

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Hollymount Private Nursing and Retirement Home
Centre ID:	OSV-0000348
Centre address:	Kilrush, Hollymount, Claremorris, Mayo.
Telephone number:	094 954 0232
Email address:	hollymountnursinghome@hotmail.com
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Doonaroom Limited
Lead inspector:	Marie Matthews
Support inspector(s):	None
Type of inspection	Unannounced Dementia Care Thematic Inspections
Number of residents on the date of inspection:	30
Number of vacancies on the date of inspection:	6

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 National Standards. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
25 April 2019 11:00	25 April 2019 19:30
26 April 2019 10:00	26 April 2019 18:30

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

Outcome	Provider's self-assessment	Our Judgment
Outcome 01: Health and Social Care Needs	Compliance demonstrated	Non-Compliant - Moderate
Outcome 02: Safeguarding and Safety	Compliance demonstrated	Compliant
Outcome 03: Residents' Rights, Dignity and Consultation	Compliance demonstrated	Non-Compliant - Moderate
Outcome 04: Complaints procedures	Compliance demonstrated	Compliant
Outcome 05: Suitable Staffing	Compliance demonstrated	Non-Compliant - Moderate
Outcome 06: Safe and Suitable Premises	Compliance demonstrated	Non-Compliant - Moderate
Outcome 07: Health and Safety and Risk Management	Not applicable	Non-Compliant - Major
Outcome 08: Governance and Management	Not applicable	Non-Compliant - Moderate

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. As part of the thematic inspection process, providers were invited to attend information seminars given by the Authority. In addition, evidence-based guidance was developed to guide the providers on best practice in dementia care and the inspection process. Prior to the inspection, the person in charge completed the provider self-assessment and compared the service with 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 provider had assessed the centre as compliant in all six areas assessed. The inspector identified areas of non-compliance under four of the six outcomes reviewed. Non-compliances were also identified in relation the risk and governance and management.

The inspector followed up on twenty actions identified during the last inspection in November 2017 and on issues raised in information of concern received by Office of Chief Inspector prior to the inspection. 16 of the actions were addressed. The action in relation to the need for additional bathrooms was in progress. An action in relation to ensuring shared bedrooms met the needs of residents without impacting on their privacy had not been addressed. The action in relation to ensuring suitable staff were deployed to oversee the social care programme was not adequately addressed. While a staff member was deployed to the role, the inspector found that the staff member was also responsible for supervision of residents which detracted from their ability to give the residents the attention required. The action in relation to fire drills was not adequately addressed and further non compliances were identified in this area. Actions not addressed are restated in this report.

The issues of concern were examined and were not substantiated by the inspector.

The centre does not have a dementia specific unit however the inspector focused on the care of residents with a dementia during this inspection. Six residents were formally diagnosed with dementia and a further five had some element of cognitive impairment. The inspector met with residents, relatives, and staff members during the inspection. The inspector tracked the journey of a number of residents with dementia within the service, observed care practices, and interactions between staff and residents who had dementia using a validated observation tool (called Quiz). The inspector also reviewed documentation such as care plans, medical records, staff files, relevant policies and the self- assessment questionnaire submitted prior to inspection.

Two restrictive conditions were applied to the registration of the centre following the last inspection in November 2017. These were as follows :

Condition 8: The physical environment in the designated centre must be reconfigured as outlined in the plans submitted to the Chief Inspector on 22 March 2018 the reconfiguration must be complete by 30 April 2019. The provider was found to be in breach of this condition.

Condition 9: The registered Provider shall:

A) Have put effective management systems in place and shall ensure that the service provided is at all times safe, appropriate to the needs of residents in effectively monitored.

B) Have addressed to the satisfaction of the Chief Inspector the regulatory non-compliances identified in the inspection reports of 7 November 2017 and 17 Feb 2017.

The provider had complied with this condition.

The provider had put in place enhanced governance arrangements. The lines of authority and accountability were clearly defined and the management team had a strong presence within the centre. However improved oversight of some aspects of the service was required as evidenced by:

- Poor supervision of residents in communal areas
- Inadequate fire evacuation procedures
- Inadequate oversight of the care of residents susceptible to developing pressure wounds.
- A dental service was no longer available to residents
- The privacy of residents in some shared rooms was impacted by the close proximity of beds.

Residents were observed to be relaxed and comfortable in the company of staff and the feedback about the service was very positive with the service and care provided. Several residents were sitting outside in the sunshine in this area during the inspection enjoying a visit by two lambs.

The centre was warm, clean, and well maintained. Additional improvements in relation to the premises were identified which are discussed in the body of the report and set out in the action plan for response.

Overall the healthcare needs of residents were met. There was evidence of regular review by the residents GP and access to a range of allied healthcare services. However improvements were required in relation to managing residents at risk of developing pressure areas, supervision of residents at risk of falls and ensuring that all residents had access to a dental service.

Staff had completed mandatory training as well as a range of training courses, including a dementia training course. The centre was experiencing difficulties recruiting and retaining staff. The inspector found that the staffing levels and the deployment of staff required review to ensure residents were appropriately supervised and their needs met at all times.

There was a clear complaints procedure in place and residents had access to an independent advocate where requested.

Residents confirmed that they felt safe in the centre and there were measures in place to safeguard residents with dementia and protect them from abuse. The staff had the skills and knowledge to help them to care for residents who have behaviour that is challenging (behaviours and psychological signs and symptoms of dementia).

The findings are discussed further in the report and improvements required are included in the Action Plan at the end of the report.

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):

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

Findings:

Residents had good access to a range of health and social care services, and for the most part their health care needs were being met. Improved oversight of the care of residents susceptible to pressure wounds and those at risk of falls was required. Improvements were also identified regarding access to a dental service.

The person in charge said she communicated by phone with residents or their families to ascertain if they could be cared for in the centre. The person in charge said that consideration was given to how the staff would be able to meet the needs of prospective residents. However the pre-assessment was usually completed with a family member and there was a risk that some care needs were not known before the decision to admit residents was made. Some residents visited the centre prior to admission which gave them an opportunity to meet with staff and see the centre.

Comprehensive up-to-date nursing assessments were in place for all residents. A range of evidence based assessments were completed for residents in relation to their risk of developing pressure ulcers, falls risk, nutritional assessment, dependency, moving and handling and continence.

A new electronic care planning system was in use and in the main, the care plans reviewed were detailed and person centered. Care plans were in place for residents with dementia which included information on how the residents' cognitive impairment impacted on their daily life. In general the care plans were person centred and there was evidence that they were reviewed regularly. Where there was a change in the residents care needs, a new care intervention was added, however, in some of those reviewed the previous interventions was not removed which made the care plans confusing and difficult to follow.

There was a process in place when residents required transferred to hospital to ensure relevant information about their care needs was shared. On review of a sample, they did

not include the latest risk assessments completed. For example one transfer letter reviewed indicated that the resident was at risk of falls but the transfer record did not refer to the risk rating from the most recent falls risk assessment in order to ensure that the acute hospital had full and accurate information about the residents care needs. Residents had access to general practitioner (GP) services and could retain their own GP if they so wished. Two GPs attended the centre and an out-of-hours GP service was available which covered night-time and weekends. The inspector reviewed a sample of medical files and found that GPs reviewed residents on a regular basis.

A full range of other allied support services was available including speech and language therapy (SALT), physiotherapy, occupational therapy (OT), dietetic services, Tissue Viability specialists, and psychiatry of later life. The inspector saw that residents were appropriately referred to these services and the advice of the specialist was recorded in the residents' progress notes and in their care plans.

Access to health screening was made available to all eligible residents. A dental service was no longer available which meant that those unable to attend their local dentist could not access this service. No alternative arrangements had been put in place by the provider at the time of the inspection.

The inspector also saw that medications were appropriately stored and were individually prescribed and administered. There was a system to ensure that each resident's medication was regularly reviewed by their GP. Where PRN (as required medications) was prescribed the maximum dosage was stated.

Residents were weighed monthly and any weight changes were closely monitored. Each resident had a nutritional assessment completed using a validated assessment tool. Where weight loss was identified, the nursing staff informed the GP and referred the resident to a dietician and speech and language therapy (SALT). Files reviewed by the inspector confirmed that their advice was incorporated. The catering staff member spoken with was familiar with the dietary preferences of the residents and knew their likes and dislikes. There was an effective system in place to ensure that all staff were made aware of residents who required a specialised or modified diet and were knowledgeable regarding the recommendations of the dietician and SALT.

The kitchen was well stocked with fresh fruit and vegetables and supplies of meat. Fruit was incorporated in the resident's diet to help ensure good bowel function. There were two meal sittings and those who required assistance had their meal first. A variety of hot and cold drinks, as well as snacks and fruit were offered and encouraged throughout the day. Residents told the inspectors that they could have something to eat or drink at any time including night time.

Low-low beds, crash mats, and sensor alarms were in provided for several residents to prevent a fall. The person in charge reviewed falls on a regular basis. Falls risk assessments were completed regularly and care plans were updated following a fall. The inspector reviewed the accident and incident log. Incident forms were completed in good detail however, more than 70% of the falls that occurred happened at night-time. Better oversight was required to ensure residents at risk of falls were appropriately

supervised.

Better oversight was also required of the care of residents susceptible to pressure wounds to ensure that all required interventions were put in place to ensure skin integrity was protected. Although preventative measures including pressure relieving mattresses and regular re-positioning turns were in place to help prevent residents at risk from developing pressure wounds, four residents had developed pressure wounds since admission to the centre. Two hourly repositioning were completed by staff however on review some records omitted the residents name and some were not signed by the staff member who completed them.

Residents had some opportunities to participate in social activities; however this was dependent on the availability of staff. This is discussed further under outcome 4.

Judgment:

Non Compliant - Moderate

Outcome 02: Safeguarding and Safety

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

The inspector spoke with seven residents during the inspection. All said they felt very safe and secure in the centre. Residents commented that the building was secure and all visitors signed the visitors' book. The person in charge confirmed that there were no safeguarding complaints under review. Training records reviewed by inspector indicated that staff were facilitated to attend training related to the care of people with dementia which included the management of behaviours and psychological symptoms of dementia (BPSD). Residents with dementia had a dementia care plan which included person centred guidance on strategies to help avoid escalations in behaviours.

Residents with dementia were provided with support that promoted a positive approach to the behaviours and psychological symptoms of dementia (BPSD). The staff were observed to be knowledgeable regarding how to respond the residents which prevent the behaviours from escalating. Interactions were respectful which resulted in positive outcomes for residents with dementia.

The provider was a qualified safeguarding trainer and delivered regular training to all grades of staff. The inspector spoke with all of the staff on duty. All were able to describe various forms of abuse and they knew the signs to look out for in residents who were unable to voice their concerns. All said they would have no hesitation in

reporting any concerns to the person in charge.

The person in charge had worked to eliminate the use of bedrail restraints and alternative less restrictive interventions such as low entry beds and the use of crash mats were used to prevent injuries.

The provider did not act as a pension agent for any of the residents. The person in charge looked after small amounts of monies for some residents. A record was available for all transactions and these were signed by two staff. The provider completed regular audits of the records. The inspector checked the balance of a sample of and the balance recorded was correct. Residents could access their money at all times.

Judgment:

Compliant

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

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

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

Findings:

Residents said they were consulted on a day to day basis regarding their day to day routine and more formally at a residents meeting which took place every six months. The inspector reviewed the minutes of past meetings. The minutes clearly recorded the actions taken in response to issues arising from the previous meeting. Issues discussed included social outings, complaints, satisfaction with the service and staffing levels. All residents spoken with said they felt free to discuss any day to day issues regarding the organisation of the centre.

An independent advocate was visiting residents the week of the inspection. Satisfaction surveys were also completed by residents from time to time. There was a high level of satisfaction expressed by residents in the sample reviewed. The previous inspection identified that the approach to meal times was institutionalised because meal times were early and fixed. The inspector saw that one of the questions asked of residents in the satisfaction survey related to meals. While the indication was that residents were happy with the quality and choice of meals provided, the survey did not solicit feedback on the timing of the meals. The main meal was served at 12pm for residents requiring assistance irrespective of the time the residents had their breakfast. The staff confirmed that residents who wanted to have their dinner earlier could do so however residents with dementia may not be able to make their preference known. The inspector judged that the timing of meals required review to ensure that it was at a time that suited

residents.

An open visiting policy was in place, with the exception of protected time for residents at mealtimes.

Residents were facilitated to exercise their civil and political rights, including voting either in the centre or their electoral area. Residents were supported to practice their respective faiths. The profile of residents was catholic and mass was celebrated in the centre once a month. Residents had access to daily newspapers, to internet and telephone facilities, and to local media. Residents' property was well maintained. The centre property list was completed on admission and the inspector saw that there was a system in place to ensure any new items were added to the list.

On the day of the inspection residents were outside in the garden and were enjoying a visit from a local farmer who had brought in two lambs. The residents said they had pet therapy regularly and a therapy dog had visited the centre the previous day. There was a variety of social activities arranged which included live music, bingo and Sonas (a therapeutic activity for residents with dementia).

On the last inspection there was no designated activities coordinator to facilitate the social care programme. Two staff members now fulfilled this role and one was deployed each day to facilitate a social activity programme. The inspector saw that the activity staff strived to improve the type and variety of activities to ensure that meaningful and interesting activities were provided for all residents, however the activity staff member was also responsible for the supervision of residents in two sitting room areas. This meant that social activities were subject to interruption if one of the residents wanted to leave or required assistance. It also made it difficult for the staff member to provide individual one to one therapies to residents with dementia who preferred a quiet environment. The staff providing activities to residents with dementia had not received any specific training. In view of the number of residents accommodated with dementia this training was recommended.

Records of the social activities attended by residents were maintained electronically. Records for some residents indicated regular attendance at social events. Some records reviewed however did not provide assurance that residents unable to participate in group activities had regularly meaningful engagement. Passive activities such as watching television were recorded and on some days there was no meaningful activity recorded. Life histories had been documented for all residents but there was no clear link between the information collected and the range of activities provided.

The inspector observed the quality of interactions between staff and residents using a validated observational tool to rate and records these interactions at five minute intervals in a dining-room, sitting room, and activity room. 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). The majority of the observation periods found positive connective care provided to residents. It was evident that the staff were knowledgeable regarding the residents they cared for and

interactions were courteous and kind. There were long periods however when there were no interactions and residents sat unsupervised with a television on in the background.

On the last inspection the inspector identified that some of the two-bedded rooms were small for two resident and the beds were positioned end to end making it difficult to attend to one resident without disturbing the other. This action was not addressed and the privacy of these residents continued to be compromised. This action is restated in this report.

Judgment:

Non-Compliant - Moderate

Outcome 04: Complaints procedures

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

There was a policy and procedures in place for the management of complaints. A summary of the complaints process was displayed in the centre. The residents who spoke with the inspector were aware of the complaints process and had confidence that any concerns they had would be addressed and they were not concerned that they would be adversely affected for having made a complaint. The staff said they would support residents with dementia to make a complaint. Contact details for an independent advocate were displayed and an advocate was due to attend the centre the following week.

A complaints log was maintained by the person in charge, who was the centre's nominated complaints officer. The inspector reviewed this log. Those recorded had details of complaints made, the investigation completed, and the actions taken in response to complaint. The complainant's satisfaction with the outcome of the complaint was also recorded. Complaints were resolved within the timeframes set out within the centre's policy. A new log was introduced in response to the last inspection which captured informal day to day issues of concern that arose. This indicated that any issues raised were promptly addressed by staff.

Judgment:

Compliant

Outcome 05: Suitable Staffing

Theme:
Workforce

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

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

Findings:

The inspector judged that a review of staffing levels was required to ensure that there was sufficient staff from each grade available to meet the assessed needs of residents. As discussed under outcome 3, residents in one sitting room were observed to be unsupervised for long periods during the inspection. The staff that facilitated the social activity programme were also responsible for supervision of residents so social activities were subject to interruption if a resident required assistance. 19 of the residents had maximum or high dependency needs and required the assistance of two staff. Care staff on duty at night time had considerable cleaning and household tasks to complete which took them away from their primary role. While the number of accidents and injuries overall had reduced, more than half of the falls sustained by residents occurred at night.

There was one nurse and four care assistants on duty during the day (in addition to a person in charge); this reduced in the evening to one nurse and three care assistants until 10pm and at night there one nurse and two care assistants on duty. A staff member was assigned to cleaning and laundry duties five days a week. This staff member also assisted with breakfast and getting residents up in the morning. Care staff on duty at night had considerable cleaning and laundry tasks to complete as a consequence in addition to their care duties. The inspector found that the records of night time safety checks on residents and records to evidence that two hourly turns were completed (for residents whose skin integrity required them to be regularly turned at night time) were poorly completed and were not signed by the staff completing the checks. The person in charge described ongoing difficulties recruiting and retaining staff. Existing staff were rostered to provide cover for staff on annual or sick leave.

There were safe recruitment procedures in place. In the sample of staff files reviewed, all of the requirements of Schedule 2 of the Regulations were met including Garda vetting clearance. Staff members had an annual appraisal. All new staff completed an induction period to help them to become familiar with the care needs of residents.

An on-going training plan was evident and a matrix was used to identify when refresher training was due. The records reviewed confirmed that regular training in mandatory areas such as fire safety, manual handling, and safeguarding was provided. The staff spoken with were able to provide feedback on the training they completed in relation to their role.

The staff were observed to be kind and respectful towards residents and were aware of the importance of effective communication for residents with dementia. The residents who were able to speak with the inspector were complimentary of the staff and described them as kind and caring. The provider confirmed that there were no

volunteers working in the centre.

Judgment:

Non-Compliant - Moderate

Outcome 06: Safe and Suitable Premises

Theme:

Effective care and support

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

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

Findings:

The premise was clean and well-maintained, with suitable heating, lighting, and ventilation. Signs were displayed identifying the dining room and sitting room and pictures were provided on bedroom doors however; additional visual cues, signage, and use of colour were required to help orientate residents with dementia to their environment. Some improvements were also required in relation to improving the amount of outdoor space available the configuration of some shared bedrooms and additional toilet facilities were required for one bedroom which didn't have an ensuite bathroom.

The building had been recently extended and two new bathrooms had been added to bring the centre into compliance with 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 2016. Work on these was in progress and the expected completion date was the end of May 2019. Both bathrooms will have had a level access shower and be accessible to residents using a wheelchair. The requirement to do this work was identified at the previous inspections and these facilities were not ready for use at the time of the inspection. This action has been restated in the compliance plan that accompanies this report.

The centre comprises 14 single bedrooms ranging in size from 9m² to 11.2m² and 11 two bedded rooms ranging in size from 14.8 m² to 18.3m². The size and layout of most bedrooms was suitable to meet the needs of residents, however, the suitability of two shared rooms required review to ensure they afforded residents sufficient space. Two shared bedrooms were small and the beds were arranged end to end against a wall. There was not sufficient space for the staff to walk between the beds to attend to the needs of one resident without disturbing the other. Assistive equipment could not be stored in the room and the residents could not sit comfortably in a chair beside their beds. This action has been restated in the compliance plan that accompanies this report.

With the exception one bedroom which had a wash hand basin, all bedrooms has ensuite toilet and wash hand basin. Bedrooms were appropriately furnished and some were personalised to reflect the residents' interests. Each room had a bedside locker, wardrobe and a chair as well as a television, and alarm call bell, clocks and calendar.

One two bedded room located at the end of a corridor did not have an ensuite toilet and was located over 20 meters from the nearest toilet. The toilet in the bathroom closest to this resident had been removed when this room was refurbished to provide accessible shower facilities. Consequently a resident occupying this room would have to walk along the main corridor, past the reception/foyer area and along another corridor to get to the nearest bathroom. The provider agreed that the toilet would be reinstated in the closest bathroom immediately.

Signage was displayed to support residents to navigate the premises. Handrails were in place on both sides of each corridor. The floor covering and wall colour throughout all of the corridors was similar and better use of colour or the provision of wall murals and picture references were required to help orientate residents. Bedroom doors were painted the same colour as bathroom doors and while each bedroom door had a picture of a flower, these pictures were similar and didn't aid orientation. Improved signage or person centred imagery was required to help residents with dementia find their room.

Alternative storage facilities had been identified and the assistive equipment was stored appropriately during this inspection. Some new garden furniture had been provided in the enclosed garden. This area was in use during the inspection and the inspector observed it was small which restricted the number of residents who could use the amenity. An extension of the enclosed garden was required to provide sufficient space to allow all residents to spend time outdoors. The door accessing the enclosed garden was linked to the centres fire alarm however so residents could not independently access this area without the support of staff.

Judgment:

Non-Compliant - Moderate

Outcome 07: Health and Safety and Risk 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:

Significant non-compliances were identified in relation to fire safety procedures during the inspection that required the provider's urgent attention to ensure the safety of residents. The provider was issued with an urgent compliance plan to address these

issues.

The records of fire evacuation drills available did not provide assurance that residents in each compartment could be safely evacuated in the event of a fire. The records omitted the evacuation times and schedule of resident dependencies and evacuation resources required (staff and equipment) for the simulated evacuation of the compartment with the highest dependencies using night time staffing levels and procedures. Therefore the provider did not have information to assure them that drills were being completed within expected timeframes.

There were no Personal Emergency Evacuation Plans (PEEPS) available detailing the assistive equipment required and level of assistance each resident required to safely evacuate residents.

Two bedroom doors were held open with a chair and no electromagnetic devices were fitted to bedroom doors to keep them open if this was the residents preferred option. This meant that if the fire alarm sounded, the door would not close to provide protection from smoke or fire.

The building comprised four fire compartments however some of these had been divided into sub compartments. The fire alarm system did not reflect this and only identified 4 fire compartments. This led to risk that staff may not know exactly where the alarm has been activated from and slow their response.

Measures identified in a premises risk fire safety risk assessment were inaccurate. The document stated that a personal emergency plan was available for each resident which was not accurate. Staff on the day were not aware of them and when the inspector requested what arrangements were in place to know residents evacuation needs ,no information was provided.

Judgment:
Non-Compliant - Major

Outcome 08: Governance and Management

Theme:
Governance, Leadership and Management

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

Findings:
The provider had strengthened the governance arrangements. The management team met once a month to discuss the operation of the centre and had a strong presence in the centre. The centre manager was based in the centre. Two staff members shared the role of person in charge and both staff members had attended training on auditing in

response to the findings in the last inspection. There were improved audit procedures evident with better analysis conducted. An annual review of the services had been completed which reference the findings of the audits completed and identified areas for improvement.

The oversight arrangements in place had not identified some of the areas of non-compliance found during the inspection and therefore required review to assess their efficiency. A review of staffing levels was required to ensure that residents assessed care needs could be met. Better oversight of the care for residents susceptible to pressure wounds was also required.

The management of fire safety procedures also required review to ensure these were fit for purpose. The fire evacuation procedures in place did not provide assurances that residents could be safely evacuated in the event of a fire.

Judgment:

Non-Compliant - Moderate

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:

Marie Matthews
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:	Hollymount Private Nursing and Retirement Home
Centre ID:	OSV-0000348
Date of inspection:	25/04/2019
Date of response:	06/06/2019

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 Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:

Pre-assessment admission assessments were not completed prior to admitting residents to the centre. There was a risk that some care needs were not known before the decision to admit the resident was made.

1. Action Required:

Under Regulation 05(2) you are required to: Arrange a comprehensive assessment, by

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

an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to the designated centre.

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

Pre-admission assessments will be completed where possible for long term/pre planned admissions.

This compliance plan response from the registered provider did not adequately assure the office of the chief inspector that the actions will result in compliance with the regulations.

Proposed Timescale: 01/06/2019

Theme:

Safe care and support

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

The precautions in place to prevent pressure wounds developing and to prevent residents sustaining falls at night time, required review.

2. Action Required:

Under Regulation 06(1) you are required to: Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

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

The Waterlow score is used by nursing staff as a tool to identify residents at risk of pressure wounds. In addition, a variety of pressure relieving aids have been sourced and are available to staff for the prevention of pressure wounds.

Accidents/incidents are reviewed monthly. Crash mats and low-low beds are in use. Audits are carried out 3 monthly. If any recurring incidents with a resident are determined then the resident is seen by the Occupational Therapist.

Proposed Timescale: 27/05/2019

Theme:

Safe care and support

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

The records of repositioning residents vulnerable to developing pressure wounds were not completed in good detail and the hospital transfer letters were not completed in sufficient detail to provide an accurate record of care

3. Action Required:

Under Regulation 21(6) you are required to: Maintain the records specified in paragraph (1) in such manner as to be safe and accessible.

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

The hospital transfer letter has been edited to include the Cannard and Waterlow score as well as Resus status.

The repositioning record has been edited to include the signature of the staff member completing the reposition.

Proposed Timescale: 16/05/2019

Outcome 03: Residents' Rights, Dignity and Consultation
Theme:

Person-centred care and support

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

Residents with dementia were not provided with access to meaningful activities

Records of the social activities attended by residents did not provide assurance that residents who could not participate in group activities had regularly meaningful engagement.

4. Action Required:

Under Regulation 09(2)(b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests and capacities.

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

Two staff members have completed SONAS training for dementia residents. The schedule of activities has been reviewed and now includes allocated time for both sitting rooms. Informal activities such as reading the newspaper, hand massage etc are carried out throughout the day.

Proposed Timescale: 29/05/2019

Theme:

Person-centred care and support

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

Residents did not have choice as the timing of meals reflected an institutional approach to care with a pre-set time each day.

5. Action Required:

Under Regulation 09(3)(a) you are required to: Ensure that each resident may exercise

choice in so far as such exercise does not interfere with the rights of other residents.

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

All residents are aware they can have their meals at any time. A resident survey was carried out to get opinions on the meal times and majority of residents prefer having their main meal early in the day. For those that prefer to have their meal at an alternate time, they are catered for without hesitation.

Proposed Timescale: 29/05/2019

Theme:

Person-centred care and support

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

The configuration of beds in shared bedrooms end- to- end and in close proximity made it difficult to ensure the privacy of both residents or for staff to attend to one resident without disturbing the other.

6. Action Required:

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

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

The furniture in some of the shared room have been re-organised to maximise space and privacy for residents.

This compliance plan response from the registered provider did not adequately assure the office of the chief inspector that the actions will result in compliance with the regulations.

Proposed Timescale: 30/05/2019

Outcome 05: Suitable Staffing

Theme:

Workforce

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

A staffing review was required

7. 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:

Staffing review with particular reference to housekeeping is being carried out and any changes that are identified from that review will be put in place

This compliance plan response from the registered provider did not adequately assure the office of the chief inspector that the actions will result in compliance with the regulations.

Proposed Timescale: 30/06/2019

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:

Additional visual cues, signage and use of colour were required to help orientate residents with dementia to their environment

8. Action Required:

Under Regulation 17(1) you are required to: Ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.

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

Signage throughout the Nursing Home will be enhanced for the benefit of residents by 30/6/2019

Proposed Timescale: 30/06/2019

Theme:

Effective care and support

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

1. Two shared bedrooms did not provide sufficient space for two residents and for the storage of their assistive equipment and belongings. Beds were positioned end to end and against the wall in these rooms making it difficult for staff to assist residents who required a hoist or the assistance of two staff. There was no room for a resident to sit out in a chair beside their bed in private.

2. Until two new bathrooms were finished and brought into use there were insufficient bathroom facilities available for 36 residents.

3. One resident did not have bathroom facilities near their bedroom.

4. The enclosed garden was small and when used by several residents at the same time, was congested.

9. 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:

The furniture in some of the shared room have been re-organised to maximise space and privacy for residents 30/5/2019

The 2 new bathrooms are planned to be operational by 30/6/2019

Toilet will be into Shower room 3 by 30/6/2019

The size of the enclosed garden will be reviewed 30/6/2020

Proposed Timescale: 30/06/2019

Outcome 07: Health and Safety and Risk Management

Theme:

Safe care and support

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

The arrangements for training staff in emergency procedures including fire evacuation procedures, building layout and escape routes required review

10. 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, firefighting 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:

Since Nov 2018 staff training in emergency procedures and fire evacuation procedures is carried out by an in-house trainer and continues throughout the year. All staff are scheduled for training throughout each calendar year.

This compliance plan response from the registered provider did not adequately assure the office of the chief inspector that the actions will result in compliance with the regulations.

Proposed Timescale: 06/06/2019

Theme:

Safe care and support

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

The records of fire evacuation drills completed did not provide assurance that residents in each compartment could be safely evacuated in the event of a fire.

11. 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:

The format of fire drills and records of fire drills has been reviewed and they include more detail on times for detection of fire, methods of evacuation of residents and evacuation times.

Proposed Timescale: 07/05/2019

Theme:

Safe care and support

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

The fire compartments had been subdivided and fire alarm system did not reflect this and only identified 4 fire compartments.

12. Action Required:

Under Regulation 28(2)(ii) you are required to: Make adequate arrangements for giving warning of fires.

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

All fire related systems are under review at present and we are awaiting a report from the Fire Engineer engaged. We expect this report on 14/6/2019

Proposed Timescale: 14/06/2019

Theme:

Safe care and support

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

There were no Personal Emergency Evacuation Plans (PEEPS) available detailing the assistive equipment required and level of assistance each resident required to safely evacuate. A Personal Emergency Evacuation Plan (PEEPS) is required to be completed for each resident.

13. Action Required:

Under Regulation 28(2)(iv) you are required to: Make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and safe placement of residents.

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

All residents have a Personal Emergency Evacuation Plan in situ

Proposed Timescale: 08/05/2019

Outcome 08: Governance and Management

Theme:

Governance, Leadership and Management

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

A review of the staffing levels was required

14. Action Required:

Under Regulation 23(a) you are required to: Ensure the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.

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

Staffing review with particular reference to housekeeping is being carried out and any changes that are identified from that review will be put in place by 30/6/2019. Staff skill and mix are under constant review by PIC.

Proposed Timescale: 30/06/2019

Theme:

Governance, Leadership and Management

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

Improved oversight of the care for residents susceptible to pressure wounds was required to ensure that appropriate interventions were put in place to protect residents at risk of developing pressure wounds.

Improved oversight of the management of fire safety procedures was required to ensure these were fit for purpose.

15. 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:

Audit of residents at risk of pressure related wounds identified by Waterlow scores has been completed 30/5/2019 and actions identified from that audit have been put in place.

Fire emergency plan, fire safety training and fire drills have been reviewed and updated. All residents have PEEPs in situ reflecting day and night procedures in case of fire emergency.

Fire safety systems are currently under review and we are awaiting a Fire Engineer report with regard to fire alarm, doors and compartments on 14/06/2019

Proposed Timescale: 14/06/2019