on progress with completion of the action plan from the last inspection of the centre in March 2014. The current registration of this centre is due to expire on 11 November 2014. In order to apply for renewal of registration the provider must submit required documentation to the Authority. Prior to the inspection the inspector reviewed written evidence, from a suitably qualified person confirming the building meets all the statutory requirements of the Fire and Planning Authority, with regard to the use

of the building as a residential centre for older people. Following improvements to address requirements to meet statutory fire safety non compliance, a revised copy of this required declaration was forwarded to the Authority. All other documents submitted by the provider as required, for the purposes of renewal of registration were reviewed prior to the inspection.

Three residents and two relatives completed pre-inspection questionnaires. The Inspector found that residents and relatives were positive in their feedback to the Authority and expressed satisfaction about the facilities, services and care provided. Residents who could verbalise their views were also complimentary about their day to day life experiences, the meals provided and the staff team caring for them in the centre on the days of inspection.

The inspector found that the person in charge who was also the provider for the centre demonstrated good leadership and was committed to providing a quality service for residents. All members of the team were clear about their areas of responsibility and reporting structures and the management structure allowed for sufficient monitoring of, and accountability for, practice. The provider/person in charge's knowledge of the regulations, standards and statutory responsibilities was sufficiently demonstrated to the inspector. The fitness of the provider/person in charge was determined by interview during the previous registration inspection and ongoing regulatory work, including subsequent inspections of the centre and level of compliance with actions arising from inspections. The clinical nurse manager and general manager also assisted with this renewal of registration inspection.

As part of the inspection process, inspectors met with residents and staff members, observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files. While systems were in place and had been improved following actions taken by the provider/person in charge since the last inspection of the centre in March 2014 to ensure a safe environment was provided to residents, the risk management policy document required further improvement to inform best practice in this area. There were policies, procedures, systems and practices in place to assess, monitor and analyze potential risks with control measures in place to mitigate risk. Fire safety procedures and preventative management was satisfactory following extensive work undertaken in this area since the last inspection in March this year.

Other areas requiring improvement included provision of recreational/social care of residents who remained in their rooms and residents access to speech and language therapy health professional assessment. Reformatting of policies and procedures to ensure no errors were made in reading hand written amendments. Some maintenance of residents' furniture and assessment of the suitability of hospital style beds in meeting the long-term needs of residents also required review.

Overall, the centre was found to be in substantial compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). The action plan at the end of this report identifies areas where improvements are required to comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013

(as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.

Section 41(1)(c) of the Health Act 2007. 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.

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 revised in May 2014 and consisted of a statement of the aims, objectives and ethos of the centre, detailed the facilities and services provided for residents and contained information in relation to the matters listed in schedule 1 of the Regulations. A copy of the statement of purpose was made available to the inspector. The provider was aware of the need to keep the document under review and notify the Chief Inspector in writing before changes could be made which would affect the purpose and function of 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):

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

Findings:

The inspector found that there was a clearly defined management structure that identifies the lines of authority and accountability in the centre. The provider, Niamh Darcy, was also in the role of person in charge of the centre. There were adequate resources in terms of staffing, equipment and facilities to ensure the effective delivery of

care as described in the statement of purpose document.

There was a comprehensive system in place for monitoring the quality and safety of care and the quality of life for residents. The inspector reviewed a broad schedule for auditing care documentation, clinical care, safety, staff training needs, maintenance of equipment and quality of life in the centre for residents. There was evidence of analysis of the information collated by audits with concomitant improvements. For example, residents are asked to make their choice of dish at teatime within an hour of serving as many resident with memory issues could look forward to their meal, The chef prepared a wide range of dishes to meet all residents favourite dishes including French toast, varied sandwiches, bananas on brown bread, home-made fish cakes and salad among others as observed by the inspector. There was evidence of consultation with residents and their representatives. For example residents were asked to make a decision regarding the felling of trees growing on the perimeter of the site, their choice favoured their removal which was respected and completed.

While, the inspector found that while there was good analysis of findings and action plan development for quality improvement, timescales for completion were not identified and as such did not facilitate planning for re-audits to monitor improvements implemented or evaluation of risk arising from incomplete actions. The provider was in the process of preparing a report on the quality and safety of care and quality of life in the centre for residents as required by regulation 23, which the provider is preparing in consultation with feedback from residents. This area was the subject of action plan developed from findings from the last inspection of the centre in March 2014 and were found to not be fully completed on this registration inspection, therefore are repeated in the action plan developed for this report.

Judgment:

Non Compliant - Moderate

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:

A copy of the residents guide was reviewed by the inspector. It was reviewed in May 2014. While the document referenced the requirements of Regulation 20 of the legislation, admission procedure did not adequately describe opportunity for sharing information with residents at the pre-admission assessment or the arrangements in place for respite admissions and visiting arrangements did not reference the availability

of an area where residents could meet their visitors in private other than bedrooms. The centre has two respite beds which cater for one or two week respite stays.

Samples of four contracts of care were reviewed by the inspector and were found to meet the requirements of the legislation. All contracts reviewed were signed and dated, contained the terms and conditions including breakdown of fees to inform residents of their personal contribution. The provider charged €25.00 for provision of social and recreational activities, newspapers and supply of toiletries.

Judgment:

Non Compliant - Minor

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:

Ms Niamh Darcy is the provider and is also the person in charge of the centre. She works full-time and is on-duty from Monday to Friday each week. She had completed mandatory training requirements and additional training in person centred assessment and care planning, continence promotion and falls management since the last registration inspection. She is also the accredited trainer for protection of vulnerable residents. There was good evidence that she was involved in the administration, governance and operational management of the centre. She is supported in her role by a general manager, clinical nurse manager, staff nurses, carers and ancillary staff.

Deputising arrangements and on call out of hours arrangements were in place. A clinical nurse manager deputises for the person in charge. She is also a registered general nurse with the required experience in older person nursing and was working in the centre on the second day of the inspection.

The person in charge demonstrated good clinical knowledge. She was knowledgeable regarding the Regulations, the Authority's Standards and her statutory responsibilities, both as the person in charge and as the provider. She had kept her professional knowledge updated by attendance at various courses and study days. She demonstrated that she had an in-depth knowledge of the residents and their individual needs. Residents said that they knew her well and referred to her as the person they would go to if they had a complaint. Relatives' questionnaires returned directly to the Authority supported satisfaction with her communication activities with families of residents in addition to care and support of residents residing in the centre.

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:

Care plan documentation was recorded on a computerised documentation management system. The inspector found that nurses' progress notes were not consistently linked to the care plans and required improvement to include comment on the psychosocial well-being of residents in some cases during the inspection in March 2014 and this finding was the subject of an action plan. Findings on this inspection confirmed that resident documentation had been reviewed to include care plan development to meet residents' needs. Progress notes reviewed on this inspection were informative and complete.

A record of all visitors to the centre was maintained and was including in the centre's statement of purpose as a required record which the provider/person in charge would maintain. All required resident records reviewed were complete including each resident's medical, nursing and where appropriate psychiatric condition on admission. In addition a record of residents' medication and administration was in place. Allied health professional referral and GP records were in place with the exception of speech and language therapy professional assessment as discussed under outcome 11.

Relevant documentation evidenced that the centre was adequately insured to protect the interest of residents. The policies and procedures required by schedule 5 of the Regulations were in place. However some required review to add additional advisory information to inform practice as outlined throughout this report. Many policy documents had been amended by hand and required reformatting to avoid risk of misreading information presented.

Judgment:

Non Compliant - Minor

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:

There were deputising arrangements in place in the event of the provider/person in charge was absent from the centre. The clinical nurse manager was the designated deputy for the person in charge in her absence. An absence has not occurred in the centre to date.

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 systems in place to protect residents from being harmed or suffering abuse. The policy advising staff on elder abuse management, was the subject of an action plan developed from findings during inspection in March 2014 as it was due for review, did not reference referral details for the elder abuse officer and did not adequately advise on the care on the immediate or short-term care of residents following an incident of abuse alleged or otherwise. The inspector found that the policy document on management of elder abuse has been updated to include the referral details of the elder abuse officer and to advise on the care of residents following any incidents of suspected or actual abuse. All staff had signed to confirm they have read the updated version of this policy. The inspector reviewed the investigation of an incident of alleged abusive behaviour by a staff member which was appropriate and demonstrated measures were in place to safeguard residents during this process. A copy of the report was requested by the Authority on completion of this investigation. A whistle-blow policy was available

to protect disclosure.

A restraint policy was in place and was reviewed in June 2014. The inspector found that practice reflected the contents of this policy. Bed-rails were in use for seven residents in response to their request for same. A robust bed-rail disengaging schedule was in place that was fully completed and was noted to be one aspect of bed-rail use that was subject to audit. In addition, residents using bed-rails has a risk assessments and remedial actions were completed to ensure injury was not suffered by the residents concerned.

Staff spoken with by the inspector was knowledgeable in protecting residents from abuse, recognising abuse and the procedures to follow in reporting disclosures. Training records reviewed by the inspector confirmed that elder abuse recognition and management training facilitated by the provider/person in charge who is an accredited trainer was attended by all staff working in the centre. This training was the subject of an action plan developed from findings during the inspection in March 2014 which was found to be completed.

Residents told inspectors that they felt safe in the centre and that staff were responsive and gentle in their approach to meeting their needs. Pre-inspection questionnaires completed by residents also confirmed this. The provider/person in charge told the inspector that she convened and led regular discussion forums with staff on protection of residents including the centre's procedures for managing elder abuse which assured her that staff were informed and knowledgeable in this area. Access by the public to the centre was controlled by staff and was recorded in the visitors' book on each occasion.

The provider was an agent for three residents' pensions. The residents concerned had named accounts within the centre's business account which was not in line with recommended best practice. However, the transactions were transparent and were supported by invoices and signed receipts and were subject to independent audit. There was evidence that other options had been explored. Consent was sought and explicit and evidenced those residents and/or their relatives were satisfied with this arrangement.

The provider/person in charge told the inspector that the centre did not maintain any residents' expense accounts in safekeeping on their behalf and residents were each provided with a lockable press in their rooms for which they had custody of the key.

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 during the last inspection of the centre in March 2014 under this outcome constituted major non-compliance in relation to risk management policy documentation, fire safety and identification of risks with controls in place to mitigate these risks. The inspector observed significant improvement in all these areas on this inspection.

Risk Management Policy.

On the inspection in March 2014 the inspector found that the risk management policy did not meet the requirements of Regulation 31 in relation to arrangements for identification, recording, investigation and learning from serious incidents or adverse events involving residents. This finding was the subject of an action plan forwarded to the provider/person in charge following inspection due for completion by 31 July 2014. However, the policy remained incomplete on this registration inspection, a revised copy forwarded on the 05 August 2014 to the Authority while amended did not adequately describe the procedure to be followed in the event of an incident occurring in the centre, for example, a resident fall. Sub-policies of the risk management policy advising on managing residents absent without leave, accidental injury to residents or staff and challenging behaviour were in place and also advised on the management of aggression and violence, assault and resident self harm.

The centre was secure and residents who were at risk of leaving the centre unaccompanied were identified and adequately supervised. A missing person policy informed practice in this area. The provider/person in charge was in the process of formatting resident profiles for use in assisting the emergency services to expedite a vulnerable resident's timely location in the event of them leaving the centre unaccompanied. There were no residents identified at risk on the days of inspection. A plan advising staff on how to manage emergencies was in place however, did not reference a predetermined place of safe refuge and arrangements for safe transportation of residents there in the event of residents requiring evacuation from the centre.

Fire Safety.

Fire safety arrangements were not adequate at inspection of the centre in March 2014. There was evidence that the provider/person in charge had undertaken a comprehensive programme of work which was nearing completion with the assistance of the local fire authority and a fire safety consultant. The Inspector observed that final fire exit doors were push bar and secured by means of an electromagnetic locking system which the inspector was told is linked into the centre's fire alarm system. All final fire exits were free of obstruction. Extensive structural works were completed to make external footpaths that formed part of the fire exit route accessible. There were arrangements in place including checking procedures to protect residents from the risk of fire and were recorded as required. Some residents with reduced mobility had fire evacuation sheets fitted on their beds and individual evacuation risk assessments were documented for each resident to reference equipment and numbers of staff for evacuation if necessary. These assessments had been tested recently with a night-time

fire drill and a day-time drill was scheduled. The commentary record included location of the simulated fire and the evacuation time and staff response.

Staff spoken with could describe the precautions in place to protect residents against the risk of fire, including the provision of suitable fire equipment, use of equipment and where it is located. Directional signage was in place internally to direct residents to the nearest final fire exit and externally to the designated fire assembly point in front of the centre if evacuation of the centre was required. Warning signage displayed alerted the fact that steps were in place on exiting one final fire exit door. A fabric curtain fitted over a final fire exit door on the inspection in March 2014 was removed and a toilet door which opened into the corridor blocking the fire exit door was revised. There were training records of fire training attendance by all staff and participation in fire drills which were reviewed with staff by the provider/person in charge to reinforce annual training.

On the March 2014 inspection, the inspector observed a number of areas in the centre that were not assessed or documented to mitigate risk to residents which findings on this registration inspection evidenced had been reviewed with adequate controls in place. An alcove in an area of corridor from the central lobby area to the dining room was upgraded with handrails fitted. The area was utilised to safely store wheelchairs. Hoists were relocated to a segregated area of the lobby. The enclosed area to the front of the centre was opened up with increased safe car parking. Surface and perimeter construction work was in progress on the days of inspection. Traffic calming measures were in place with appropriate warning signage displayed. A new ramp with handrails in place on both sides was newly constructed facilitating safe access from the higher patio area to the front of the centre. Risk assessments and controls referenced each of these areas of risk to residents in addition to roped-off access to stairs to the first floor and to staff changing accommodation. An annually reviewed safety statement was in place. Equipment used by residents was serviced annually. Hoists were last serviced on 14 July 2014 to mitigate any risk of injury to residents from same.

There was a record maintained of all accidents and incidents and was reviewed by the inspector and found to reference five incidents for this year to date. These records were noted to outline factual and substantiated information on the event and the actions taken by staff in response to ensure the well-being of residents who fell including completion of neurological observations where falls were not witnessed to promptly identify changes in the residents' condition requiring intervention. Medical review was appropriately sought and completed in each case. There was also evidence of assessment by a physiotherapist and revision of residents' care plans and risk assessments post falls.

Moving and handling practice observed by the inspector during the inspection was safe and training records confirmed that all staff had attended same. Catering staff had completed training in food hygiene.

There were measures in place to control the spread of infection. These included provision of supplies for personal protective equipment, training for staff in infection control and the availability of policies and procedures relating to infection control. Hand hygiene procedures were carried out appropriately by staff and hand hygiene procedure advisory signage was displayed by sinks. Additional measures in place to control and

prevent infection, included arrangements for the segregation and disposal of waste, which had been revised since the inspection in March 2014 in response to an action plan required in relation to provision of approved non-clinical waste bins. There were no residents with potentially communicable infections residing in the centre on the days of inspection. The infection control policy in place did not advise on the procedures and arrangements to be followed in the event of an outbreak of infection such as influenza.

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:

Medication management policies and procedures were reviewed by the Authority as part of this inspection. Review of this document was the subject of an action plan from inspection in March 2014 which was completed in March 2014. While medication disposal was referenced, it lacked sufficient detail to fully inform this process in practice. There were no medications observed that required disposal on the day of inspection. The provider/person in charge described the procedure in place which was adequate. Prescribing, administration and recording practices and procedures were also reviewed and found to be compliant following revision in response to an action plan developed from findings during the last inspection. Documented pain assessments were completed with care plan development if a resident is receiving pain relief or end of life care using an accredited pain assessment tool to assess and monitor level of pain and effect of pain relief administered. All prescriptions had the resident's photograph attached to mitigate risk of administration error. All medication prescriptions in the sample reviewed were individually signed by a GP. Discontinued medications were signed and dated by a GP as required. Statement of maximum medication dosage that can be administered over a 24 hour period in relation to 'as required' (PRN) medications and 'crush' medication prescriptions met requirements. A list of medications that should not be administered together in crushed format and medications that were not suitable for crushing was secured to the medication trolley for ease of reference by staff administering medications. Residents who had difficulty swallowing oral tablets were provided with liquid preparations of the relevant medications where available. Allergy status was recorded on each resident's medication record. There was inadequate space on medication administration records to record relevant comments other than a letter which was linked to variant resident outcomes constituting non-administration of prescribed medications.

Transcription of residents' medication prescriptions was undertaken by the person in charge and nursing staff in the centre. These were signed by transcribers, a checking nurse and the residents GPs. Controlled medications were secured in a locked press within a locked press. Controlled medications were dispensed on a named resident basis only in line with the legislation governing controlled medication management in private nursing homes. A controlled drug register was maintained and complete. Prescription levels stored were checked twice every 24 hours by two registered nurses to ensure balances were accurately accounted for. Many of the staff nurses in the centre had completed medication management training.

The pharmacist supplying medication to the centre completes a medication audit every three months which includes content of prescriptions and alerts staff to areas of same requiring review in addition to assessing stock levels held in the centre. The staff in the centre audits the contents of blister packs, discrepancies are recorded and informed to the pharmacist. A medication audit is completed twice yearly, last completed in May 2014 by the provider/person in charge.

The inspector was told by the provider/person in charge and also observed that some residents were generally familiar with their pharmacist. The inspector was also told that the pharmacist surveyed residents and accepted consent documentation to assure him that he and his service was acceptable to residents. The provider/person in charge told the inspector that the pharmacist was arranging tutorials to strengthen resident accessibility to his service in line with the legislation.

Judgment:

Non Compliant - Minor

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:

The provider/person in charge was aware of the legal requirement to notify the Chief Inspector regarding incidents and accidents. To date all relevant notifications had been submitted to the Chief Inspector as required.

Records were maintained of all accidents and incidents. There was regular monitoring of incidents and these were reviewed by nursing staff and the person in charge to prevent further episodes particularly in relation to resident falls.

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 were eighteen residents accommodated in the centre on the days of this inspection two of which were admitted for respite care. Residents residing in the centre on a long-term care basis had varying assessed dependency levels and underlying medical conditions including a small number with mild dementia or cognitive disability care needs. On the day of inspection, seven (44%) of the resident group were assessed as having maximum care needs, one resident had assessed high care needs and 8 (50%) had assessed medium and low needs. Assessment records, care plans and daily progress notes were maintained for each resident on a computerised document management system.

During the last inspection in March 2014, the inspector found that the standard of care planning required improvement to ensure all residents care needs had an associated care plan in place. Findings from this registration renewal inspection evidenced that each resident had an activities of living care plan that informed their basic care needs. Additional care plans were developed to inform care for specific needs of individual residents such as care of wounds, pain management and end of life care needs. Assessment tools were utilised to risk assess each resident's vulnerability to falls, pressure related skin breakdown, nutritional needs among others. During the inspection in March 2014, progress notes were not consistently linked to care plans and required improvement. Findings on this registration inspection also evidenced improvement in this documentation on this inspection. Information gained from on-going input of information in relation to each resident using touch screen units enhanced the quality of progress documentation.

Residents had access to a GP of their choice and to allied health professionals as required and referrals with follow-up consultations were evidenced for physiotherapy, occupational therapy, optical and dental care. However, some residents received modified consistency diets which was a control to mitigate risk posed by compromised swallowing reflexes did not have access to a speech and language therapy assessment. An incident had occurred where a resident in receipt of respite care required first aid in

response to respiratory obstruction related to food intake. The person in charge completed a referral to ensure follow-up was initiated for a swallowing assessment to be completed in the community on discharge.

Three monthly reviews of care plans were found to be in consultation with residents and/or their relatives and included a narrative on any changes made as a result.

One resident continued her day programme following admission from the disability services. The inspector observed that this resident left the centre each day to participate in an occupational programme. In addition she had a busy social/recreational schedule activity outside the centre and also participated in the activities on offer on her return each afternoon which she told the inspector she thoroughly enjoyed. Other residents in the centre availed of a social programme developed designed to suit their collective capabilities and interests. The provider/person in charge told the inspector that work was in progress with completing life histories for residents which will be used to ensure the programme on offer meets all residents' interests. The social care programme currently in place was organised by the general manager and facilitated by the care staff team. The inspector observed a skittles game in progress which was well attended by residents and those spoken with told the inspector that they enjoyed skittles. Two residents remained in their bedrooms on the days of inspection Although staff were attentive to these residents, some work is required to ensure they each have a tailored programme to meet their individual recreational needs. This finding is discussed further under outcome 16 of this report. All residents paid money in addition to their residential fee for activities, a newspaper and supply of toiletries. Therefore all residents who cannot attend scheduled communal activities should be provided with a meaningful tailored programme to ensure their occupational and recreational needs are met following assessment. The inspector spoke with two of three residents who remained in their bedrooms throughout the inspection. Clergy from differing faiths visited the centre and could be contacted as required by residents or by the staff. Religious services were scheduled on a monthly basis.

The inspectors found that staff knew residents well and had a comprehensive knowledge of their care needs. Residents told the inspector in one to one conversations with them during the inspection that they valued the staff who cared for them and described areas of individual care activities that meant a lot to them including being able to have food that they liked, able to get up when they liked in the mornings and having assistance when they needed it. Residents said that when they were up and about they could move freely around the centre including going outdoors.

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):

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

Findings:

The centre is a storey and a half in design. The residents' accommodation is located on the ground floor only. For the most part the location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs. Residents' accommodation consists of fourteen single bedrooms of which one single bedroom has en-suite toilet and sink facilities, and two twin bedrooms, without en-suite facilities. All bedrooms without en-suite facilities have sinks fitted. Each bed space had a call bell fitted so residents can alert staff if necessary. There were adequate communal toilets and bathroom and shower facilities to meet the needs of residents and in line with the National Standards guidelines. Lack of assistive grab rails in communal toileting and bathing facilities was the subject of an action plan developed from findings during the last inspection in March 2014 had been addressed as required.

The centre has a comfortable ambience and there was a variety of places where residents could sit and spend time during the day. There was adequate communal space for the number of residents accommodated. Furnishings in some bedrooms required attention in relation to surface painting. Surface paint was chipped and/or missing on some furniture surfaces. Most residents slept on hospital style beds. While some of these beds had been replaced, there was no record to evidence assessment of the suitability of long-term use of this bed type which is primarily designed for short-term use. The walls in one of the two twin bedrooms required re-painting. Residents had access to space to see visitors in private or to could spend quiet time there. Storage for residents' equipment required review; commodes were stored in bedrooms which may impact on the privacy and dignity of residents especially in twin rooms.

The centre premises has adequate dining and sitting accommodation, sluicing facilities and a laundry. During this inspection the premises were noted to be clean, well maintained and there were measures in place to control and prevent infection which staff described for the inspector. Staff were noted to take appropriate infection control precautions that included the use of personal protective clothing while attending to residents' care needs and adhering to hand hygiene precautions displayed in the centre. Hand-washing/sanitising facilities were strategically placed throughout the centre and readily accessible for staff and visitors.

A cleaners' room with a sink and secure storage was located off the sluice area. There was hand hygiene gel dispenser units fitted at convenient intervals with advisory hand hygiene procedure instructions displayed. Inappropriate waste bins were the subject of the last inspection of the centre in March 2014 had been replaced in line with waste management guidelines. A supply of personal protective equipment was available for staff use.

An external garden space surrounding the centre to the front and side was available to residents; one resident told the inspector that she enjoyed walking around the newly installed accessible pathways. An external raised patio area with seating to the front of the centre and accessible from the sitting room was also available to residents who wished to sit outside.

There were records to show that assistive equipment such as hoists, baths and pressure relieving mattresses had been serviced regularly through a contract arrangement.

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):

No actions were required from the previous inspection.

Findings:

Residents told the inspector that they felt they could make a complaint if they wished and felt they would be listened to. Residents spoken with said they would make a complaint to the provider/person in charge or a member of staff. The complaints procedure was displayed and was included in the residents' guide and statement of purpose documents.

There was one active complaint that was in the process of investigation by the provider/person in charge. A narrative of the complaint was documented and timescales were stated. There was evidence that the resident concerned was kept up to date on the progress of the investigation.

However the documented complaints procedure, reviewed in April 2014, did not meet some of the requirements of Regulation 34 of the legislation as required. The designated complaints officer for the centre was not named and reference to the person required under regulation 34(3) was missing.

Judgment:

Non Compliant - Minor

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.

<p>Theme: Person-centred care and support</p>
<p>Outstanding requirement(s) from previous inspection(s): No actions were required from the previous inspection.</p> <p>Findings: The inspector found that residents end of life wishes were adequately met. Two residents were in receipt of end of life care on the days of inspection. A policy document informing best practice was available and was reviewed on 22 April 2014. However the document did not inform the procedures to be respected for the period up to and after death for residents of differing faiths.</p> <p>Facilities were available for family of residents in receipt of end of life care to stay with them overnight with availability of refreshments and pertinent information. Religious clergy attended the centre regularly and on request.</p> <p>Both residents had pain management arrangements in place. Their pain was assessed and monitored using an accredited tool which was also suitable for non-verbal assessment should the time come when illness had a negative impact on their verbal communication skills. Residents had access to palliative care services on referral by the resident's GP. Members of staff had training in management of syringe driver medication administration pumps, pain assessment and end of life care.</p>
<p>Judgment: Non Compliant - Minor</p>

<p>Outcome 15: Food and Nutrition <i>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.</i></p>
<p>Theme: Person-centred care and support</p>
<p>Outstanding requirement(s) from previous inspection(s): No actions were required from the previous inspection.</p> <p>Findings: Residents received a nutritious and varied diet that offered choice and overall mealtimes were social occasions that provided opportunities for residents to interact with each other. Adequate staff were available to assist residents in the dining room if required. The inspector saw that residents had a wide choice of dish for their evening meal. The inspector was told that a wide choice of dish was made available in the evening time as on review, some residents appetites were reduced in this time following their lunchtime meal. This initiative was implemented to stimulate appetites and also to ensure that all</p>

residents were provided with a choice that met their nutritional needs.

The menus reflected an emphasis on home cooking and residents told the inspector they were happy with the food they received, their mealtime experience and the choice afforded to them. Many residents told the inspectors that they could come to the dining room or remain in their bedroom for breakfast which they could have from early until mid-morning. The inspectors observed that meals were well presented in appetising individual portions. The atmosphere at mealtimes was enhanced by relaxing music and some residents were observed to sit on in the dining room after lunch had finished chatting together over a cup of tea. Staff were seen to assist residents discreetly and respectfully when required. Residents told inspectors that they could have tea or coffee and snacks at any time.

Catering staff had specific instructions for residents who had specific dietary needs or required special diets. The inspector discussed the special dietary requirements of individual residents with the chef and found that catering staff had comprehensive information on residents' dietary needs and preferences.

Care plans informed care and daily progress notes evaluated how residents were responding to treatment plans. Residents' weights were monitored to alert staff of weight increase or loss. However the inspector noted that where residents were at risk of weight loss that the policy did not guide staff effectively or prompt them on when to intervene when a resident experienced weight loss. In addition the policy did not discuss food fortification, modification of consistency or thickening of fluids. While the centre had developed crude assessment procedures to assess residents' swallowing, residents did not have sufficient access to accredited speech and language therapy assessment as discussed under outcome 11 of this report. This posed a risk to residents' health as there were residents in the centre in receipt of modified consistency foods and thickened fluids due to swallowing difficulties. An incident where a resident's airway became partially obstructed by food was recorded. The inspector observed from training records that staff had attended relevant training and satisfactorily responded to this incident. Residents had access to nutritional assessment and advice by a dietician.

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:

The inspector found that residents' privacy and dignity was respected by staff. Staff were observed to knock before entering residents' bedrooms and to respect their privacy needs during personal care procedures by closing doors and bed screen curtains in twin rooms. The inspector observed staff interacting with residents in a courteous manner and addressing them by their preferred names. There were several examples of positive interactions between staff and residents who chatted together in a comfortable way. Residents who had communication problems or confusion were noted to have regular input from staff, were supervised and received good emotional support when required. There was an open visiting policy and contact with family members was facilitated and supported. Residents could meet their visitors in private in a second quiet sitting room rather than their bedrooms if they wished.

Residents were facilitated and encouraged to exercise personal choices and autonomy supported by many examples observed by the inspector during the days of the inspection including choice of food, time of dining and time of getting up and going to bed.

The provider/person in charge and staff told the inspector how they valued and sought resident's feedback. Residents meetings were held on a monthly basis and were well attended with evidence from the minutes of discussion including experiences of the service and suggestions where improvements could be made which were acted upon. Residents confirmed that they had opportunities to discuss issues as they arose with the provider/person in charge and members of staff. The meetings were used to communicate changes and to elicit residents' views. The inspector saw where residents were afforded the final decision on the fate of trees growing along the boundary of the site which were to be removed in response to their views. A communication policy detailing communication guidelines and procedures for residents with impaired communication skills was in place. Residents religious and civil rights were supported. Mass and other services and celebrations took place regularly.

Residents' independence was promoted by staff. The inspector saw staff assisting residents to walk around at a leisurely pace. Some residents went out with their families and friends and one resident enjoyed a busy recreational and occupational programme. The inspector found that most residents said they had flexibility in their daily routines, for example, residents could decide whether to participate in activities available to them. They chose when to go to bed, the time they got up and where they wished to spend their day. However, two residents remained in their bedrooms on the days of inspection. Although staff were attentive to these residents, some work is required to ensure they each have a tailored programme to meet their individual recreational needs.

Windows on two residents' bedrooms were located in the walls to the back of the patio area and the finding that all options were not explored to preserve these residents' privacy in their bedrooms had been the subject of an action plan developed following inspection by the Authority in March 2014. The inspector found on this registration inspection that one of the two residents availed of an option to move rooms while the other resident was happy to stay in her room and close the curtains during personal care. The provider/person in charge explained that the risk of breach of privacy due to

the position of windows in these two rooms would be subject to specific ongoing assessment. Storage of commodes in some bedrooms while residents were not in their rooms was discussed with the provider/person in charge especially the potential impact of commode use on privacy and dignity of residents in twin rooms. This finding required review to ensure these residents' privacy and dignity needs were respected.

Judgment:

Non Compliant - Moderate

Outcome 17: Residents' clothing and personal property and possessions

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

Theme:

Person-centred care and support

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

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

Findings:

Residents had adequate storage for personal belongings in their bedrooms. Clothing was labelled and was well looked after by the centre staff. Residents' personal clothing was stored neatly, hanging in wardrobes and folded on shelves and in drawers as appropriate. A record of property and clothing was compiled when residents were admitted and kept updated by nurses and care staff as new personal items were added or discarded by residents or relatives.

The inspector observed and residents confirmed, that they were encouraged to personalise their rooms. Many of the bedrooms were decorated with pictures, photographs and ornaments precious to them from their own homes. Residents were empowered to have control over and store their personal valuables. They had access to private lockable space in their bedrooms and they held the key to same.

The laundry was adequately equipped. Lack of sufficient floor space for ease of manoeuvre around machines and lack of worktop space for sorting clothing and segregation of potentially hazardous linen was the subject of an action plan developed following the last inspection of the centre in March 2014. The inspector found that although the floor space had not been increased, review of the layout and installation of additional worktop space afforded improved ease of movement and space for sorting and segregation of used linen. While, this area is improved and is generally fit for purpose, any future renovations should include review of this laundry room. The inspector spoke to the staff in relation to practice in the laundry and found that they were knowledgeable about the systems in place to segregate laundry and prevent the spread of infection. The inspector asked some residents if they were satisfied with the way in which their clothes were cared for and all responded that they were happy with the service.

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:

The inspector was provided with copies of the staff rotas, training records and staff files as requested which were reviewed to assess compliance with the legislation in each case. The inspector was satisfied that staffing levels and the skill mix in place was appropriate to meet the needs of residents. The provider/person in charge explained to the inspector that she calculated staffing levels and skill mix of staff by reviewing the dependency levels and needs of residents. There was evidence of increase in staffing in response to increased resident needs. By carrying out a simulated night-time fire evacuation drill, the provider/person in charge had assured herself that two staff on night duty was sufficient to meet the needs of residents should evacuation be required due to an emergency such as fire.

There were recruitment procedures that ensured that staff were appropriately selected and vetted. The inspector examined the files of three staff members as part of the assessment of this outcome. The inspector found that the required information on staff employment files as detailed in schedule 2 of the Regulations was complete and in place.

Staff were supported by guidance and supervision from the provider/person in charge and clinical nurse manager, staff meetings and regular feedback. Staff said they could highlight issues without difficulty and said that the person in charge was receptive to ideas for change.

The inspector spoke with staff members and found that they were knowledgeable about the residents' individual needs, the centre's policies, fire procedures and the procedures for reporting complaints and allegations of elder abuse. The inspector observed them responding to residents' needs in a respectful manner. Staff told the inspector that they were well supported by the provider/person in charge and clinical nurse manager.

There was a record of the training courses that staff had attended There was evidence that staff had undertaken training on a range of healthcare topics relevant to their roles for example, medication management, continence promotion, falls prevention and crisis prevention intervention among others. Findings during the inspection in March 2014 in relation to incomplete staff training in resident protection, safe moving and handling and fire safety was the subject of an action plan which was found to be completed on this inspection. Residents spoken with spoke positively in relation to staff competence and skill in meeting their 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
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	Boyne Valley Nursing Home
Centre ID:	OSV-0000119
Date of inspection:	28/07/2014
Date of response:	05/11/2014

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:

The provider was in the process of preparing a report on the quality and safety of care and quality of life in the centre for residents as required by regulation 23, which the provider is preparing in consultation with feedback from residents. This report was not available for review on this inspection.

Action Required:

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

Under Regulation 23(e) you are required to: Prepare the review referred to in regulation 23(1)(d) in consultation with residents and their families.

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

An annual questionnaire on the quality of care will be issued to residents and family members each November, the results of which will be reviewed and incorporated into policies and procedures as appropriate.

Management will carry out and document an observational review of the quality and safety of care delivered to residents every six months. Amendments to training schedules and policies and procedures will be made as appropriate following these reviews. The outcome of these amendments will be monitored and documented.

Proposed Timescale: 30/11/2014

Theme:

Governance, Leadership and Management

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

Timescales for completion of quality improvement action plans was not consistently identified and as such did not result in residents availing of positive outcomes in some areas identified for improvement.

Action Required:

Under Regulation 23(d) you are required to: Ensure there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.

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

- 1) A Quality Improvement Plan Template is being compiled which will now include the time scale for completion of actions which have been identified through individual Quality and Safety audits
- 2) The risk register has been updated to include timescales for completion of quality improvement and the outcome of these quality improvement measures.
- 3) A new risk management policy has been read by all staff and implemented.

Proposed Timescale: 05/11/2014

Outcome 03: Information for residents

Theme:

Governance, Leadership and Management

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

There was no reference to the arrangements for residents to meet their visitors in

private other than in their bedrooms. Clarity was required to ensure all residents had adequate admission information to inform their decisions.

Action Required:

Under Regulation 20(2)(b) you are required to: Prepare a guide in respect of the designated centre which includes the terms and conditions relating to residence in the centre.

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

Residents' Information Booklet has been updated to include reference to Visitors Room as an option other than their own rooms where residents may meet visitors in private

Proposed Timescale: 05/11/2014

Outcome 05: Documentation to be kept at a designated centre

Theme:

Governance, Leadership and Management

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

Some policies required review to add additional advisory information to inform practice as outlined throughout this report. Many policy documents had been amended by hand and as such required reformatting to avoid risk of misreading the information presented.

Action Required:

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

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

All policies have been reviewed and those with additional hand written entries and/or amendments have been printed and discussed with staff. All policies have been implemented and are current practice in the nursing home.

Proposed Timescale: 05/11/2014

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:

A revised copy of the risk management policy forwarded on the 08 August 2014 to the Authority while amended did not adequately describe the procedure to be followed in the event of an incident occurring in the centre.

Action Required:

Under Regulation 26(1)(d) you are required to: Ensure that the risk management policy set out in Schedule 5 includes arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.

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

All staff will be provided with training in relation to identified risks and the controls in place to mitigate these risks. Management will record and investigate all serious or adverse events involving residents and will ensure any necessary amendments to existing policies, procedures and practices as a result of such incidents are completed and implemented within an appropriate timescale.

A new risk management policy will be instated to reflect this change.

Proposed Timescale: 31/10/2014

Theme:

Safe care and support

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

An emergency plan advising staff on how to manage emergencies was in place however, did not reference a predetermined place of safe refuge and arrangements for safe transportation of residents there in the event of residents requiring evacuation from the centre.

Action Required:

Under Regulation 26(2) you are required to: Ensure that there is a plan in place for responding to major incidents likely to cause death or injury, serious disruption to essential services or damage to property.

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

This policy is currently being updated to include reference to the transportation of residents to a designated safe refuge in the locality, in the event of evacuation of the home.

We are currently awaiting confirmation of agreed transport arrangements from local transport providers should the need for an evacuation arise.

Proposed Timescale: 17/10/2014

Theme:

Safe care and support

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

The infection control policy in place did not advise on the procedures and arrangements to be followed in the event of an outbreak of infection such as influenza in the centre in

line with standards for the prevention and control of healthcare associated infections published by the Authority.

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:

The policy has been updated to include procedures and arrangements to be followed in the event of an outbreak of infection. All staff are aware that this policy is to be implemented in the event of an outbreak of infection.

Proposed Timescale: 05/11/2014

Outcome 09: Medication Management

Theme:

Safe care and support

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

There was inadequate space on medication administration records to record relevant comments other than a letter which was linked to variant resident outcomes constituting non-administration of prescribed medications.

Action Required:

Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.

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

Non-administration of prescribed medicines is now recorded on the reverse of the medication administration records by the nurse on duty.

Also, the pharmacist is currently working with their IT department to adjust the formatting of the medication administration records for improved legibility.

Proposed Timescale: 31/10/2014

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:

Some residents received modified consistency diets which was a control to mitigate risk posed by compromised swallowing reflexes, did not have access to a speech and language therapy assessment. .

Action Required:

Under Regulation 06(2)(c) you are required to: Provide access to treatment for a resident where the care referred to in Regulation 6(1) or other health care service requires additional professional expertise.

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

All residents currently in receipt of modified consistency diets have been assessed by a speech and language therapist prior to admission. Review assessments are requested of the HSE as necessary. A private speech and language therapist has been engaged and will be available to residents should the need arise.

Proposed Timescale: 05/11/2014

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:

Furnishings in some bedrooms required attention in relation to surface painting. Surface paint was chipped and/or missing on some furniture surfaces.

The walls in one of the two twin bedrooms required re-painting.

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:

All bedrooms and bedroom furnishings have been assessed and areas requiring re-freshing/re-painting are currently being attended to.

Proposed Timescale: 31/12/2014

Theme:

Effective care and support

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

Most residents slept on hospital style beds. While some of these beds had been replaced, there was no record to evidence assessment of the suitability of long-term

use of this bed type which is primarily designed for short-term use.

Storage for residents' equipment required review, commodes were stored in bedrooms which may impact on the privacy and dignity of residents especially in twin rooms.

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:

Suitability of beds available for long-term use to be assessed and documented.
A designated storage area for commodes is currently being prepared.

Proposed Timescale: 31/10/2014

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:

The designated complaints officer for the centre was not named and reference to the person required under regulation 34(3) was missing.

Action Required:

Under Regulation 34(3) you are required to: Nominate a person, other than the person nominated in Regulation 34 (1)(c), to be available in a designated centre to ensure that all complaints are appropriately responded to and that the person nominated under Regulation 34 (1)(c) maintains the records specified under in Regulation 34 (1)(f).

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

Complaints Policy has been updated to include the name of the Complaints Officer and to reference the person required under Regulation 34(3)

Proposed Timescale: 05/11/2014

Outcome 14: End of Life Care

Theme:

Person-centred care and support

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

The policy document did not inform the procedures to be respected for the period up to and after death for residents of differing faiths.

Action Required:

Under Regulation 13(1)(b) you are required to: Ensure the religious and cultural needs of the resident approaching end of life are met, in so far as is reasonably practicable.

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

Customs and religious protocols for various beliefs have been sourced, printed off and attached to the End of Life policy document. A section has also been included in the policy document to inform of same. This policy has been implemented.

Training will also be provided to staff to ensure that they are aware of the customs relevant to people of different faiths whilst resident in the nursing home and when approaching the end of life.

The HSE's Health Service Intercultural Guide is also available in the nursing home to all staff and residents.

Proposed Timescale: 31/10/2014

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:

Storage of commodes in some bedrooms was not assessed to ensure this finding did not impact negatively on their privacy and dignity needs.

Action Required:

Under Regulation 09(3)(b) you are required to: Ensure that each resident may undertake personal activities in private.

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

Residents' wishes in relation to the presence of a commode in their room are currently being complied with, however, these will be considered in addition to an assessment of the need for a commode in residents' rooms during the day.

Proposed Timescale: 17/10/2014

Theme:

Person-centred care and support

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

Two residents remained in their bedrooms on the days of inspection Although staff were attentive to these residents, some work is required to ensure they each have a tailored programme to meet their individual recreational needs.

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:

Programme in relation to the individual recreational needs of those residents who remain in their rooms to be completed

Proposed Timescale: 31/10/2014