<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Annabeg Nursing Home</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000005</td>
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<tr>
<td>Centre address:</td>
<td>Meadow Court, Ballybrack, Dublin 18.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>01 272 0201</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:brendanoconnell@annabeg.ie">brendanoconnell@annabeg.ie</a></td>
</tr>
<tr>
<td>Type of centre:</td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
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<tr>
<td>Registered provider:</td>
<td>Annabeg Enterprises Limited</td>
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<tr>
<td>Provider Nominee:</td>
<td>Brendan O'Connell</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Linda Moore</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>None</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Announced</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>23</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>0</td>
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About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.
Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

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

The inspection took place over the following dates and times
From: To:
08 July 2014 08:30 08 July 2014 17:00
09 July 2014 07:00 09 July 2014 14:30

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

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<th>Outcome 01: Statement of Purpose</th>
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<td>Outcome 07: Safeguarding and Safety</td>
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<td>Outcome 09: Medication Management</td>
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<td>Outcome 12: Safe and Suitable Premises</td>
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<td>Outcome 13: Complaints procedures</td>
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<td>Outcome 14: End of Life Care</td>
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<td>Outcome 15: Food and Nutrition</td>
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<td>Outcome 16: Residents' Rights, Dignity and Consultation</td>
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Summary of findings from this inspection
This was an announced inspection which took place over two days and was for the purpose of informing an application to renew the registration of Annabeg Nursing Home. The provider had applied for registration for 23 places. This report sets out the findings of the inspection.

Overall, the inspector found that the provider met the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland to a high standard. The provider is aware that the current environment does not meet the requirements
of the Regulations and has begun development of an extension and redevelopment plan to address this. He aims to complete part of this project before the end of 2014 and the remainder by June 2015. The provider is currently registered for 28 places, but reduced this to 23 to accommodate the new building.

There was a very committed management team in place who worked hard to ensure that there was a strong governance structure in place.

The centre was set up in 1987 as a family business. There are two directors, Brendan O Connell works full-time in the centre. Brendan is the nominated person on behalf of the provider. The person in charge is Sinead Beirne. They are supported in their role by staff nurses.

The inspector found that the health needs of residents were met to a high standard. Residents had access to general practitioner (GP) services, to a range of other health services and the nursing care provided was of a high standard. The quality of residents’ lives was enhanced by the provision of a choice of interesting things for them to do during the day.

Residents were consulted about the operation of the centre and there was an active residents’ committee. Residents and relatives knew the management on a first name basis. The collective feedback from residents was one of satisfaction with the service and care provided.

The provider and person in charge promoted the safety of residents. A risk management process was in place for all areas of the centre. Staff had received training and were knowledgeable about the prevention of elder abuse and other relevant areas. Staff had an in-depth knowledge of residents and their needs. Recruitment practices met the requirements of the Regulations. Three actions identified at the previous inspection in April 2013 were addressed.

Areas for improvement identified included:

- Premises issues

These areas for improvement are discussed further in the report and are included in the Action Plan at the end of this report.
Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

### Outcome 01: Statement of Purpose

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

**Theme:**
Governance, Leadership and Management

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

**Findings:**
The inspector found that the statement of purpose contained all of the information as required by the Regulations. The provider had made a copy available to residents. This clearly described the range of needs that the designated centre intended to meet. This document was revised to include the revised number of places in the centre.

**Judgment:**
Compliant

### Outcome 02: Governance and Management

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

**Theme:**
Governance, Leadership and Management

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

**Findings:**
The inspector found that systems were in place to ensure that the quality of care given to residents was monitored, developed and improved on an ongoing basis. Audits were completed on several areas such as nutrition, infection control, hand hygiene, falls, medication management and restraint. There was evidence of improvements being identified following these audits and interventions put in place to address them. These included a reduction in the use of restraint since the previous inspection. An external audit of the service was completed in June 2013 and the report was not received at the
Data was also collected each week on the number of key quality indicators such as the use of antipsychotics, use of restraint, incidents, residents at risk of choking, residents requiring supplements and those with a nutrition score of 2 or greater to monitor trends and identify areas for improvement. The results were shared with staff who discussed them with the inspector. The person in charge also reviews care plans three monthly with the resident or relative to ensure they were involved and they guided the care to the resident. The inspector found that clinical information continued to be used to improve the service. For example, the number of falls had continued to be reduced in 2014. Staff attributed this to the increased supervision and the additional equipment, such as sensor alarms, purchased by the provider. This information was discussed at the risk management committee meetings and appropriate action taken as required.

The person in charge also reviewed residents medication records monthly and was in the process of developing a medication reconciliation form. There was a process to ensure that residents pain patches were placed safely and monitored daily. A residents and relative satisfaction survey took place annually and the results were positive.

There is a clearly defined management structure that identifies the lines of authority and accountability as outlined in the statement of purpose. The provider works full time in the centre and supports the person in charge. Appropriate resources were allocated to meet residents needs. These included the new extension and exercise equipment, for example.

**Judgment:**
Compliant

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**Outcome 03: Information for residents**

A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

**Theme:**
Governance, Leadership and Management

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

No actions were required from the previous inspection.

**Findings:**
A resident’s guide is available to each resident which describes the services.

The inspector read a sample of completed contracts and saw that they adequately met the requirements of the Regulations as they included adequate details of the services to be provided and the fees to be charged.
Outcomes:

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

**Theme:**
Governance, Leadership and Management

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

**Findings:**
The person in charge was a registered nurse and she worked full-time in the centre. She was on duty for the duration of the inspection and was supported by two staff nurses. The person in charge had good knowledge of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the Authority's Standards.

The person in charge demonstrated strong leadership and good communication with her team. She was frequently observed meeting with residents, relatives and staff and ensured good supervision to all staff. She was an organised manager and all documentation requested by the inspector was readily available. The person in charge had deputising and on call arrangements in place.

The inspector observed that she were well known to staff, residents and relatives with many referring to her by her first name. She had maintained her continuous professional development and had recently completed training in the revised Regulations, end of life, information governance, falls prevention and all other courses mentioned in outcome 18. She had also attended a conference on dementia care. The senior nurse who deputises for the person in charge also kept herself up to date.

**Judgment:**
Compliant

**Outcome 05: Documentation to be kept at a designated centre**
The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

**Theme:**
Governance, Leadership and Management

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

**Findings:**
The inspector was satisfied that the records listed in schedules 2, 3 and 4 of the Regulations were maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre had all of the written operational policies as required by Schedule 5 of the Regulations.

Records were stored securely. While all records were maintained in line with the regulations, the policy on the destruction of records did not meet these requirements.

An up to date insurance policy was in place for the centre which included cover for resident’s personal property and accident and injury to residents in compliance with all the requirements of the Regulations.

**Judgment:**
Non Compliant - Minor

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**Outcome 06: Absence of the Person in charge**
The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.

**Theme:**
Governance, Leadership and Management

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

**Findings:**
The provider was aware of his responsibility to notify the Chief Inspector of the absence of the person in charge.

**Judgment:**
Compliant

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**Outcome 07: Safeguarding and Safety**
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.
### Theme:
Safe care and support

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

### Findings:
The inspector found that measures were in place to protect residents from being harmed or abused. All staff had received training on identifying and responding to allegations of elder abuse. The provider was the trainer in the protection of vulnerable adults. A centre-specific policy was available which gave guidance to staff on the assessment, reporting and investigation of any allegation of abuse.

The provider, person in charge and staff spoken to displayed sufficient knowledge of the different forms of elder abuse and all were clear on reporting procedures. A review of incidents since the previous inspection showed that there were no allegations of abuse in the centre.

Residents spoken to and those who had completed the Authority’s questionnaire commented that they felt safe and secure in the centre. They attributed this to the fact that there was access to call bells and the doors were locked.

There are systems in place to safeguard resident’s money. The staff currently do not manage any resident’s finances. The policy would guide practices.

There is a policy on and procedures for managing behaviours that challenge. Staff had appropriate skills to respond to and manage this behaviour. Training had been provided in 2013. The residents care plans would guide care. There was evidence that the GP and Psychiatric services were involved in the care as required. While a PRN was used infrequently as required for a resident to manage behaviours, this practice would be enhanced if a protocol was developed to guide practice. The use of restraint was in line with the national policy on restraint. The rationale for use was clearly documented. The restraint register was reviewed monthly. There was a system in place to monitor all residents using restraint.

### Judgment:
Compliant

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

### Theme:
Safe care and support

### Outstanding requirement(s) from previous inspection(s):
The action(s) required from the previous inspection were satisfactorily implemented.
**Findings:**
The inspector found that there were robust systems in place in relation to promoting the health and safety of residents, staff and visitors.

The inspector read the risk management policies which were developed in line with the Regulations and guided practice. They included the policies on violence and aggression, assault, residents going missing, self-harm and accidental injuries to residents and staff.

A clinical governance committee continued to meet bi-monthly and the minutes of the last two meetings were reviewed by the inspector. All environmental issues which were identified on a daily basis were recorded in the maintenance books and discussed at the meeting. A health and safety walk about was completed and recorded two monthly, all issues were addressed. There was a health and safety statement in place which had been reviewed and it related to the health and safety of residents, staff and visitors.

The provider and person in charge had continued to update the risk register to identify and manage the risks in the centre. Some measures were in place to prevent accidents and facilitate residents’ mobility, including non-slip floor covering in bathrooms and toilets. The inspector found that there was a system to record and learn from incidents and complaints and a root cause analysis was completed. The learning was shared with staff. This included the new documentation for the management of residents who are being transferred to another facility.

The bedrails had been fitted with new brackets since the previous inspection, and there was a process in place to check these. The inspector found that none of the bedrails were loose at this inspection.

The inspector reviewed the emergency plan and found that it provided sufficient guidance to staff on the procedures to follow in the event of an emergency.

The provider and person in charge had adequate control measures in place to monitor all visitors to the building. A visitors’ book was maintained and completed daily.

Overall fire safety was well managed.

The inspector viewed the fire training records and found that all staff had received up-to-date mandatory fire safety training and this was confirmed by staff. There were dates for further fire training in 2014.

All staff spoken to knew what to do in the event of a fire and regular fire drills were carried out by staff at suitable intervals as defined by the Regulations. One of the residents was involved in the monthly drills. The inspector viewed the fire records which showed that fire equipment had been regularly serviced. The fire alarm had been serviced quarterly. The inspector found that all internal fire exits were clear and unobstructed during the inspection. There was a robust system whereby staff checked fire exits daily and this was documented.

Written confirmation from a competent person that of all requirements of the statutory fire authority, was submitted to the Authority prior to the inspection.
All staff had been trained in manual handling and appropriate practices were observed by the inspector.

The inspector found that there were measures in place to control and prevent infection. Staff were knowledgeable in infection control. Staff had access to supplies of gloves and disposable aprons and they were observed using the alcohol hand gels which were available discretely throughout the centre. A policy guided the practice.

**Judgment:**
Compliant

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

**Theme:**
Safe care and support

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

**Findings:**
The inspector was satisfied that each resident was protected by the designated centre’s policies and procedures for medication management. There was a medication policy which guided practice. This had been revised since the previous inspection and now included the maximum dose of as required medication.

The inspector read a sample of completed prescription and administration records and saw that they were in line with best practice guidelines. Written evidence was available that three-monthly reviews were carried out. The inspector observed a medication round and found that medication was administered in line with the policy and best practice.

Medications that required strict control measures (MDAs) were carefully managed and kept in a secure cabinet in keeping with professional guidelines. Nurses kept a register of MDAs. The stock balance was checked and signed by two nurses at the change of each shift. The inspector checked a sample of balances and found them to be correct.

Medication audits were completed to identify areas for improvement and there was documentary evidence to support this. The pharmacist was involved in medication safety and review in the centre. The pharmacist reviewed records three monthly, audited practices and also completed competency assessments with staff. While competency assessments were completed as part of the audit it was not clearly documented which staff had been involved. Medication errors were reviewed by the person in charge and systems were in place to minimise the risk of future incidents.

There were appropriate procedures for the handling and disposal of unused and out of date medicines. All staff nurses involved in the administration of medications had
undertaken medication management training.

**Judgment:**
Compliant

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**Outcome 10: Notification of Incidents**

*A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.*

**Theme:**
Safe care and support

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

**Findings:**
The person in charge was aware of the legal requirement to notify the Chief Inspector regarding incidents and accidents. To date and to the knowledge of inspectors, all relevant incidents had been notified to the Chief Inspector by the person in charge.

**Judgment:**
Compliant

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**Outcome 11: Health and Social Care Needs**

*Each resident’s wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident’s assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.*

**Theme:**
Effective care and support

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

**Findings:**
The inspector was satisfied that residents' healthcare needs were met to a high standard. Residents had access to GP services and a full range of other services was available on referral including speech and language therapy (SALT) and dietetic services. Chiropody, dental and optical services were also provided. A physiotherapist was available as required. The inspector reviewed residents’ records and found that residents had been referred to these services and results of appointments were written up in the residents’ notes.
The inspector reviewed a sample of residents’ files and noted that a nursing assessment and additional clinical risk assessments were carried out for residents. Daily notes were being recorded in line with professional guidelines.

Overall care plans contained the required information to guide the care for residents. Residents and/or relatives were involved in the development of their care plans and they discussed this with the inspector. However there was one area for improvement in that the care plans for end of life did not guide the care to be delivered. See outcome 14.

Falls Management
The inspector read the care plans of residents who had fallen and saw that risk assessments were undertaken and a care plan was devised. Preventative measures undertaken included the use of bed alarm sensors and hip protectors. There was very good supervision of residents in communal areas and good staff levels to ensure resident safety was maintained. There was an adequate policy in place on falls prevention to guide staff. Neurological observations were completed when residents sustained an unwitnessed fall. Each resident was reviewed by the GP, physiotherapist if required and person in charge following a fall and a detailed plan was provided to staff to minimise the risk of future falls. Post falls assessments were completed and care plan in place to guide the care to be delivered.

Restraint Management
Inspectors found that there was an emphasis on reducing the use of restraint. Risk assessments were completed and kept updated for the use of bedrails. There was evidence of alternatives available. There was a system in place to monitor all residents using restraint.

Wound
There were no pressure ulcers or wounds in the centre. An evidence-based policy was in place and was this used to guide practice. Staff spoken to were knowledgeable of the strategies to be taken to prevent pressure ulcers.

Nutrition
There were policies on nutrition and hydration which were being adhered to and supported good practices. These had been reviewed since the previous inspection. See outcome 15.

Judgment:
Non Compliant - Minor

Outcome 12: Safe and Suitable Premises
The location, design and layout of the centre is suitable for its stated purpose and meets residents’ individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.
Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
The physical environment in the centre still did not meet the requirements of the Regulations. The provider was aware of the requirements in the Authority's Standards which needed to be put in place in relation to the premises by 2015. The inspector observed that building work had commenced at the time of the inspection to address the deficits. The provider said they would have completed the building in 2015.

There was one three bedded room, which did not meet residents needs and was being addressed in the new building. The plans were viewed by the inspector. The person in charge had resourced material and used this to enhance the building from a dementia perspective. Visual unique elements were placed on the corridor walls, these fixtures and fittings aided distraction and interests for residents with a cognitive impairment. She planned on developing this further in the new build.

There was no cleaners’ rooms in the centre for the storage of cleaning equipment and chemicals. The inspector spoke to domestic staff who were knowledgeable on cleaning processes in place.

There was inadequate storage space. The inspector observed residents equipment stored in bathrooms and bedrooms used by residents.

Facilities for staff changing required improvement. There was plans to address this in the new building.

There was a lack of private space available on the units where residents could go if they required some quiet time. This was being addressed.

The centre was clean, comfortable, welcoming and well maintained both internally and externally. The inspector found that the communal spaces and bedrooms were homely in design, decor and furnishings and this was also frequently mentioned by residents and their relatives. Hand rails were provided in circulation areas.

A small passenger lift was provided and was maintained.

The external grounds were well maintained and there was a small secure garden area, which was used by many of the residents during the inspection.

There were records to show that assistive equipment such as hoists, baths and pressure relieving mattresses had been serviced regularly. Service contracts were in place for equipment. All residents were provided with a call bell to enable residents to summon assistance when they required.

The kitchen was found to be well equipped. The inspector observed a plentiful supply of
fresh food.

**Judgment:**
Non Compliant - Moderate

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**Outcome 13: Complaints procedures**

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

**Theme:**
Person-centred care and support

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

No actions were required from the previous inspection.

**Findings:**

Complaints were well managed. The complaint’s policy was in place and the inspector noted that it met the requirements of the Regulations. The complaints procedure was on display at in the centre. Relatives and residents who spoke with the inspector knew the procedure if they wished to make a complaint. The complaints policy contained an independent appeals process.

Complaints and feedback from residents were viewed positively by the provider and the person in charge. There were a small number of complaints since the previous inspection. These were appropriately managed to the satisfaction of the complainant. Residents and relatives were aware of the name of provider and person in charge and spoke about how they were so approachable.

**Judgment:**
Compliant

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**Outcome 14: End of Life Care**

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

**Theme:**
Person-centred care and support

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

No actions were required from the previous inspection.

**Findings:**

Residents received a high standard of end-of-life care which was person centred and respected the values and preferences of the individual and resulted in positive outcomes for residents.
There was a policy on end-of-life care which was centre specific and provided detailed guidance to staff. Staff members were knowledgeable about this policy. The self assessment for the thematic inspection was submitted prior to the inspection and reviewed by the inspector. The person in charge had identified a minor non compliance in the self assessment and was addressing the areas identified she informed the inspector that the care plans were still being reviewed to ensure they met the needs of residents.

Care plans were found to reference the religious needs, social and spiritual needs of the resident as well as preferences as to the place of death and funeral arrangements as appropriate. Residents confirmed that their preferences and choices at their end of life had been discussed with them or their family.

Regular family meetings were held. While the decisions concerning future health care needs had been fully discussed with the resident or family, this had not included the GP. Therefore there was insufficient guidance for staff.

The care plans were not guiding practice in this regard. See outcome 11. While the inspector found that the care had been delivered to a resident at their end of life, the care plan did not guide practice.

The majority of residents resided in single rooms. There were three multi occupancy rooms, however a single room would be available as much as possible.

Overnight facilities were not provided for visiting family members, however relatives were accommodated if they wished to stay with their loved one. Refreshments were offered. The person in charge stated that the centre received support from the local palliative care team when required.

Records showed that staff had received training in end-of-life care in 2014 and further training was planned.

Mass took place monthly and access to a service from other religious denominations was available as required. Residents and visitors were informed sensitively when there was a death in the centre. Residents were informed in person and allowed to pay their respects if they wished to do so. Residents said they are invited to sit and pray if appropriate. Residents can have their favourite music on at any time.

The inspector read the information available for distributing to families following the death of a loved one. This document provided a lot of useful information including details of how to register a death.

The person in charge had put together an end of life box for the use of staff during this time of residents life. This included all equipment as required by the staff. For example, signage which was displayed to inform all staff, relatives and residents that a resident had died.
Appropriate boxes were used to handover personal possessions. However the all returned property was not documented and signed in the property checklist.

Last rites were provided and documented. Respect for the remains of the deceased was noted but not documented, however the family were consulted throughout the whole process. Resident’s wishes were facilitated. A number of the staff and residents attended resident's funerals. Staff stated that a residents could return home following death and the provider supplied refreshments to their house. One residents plan stated this was the wish of the resident.

A post death review was completed with staff following a death to review the areas of good practice and any areas for improvement. Relatives spoke of the dignity and care which was shown to their loved one at this time and in particular the care delivered by the provider.

Judgment:
Compliant

Outcome 15: Food and Nutrition
Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.

Theme:
Person-centred care and support

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

Findings:
The inspector found that the dining experience was dignified, pleasant and relaxed with a strong emphasis on providing a high quality dining experience for residents.

The self assessment for nutrition was submitted prior to the inspection and reviewed by the inspector. There were no areas for improvement identified.

The inspector noted that meals were well presented and all residents expressed satisfaction with their meals.

The inspector observed the breakfast and main meal and found that it was hot and attractively presented. Residents were offered a choice of food at each meal time and individual preferences were readily accommodated. The nursing staff monitored the main meal times closely. Residents, who required their food to be modified, for example pureed, were served this food in individual portions and had the same choice of food at the main meal. Regular fluids were provided during the day. Portion sizes were appropriate and second helpings were offered. Residents who required assistance received this in a sensitive manner. The meal time provided opportunity for social
interaction between staff, residents and relatives.

The menu had been reviewed by the dietician in 2014 and advice and recommendations had been taken on board such as the choice. A breakfast menu was also in place and residents were offered a fry or scrambled eggs if they prefer, for example. Relevant information pertinent to the meal time and consistency of fluids was in place and was reviewed daily by the person in charge and this guided the care delivered. The inspector met with the chef who demonstrated an in depth knowledge of residents dietary needs, likes and dislikes and this was documented. Snacks were provided at any time as requested, the person in charge had introduced a variety of snacks, such as smoothies.

The inspector found that weight records showed that residents’ weights were checked monthly or more regularly if required. Nutrition assessments were used to identify residents at risk and were also repeated on a regular basis. Records also showed that some residents had been referred for and received a recent dietetic and (SALT) speech and language review. The treatment plans for residents was recorded in the residents’ files. Medication records showed that supplements were prescribed by a doctor and administered appropriately. However staff provided fortified meals as a first choice as required.

All staff had received training in dysphagia at least once in the past twelve months and also completed on line courses in food fortification and the malnutrition universal screening tool. (MUST). All residents at risk of choking had a risk assessment and care plan in place. Control measures were in place such as a resident choosing to sit alone while eating to decrease the distractions.

Judgment:
Compliant

**Outcome 16: Residents' Rights, Dignity and Consultation**

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

**Theme:**
Person-centred care and support

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

**Findings:**
The inspector was satisfied that staff treated residents with privacy and dignity and that strong emphasis was placed on these values by the provider and person in charge. There was an area for improvement in that the CCTV required review.
Staff were observed knocking on bedroom, toilet and bathroom doors and waiting for a response to enter and this was confirmed by residents. The inspector observed staff interacting with residents in a friendly and courteous manner. There was an open visiting policy and contact with family members was encouraged.

There was a residents’ forum within the centre where relatives also attended. The inspector read the minutes of these meetings and found that residents were positive about the service. This meeting was used to discuss policies, activities, the statement of purpose, meal time requirements, any suggestions and the changes to the premises.

Many residents told the inspector they had opportunities to discuss issues as they arose with the person in charge, provider or any staff member. The person in charge and all staff were seen to interact well with residents during the inspection. The chef attended the meetings and also visited residents after meals to seek their feedback and this was observed by the inspector.

Residents have access to an independent advocacy services. The inspector noted that residents were provided with access to a computer package to communicate with family abroad at their birthday. Families who were abroad were kept up to date on any changes in the resident’s condition, this was facilitated through email.

Relatives said if they had any query it is addressed immediately. Relatives said they were kept up to date on their family status and any changes. Many residents went out with their families and friends during the day which they said they enjoyed. Many of the staff also brought residents out for coffee and to do shopping which they enjoyed.

The inspector found that residents said they had flexibility in their daily routines, for example, residents could decide whether to participate in activities available to them. They chose when to go to for example, bed and the time they got up. Two of the residents got up early and liked to have early breakfast and this was accommodated.

Residents voted in the recent election in the centre or had the option of going out to vote with support. The inspector noted that televisions had been provided in residents’ bedrooms. Residents had access to newspapers daily and the staff read sections of the paper to residents.

Residents had opportunities to participate in meaningful activities, appropriate to their interests and preferences. However the inspector found that this could be enhanced for residents with a dementia. Activities were provided seven days per week. There was an activity staff employed in the centre and the benefits to residents were apparent. The inspector noted that various activities were being provided throughout the centre. The hairdresser visited weekly. Residents commented they enjoyed the experience. There was evidence that residents engaged in activities such as music, SONAS (a therapeutic programme specifically for residents with dementia), exercises, music, pottery and hand massage. There was an emphasis on organising day trips for residents, for example residents recently enjoyed a trip to the national concert hall. There was a dog living in the centre and one of the residents walked and fed it daily. There was also a budgie and another resident cleaned the cage. The inspector found that the layout of the two sitting rooms did not facilitate all residents’ inclusion in the activities on the day of the
inspection, particularly those with a cognitive impairment, which the other residents enjoyed. Many of the residents enjoyed music and they chose what was played throughout the centre. Live music was provided regularly based on feedback. Many of the residents enjoyed this on the first day of the inspection. Social care plans were completed in respect of all residents.

The inspector noted that closed circuit television was in use in a communal area in the centre, while the provider explained the rationale for its use the policy in place did not guide practice. Signage was not displayed at all cameras and consent for its use had not been obtained. This may impact on the privacy and dignity of residents in that residents many not be able to undertake personal activities in private.

**Judgment:**
Non Compliant - Minor

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**Outcome 17: Residents' clothing and personal property and possessions**

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

**Theme:**
Person-centred care and support

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

**Findings:**
Residents clothing was laundered outside of the centre. Residents and relatives expressed satisfaction with the laundry service provided. Adequate storage space was provided in residents bedrooms and clothing was returned in an appropriate manner.

Residents had access to a locked space in their bedroom if they wished to store their belongings. There was a policy in place of residents’ property in line with the Regulations and a list of residents' property was maintained. These could be further enhanced in line with the policy. Not all property lists contained two signatures or that of the resident.

**Judgment:**
Non Compliant - Minor

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**Outcome 18: Suitable Staffing**

There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in
Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

**Theme:**
Workforce

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

**Findings:**
The inspector found that there was a very committed and caring staff team. The person in charge and provider placed strong emphasis on training and continuous professional development for staff. All staff told inspectors that they felt well supported by person in charge and provider and described the workforce as like a family. The inspector observed that staff interacted well with residents and residents appeared very comfortable with staff.

The inspector carried out interviews with staff members and found that all were knowledgeable of residents’ individual needs, the centre’s policies, fire procedures and the guidelines for reporting suspicions of elder abuse.

The inspector found that the current staffing levels, qualifications and skill mix were appropriate for the assessed needs of residents on the day of the inspection. Resident dependency was assessed using a recognised dependency scale. An additional nurse was on duty for the inspection. Relatives and residents stated that there were adequate levels of staff on duty. However the number of staff nurses was reduced to one at the weekends and the evening time recently due to the decrease in the number of residents to 23. The inspector was not satisfied that one nurse could supervise and deliver care due to the layout of the premises. There was no risk assessment completed in this regard. The provider and person in charge said they were satisfied with the staffing numbers and would continue to monitor the staff nurse levels and the outcomes for residents.

The inspector found that there were procedures in place for constant supervision of residents in communal areas.

There was a recruitment policy in place and the inspector was satisfied that staff recruitment was in line with the Regulations. A sample of staff files were examined and the inspector noted that all relevant documents were present.

Staff told the inspector they had received a broad range of training which included falls prevention, medication management, infection control, Dysphagia, diabetes and the use of the malnutrition universal screening tool, for example.

A training plan for 2014 was shown to the inspector. This included cardio pulmonary resuscitation, end of life, food safety and Dysphagia. All care assistants had either completed Fetac Education and Training Awards Council (FETAC) level five or above or were in the process of completing this. The provider and person in charge regularly
reviewed the training files to ensure all relevant training was provided. One of the care assistants had completed a train the trainer course to provide the skills to support new staff.

The inspector reviewed all files and found that nursing staff had up to date registration with An Bord Altranais agus Cnáimhseachais na hÉireann (Nursing and Midwifery Board of Ireland) for 2013.

There were no volunteers in the centre.

Staff told inspectors there were open informal and formal communication within the centre where they could raise issues and discuss residents needs. These forums were also used to review and improve the service. Such as the governance meeting, catering, nurses and care assistant meetings. Monthly updates took place with staff, this included a review of policies, CPR, the use of the anti choking device and fire instruction.

The inspector found that there were good induction arrangements for newly employed staff members and staff appraisals were used to monitor performance and support staff. The staff induction booklet was recently revised.

**Judgment:**
Non Compliant - Minor

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**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:**

Linda Moore
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report

<table>
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<th>Centre name:</th>
<th>Annabeg Nursing Home</th>
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<tr>
<td>Centre ID:</td>
<td>OSV-0000005</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>08/07/2014</td>
</tr>
<tr>
<td>Date of response:</td>
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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.

Outcome 05: Documentation to be kept at a designated centre

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The policy on the destruction of records did not meet the requirements of the regulations.

Action Required:
Under Regulation 21(5) you are required to: Retain the records set out in paragraphs (7) and (8) of Schedule 4 for a period of not less than 7 years from the date of their making.

Please state the actions you have taken or are planning to take:
We have reviewed our policy on the destruction of records (as per Schedule 5, Nursing Home Regulations) to ensure full compliance with regulations.

1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Outcome 11: Health and Social Care Needs

**Theme:**
Effective care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The care plans for end of life did not guide the good care being delivered and were not reviewed when a resident condition deteriorated.

**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:**
We are currently reviewing all residents End of Life Care Plans to include specifically the date clinical decisions were made as opposed to just documenting the outcome of the clinicians meeting and decision in the End of Life Care Plan i.e DNAR, hospitalise if unwell or otherwise. We are also revising the POLST form to ensure all areas of care/treatment options available are documented and discussed with nursing home residents regarding their future/long term care. Care plans will be reviewed as residents conditions change and every four months.

All Care Plans (including End of Life Care) to be fully reviewed by 30 November with residents/n.o.k , g.p (if applicable) and nursing staff.

Proposed Timescale: 30/11/2014

Outcome 12: Safe and Suitable Premises

**Theme:**
Effective care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The premises does not meet the requirements of the Regulations or residents needs.

**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.
We are currently in the process of an extension, refurbishment and renovations to our facility. On completion residents will have more communal areas, rooms for activities/quiet time, visitors rooms, therapy rooms and dining space. Overall their quality of life will be enhanced by our beautiful new facility with our state of the art secure garden which we hope will be a haven for many.

In addition there will be two new sluice rooms, a treatment room, a hair salon, increased storage, two passenger lifts, a cleaners/housekeeping storage room, staff showers/changing rooms and a newly built kitchen.

Building and renovation works deadline for completion is July 2015.

Proposed Timescale: 01/07/2015

Outcome 16: Residents' Rights, Dignity and Consultation
Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The use of CCTV may impact on residents right to privacy.

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:
CCTV has been removed from our dining area. Staff continue to supervise residents during mealtimes. CCTV signs have been placed at all CCTV camera points.

Proposed Timescale: 05/08/2014

Outcome 18: Suitable Staffing
Theme:
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The number of nurses on duty at the weekend may not be sufficient based on the layout of the centre.

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:
At present we are satisfied with our current staffing levels which we review based on our occupancy levels and as our residents conditions/care needs change. At present all communal areas are supervised as are mealtimes in the dining room. There are no residents bedridden at present. We are also presently closed to admissions during building works. As the inspector observed there are no dressings, wounds/ulcers etc to attend to. An additional health care assistant is on duty at weekends to allow the nurse to supervise care. The nurse is supported on his/her shift by a strong, competent and highly trained team (two of which are senior Health Care Assistants). The Person in Charge/ Senior nurse is also on call if required and available to attend the centre. The provider is also on duty at weekends. Resident care is paramount for those residing at Annabeg and would never be compromised. If residents needs change/increase then staffing levels are revised/increased to reflect this change and to ensure residents needs are met as a matter of priority. We feel our high standard of care as reflected in this report is evidence of our commitment to ensuring we deliver the highest possible standards of care to those entrusted to our care.

There can be no definitive timescale regarding staffing levels as staffing levels must be continuously reviewed as occupancy levels change and residents dependency levels/care needs change. Additional staff will be rostered to cover our ‘settling in period’ on completion of our building and renovation works to minimise any disruption/risks to our residents and ensure their care needs are met during this time of transition for them. At present staffing levels are reviewed at the beginning of the month and were last reviewed on August 01st and September 1st. Our next staffing review will be October 1st or earlier if required.

Proposed Timescale: 01/10/2014