

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Abbeylands Nursing Home
Centre ID:	OSV-0000187
Centre address:	Carhoo, Kildorrery, Cork.
Telephone number:	022 25 090
Email address:	info@abbeylandsnursinghome.com
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Abbeylands Nursing Home & Alzheimer Unit Limited
Provider Nominee:	Kevin Regan
Lead inspector:	John Greaney
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	50
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.

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 monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 05 July 2017 08:30 To: 05 July 2017 17:30

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 - Moderate
Outcome 05: Documentation to be kept at a designated centre	Substantially Compliant
Outcome 07: Safeguarding and Safety	Non Compliant - Major
Outcome 08: Health and Safety and Risk Management	Non Compliant - Major
Outcome 09: Medication Management	Non Compliant - Moderate
Outcome 10: Notification of Incidents	Non Compliant - Moderate
Outcome 12: Safe and Suitable Premises	Substantially Compliant
Outcome 13: Complaints procedures	Substantially Compliant
Outcome 14: End of Life Care	Substantially Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Compliant
Outcome 18: Suitable Staffing	Substantially Compliant

Summary of findings from this inspection

Abbeylands Nursing Home is a purpose-built, single storey residential centre with accommodation for 50 residents. The centre is located in a rural area of Co. Cork, close to the village of Kildorrery, on large, well maintained grounds with ample parking facilities.

This report sets out the findings of a one day unannounced inspection, which was a follow-up inspection to an inspection carried out in January 2017. The purpose of the inspection was to monitor compliance with regulations and standards and to ascertain progress of the implementation of the action plan from the previous inspection. As part of the inspection process, the inspector met with residents, staff members, and the person in charge. The inspector observed practices and reviewed documentation, such as policies and procedures, training records, staff rosters, and care plans.

On the day of the inspection, the centre was bright, clean and spacious with lots of natural light and was generally well maintained. Residents' bedrooms were adequate in size, had suitable space for storing personal possessions and many were personalised with individual memorabilia from the residents. Residents to whom the inspector spoke said that they were happy living in the centre and that they felt safe there. Overall staff were able to demonstrate good knowledge of the residents' care needs when speaking with the inspector. The inspector observed staff interacting with residents in an appropriate and respectful manner. A range of activities were available for residents each day, including one-to-one activities.

Some of the actions identified at the last inspection were addressed satisfactorily, however, a number were outstanding. For example, an annual review of the quality and safety of care had been completed. A programme of training was in place and many staff had attended training on topics such as safeguarding, responsive behaviour, manual and people handling, fire evacuation, end of life care and infection control. However, not all staff had attended this training.

Improvements had been made to the premises. Walls and bedroom doors on the corridors had recently been painted. Paintings had been hung in the sitting room of Lee Suite making it appear a little more homely and a pine table and chairs had been placed here. Some of the bedrooms, however, remained in need of redecorating as paintwork, particularly on skirting boards and bathroom doors, was scuffed and some carpets were badly stained.

Since the last inspection, most staff had attended fire evacuation training and staff were knowledgeable of evacuation procedures and what to do in the event that a resident's clothes caught fire. While fire evacuation training had been provided, no in-house fire drills had taken place to assess staff performance and to identify required improvements, if any.

While there was a policy on responding to allegations of abuse, the inspector was not satisfied that it was sufficiently comprehensive to identify how to respond, when there were suspicions or allegations of abuse against a fellow resident. The inspector was not satisfied that at all times appropriate measures were taken to protect residents from abuse following allegations of abuse.

Other required improvements included:

- the management of restraint
- access to areas such as store rooms, staff changing room, and sluice rooms
- there were no window restrictors in the main sitting room
- the risk assessment policy and safety statement remained in draft format
- emergency evacuation signage
- medication management
- submission of notifications

The action plan at the end of this report identifies where improvements are needed to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in

Designated Centres for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland.

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

Outcome 01: Statement of Purpose

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

Theme:

Governance, Leadership and Management

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

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

Findings:

The statement of purpose was updated since the last inspection and now included all of the information required by the regulations.

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:

There is a clearly defined management structure that identified reporting relationships. The person in charge reported to the provider, who was a director of the centre. The person in charge was supported by a clinical nurse manager.

At the last inspection it was identified that there was no annual review of the quality and safety of care. Since then an annual review was completed, based on guidance issued

by HIQA. The review included an action plan and timelines within which each action should be completed. The review, however, had not been made available to residents as required by the regulations.

It was also identified at the last inspection that there were insufficient staff on duty, particularly in the evening time. Since then an additional staff nurse was rostered to work from 20:00hrs to 22:00hrs each day. Staff members spoken with stated that, while it was busy at times, there were adequate numbers of staff on duty to meet the needs of residents.

Improvements were required in relation to the governance and management of the centre. The person in charge stated that due to the recruitment of new staff that required a high level of support and mentoring, she had only recently become supernumerary to allow her to attend to management duties. There are a number of persistent and on-going non compliances brought to the attention of the provider previously, which remain, in spite of assurances from the provider that these would be addressed. For example, a number of rooms that contained potential dangers for residents were unlocked on the day of the inspection. Hand rails had not been installed at the entrance to the centre or at the exit to the enclosed garden. It was noted that a number of policies were due for review on the date of inspection, but had not yet been reviewed. These included the fire safety policy, protection of residents from abuse and responding to allegations of abuse policies, and end of life care policy. A notification of an allegation of abuse was not submitted in a timely manner. Other required improvements included the inadequate safeguarding arrangements put in place following suspicions or allegations of abuse. This is addressed in more detail under Outcome 07.

Judgment:

Non Compliant - Moderate

***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:

At the last inspection it was identified that policies contained a statement that practices would be audited for compliance with policies on a quarterly basis, however, audits were not carried out in compliance with this statement. The policies were reviewed and this statement was amended to reflect annual audits. Some policies were due for renewal on 01 June 2017, such as protection from abuse policy, end of life care policy and fire safety management policy, however, it was not evident that this review had taken place.

There was a fire safety register that contained details of the preventive maintenance of fire safety equipment, emergency lighting and fire alarm. The register also contained records of attendance at relevant training by staff. There was a fire safety management policy that made frequent references to a fire management plan, however, this plan was not available in the centre on the day of inspection.

While there was a policy on responding to allegations of abuse, the inspector was not satisfied that it was sufficiently comprehensive to identify how to respond when there were suspicions or allegations of abuse against a fellow resident. This finding was further detailed and actioned in outcome 8 of this report.

At the last inspection, the inspector noted that there were a number of documents with residents' personal information including staff observational records and residents' care and welfare details had been left unsupervised by staff on a table in a residents' sitting room. On this inspection, the inspector observed that all records and documentation available were securely controlled, maintained in good order and retrievable for monitoring purposes.

Judgment:

Substantially 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):

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

Findings:

There were policies and procedures in place for protecting residents from abuse and responding to suspicions or allegations of abuse. Residents spoken with by the inspector stated that they felt safe in the centre. At the last inspection it was identified that not all staff had attended training on recognising and responding to abuse. Since then, training

had been provided to staff, however, a small number of staff had not yet attended this training. It was also identified at the last inspection that not all staff had attended training in responsive behaviour. Training had also been facilitated for staff since the last inspection, however, a number of staff were yet to attend this training.

While there was a policy on responding to allegations of abuse, the inspector was not satisfied that it was sufficiently comprehensive to identify how to respond when there were suspicions or allegations of abuse against a fellow resident. The inspector was not satisfied that at all times appropriate measures were taken to protect residents from abuse following allegations of abuse. There was not adequate supervision arrangements put in place to ensure that residents were at all times safe. The person in charge addressed this issue on the day of the inspection.

There was a restraint register. The only form of restraint in use were bedrails. Risk assessments were completed in advance of the use of bedrails and these were reviewed regularly. The inspector was not satisfied, however, that the risk assessments were completed in line with national policy on the use of restraint. For example, the risk assessments did not detail what alternatives, if any, were explored prior to the use of bedrails and in some cases it was stated that no alternatives were explored. This was also a finding at the last inspection. In addition, the level of supervision required when bedrails were in place, according to the risk assessments, was not adequate and did not reflect the needs and capacity of each resident. For example, the risk assessment for one resident stated that he should have safety checks completed every four hours. It was noted in the risk assessment that, while a call bell was made available to the resident, he did not have the capability to use it. The reason for the use of bedrails was also not recorded for all residents. While there was a record of safety checks maintained while restraint was in place, it was not a contemporaneous record and did not actually reflect when safety checks were done. For example, the safety checks at night time were recorded as being completed at 12am, 2am, 4am, and 6am for all residents.

Judgment:
Non Compliant - Major

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:
At the last inspection it was identified that significant improvements were required in relation to fire safety practices. Some of the issues identified at that inspection have

since been addressed, however, some remained outstanding. For example, personal emergency evacuation plans were now in place for all residents outlining the most appropriate means of evacuation in an emergency, such as a fire. At the last inspection it was observed that a door was being held open with a chair. On this inspection the inspector did not observe any doors being inappropriately held open. Fire evacuation training had been facilitated since the last inspection and most staff had attended. However, a small number of staff did not have recent fire safety training. While fire evacuation training had been facilitated by an external provider, there were not any fire evacuation drills conducted, separate from this training, to ascertain how staff would respond in the event of a fire. Staff members spoken with by the inspector were knowledgeable of how to evacuate residents with a mobility impairment and how to respond should a resident's clothes catch fire.

Painting and redecorating work had recently been completed, however, signage to support residents, visitors and staff navigate to the nearest exit had not been replaced following the completion of the works. Some signs had been replaced prior to the completion of the inspection, however, there were not enough signs located in key areas throughout the premises, given the design and layout of the centre. There was a fire safety policy that referenced a fire management plan to detail specifics around fire safety notices, staff training and frequency of fire drills, however, this plan was not available to the inspector on the day of the inspection. This is actioned under Outcome 5.

Records indicated that fire safety equipment, the fire alarm system and emergency lighting had preventive maintenance in line with relevant guidance. There were daily checks of means of escape and weekly sounding of the fire alarm system. Since the last inspection, systems were put in place to safeguard residents due to the disengagement of electronic locking mechanisms to doors during the alarm testing process. Automatic door release mechanisms were tested weekly, however, a fault had been identified in one bedroom door approximately three weeks prior to this inspection but it had not been rectified.

It was identified at the last inspection that the risk management policy was not in compliance with regulations. Since then, an external provider had been commissioned to develop a new safety statement and risk management policy, however, this was not yet complete. A draft of the risk management policy, viewed by the inspector, did not address all of the items specified in the regulations. An environmental risk register was also being developed by the external provider but this was not yet complete.

Issues identified at the last inspection in relation to risk identification and management that were not satisfactorily addressed on this inspection included:

- window restrictors were applied to many of the windows, however, there were no window restrictors on the windows in the main sitting room
- a coded lock had been applied to the staff changing room, however, the inspector found that the door was unlocked on two occasions and staff were not present in the room. Personal items were stored in the room including personal bags
- there were no hand or grab rails at the entrance to the centre or at the exit to the external gardens to support residents or visitors with reduced mobility
- a coded lock had been applied to a storeroom that contained latex gloves and aprons,

however, this was found to be open on one occasion by the inspector

- while there was a coded lock on the door leading to the sluice room and laundry, this door was found to be open by the inspector and staff were not present in either room.

Issues identified in relation to risk management that were satisfactorily addressed on this inspection included:

- paths in the external garden had been cleaned of slippery film and were now cleaned to a good standard
- there were covers on all shower drains in residents' en suite bathrooms
- all fire evacuation signs were now illuminated
- the nurses office was locked when not occupied.

Training records indicated that a number of staff had attended training on manual and people handling practices, however, some staff were due for refresher training. At the last inspection it was identified that slings used to transfer residents with a mobility impairment were not individualised to residents. This was also the case on this inspection and there was no protocol in place to support the sharing of slings and to minimise the risk of cross contamination between residents.

Judgment:

Non Compliant - Major

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):

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

Findings:

There were operational policies and procedures relating to ordering, prescribing, storage and administration of medicines. Medication administration practices observed by the inspector were largely in compliance with relevant guidance. All medicines were stored securely. Medicines requiring refrigeration were stored appropriately and the fridge temperature was monitored and recorded. A new fridge had been purchased following the last inspection and records indicated that the fridge temperature was within the recommended range.

Prescription and administration records viewed by the inspector contained appropriate identifying information. However, the prescription for one resident was a faxed copy, which meant that nurses were administering medication in contravention of relevant professional guidance. The original prescription had been inadvertently removed by a visiting specialist team, approximately six days prior to this inspection and had not been

returned.

At the last inspection it was identified that errors in receiving medicines had not been record on the medication error log. The person in charge informed the inspector that there had been no errors in receiving medication since the last inspection. However, the inspector was informed that there was no system for reconciliation to ensure that medicines delivered correlated with the prescription.

At the last inspection it was identified that there was no audit of stock medications and that some medicines were out-of-date. On this inspection it was noted that a weekly audit had commenced and a sample of medicines checked were all within the expiry date. However, the audit had not been completed in the weeks prior to this inspection and the records of stock medicines did not always correlate with the medicines stored in the centre. Records indicated that a number of staff had completed medication management training since the last inspection, however, two nurses had not completed this training.

Judgment:

Non Compliant - Moderate

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):

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

Findings:

A record of incidents was maintained in the centre and notifications were submitted to HIQA as required by the regulations. However, a notification in relation to allegations of abuse was not submitted to HIQA within the required timeframe.

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):

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

Findings:

Abbeylands Nursing Home is a purpose-built, single storey residential centre with accommodation for 50 residents. The location, layout and design of the centre was suitable for its stated purpose and met the needs of the resident in a comfortable way. The centre is situated on large, well maintained grounds in a rural area of Co. Cork with ample parking facilities.

Resident' accommodation comprised 16 single and 17 twin-bedded rooms, all except one of which were en suite with shower, toilet and wash-hand basin. The remaining bed room had a wash hand basin only. The centre was divided into three suites: Funchion suite (23 beds), Blackwater suite (14 beds), and the designated dementia unit, Lee suite (13 beds).

On the day of the inspection, the centre was bright, clean and spacious with lots of natural light and was generally well maintained. Residents' bedrooms were adequate in size, had suitable space for storing personal possessions and many were personalised with individual memorabilia from the residents.

At the last inspection it was identified that a number of rooms had been repainted and the décor had been upgraded, particularly in the Lee suite, however, some of the bedrooms in the other units required re-decorating as the paint was scuffed on some walls and bedroom doors. On this inspection it was noted that the walls and doors to bedrooms on the corridors of Funchion and Blackwater had been repainted a number of weeks prior to this inspection. However, it was noted that redecorating of the walls and doors internally in the bedrooms had not yet been completed. Paintwork was badly scuffed on the walls, skirting boards and doors to en suites in some bedrooms and there were stains on the carpet in at least one of the rooms.

Redecorating of the Lee suite was now complete. Doors to bedrooms were painted in various colours; a new pine table and chairs were in place in the sitting room; there were paintings on the walls that brightened up the unit; there were curtains on the windows; and more signage and visual cues were in place to support residents navigate the unit.

The grounds of the premises were well maintained, and there was an enclosed garden that could be used by residents. There was a chapel available in the centre that was well maintained and a call bell had been installed since the last inspection. Corridors had grab rails, and were seen to be clear of any obstructions. Residents were seen to be moving as they chose within the centre and the dementia unit allowed residents to walk freely around the corridor which was circular in design.

Judgment:

Substantially Compliant

Outcome 13: Complaints procedures

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

Theme:

Person-centred care and support

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

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

Findings:

There was a complaints policy that was most recently reviewed in March 2017. The policy identified the complaints officer, and independent appeals process and a person responsible for overseeing complaints to ensure they are appropriately responded to and adequate records are maintained. The complaints procedure was on prominent display in the entrance hallway. However, the independent appeals process identified on the notice was different to that identified in the complaints policy.

The inspector reviewed the complaints log. At the last inspection it was identified that only three complaints had been recorded in 2016, satisfaction or otherwise with the complaints process was not recorded, and complaints were recorded in a diary without any template. On this inspection it was noted that complaints were now recorded in a complaints log on a template that guided staff to record all aspects of the complaint. Only two complaints had been recorded since the last inspection in January 2017. Of the complaints recorded, both records indicated that the complainants were satisfied with the outcome of the complaints process.

Residents spoken with by the inspector stated that if they had any complaints they would have no difficulty in making this known to staff.

Judgment:

Substantially Compliant

Outcome 14: End of Life Care

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

Theme:

Person-centred care and support

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

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

Findings:

There were end of life policies and procedures in place, which were reviewed and updated since the last inspection. The inspector was informed that there were no residents at active end of life stage on the day of inspection. At the last inspection, it was identified that improvements were required in advance planning for end of life care and in supporting staff to acquire the necessary skills and confidence to initiate end of life care discussions with residents and relatives. Training records viewed by the inspector indicated that a number of staff had attended end of life care training during March 2017.

Records viewed by the inspector indicated that discussions around end of life care preferences had taken place with a small number of residents. The person in charge stated that some residents were not comfortable discussing end of life care. It was not evident, however, that end of life preference were discussed with residents other than the small number of residents for whom "not for resuscitation" orders were in place. Improvements were also required in relation to readily identifying which residents were not for cardiopulmonary resuscitation in the event of a cardiac arrest.

Judgment:

Substantially 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 observed staff interacting with residents in an appropriate and respectful manner. Residents chose what they liked to wear and inspectors saw residents looking well dressed, including jewellery and makeup. A number of residents were observed having their hair done in the hairdressing salon on the day of inspection.

There was one activities coordinator on duty each day from Monday to Friday and she

was supported by a second activities on at least two of those days. A range of activities were available each day, such as card games, music, bingo and relaxation. There were also one-to-one activities, such as hand massage, for residents that do not participate in group activities. Residents appeared to actively engage in the programme of activities and the activities staff appeared to be familiar with the individual communication needs of various residents.

Residents confirmed that their religious and civil rights were supported. The preferences of all religious denominations were respected and facilitated. There was a chapel available in the centre that was nicely decorated. Religious ceremonies were celebrated in the centre that included a weekly mass for Catholic residents, usually on Saturdays. Outside of religious ceremonies, the chapel was available as a quiet space for residents to pray and reflect.

Closed circuit television cameras (CCTV) were in operation at a number of locations, including the reception area and on corridors and there was policy in place governing the use of CCTV cameras. There was signage indicating there were CCTV cameras in the centre. At the last inspection it was identified that CCTV cameras were also in place in the sitting room of Lee unit, where residents should have a reasonable expectation of privacy. On this inspection it was noted that the camera no longer recorded images from the sitting room and now faced the door at the entrance to the sitting room.

Access out of the dementia specific unit was by finger print technology and a number of visitors had access to this means of exit. It was identified at the last inspection that there was no policy available in relation to the management of this technology and particularly the management and storage of personal data of visitors and staff. On this inspection the policy was still not in place.

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):

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

Findings:

The staffing rota confirmed that there was a nurse on duty at all times. At the last inspection it was identified that there were insufficient staff with the right skills, qualifications and experience to meet the assessed needs of the residents. It was identified that there was only one staff nurse on duty from 8am until 8pm each day to manage the care and treatment of up to 50 residents. On this inspection the staffing roster indicated that there were two staff nurses on duty each day, one of which worked 08:00hrs to 20:00hrs and the other worked from 08:00hrs to 22:00hrs. In addition to the staff nurses, the person in charge was present in the centre for four days each week from 08:00hrs to 18:00hrs. Staff members spoken with by the inspector indicated that, while it was busy, there were adequate numbers of staff to meet the needs of residents.

There was an education and training programme available to staff and the training matrix indicated that most staff were up-to-date with mandatory training. Training sessions attended by staff since the last inspection included manual and people handling, fire evacuation drills, responsive behaviour, protection of vulnerable older adult, infection prevention, and control and end of life care. However, as identified and actioned under relevant outcomes of this report, not all staff had received up to date training in fire safety, manual and people handling, safeguarding, and responsive behaviour.

Judgment:

Substantially 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:

John Greaney
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	Abbeylands Nursing Home
Centre ID:	OSV-0000187
Date of inspection:	05/07/2017
Date of response:	25/07/2017

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:

Improvements were required in relation to the governance and management of the centre. The person in charge stated that due to the recruitment of new staff that required a high level of support and mentoring, she had only recently become supernumerary to allow her to attend to management duties. For example:

- it was noted that a number of policies were due for review on the date of inspection, but had not yet been reviewed

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

- inadequate safeguarding arrangements were put in place following allegations of abuse
- notifications were not always submitted in a timely manner.

1. Action Required:

Under Regulation 23(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

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

We have reviewed all of our policies since the most recent follow up inspection and all have been revised to reflect this review.

The notifications particular to two incidents reported to HIQA represent an incident which occurred on Saturday June 24th duly reported to HIQA on Monday June 26th (by post) and the incident which occurred on the evening of Wednesday June 28th which was reported to HIQA on Monday July 3rd both which we feel were within the three working days set out. We will electronically notify you in the future with a follow up copy by post.

Proposed Timescale: 18/07/2017

Theme:

Governance, Leadership and Management

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

The annual review of the quality and safety of care had not been made available to residents as required by the regulations.

2. Action Required:

Under Regulation 23(f) you are required to: Make available a copy of the review referred to in regulation 23(d) to residents and, if requested, to the chief inspector.

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

The annual review of quality and safety of care whilst complete was not made available to residents and has since been printed (several copies) and left on display for all residents to access should they wish to.

Proposed Timescale: 16/07/2017

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 were due for renewal on 01 June 2017, such as protection from abuse policy, end of life care policy and fire safety management policy, however, it was not evident that this review had taken place.

3. Action Required:

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

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

All policies have since been reviewed and updated.

Proposed Timescale: 18/07/2017

Theme:

Governance, Leadership and Management

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

There was a fire safety policy that referenced a fire management plan to detail specifics around fire safety notices, staff training and frequency of fire drills, however, this plan was not available to the inspector on the day of the inspection.

4. 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:

A new fire plan devised and prepared in conjunction with an expert 3rd party has been devised adopted and implemented by all staff members.

Proposed Timescale: 22/07/2017

Theme:

Governance, Leadership and Management

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

While there was a policy on responding to allegations of abuse, the inspector was not satisfied that it was sufficiently comprehensive to identify how to respond when there were suspicions or allegations of abuse against a fellow resident.

5. Action Required:

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

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

We have a new policy for responding to allegations of abuse to reflect the possibility of potential for abuse between fellow residents.

Proposed Timescale: 05/10/2017

Outcome 07: Safeguarding and Safety

Theme:

Safe care and support

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

Restraint practices in relation to the use of bedrails were not adequate. For example;

- risk assessments did not detail what alternatives, if any, were taken prior to the use of bedrails and in some cases it was stated that no alternatives were explored
- the level of supervision required when bedrails were in place, according to the risk assessments, was not adequate and did not reflect the needs and capacity of each resident
- the reason for the use of bedrails was also not recorded for all residents
- record of safety checks maintained while restraint was in place were not contemporaneous.

6. Action Required:

Under Regulation 07(3) you are required to: Ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.

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

The risk assessments now reflect the alternatives taken prior to the use of bedrails such as a low bed options for residents.

The level of supervision required for residents when bedrails are in place has been revised and implemented to reflect the supervision set out in the risk assessments.

The risk assessments have been revised to record the reasons for the use of bedrails for any given resident. The records for safety checks while restraints are in place have been stringently adhered to and supervised by the DON and the CNM from July 5th onwards.

Proposed Timescale: 16/07/2017

Theme:

Safe care and support

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

Training had been facilitated for staff on responsive behaviour since the last inspection, however, a number of staff were yet to attend this training.

7. Action Required:

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

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

We have booked additional training for the staff who missed previous training opportunities provided by Abbeylands Nursing Home for July 24th 2017 along with additional manual handling training updates for staff which occurred on July 17th 2017.

Proposed Timescale: 25/07/2017

Theme:

Safe care and support

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

A small number of staff had not yet attended training on recognising and responding to abuse .

8. Action Required:

Under Regulation 08(2) you are required to: Ensure staff are trained in the detection and prevention of and responses to abuse.

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

The four staff not yet trained in the recognition and response to abuse will receive training on July 24th 2017.

Proposed Timescale: 24/07/2017

Theme:

Safe care and support

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

Improvements were required in responding to allegations of abuse. For example, there was not adequate supervision arrangements put in place to ensure that residents were at all times safe following an allegation of abuse.

9. Action Required:

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

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

We did following a recent incident in the Home put in place temporary safeguarding measures to ensure that all of our residents were at all times safe, this was then

upgraded to a more fixed arrangement with an additional staff member allocated specifically the task of monitoring this potential risk.

Proposed Timescale: 06/07/2017

Outcome 08: Health and Safety and Risk Management

Theme:

Safe care and support

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

An external provider had been commissioned to develop a new safety statement and risk management policy, however, this was not yet complete.

The draft version of the risk management policy viewed by the inspector did not address the items specified in regulation 26 (1) c.

10. Action Required:

Under Regulation 26(1) you are required to: Ensure that the risk management policy set out in Schedule 5 includes all requirements of Regulation 26(1)

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

We have since consulted out industry specialist in this regard and will have fully implemented our new safety statement and risk management policy.

Proposed Timescale: 03/08/2017

Theme:

Safe care and support

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

An environmental risk register was also being developed by the external provider but this was not yet complete.

Issues identified at the last inspection in relation to risk identification and management that were not satisfactorily addressed on this inspection included:

- window restrictors were applied to many of the windows, however, there were no window restrictors on the windows in the main sitting room
- a coded lock had been applied to the staff changing room, however, the inspector found that the door was unlocked on two occasions and staff were not present in the room. Personal items were stored in the room including personal bags
- there were no hand or grab rails at the entrance to the centre or at the exit to the external gardens to support residents or visitors with reduced mobility
- a coded lock had been applied to a storeroom that contained latex gloves and aprons, however, this was found to be open on one occasion by the inspector
- while there was a coded lock on the door leading to the sluice room and laundry, this

door was found to be open by the inspector and staff were not present in either room.

11. 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:

A Hazard Analysis and a Risk Assessment has been carried out by a competent person. In accordance with Statutory Requirements a Health and Safety Statement has been prepared by a competent person. Policies and procedures are in place to assist mitigate high risk areas. All staff are aware of any hazards identified and the current control measures in place.

The Health and Safety programme is audited on an annual basis by the Safety Representative and an update and review of the H&S Statement conducted by the QIM Window restrictors are now on the windows in the main sitting room and the door to the changing room will be locked at all sluice room has a coded lock fitted to restrict the movement of residents into this area.

This is supervised by the DON and the Registered Provider on a daily basis.

Grab rails are now at the entrance to the centre and at the exit to the external gardens to support residents or visitors with reduced mobility. July 6th (they were booked to fit on this date following a delay in manufacture beyond our control)

All staff have been advised that they must keep all coded doors locked at all times, this is supervised by the DON and the Registered provider on a daily basis

Proposed Timescale: 16/07/2017

Theme:

Safe care and support

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

At the last inspection it was identified that slings used to transfer residents with a mobility impairment were not individualised to residents. This was also the case on this inspection and there was no protocol in place to support the sharing of slings and to minimise the risk of cross contamination between residents.

12. 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:

Individual slings for residents where required have been procured and are retained on a personal basis, there is no sharing of slings.

Proposed Timescale: 31/07/2017

Theme:

Safe care and support

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

Signage to support residents, visitors and staff navigate to the nearest exit had not been replaced following the completion of the works. Some signs had been replaced prior to the completion of the inspection, however, there were not enough signs located in key areas throughout the premises,

13. Action Required:

Under Regulation 28(3) you are required to: Display the procedures to be followed in the event of fire in a prominent place in the designated centre.

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

These signs have been replaced following decoration works. In an effort to bring further improvement to the Home I am in the process of procuring additional signs to compliment those already in position, what is in position meets with Regulation 28(3)

Proposed Timescale: 06/07/2017

Theme:

Safe care and support

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

A small number of staff did not have recent fire safety training and not all staff were familiar with the process of horizontal evacuation.

14. Action Required:

Under Regulation 28(1)(d) you are required to: Make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.

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

Additional training had been booked for July 6th (the day after the follow up inspection) for the new staff members to undergo the necessary fire safety training.

Proposed Timescale: 06/07/2017

Theme:

Safe care and support

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

the following respect:

While fire evacuation training had been facilitated by an external provider there were not any fire evacuation drills conducted separate from this training to ascertain how staff would respond in the event of a fire.

15. Action Required:

Under Regulation 28(1)(e) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and residents are aware of the procedure to be followed in the case of fire.

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

We have further engaged our fire safety provider to assist in the implementation and supervision of fire safety drills including but not limited to fire evacuation drills. Members of staff who will lead and monitor the fire safety checks and practice drills will be carrying out such practice drills on a more frequent basis with all such drills recorded accordingly. To date we have recorded five such fire evacuation drills with staff leading the process from inception through to completion.

Proposed Timescale: 17/08/2017

Theme:

Safe care and support

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

Automatic door release mechanisms were tested weekly, however, a fault had been identified in one bedroom door approximately three weeks prior to this inspection but it had not been rectified.

16. Action Required:

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

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

We have repaired the defective door release mechanism, our fire prevention and safety systems are being checked and monitored regularly.

Proposed Timescale: 07/07/2017

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:

The prescription for one resident was a faxed copy, which meant that nurses were administering medication in contravention of relevant professional guidance.

17. 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:

The faxed copy of the prescription for one resident was as a result of the Psychiatric team inadvertently removing the prescription from the Home and without our knowledge or permission, the DON recognised this was missing and received a faxed copy of the prescription as a temporary measure, the Psychiatric team returned the original prescription to Abbeylands Nursing Home on July 7th.

Proposed Timescale: 07/07/2017

Theme:

Safe care and support

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

There was no system for reconciliation to ensure that medicines delivered correlated with the prescription.

18. 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:

We have allocated 2 Staff Nurses to check each delivery on arrival to ensure it correlates with the prescriptions and their requirements.

Proposed Timescale: 08/07/2017

Outcome 10: Notification of Incidents

Theme:

Safe care and support

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

A notification in relation to allegations of abuse was not submitted to HIQA within the required timeframe.

19. Action Required:

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

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

We understand the notification period is three working days and did believe we submitted our notification of two specific incidents within the three working day period, we will however in the future not rely on the postal method of submission but will electronically notify HIQA of any notifiable incident in the future.

Proposed Timescale: 06/07/2017

Outcome 12: Safe and Suitable Premises**Theme:**

Effective care and support

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

Redecorating of the walls and doors internally in the bedrooms had not yet been completed. Paintwork was badly scuffed on the walls, skirting boards and doors to en suites in some bedrooms and there were stains on the carpet in at least one of the rooms.

20. 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:

Carpet for the one affected room has been fitted, some of the bedrooms have been painted including walls, ceilings, doors, skirting and architraves, this process is ongoing and will form part of our planned preventative programme. We intend to review and devise a revised planned and preventative maintenance programme which we will forward to you by the end of October 2017. Aside from our revised planned and preventative programme it is planned to continue this ongoing program into further bedrooms and bathrooms whilst managing the residents and their particular preferences. Due care and attention will be taken given that the bedrooms planned for redecoration will be occupied by the residents during this time.

Proposed Timescale: 27/10/2017

Outcome 13: Complaints procedures**Theme:**

Person-centred care and support

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

The independent appeals process identified on the notice on display was different to that identified in the complaints policy.

21. Action Required:

Under Regulation 34(1) you are required to: Provide an accessible and effective complaints procedure which includes an appeals procedure.

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

This anomaly has been rectified.

Proposed Timescale: 16/07/2017

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:

It was not evident, however, that end of life preference were discussed with residents other than the small number of residents for whom "not for resuscitation" orders were in place.

Improvements were also required in relation to readily identifying which residents were not for cardiopulmonary resuscitation in the event of a cardiac arrest.

22. Action Required:

Under Regulation 13(1)(d) you are required to: Where the resident approaching end of life indicates a preference as to his or her location (for example a preference to return home or for a private room), facilitate such preference in so far as is reasonably practicable.

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

The necessary consultations have commenced with Residents and their Next of Kin to ensure that those approaching end of life are presented with choices and that their wishes wherever possible are acceded to.

Proposed Timescale: 22/09/2017

Outcome 18: Suitable Staffing

Theme:

Workforce

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

Not all staff had received up to date training in manual and people handling or medication management.

23. Action Required:

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

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

Training has been organised and booked for the staff that required medication management training, manual and people handling.

Proposed Timescale: 17/07/2017