## Centre name: Atlanta Nursing Home

### Centre ID: OSV-0000010

### Centre address: Sidmonton Road, Bray, Wicklow.

### Telephone number: 01 286 0398

### Email address: info@atlantanursinghome.ie

### Type of centre: A Nursing Home as per Health (Nursing Homes) Act 1990

### Registered provider: Atlanta Nursing Home Limited

### Lead inspector: Mary O'Donnell

### Support inspector(s): Margo O'Neill

### Type of inspection: Unannounced Dementia Care Thematic Inspections

### Number of residents on the date of inspection: 43

### Number of vacancies on the date of inspection: 0
About Dementia Care Thematic Inspections

The purpose of regulation in relation to residential care of dependent Older Persons is to safeguard and ensure that the health, wellbeing and quality of life of residents is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer and more fulfilling lives. This provides assurances to the public, relatives and residents that a service meets the requirements of quality standards which are underpinned by regulations.

Thematic inspections were developed to drive quality improvement and focus on a specific aspect of care. The dementia care thematic inspection focuses on the quality of life of people with dementia and monitors the level of compliance with the regulations and standards in relation to residents with dementia. The aim of these inspections is to understand the lived experiences of people with dementia in designated centres and to promote best practice in relation to residents receiving meaningful, individualised, person centred care.

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 compliance with specific outcomes as part of a thematic inspection. This monitoring inspection was un-announced and took place over 1 day(s).

**The inspection took place over the following dates and times**
From: 11 April 2019 09:30  
To: 11 April 2019 18:30

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

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**Summary of findings from this inspection**
This inspection report sets out the findings of a thematic inspection which focused on specific outcomes relevant to dementia care. Inspectors also followed up and found that actions required to address non-compliances with the regulations from the previous inspection in March 2018 had been completed.

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

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

On the day of inspection 25 of the 43 residents in the centre were deemed to have a dementia related condition. Twenty three of these residents had a formal diagnosis of dementia and two were under 65 years of age. The centre did not have a dementia specific unit. The service was organised with the residents at the centre and staff were skilled to support residents and to provide person-centred care. Positive connective care was observed during the formal observation periods and throughout the day.

Each resident was assessed prior to admission to ensure the service could meet their needs and to determine the suitability of the placement. Following admission, residents had a comprehensive assessment and care plans were in place to meet their assessed needs. Improvement was required to ensure that care plans were reviewed in line with residents changing needs and implemented by staff.

The health needs of residents were met to a high standard. Residents had access to medical services, in-house physiotherapy, a range of health services and evidence-based nursing care. The provider described difficulties in obtaining timely access to community based occupational therapy and speech and language assessments. The provider had taken measures to ensure that residents could access alternative services if required urgently. There was evidence of good interdisciplinary approaches in the management of behaviours that challenge with positive outcomes for residents. The service functioned in a way that supported residents to lead purposeful lives with plenty of interesting things to do.

These issues are discussed further in the body of the report and the actions required are included in the action plan at the end.
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: Health and Social Care Needs**

**Theme:**
Safe care and support

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

**Findings:**
This outcome sets out the inspection findings relating to healthcare, nursing assessments and care planning. The social care of residents with dementia is comprehensively covered in Outcome 3.

There were suitable arrangements in place to meet the health and nursing needs of residents with dementia. Comprehensive assessments were carried out and residents and their families, where appropriate were involved in the care planning process, including end of life care plans which reflected the wishes of residents with dementia. The nutritional and hydration needs of residents with dementia were met and residents were protected by safe medication policies and procedures. Gaps in care planning were identified.

Residents had access to general practitioners (GPs) of their choice, and to allied healthcare professionals including dietetic, dental, ophthalmology and podiatry services. The provider employed a physiotherapist who treated resident in the centre three days a week. The provider described difficulties in obtaining timely access to community based occupational therapy and speech and language assessments. The provider had taken measures to ensure that residents could access alternative services if required urgently.

Inspectors tracked the journey of a number of residents with dementia. They also reviewed specific aspects of care such as nutrition, diabetes or wound care in relation to other residents.

The person in charge or the registered provider representative visited prospective residents and completed a pre admission assessment, residents and families were invited to visit the centre. This gave the resident and their family information about the centre and also to ensure that the service could adequately meet the needs of the resident.

Inspectors examined the files of residents who were transferred to hospital from the centre and found that appropriate information about their health, medications and their
specific communication needs were included with the transfer letter.

Residents had a comprehensive nursing assessment on admission. The assessment process involved the use of validated tools to assess each resident’s risk of malnutrition, falls, level of cognitive impairment and their skin integrity. A care plan was developed within 48 hours of admission based on the residents assessed needs. Care plans contained the required information to guide the care of residents, and were updated routinely on a four monthly basis. Specialist advice was included in care plans. There was documentary evidence that residents and relatives where appropriate had provided information to inform the assessments and the care plans. Staff nurses, health care assistants, residents and relatives who spoke with inspectors demonstrated appropriate levels of knowledge about care plans. Pressure sores occurred rarely and residents had access to a tissue viability nurse when required.

Improvement was required to ensure that care plans were updated to reflect the residents' changing care needs. Stronger supervision was also required to ensure that care plans were consistently implemented. For example a resident who was due to be weighed monthly had not been weighed since Feb 2019. In the case of a resident who had a pressure legion and a moisture wound, the pressure relieving mattress was set too high to provide pressure relief. The wounds had not been formally assessed and there was no care plan in place to support a consistent approach for wound care. Narrative notes did not provide adequate information about care provided. In the case of a resident with high support needs, the care staff made entries in bedside charts to indicate that care had been given, for example when the resident's position was changed and the amount of food and fluids taken, but the daily nursing notes did not refer to this information. Although the activity facilitator maintained daily and weekly records for individual residents, social engagement was not referenced in the daily nursing notes.

Staff provided end of life care to residents with the support of their general practitioner and the community palliative care team. Residents had an end of life care plan in place. Staff were competent to discuss end of life care with residents and family members. The inspectors reviewed a number of 'End of life' care plans that outlined the physical, psychological and spiritual needs of the residents, including residents' preferences regarding their preferred setting for delivery of care. Single rooms were available for end of life care. Facilities were provided for families whenever a resident was sick. Families were invited to attend an annual service for deceased residents in November each year.

There were good falls management practices in place. Residents were assessed for the risk of falls on admission and routinely thereafter. Care plans were developed to minimise the risk of falling. Residents were supported to maintain their independence through ongoing physical activation and positive risk taking, that incorporated safety strategies to minimise the impact of any identified risk. The falls audits showed a low level of falls and injury from falls.

Residents with diabetes were appropriately monitored and managed. They had comprehensive care plans in place. Inspectors observed staff measuring residents’ blood glucose levels and found the staff who undertook the procedure adhered to the HIQA guidance of blood glucose monitoring. Residents with diabetes were managed by the GP
and referred to the diabetic clinic where appropriate.

Health screening including retinal, bowel and breast screening was made available to residents as appropriate.

There were systems in place to ensure residents' nutritional needs were met, and that they did not experience poor hydration. Residents were screened for nutritional risk on admission and reviewed regularly thereafter. Residents' weights were checked on a monthly basis, and more frequently when indicated. Nutritional care plans were in place that detailed residents' individual food preferences, and outlined the recommendations of dieticians and speech and language therapists where appropriate. Nutritional and fluid intake records when required were appropriately maintained. Inspectors were present while residents had their lunch and saw that a choice of meals was offered. There was an effective system of communication between nursing, health care assistants and catering staff to support residents with special dietary requirements. Inspectors found that residents on diabetic and fortified diets, and also residents who required modified consistency diets and thickened fluids received the correct diet and modified meals were attractively served.

There were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents which were implemented in practice. Inspectors found that practices in relation to prescribing and medication reviews met with regulatory requirements and staff were observed to follow appropriate administration practices. Medication audits were carried out with action plans to address areas where improvement was required. The centre had piloted an electronic system for prescribing and recording medication administration. Following a review of the project and feedback from nurses, the person in charge told inspectors that they had decided to continue with the paper based model.

Six residents smoked and they all had a risk assessment and a care plan to control any risks identified. Staff, residents and visitors who spoke with inspectors were aware of these plans.

Every resident had a personal evacuation plan (PEEP), which stated their mobility status, the number of staff and any equipment required to evacuate them quickly. The safety of the resident would be further assured with the inclusion of information about potential behaviors which a resident may exhibit on an emergency situation. It should also state if staff were required to remain with the resident to ensure that they did not attempt to reenter the danger zone.

**Judgment:**
Non Compliant - Moderate

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**Outcome 02: Safeguarding and Safety**

**Theme:**
Safe care and support
Outstanding requirement(s) from previous inspection(s):

Findings:
There were measures and procedures in place to protect residents. Staff were facilitated to attend safeguarding training and those who spoke with the inspectors were knowledgeable regarding prevention, detection and response to abuse. The provider and person in charge ensured that there were no barriers to staff or residents disclosing any concerns and that there are systems in place to safeguard residents with dementia. Residents who spoke with the inspectors said that they felt safe in the centre and visitors commented that staff treated residents with dignity.

Residents with dementia can at times be predisposed to episodes of responsive behaviours (how persons with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). Staff were knowledgeable and skilled with supporting these residents and managing episodes of responsive behaviours that they experienced. Staff in the centre were facilitated to attend training in dementia care and managing responsive behaviours inclusive of communication training. The inspectors saw that residents' responsive behaviours were well-managed with person centred preventative and de-escalation strategies implemented by staff who knew residents well.

The provider was a pension agent for six residents in the centre and had robust systems in place to safeguard residents’ monies. Monthly statements were issued to residents and sample of balances checked were found to be in order. The centre is preparing to transition to 'person in care' accounts that are set up individually. Lockable units are available for each resident in their bedroom for securing their personal possessions and there is also a facility for residents to place a small amount of money for their day-to-day expenses in safekeeping by the centre. This money was held securely and all transactions were transparent and signed by the resident where possible. A sample of balances of individual resident's money held in safekeeping was checked by the inspector and found to be correct.

A restraint-free environment was promoted within the centre with bedrails in use for only two residents. One resident had recently been admitted and was awaiting assessment and care planning. The other resident had an appropriate assessment and regular four monthly reviews recorded. Staff reported that safety checks were carried out, however documentation of safety checks for the restraint could be provided on request. This is actioned under Outcome 1.

Judgment:
Compliant

Outcome 03: Residents' Rights, Dignity and Consultation
Theme:
Person-centred care and support

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

Findings:
Inspectors were satisfied that residents were consulted in relation to the organisation of the centre, and that their privacy and dignity was respected.

The monthly residents meetings were well attended and records of these meeting showed that management took action in relation to the issues raised. Residents also availed of opportunities to express their views and make their wishes known when they met with the provider representative and the person in charge during the day. An annual satisfaction survey was administered to residents and relatives to elicit their opinion of the service. The feedback was overwhelmingly positive, and some residents aired their views on matters such as, menu options, activities and excursions. Inspectors met the nominated resident advocate who meets with residents every two to three weeks and raised issues on their behalf. He also issued a quarterly report. Examples of improvements resulting from advocacy services included more robust arrangements for the supervision of residents in the day room and improvements to the laundry services, so that residents’ clothes rarely went missing. Residents told inspectors their clothes were well looked after, and rarely got lost. Each resident had adequate wardrobe space to hang to hang their clothes and drawers for additional storage.

Residents confirmed that their religious and civil rights were supported. Religious ceremonies were held, included a weekly communion service and Mass were celebrated on a weekly basis in the centre. Residents were also supported to attend services in the local community. There was documentary evidence that residents' right to refuse treatment was respected.

Residents confirmed that they could vote in-house and they were also supported to travel to the local polling station if they wished to do so.

Inspectors found the management style of the centre maximised residents’ capacity to exercise personal autonomy and choice. Residents told inspectors they were free to plan their own day, to join in an activity or to spend quiet time in the conservatory or in their room if they wished to do so. One resident was pleased that he had quite time to practice meditation. Another resident informed inspectors that the management and staff had supported him to acquire and maintain a motorised scooter. They also facilitated him to go out on a regular basis. A third resident said he was pleased that he had choice over how to spend his time for example he was aware of the regular movie night arranged by the staff in the centre but preferred to watch and enjoy movies in his bedroom. Inspectors observed residents with dementia being encouraged and supported to follow their own routines.

Residents were supported to come to the dining room at a time of their choice. Staff told inspectors that meal times extended over two hours to offer residents choice.
around meal times. Menu options were offered at each meal. Inspectors observed that residents had three choices at lunch time and staff also enquired about sauces and portion size. Some of the residents who required assistance took their lunch in the day room. Residents who spoke with inspectors said they preferred to eat there because it was more peaceful than the dining room. One to one assistance was offered and staff who provided assistance used small individual folding tables and sat opposite the resident at a level to maintain eye contact. The seating arrangement facilitated social interaction between residents, and the atmosphere was peaceful. This supported meaningful engagement and allowed residents to concentrate on eating their meal without too much distraction or noise.

Friendships between staff and residents was evident. One resident said she only wanted a small lunch because she was joining the staff for a take away meal in the afternoon. Residents choose what they liked to wear and inspectors saw that residents looked well dressed. A resident told inspectors that her eyesight was poor, and when staff helped her to get dressed they support her to choose what clothes to wear. They always described her clothes, and allowed her time to feel the texture of the garments before she decided what outfit to wear.

Inspectors found that residents’ privacy and dignity was respected and promoted. For example, staff used privacy signs when providing personal care and they were observed knocking on bedrooms and bathroom doors and waiting for permission to enter. Staff were observed to be speaking with residents in a respectful way, and using their preferred names. Conversations were paced appropriately to allow residents time to respond to questions. Residents who had difficulty communicating were supported to communicate. All residents had a section in their care plan that covered communication needs, and staff were seen to be familiar with them. Residents had bi-annual optical assessments and were provided with spectacles as appropriate. Some residents had hearing aids and staff were familiar with the care and maintenance of hearing devices.

As part of the inspection, inspectors spent a period of time observing staff interactions with residents who had dementia. Inspectors used a validated observational tool (the quality of interactions schedule, or QUIS) to rate and record at five minute intervals the quality of interactions between staff and residents on the ground floor communal areas. The scores for the quality of interactions are +2 (positive connective care), +1 (task orientated care), 0 (neutral care), -1 (protective and controlling), -2 (institutional, controlling care). Inspectors found overall the interactions were positive with a score of +2 (positive connective care), most frequently awarded. Positive connective care was also observed throughout the day when staff sat with the residents and offered appropriate assistance, offered choice and shared the moment with residents, as they chatted. For example staff greeted the residents by name and chatted while offering residents a smoothie to sample. Tissues were discretely offered and residents’ opinions sought. Staff were familiar with family members and enquired about aspects of children and grandchildren’s lives. Toys were available to encourage children to visit the centre. There was a lot of good humoured banter between staff and residents and humour was often used effectively when dealing with residents who had responsive behaviours. Staff also displayed empathy. One care assistant while helping a resident with her lunch noticed that a lady with sensory impairment, sitting nearby looked lonely. She placed
her hand on the lady’s lap and spoke softly to remind her that she was with friends. Generally residents exuded signs of positive wellbeing. They were interested in what was going on around them. They chatted together, supported each other and offered advice or assistance when it was required.

The trained activity staff member worked full time and was on duty every day, including Saturdays. She organised a varied and comprehensive activity roster for residents, offering both group and individual activities. These activities were facilitated with assistance from care staff. Inspectors spoke with the activity staff who described the range and type of activities, which included quizzes, games, exercise, music and reading. The coordinator reported that residents input, when considering and designing the activity roster, was gathered through discussion with the residents about their likes, dislikes and life stories. Documentation was completed post activities on residents’ enjoyment, engagement, interest and mood during the activity and that this helped inform future activity rosters. There was evidence of one previous planned group outing last summer for residents; no other outing was planned at the time of inspection.

The environment was interesting and stimulating for residents. The conservatory had a hall-stand with coats and hats. Residents who met with inspectors said they enjoyed the activities and music was a favourite for many residents. One resident said he liked the activities and he also liked to do his own thing. He was learning the words of a song so that he could sing it when the music man came at the weekend.

Newspapers were delivered to the centre on a daily basis, and included national and local editions. Each bedroom had a television set and many residents had radios. Some residents had mobile phones and residents had access to a phone to take or make calls including a phone with adjustable volume for residents who were hearing impaired. There was an open visiting policy in place and residents could entertain visitors in a number of rooms including a family room with a kitchenette where they could make refreshments.

Judgment:
Compliant

Outcome 04: Complaints procedures

Theme:
Person-centred care and support

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

Findings:
A policy and procedure was in place to inform management of complaints in the centre. A summary of the complaints procedure was displayed in the entrance hall to assist residents and relatives to understand the process. The complaints procedure was also
described in the residents' guide which was available to each resident. The Residents Guide also advised residents that they can also raise issues or concerns at the residents' meetings and with staff or management at any time. The Advocate met with new residents and informed them that he is available to assist them to raise any concerns or to make a complaint.

A record of complaints raised by residents or relatives was maintained. All issues were investigated and closed out. The actions taken to resolve these complaints were recorded and communicated to complainants and their level of satisfaction with the outcome was recorded to inform the appeals process.

The complaints' policy included details of the person nominated to deal with complaints and outlined details of the independent appeals process. The centre had recently appointed a nominated person to ensure that complaints are appropriately recorded and responded to. The policy and procedure needs updating to reflect this change.

**Judgment:**
Substantially Compliant

### Outcome 05: Suitable Staffing

#### Theme:
Workforce

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

#### Findings:
An actual and planned roster was maintained in the centre with any changes clearly indicated. Inspectors reviewed staff rosters which showed there were two nurses on duty during the day, with management and a regular pattern of rostered care staff. The staffing complement included activity therapists, catering, housekeeping, administration and maintenance staff. The person in charge organised nurse led teams which were allocated to care for a specific group of residents. This ensured accountability and continuity of care to the residents.

The staffing roster reflected the staff on duty on the day of inspection. Inspectors found there was an appropriate number and skill mix of staff to meet the holistic and assessed needs of the residents during the day. Residents who spoke with inspectors said they were satisfied that staff were available to provide timely assistance during the day and at night. Inspectors held the view that night duty staffing levels of one nurse and two health care assistants, required review to ensure residents had timely assistance and that their emergency evacuation needs could be met if necessary. There was no evidence that night time staffing impacted negatively on residents. Staff confirmed that many of the residents with low dependency retired to bed late and less able residents stayed up later if they wished to do so. The management team agreed to review night
time staffing arrangements and to organise a simulated evacuation drill to reflect night
time staffing levels.

On the day of inspection staff were appropriately supervised and annual staff appraisals
were conducted.

New staff were suitably inducted and mentored. There was a varied programme of
training for staff. The person in charge used a training matrix to ensure that staff
attended mandatory training and refresher training, as well as other recommended
training events. Training records, confirmed all staff had completed mandatory training
in areas such as safeguarding, manual handling,behaviours that challenge and fire
safety. Staff also attended annual food hygiene training. All staff had attended dementia
training in 2018. The training plan for 2019 included wound care, care planning and
infection control.

The registered provider representative was a safeguarding trainer and she ensured that
all new staff attended a 3 hour training session on safeguarding as well as refresher
training for all staff. She held informal staff training sessions twice weekly. She was
currently updating staff on the revised policies and some sessions were held at 7:00 am
to facilitate night staff.

A recruitment policy in line with the requirements of the Regulations was implemented
in practice. Inspectors reviewed a sample of staff files which included all the information
required by Schedule 2 of the Regulations. Volunteers working in the centre were Garda
Vetted and there was a written statement setting out their role and level of involvement
in the centre.

Judgment:
Substantially Compliant

Outcome 06: Safe and Suitable Premises

Theme:
Effective care and support

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

Findings:
The location, design and layout of the centre were suitable for its stated purpose and
met residents’ individual and collective needs in a comfortable and homely way. Actions
to achieve compliance had been completed. Stair lifts are installed. Ramps were fitted to
improve access to assisted bathrooms and staff were provided with alternative facilities
so that the family room was available to visitors.

Entrance to the centre was through a pleasant reception area which was adjacent to the
management office and the front parlour. Additional communal day rooms and a dining room were located on the first floor. The centre had been extended to create a conservatory which brought light into the interior sitting and dining rooms. The interior sitting room was spacious and bright yet calm and homely owing to the soft furnishes throughout. Tea, coffee and water facilities were available to residents in this area. Activities were facilitated in this room and the Easter decorations and artwork which residents made were evident throughout the centre. The conservatory opened up the day room to views of the outdoors and was designed with temperature controls to ensure that it was comfortable for residents use all year round. The large windows looked out on the secure landscaped Japanese garden with safe circular pathways.

The garden was pleasant and inviting with abundant green shrubbery and figurines to stimulate interest for residents such as a bird house and an ornamental sheep dog with a bowl of water, which was bought for a man who missed his dog. Residents had free access to the garden and they told inspectors they loved the garden because it was peaceful to sit in and beautiful to look at when weather was inclement. An attractive garden tea house with Japanese lanterns was used as the smoking room, this area was decorated with hanging lanterns and wind chimes. All necessary fire prevention measures and fire fighting equipment were present. Some bedrooms on the ground floor opened out into the garden. Throughout the garden there was seating provided for residents to sit and enjoy the outdoor space. Both side exits to the front of the house that are designated as fire exits were clear of obstacles.

Bedroom accommodation was provided on three floors in single and twin rooms, many of which had ensuite toilet and shower facilities. The inspectors were satisfied that the bedroom accommodation met residents’ needs for privacy, leisure and comfort. In total, there were 14 single and 13 twin rooms. There was a spacious treble bedroom on the second floor. Some rooms had ensuite toilets and others had full en-suite shower facilities. Many of the residents had personalised their bedrooms with family photographs, favourite ornaments and small items of furniture. Short ‘potted-history’ signs were displayed at residents’ bedsides, with resident’s consent. These were used to aid meaningful engagement and connection between residents, their visitors and staff at the centre. Each bedroom had a television and a wall clock. Adequate screening was provided in shared accommodation. Built in wardrobes and lockable drawer units provided adequate storage space for residents clothing and personal items. Privacy signs were observed throughout the premises on bedroom doors to ensure others observed residents’ right to privacy and dignity.

Chair lifts provided access between the floors. Five twin rooms and one single room were on a level with steps, which made them suitable for mobile residents only. Residents who occupied these rooms and the upper floor were assessed regularly to determine that they were suitably mobile to negotiate steps and/or to use the chair lift. Inspectors found that accommodation provided was suitable for the residents. There was a bathroom available to offer choice to residents and there were sufficient number of showers and toilets in the centre. Since the last inspection ramps had been installed on the second floor to improve accessibility. There were additional assisted toilets and bathrooms throughout the premises; these are located strategically, for example, close to day-rooms and along the corridors. The provider also had plans to build a wet room.
The building promoted a dementia-friendly environment. Many items displayed on walls were historical to promote conversation and reminiscence. Contrasting colours were also used in the toilets and shower rooms to aid orientation. Appropriate signage, in word and picture format, was available at eye level height throughout the centre to orientate residents and to promote independence. Plain, matt floor coverings were used and carpets and soft furnishing effectively minimised glare and noise. Grab rails were in place in circulating areas to support residents to move about safely.

The sluice room was secured by a code lock and it was suitably equipped. Adequate arrangements were in place for the disposal of clinical and domestic waste. There was adequate storage space provided to ensure that equipment and assistive devices were stored in a safe and discreet manner. Assistive equipment such as air mattresses and hoists were available, and servicing contracts were in place.

Call bells were provided in all bedrooms and communal areas.

The inspectors found that a high level of cleanliness and hygiene was maintained throughout the building. Staff spoken with were knowledgeable as regards infection control measures, and the safe use and storage of cleaning chemicals and disinfectant agents.

Opportunities for improvement were discussed including:
- The installation of additional lever/grab rails in the toilets.
- An additional gel dispenser on the first floor return area
- Arrangements to open a locked gate on the fire evacuation pathway.
- Review arrangements to control continence odours in two bedrooms.

Judgment:
Substantially Compliant

**Outcome 08: Governance and Management**

**Theme:**
Governance, Leadership and Management

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

**Findings:**
The centre had effective leadership and governance and management arrangements in place and clear lines of accountability. The quality of care and experience of residents
was monitored and improved on an on-going basis. The provider understood the business and it's functions as outlined in relevant legislation, regulations and standards. The provider adequately resourced the service to provide person centred, effective and safe services for residents.

The management team comprised the registered provider representative (RPR) the person in charge (PIC) and the administrator. The RPR was a company director and worked in the centre from Monday to Friday. The RPR was actively engaged in quality improvement, staff training and had a special interest in promoting person centred care. She was very visible on the floor and well known to residents and visitors. The person in charge worked full time and she took a clinical lead. She was supported by a team of nurses and had a protected management day each week. The RPR deputised when the person in charge was not on duty.

The management team held formal weekly meetings. They also held a quality improvement meeting each month, which was attended by an external consultant. Residents’ rights and dignity was a standing agenda item. Records showed that fire safety and dementia training were discussed and it was confirmed that all Schedule 5 Policies had been reviewed.

Staff told inspectors that the provider representative and person in charge were approachable and they operated an open door policy. Formal meetings were held twice yearly, where management met with all staff.

Effective auditing and quality improvement initiatives were in place to ensure the provider had an effective system to provide oversight of the service provided. Action plans were drawn up and implemented to improve the service. Systems are in place to consult with residents and their views were reflected in the Annual Review of the quality and safety of care. The review had been discussed at the residents meeting and was available for residents, staff and visitor to read.

Judgment:
Compliant

Outcome 09: Statement of Purpose

Theme:
Governance, Leadership and Management

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

Findings:
The revised Statement of Purpose held all the required information as set out in Schedule 1.
### Outcome 10: Suitable Person in Charge

**Theme:**
Governance, Leadership and Management

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

**Findings:**
The person in charge had been in post since 2009. She was a registered nurse with a post graduate qualification in management and gerontological nursing. She worked full time in the centre. Suitable arrangements were in place for the registered provider representative to deputise when the person in charge was on leave.

**Judgment:**
Compliant

### Outcome 12: Notification of Incidents

**Theme:**
Effective care and support

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

**Findings:**
All requirements outlined in regulation 31 concerning notifiable incidents and required reporting to the Office of the Chief Inspector were observed.

**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:**

Mary O'Donnell  
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 report

Centre name: Atlanta Nursing Home
Centre ID: OSV-0000010
Date of inspection: 11/04/2019
Date of response: 14/05/2019

Requirements

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

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

Outcome 01: Health and Social Care Needs

Theme: Safe care and support

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

Improvement was required to ensure that care plans were updated to reflect the residents' changing care needs. Stronger supervision was required to ensure that care plans were consistently implemented. Personal Emergency Evacuation Plans required more information to guide staff and ensure the safety of the resident post evacuation.

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
1. Action Required:
Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident’s family.

Please state the actions you have taken or are planning to take:
(a) All care plans have been reviewed per Regulations 05(3) and 05(4) 2nd May
(b) A new format for care Plans is being introduced

Proposed Timescale: 31/05/2019

Outcome 04: Complaints procedures
Theme:
Person-centred care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The centre had recently appointed a nominated person to ensure that complaints are appropriately recorded and responded to. The policy and procedure needs updating to reflect this change.

2. 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:
(a) This is contained in our Statement of Purpose. 3rd May
(b) Policy and Procedure as to recent appointment of external auditor being drafted.

Proposed Timescale: 17/05/2019

Outcome 05: Suitable Staffing
Theme:
Workforce

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Night duty staffing levels of one nurse and two carers required review to ensure residents received timely assistance when retiring at night and their emergency evacuation needs could be met if necessary.

3. Action Required:
Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

**Please state the actions you have taken or are planning to take:**
Number and skill mix reassessed and deemed adequate. We are however endeavouring to recruit an additional HCA for the evening shift (20.00H to 23.00H).

**Proposed Timescale:** 31/05/2019

**Outcome 06: Safe and Suitable Premises**

**Theme:**
Effective care and support

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
Opportunities for improvement were identified to enhance the safety and wellbeing of residents:
- The installation of additional lever grab rails in the toilets.
- An additional gel dispenser on the first floor return area.
- Review the location of the key to a gate on the fire evacuation pathway.
- Review arrangements to control continence odours in two bedrooms.

4. **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:**
These opportunities for improvement have been actioned.

**Proposed Timescale:** 17/05/2019