### Health Information and Quality Authority

**Regulation Directorate**

**Compliance Monitoring Inspection report**

**Designated Centres under Health Act 2007, as amended**

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Archview Lodge</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000314</td>
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<tr>
<td>Centre address:</td>
<td>Drumany, Letterkenny, Donegal.</td>
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<tr>
<td>Telephone number:</td>
<td>074 91 24676</td>
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<tr>
<td>Email address:</td>
<td><a href="mailto:archviewlodgenh@gmail.com">archviewlodgenh@gmail.com</a></td>
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<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>Archview Lodge Nursing Home Limited</td>
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<tr>
<td>Provider Nominee:</td>
<td>Patrick Sweeney</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Geraldine Jolley</td>
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<tr>
<td>Support inspector(s):</td>
<td>None</td>
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<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>34</td>
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<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: 08 July 2014 10:30
To: 08 July 2014 18:30
From: 09 July 2014 09:00
To: 09 July 2014 16:00

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

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

Summary of findings from this inspection
Archview Lodge provides care to dependent persons mainly over the age of 65, some of whom have dementia or memory problems.
This registration renewal inspection was the sixth inspection of the centre by the Authority. Following the last inspection that took place on 11 July 2013, improvements were necessary to improve upon the quality and safety of the care and services provided to residents and to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland. The required improvements included: Better arrangements for the governance of the centre including for the supervision
of staff
- Improvements to assessments of care, care planning and record keeping and
- Premises issues such as multiple occupancy rooms that do not provide appropriate standards of privacy.

During this inspection the inspector found that the provider nominee and person in charge had a clear vision for the service and was committed to the provision of safe, quality care and appropriate services to the residents. Satisfactory progress had been made by the provider in the implementation of the required improvements and actions directly relevant to the care and well being of residents such as governance, care planning, staff training and risk management had been implemented to a good standard. Significant structural work had been completed around the exterior of the building which had improved the garden area, parking space and enhanced levels of light internally.

This inspection was announced and took place over two days. The inspector talked to residents, relatives, and members of the staff team as well as the provider and person in charge. The delivery of care, cleaning and laundry services were observed and documentation such as care plans, medical records, accident reports, policies and procedures, fire safety and risk management documentation, complaints records and staff files were reviewed. The inspection findings were satisfactory with significant regulatory compliance and good practice evidenced. The provider had implemented the majority of the actions from the last inspection with the exception of premises changes that are required. The centre has three multiple occupancy rooms where space does not allow good standards of privacy and while significant work had been completed to improve the garden area, a secure safe outdoor space is still outstanding.

Residents who spoke to the inspector said that were pleased with services in the centre and felt that they had the care and attention that they required. Relatives also said that services met the needs of their relatives and were confident that if they had concerns they would be listened to and addressed. The feedback questionnaires returned to the Authority contained many positive comments and this feedback is integrated into the body of the report where relevant.

In summary, the inspector was satisfied that the care and services provided to residents were of a good standard and that there were measures in place to monitor aspects of the service to continually improve the quality of care for residents. Improvements required are discussed in detail in the body of the report and in the action plan at the end of the report. Some of the required improvements included minor amendments to policy documents for end of life care and medication. The more significant action plans include requirements for better information in some care assessments and the production of plans to address the premises deficits.
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):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
The statement of purpose had been reviewed following the last inspection and now provided an accurate reflection of the services provided. The inspection findings supported that the aims and objectives were implemented in practice. The statement of purpose was kept under review by the provider.

A minor change was required to the section on complaints to ensure full compliance as the Authority does not have a role in any appeals process for complaints that are not resolved.

Judgment:
Non Compliant - Minor

Outcome 02: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.

Theme:
Governance, Leadership and Management

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

Findings:
The inspector found that there were governance systems in place that ensured the effective operation of the service and that the provider and person in charge worked full time in the centre. Residents were able to describe who was in charge and the varied
roles of senior staff. They also knew nurses, carers and other staff that carried out duties in the centre.

An action plan in the last report required that supervision arrangements and governance were improved, particularly in relation to the role of the person in charge. The inspector found that this had been addressed. The person in charge and her deputy had attended training on clinical governance in December 2013 and had introduced regular governance meetings that included senior nursing staff. These meetings take place every 4-6 weeks and are used to discuss improvements to the service, clinical and operational issues. Changes to policy documents are also discussed and the introduction of changes to end of life care and nutrition policies formed a significant part of the work completed at governance meetings during 2014. A training plan for the service had been devised for 2014 and was well under way.

A report in accordance with regulation 23 -Governance and Management had been compiled. This report included progress on changes that had been assessed as necessary such as improvements to the environment for residents and new activities. It also provided an overview of the training provided for staff. The inspector noted that there was evidence of consultation with residents and audits on varied aspects of the service including a review of the service against the Authority's standards as required. The inspector was satisfied that there were sufficient resources to support the operation of the service and that the provider and person in charge had leading and active roles in the day to day operation of the service.

**Judgment:**
Compliant

**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:**
There was a guide for residents that described the services available and that complied with regulation 20-Information for Residents. The process for making complaints and the arrangements for visits were described. A sample of contracts were reviewed. The inspector found that the contract described the services available and while all residents had been issued with a contract, not all contracts described the fee to be charged, the resident's contribution or services that incurred extra charges.

Feedback from relatives indicated that detailed information was provided at the time of
admission and that they were encouraged to visit the centre to ensure that the placement was appropriate for their relative. Residents confirmed to the inspector that they had been able to make decisions based on the information provided to them by staff.

**Judgment:**
Non Compliant - Minor

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

**Findings:**
The person in charge was a registered nurse and evidence of her current registration with her regulatory body was in place. The person in charge has worked at the centre since 2001 when she and her husband, who is the nominated provider, took over ownership of the business. The person in charge worked full time and was present in the centre Monday to Friday. This was confirmed by a review of the staff roster and by staff and residents the inspector talked to who confirmed that she is often there at varied hours to see staff and relatives. The person in charge was observed to know all residents and visitors well and was available to residents and relatives who wished to talk to her during the inspection.

It was noted that she was actively engaged in the supervision of staff and that the design and delivery of care and services to residents was based on her declared commitment to the provision of "a home like environment where residents felt safe and were well cared for". The person in charge had engaged in professional development relevant to her role and since the last inspection had completed education and training in governance, end of life care, nutrition, data protection and information governance and promoting a restraint free environment. Other clinical education completed included the person centred management of challenging behaviours, moving and handling and infection control. The inspection findings indicated that the training undertaken by the person in charge and identified as a requirement for the appropriate management of the service at the last inspection had enhanced service delivery and supported managerial and clinical competence.

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

**Findings:**
The inspector found that the action plans related to the accessibility of documentation and the availability of centre specific policies and procedures had been addressed or were in progress. Care records were noted to be organised in a manner that enabled anyone requiring information on residents welfare to access this easily. The general records required by legislation were maintained and were provided for inspection without delay.

**Staff records:**
A sample of four staff files were reviewed. They were fully complete in accordance with legislative requirements. The provider and person in charge were aware of the changes to the documentation required for staff that had been introduced on July 1.

**Medical records:**
The required medical records including medication records were maintained. A record of all restraints including restraints used as enablers was available, was up to date and outlined where bed-rails and specialist chairs were in use as protection or supports to residents.

**Residents records:**
All the required records in relation to residents were in place. Comments relevant to care plans are described in Outcome 11.

**General records:**
All records in this category were maintained.
Operating Policies and Procedures:

The required policies and procedures were available. An action plan in the last report required that a policy on self harm was put in place and this had been addressed but required further attention to appropriately guide staff as there was no indicators as to how residents would be supervised and cared for if self harming behaviour was a factor in their care needs.

Judgment:
Non Compliant - Minor

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

Theme:
Governance, Leadership and Management

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

Findings:
The person in charge confirmed that she had not been absent from the centre for any period of time that required notification to the Chief Inspector.

There were appropriate deputising arrangements for the person in charge and these had remained unchanged since the last registration. The nurse who takes charge is part of the governance team and had engaged in continuous professional development by attending training regularly on topics such as medication management, moving and handling, nutrition, adult protection and end of life care.

Judgment:
Compliant

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

Theme:
Safe care and support

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

**Findings:**
The centre was safe and secure. There was a keypad system in place and all visitors were received and greeted by a member of staff when they entered the building.

Staff training records indicated that all staff had attended education and training on the prevention, detection and response to abuse at regular intervals and all new staff received information on the centre’s procedures as part of their induction programme. Staff spoken to confirmed their attendance at training, were clear about their responsibilities, described that any potential abusive behaviour towards a resident was not tolerated and conveyed confidence in the person in charge and provider to act on any concerns that they may raise. The inspector in conversation with residents and relatives established that they felt safe and secure and that they had confidence in the staff team to provide safe care and that they would address appropriately any potential or actual abuse situation.

The policy on protection was detailed and set out the actions to be taken in the event of any alleged, suspected or reported abuse. However, the information on the requirement to report to the senior case worker in the Health Service Executive needed review as all allegations are required to be reported not only allegations that are found to be substantiated.

Finances held on behalf of residents were appropriately accounted for and receipts were issued for all monies held or issued to residents. Residents and a member of staff sign for all transactions and if residents are unable to do so relatives sign on their behalf. The inspector noted that residents were encouraged to personally manage their money where possible to help maintain their independence.

**Judgment:**
Non Compliant - Minor

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

**Findings:**
There was an up to date health and safety statement that was supported by a risk identification system that contained a range of centre-specific risk assessments. There was evidence that risks, risk assessments and control measures were reviewed by the nominated registered provider and the person in charge. The risks as specifically
identified in Regulation 26 were included in the risk management procedures. Staff were observed to carry out duties such as cleaning, handling laundry and using equipment safely. Staff used protective clothing and this was readily accessible. The centre had an infection control policy to guide staff actions when managing an outbreak of infectious illness or when dealing with infection. There was a missing persons procedure to guide staff through the actions to take in this situation. The inspector found that staff had photographs and adequate information that would enable them to complete resident details in this event.

The fire safety arrangements were reviewed. These had been upgraded recently and included the installation of new emergency lights throughout the building. There was a comprehensive fire safety policy and procedure in place. The provider is trained to fire warden standard and this training is updated every two years. Smoke detectors were located in all bedrooms and general purpose areas. The inspector viewed contracts for the servicing of fire alarms, smoke and heat detectors. Confirmation that the fire alarm and fire extinguishers were regularly serviced was available and this was noted to have been completed last in June 2014. Routine inspections of the fire panel were undertaken weekly to ensure it was fully operational and these checks were recorded.

Fire escape plans indicating the route to the nearest fire exit were displayed around the building. Daily checks of fire exits were recorded and were fully complete. There were weekly activations of the fire alarm undertaken from different points in the building and the staff response was monitored to ensure it was appropriate and timely. When inspected, fire exits were found to be in good condition and unobstructed. The inspector viewed records of fire training and saw that training had been provided in March and April 2014 and that so far 25 staff had attended. All staff were scheduled to have had the required training within a 12 month period. The inspector noted that while staff had good knowledge of residents needs there were no personal emergency evacuation plans (PEEPS) available that outlined the specific needs of residents should evacuation of the centre be required. There were evacuation sheets available for use. The inspector also noted that there were two versions of the emergency plan which could cause confusion for staff. One version did not indicate where residents could be evacuated to if this was required. The provider and person in charge said this would be reviewed. The local fire authority had written to the provider to indicate that a visit to the centre to assess fire safety arrangements was scheduled.

There were arrangements in place for recording and investigating untoward incidents and accidents. All incidents were recorded. The inspector found that there were comprehensive details of the situation and the actions taken at the time. Information recorded included factual details of the accident/incident, date and time event occurred, name and details of any witnesses and whether the GP and next of kin had been contacted. Additional supervision, ensuring calls bells were accessible, clean unobstructed floors and the use of equipment such as hip protectors if a resident was assessed at high risk of falls were some of the measures considered.

Equipment used for moving and handling such as hoists were available and were serviced regularly. Equipment such as specialist beds, wheelchairs and overlay
mattresses were provided in accordance with residents' needs. There were moving and handling assessments available for all residents however where a hoist was required the assessment did not indicate the type of hoist to be used.

**Judgment:**
Non Compliant - Moderate

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**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):**
No actions were required from the previous inspection.

**Findings:**
The inspector found that appropriate and safe medication management practice in accordance with current regulations and regulatory guidance was in place. The inspector saw that practice was supported by a comprehensive medication management policy. All prescriptions were signed by the relevant General Practitioner (GP) and were reviewed at the required three month intervals.

The management of controlled drugs was in line with legislative requirements. There was appropriate secure storage available and the supply was checked and a record maintained by two nurses, one from each shift as required. Medications requiring refrigeration were appropriately stored and the fridge temperature was monitored daily.

Authorisation was in place for the administration of medications in an altered format (crushed) however where medication was given on an "as required" basis the maximum dose to be given in a 24 hour period was not always outlined..

Signed records were maintained of all unused/unwanted medications returned to the pharmacy.

**Judgment:**
Non Compliant - Minor

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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:**
Policies and procedures were in place for the identification, recording, investigation and learning from accidents and incidents. Measures were in place for the prevention of accidents and incidents. The inspector saw that accident and incidents were appropriately recorded and that serious incidents such as fractures were reported to the Authority within the required three day time scale. There had been one such incident for 2014.

Systems were in place to ensure that the person in charge reviewed each accident and incident record to ascertain that the record was complete, that staff had taken adequate and appropriate action and to identify if further measures were required to prevent reoccurrence. The inspector saw that preventative measures were put in place and these included the use of low low beds and mats placed by beds to prevent injury.

The inspector found that while all incidents had been reported, the full range of quarterly returns had not always been made. The requirement to make a nil return in respect of other events prescribed by the Chief Inspector at the end of each six month period was discussed with the person in charge.

**Judgment:**
Non Compliant - Minor

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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

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

**Findings:**
At the time of inspection there were 32 residents living in the centre the majority of whom were in receipt of long-term care. Staff had assessed the care requirements of eight residents as maximum, thirteen as high, eight medium and three as low. Based on their observations, interactions with staff, residents and relatives and a review of medical and nursing records, the inspector was satisfied that residents’ needs were met to a good standard. A pre-admission assessment was completed to ensure that the
centre could meet the needs of each prospective resident. Systems for monitoring the exchange and receipt of relevant information when residents were transferred to or returned from another healthcare setting were in place. Medical records reviewed indicated that residents had access to equitable and timely medical reviews and treatment. There were appropriate referral and access arrangements to other health care services such as occupational therapy, physiotherapy, chiropody, dietetic services, speech and language therapy and mental health services as appropriate to meet residents’ needs. Staff could convey the individual care needs of residents readily and were knowledgeable about prescribed treatments.

The arrangements to meet residents' assessed needs were set out in individual care plans. Recognised assessment tools were used to determine levels of dependency and care needs, and to assess levels of risk for deterioration, for example vulnerability to falls, nutritional care, and the risk of developing pressure sores and moving and handling assessments. There was a record of the resident's health condition and treatment given completed twice daily. The standard of care planning had improved since the last inspection. New documentation had been introduced and the person in charge and senior nurses were monitoring and supervising staff to ensure that the system met legislative requirements. Care plans were seen to be closely aligned to assessed needs, planned nursing interventions were personalised and inspectors were satisfied that the care that was planned was delivered. The planning of care was supported by a suite of validated risk assessment tools. Care plans were seen to be discussed with the resident or where this was not possible with the appropriate family member. The inspector saw that where families wished to provide they were enabled to do so at times that suited them.

Care plans and assessment tools were seen to be reviewed and amended at a minimum three monthly or more frequently if necessary in line with the residents changing needs.

The inspector was satisfied that critical areas of care reflected evidence based practice. Structured protective and preventative systems were in place for managing falls including assessment and reassessment, care plans and interventions including hip-protectors, impact reducing floor mats, low-low beds, and falls risk indicators were in use to prompt additional care and supervision. Wound care documentation included the assessment procedure, wound management plan and measurements of the wound site. There was one small pressure area problem in receipt of attention during the inspection. Residents were provided with the appropriate pressure relieving equipment relative to their assessed level of risk. Restraint practice was in line with the recommendations of nationally agreed best practice guidelines on the use of restraint in residential care settings. Challenging behaviours were objectively recorded and evaluated and referral sought as appropriate for advice and where medication management was required, medications were monitored, reviewed and amended.

A resident’s right to refuse treatment was seen to be respected, recorded and monitored.

However, while the inspector was satisfied that the standard of care planning supported the delivery of care to residents not all plans of care reviewed were adequate to ensure the provision of suitable and sufficient care. The prevalence of dementia care needs was difficult to decipher from care plans. The daily nursing records were noted to contain
meaningful information on levels of orientation that could not be determined from care plans. This was similar to a finding in the last inspection. The inspector did note that some records provided good accounts of who residents recognised and what capacity they retained so that staff could encourage them to maintain this level of independence.

Each resident’s vital signs were checked on a monthly basis. Residents’ weights were monitored monthly and those identified at risk had their weight reviewed on a weekly basis. The GP was informed in the first instance of the weight loss. Referrals were made to dietetics for specialist advice. Supplements were prescribed for residents identified as a nutritional risk by the GP and advice on calorie intake and fortification of food provided by the dietician was noted to be adhered to by staff with good outcomes for residents.

Where residents had specialist care needs such as mental health problems there were good links with community mental health services and the team for old age psychiatry will visit the centre to review residents on referral from the GP.

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.

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:
Archview Lodge is a purpose-built, single-storey centre that opened in 1981 and provides care for up to 34 older people. The front door leads into a conservatory and a hallway that provides access to the main communal, residential, and office areas. There are three sitting rooms and a dining room. Two of the sitting rooms are in constant use during the day and were noted to be furnished with a range of seating appropriate to residents’ needs. The third sitting room is designated a quiet space where residents can pursue their own interests or receive visitors. It is comfortably furnished with a sofa, armchairs and a fireplace which contributes a home like atmosphere. The bedrooms and bathrooms are located off the main hallways. There are 11 single rooms, seven twin and three three-bedded rooms. All rooms have wash hand basins and seven rooms have en suite shower, wash hand basin and toilet facilities. There is also an oratory, catering kitchen with associated storage and laundry facilities.
Archview Lodge had a comfortable and relaxed atmosphere. The domestic-type furnishings, pictures and layout conveyed a home-like quality. Residents said they liked their rooms and said that they were free to move around the building whenever they wished. Communal areas and bedrooms were noted to be in good decorative condition and were visibly clean. Furnishings were in good condition and there was an ongoing programme of maintenance and refurbishment in place. The centre operates a non-smoking policy.

The provider had completed considerable work to improve the premises and garden area since the last registration inspection. The grounds had been cleared, a substantial number of trees had been removed and the garden area had been further cultivated and new parking spaces created. A perimeter wall had been moved and the inspector saw that these works had improved the views and the light to the centre particularly to some bedrooms.

The inspector viewed residents’ bedrooms, all the communal facilities and the laundry. Residents had been enabled to personalise their rooms with photographs, books, ornaments and other personal items that reflected individual choices and personal interests. Several residents said that staff had encouraged them to bring in personal items and photographs and ensured that they were displayed where they could see them easily. Residents and relatives interviewed said they were happy with the facilities and said that any changes that they suggested were listened to by the person in charge and staff and had been addressed.

Infection control guidelines were in place and being followed by staff. There was good information available on how to manage and control infection and a plentiful supply of protective clothing was available for staff and was being used appropriately. There was good attention to hand hygiene and hand gels were available in locations throughout the building. Laundry staff could describe the segregation system and temperatures required to effectively wash infected laundry. The laundry area is confined and has only one door which means that soiled and cleaned laundry has to go through the one access point. Laundry staff said this was not a problem as she ensured that all laundry to be washed was dealt with before clean laundry had to be moved to residents rooms or the linen storage area.

The inspector observed a variety of assistive equipment such as specialist chairs, wheelchairs, walking aids and hoists in use. Staff observed using this equipment were knowledgeable about its proper use and took safety precautions. The provider had contracts for the maintenance of equipment. Corridors had supportive handrails on both sides and were sufficiently wide to allow residents to walk or move their wheelchairs in comfort. The centre was noted to be comfortably warm and well ventilated. There were accessible toilets near the communal areas. Hot water tested in a bedroom and toilet area did not present a scald risk.

The inspector noted that there was adequate communal space and the majority of rooms are single or twin occupancy. While these rooms meet the Authority’s indicative size requirements all the space available is not usable space due to the layout of fixtures and fittings. Other aspects of the building do not meet the specifications outlined in the
Authority's standards. The areas of deficit were:

Three bedrooms accommodated three residents and the linear layout that had to be adopted to accommodate the three beds did not facilitate the provision of effective standards of privacy and dignity.

Two rooms, 12 and 12A had natural light provided by sky lights in the ceiling but had no windows that residents could look out of.

Four rooms have a compromised outlook as the windows look onto the exterior wall of another part of the building. Efforts to enhance the view by providing a scenic mural had improved the visual aspect to some rooms.

Room 13 (shared by two residents) was also undersized measuring 13.6 square metres instead of recommended minimum of 14.8 square metres.

There was no treatment room where residents could meet with health professionals in private and although there is an attractive large garden there is no secure outdoor space that residents can use safely and unaccompanied.

As described in previous inspection reports aspects of the design and layout need review to ensure the centre meets the needs of all residents in terms of design and layout and facilitates the use of equipment required by residents. The action plan requires the provider to supply information to the Chief Inspector on how the premises compliance standards will be met.

Judgment:
Non Compliant - Moderate

**Outcome 13: Complaints procedures**
*The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.*

Theme:
Person-centred care and support

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

**Findings:**
The management of complaints was satisfactory and met the requirements of the legislation. There was a complaints policy specific to the centre. This had been reviewed in July 2013. Issues of concern are addressed immediately at local level by staff or by the person in charge. Residents and relatives spoken with told the inspector they felt comfortable raising any concerns with the provider/person in charge or any member of staff should the need arise. They described the staff as receptive to their concerns and said that they made "great efforts to address matters raised and to resolve them".

The complaints record contained the facility to record all relevant information about the complaint, investigation made and the outcome. No complaints were being investigated
at the time of inspection and complaints recorded had been successfully addressed to the satisfaction of the complainant according to the records reviewed. Varied issues had been addressed including communication with family members and care practice. As described earlier reference to the Authority as a resource to address complaints needed to be removed from the documentation.

**Judgment:**
Compliant

**Outcome 14: End of Life Care**
Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.

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

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

**Findings:**
The inspector was satisfied that caring for a resident at end-of-life was regarded as an integral part of the care service provided in the centre and could be provided to a good standard. The person in charge and nursing staff had prepared a resource folder of information on topics relevant to end of life care and the person in charge and her deputy had attended the Authority's education sessions on this topic. The delivery of care is informed by the centre's policy on end-of-life care which had been reviewed earlier this year was reviewed by the inspector. This was a comprehensive document that outlined the majority of factors relevant to care practice. Information on the indicators for referral to the palliative care service and when end of life care became care of the dying would the inspector found make the policy more effective. The centre had materials and symbols from the Hospice Friendly Hospitals programme available for use when end of life care was in progress and also had material on bereavement support to offer families.

There were end of life care plans in the sample of care records examined and where residents had indicated that they did not wish to discuss this topic this was recorded. The inspector found that families were included in discussions at residents' request and that their views were included in the decisions made. If residents decided that they did not wish to have active interventions or treatments this was recorded in care and medical records and was readily available to staff. The inspector was told that where possible residents were moved to a single room and relatives/visitors were offered hospitality and supported to remain with their loved one as long as they wished.

The local palliative care team was available to provide support and advice when required. Additional training on end of life care had been provided to the majority of nurses and carers to ensure resident’s needs would be met in an informed way at this time.
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):
No actions were required from the previous inspection.

Findings:
The inspectors saw that adequate policies and procedures were in place to ensure that each resident was provided with a varied and nutritious diet. The procedures had been reviewed during 2014. The inspector saw that an adequate and varied supply of fresh, frozen and dry foodstuffs were available and dishes were home cooked daily. There was an emphasis on providing a good quality diet for residents and menus had been reviewed by a dietician to ensure that the required quantities of fresh fruit, vegetables, fibre and variety were made available to residents. The menu was clearly displayed and offered choice at each mealtime. Staff were seen to ascertain resident preferences including those of more dependent residents before each main meal. The inspector saw that meals were well presented, had an appealing aroma, portions were sufficient and residents said that they enjoyed their meals. Staff provided assistance to residents in a respectful manner as required. The dining room was well organised and was used by most residents at main meal times.

Catering staff retained information on each individual resident’s preferences, general likes and dislikes and any specific nutritional requirements such as modified diets and fluids. The inspector saw that residents had access to services such as speech and language therapy and dieticians and the provision of modified diets was informed by these referrals and recommendations. Staff spoken with had good knowledge of residents nutritional care plans.

The inspector saw that systems were in place for monitoring resident’s nutritional status including monthly monitoring of body weight, the use of the Malnutrition Universal Screening Tool (MUST), daily dietary and fluid intake records and referral as necessary when Must scores indicated concern. The majority of staff had attended training on nutrition, the fortification of food, specialist diets and care planning and assessment of nutritional needs.

Judgment: Compliant
**Outcome 16: Residents’ Rights, Dignity and Consultation**

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

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

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

**Findings:**
The inspector found that residents were treated with dignity and respect. Residents said that staff treated them kindly, were respectful at all times and adhered to their choices and preferences. One resident said that she told staff of her likes and dislikes on admission and they had adhered to and respected her wishes "ever since". The centre had a range of activities available and the programme was on display outside the dining and sitting areas. The inspector saw that the programme was varied and aimed at meeting the varied needs of residents. There were discussion groups, reminiscence and orientation sessions. A Sonas activity was scheduled twice a week with a trained member of staff. (This activity is targeted towards people with dementia and is based on sensory stimulation to prompt memory). Staff also engage in one to one activities with residents who are unable to take part in group work. Board and card games were particularly popular.

Four residents told the inspector about how they spent their time. They said that they read the paper daily, took part in music and singing, watched films and played cards. Female residents said they could have their hair and nails done regularly and that staff regularly did hand and foot massages for them. An action plan in the last report required that the social care to residents who were very frail was improved. The inspector found that where residents were in bed for regular periods or preferred to spend their time in their rooms that staff visited them regularly, spent time chatting to them, ensured that their radios and TVs were set at stations/programmes they liked and took time with their personal care.

Residents were free to communicate and in the majority of records reviewed their needs were identified to ensure that staff were appropriately informed if residents had communication problems. Some residents had mobile phones and staff were observed to ensure that these were ready for use and charged. Nurses had a system of symbols that indicated levels of pain which they used to determine the need for pain relief medication and other comfort measures to relieve pain.

**Judgment:**
Compliant
### 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:**
The inspector noted that there was good provision of storage space for residents to store their belongings. Residents clothing was noted to be carefully laundered and well organised by staff.

There is a laundry service every day and staff were able to describe how personal and general laundry is managed. There was an effective labelling system which the inspector was told was placed discreetly on clothing and which had proved to be durable. There were no problems with lost or misplaced laundry items at the time of inspection. A record was maintained of each residents' personal belongs and clothing.

**Judgment:**
Compliant

### Outcome 18: Suitable Staffing

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

**Theme:**
Workforce

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

**Findings:**
The inspector found that the centre had a dedicated and committed staff team. Carers and nurses had a good knowledge of residents care needs, their choices and preferences and were able to describe for the inspector how individual choices and expectations were met. They were familiar with the changing communication needs of residents who were becoming mentally and physically frail and had developed good
working relationships with family members and the inspector saw examples of how they ensured that families were included in resident’s care from the regular reviews and from information provided during the inspection.

The inspector examined the staff duty rota for a two week period. This described the staff complement on duty over each 24-hour period. The inspector noted that the planned staff rota matched the staffing levels on duty. The inspector was satisfied that the number and skill mix deployed was adequate to meet the needs of residents. There were six staff including the person in charge and provider working in the centre during morning periods. During the afternoon there were five staff in duty. In addition there was a carer and laundry staff available each day. At night there was a nurse and two carers available until 23:00 hours when staffing levels reduced to one carer and a nurse.

There was evidence that staff had been provided with training opportunities and had attended training on a range of topics from the attendance records and reports from staff. In addition to the mandatory topics such as elder abuse, moving and handling and fire safety staff had attended training on nutrition, care planning, end of life care, infection control and laundry management. Three nurses had attended wound management training and almost all had attended a specialist diagnostic elderly care assessment training.

An action plan in the last inspection report required that staff training records were kept up to date and the inspector found that this had been addressed. Records were maintained for individual staff and there was an overall record that indicated when training had been scheduled and who had attended.

**Judgment:**
Compliant

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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:**

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

Centre name: Archview Lodge
Centre ID: OSV-0000314
Date of inspection: 08/07/2014
Date of response: 21/08/2014

Requirements

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

Outcome 01: Statement of Purpose

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The section on complaints in the statement of purpose needed revision to reflect accurately the appeals process as the Authority does not have a role in the resolution of individual complaints.

Action Required:
Under Regulation 03(1) you are required to: Prepare a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Please state the actions you have taken or are planning to take:
Statement of Purpose will be reviewed and updated.

1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
**Proposed Timescale:** 30/08/2014

**Outcome 03: Information for residents**

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The contracts for services did not always indicate the fee to be charged or the fees for additional services outside the contract specification.

**Action Required:**
Under Regulation 24(2)(d) you are required to: Ensure the agreement referred to in regulation 24 (1) includes details of any other service which the resident may choose to avail of but which is not included in the Nursing Homes Support Scheme or which the resident is not entitled to under any other health entitlement.

**Please state the actions you have taken or are planning to take:**
Contracts for Care are being updated in accordance with the new Care and Welfare Regulations and in conjunction with the contracts for Care being developed by Nursing Homes Ireland. This will include a detailed breakdown of fees to be paid by residents for additional services outside the contract specification.

**Proposed Timescale:** 30/09/2014

**Outcome 05: Documentation to be kept at a designated centre**

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The policy on self harm needed revision to appropriately guide staff.

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

**Please state the actions you have taken or are planning to take:**
Policy will be reviewed and updated.
**Outcome 07: Safeguarding and Safety**

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The information provided to staff in the abuse procedure and in training did not convey the correct statutory reporting responsibilities.

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

Please state the actions you have taken or are planning to take:
Policy reviewed and updated to reflect appropriate statutory reporting responsibility.

**Proposed Timescale:** 21/08/2014

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**Outcome 08: Health and Safety and Risk Management**

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
While the centre had an emergency plan the presence of two versions could cause confusion for staff and one version did not indicate where residents could be moved to should the centre have to be evacuated.

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

Please state the actions you have taken or are planning to take:
The second version of Emergency Plan has been removed and only the relevant plan now exists.

Completed

**Proposed Timescale:** 21/08/2014
**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Moving and handling assessments did not indicate the type of hoist to be used to guide and inform staff effectively when undertaking moving and handling manoeuvres.

**Action Required:**
Under Regulation 26(1)(b) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the risks identified.

**Please state the actions you have taken or are planning to take:**
Type of Hoist to be used identified in Residents Assessments.

**Completed**

**Proposed Timescale:** 21/08/2014

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was no information to indicate residents' needs in the event that the centre had to be evacuated.

**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 will have a PEEP Assessment carried out to indicate their specific individual needs should an evacuation be required.

**Proposed Timescale:** 19/09/2014

**Outcome 09: Medication Management**

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Medicines to be given on an "as required" basis did not have the maximum dose to be given in a twenty four hour period outlined.

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

Please state the actions you have taken or are planning to take:
Medicines to be given on an "as required" basis will have the maximum dose to be given in a 24 hour period outlined.

Proposed Timescale: 30/08/2014

Outcome 10: Notification of Incidents

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Information required into events such as loss of power, theft or burglary had not been provided as required.

Action Required:
Under Regulation 31(4) you are required to: Where no report is required under regulation 31(1) or 31(3), report this to the Chief Inspector at the end of each 6 month period.

Please state the actions you have taken or are planning to take:
Notifications of Incidents in accordance with Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 will be adhered to and will commence on next quarterly returns 31st October, 2014.

Proposed Timescale: 31/10/2014

Outcome 11: Health and Social Care Needs

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The assessment and recording of dementia care needs and levels of orientation required improvement as it was not possible to determine from some records what levels of care were required to assist their orientation and ensure appropriate care.

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 assessment of dementia care needs and levels of orientation will be improved to reflect levels of care required to assist residents orientation and ensure appropriate care.

Proposed Timescale: 30/09/2014

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 were deficient in the following areas:
Three bedrooms accommodated three residents and the linear layout that had to be adopted to accommodate the three beds did not facilitate the provision of appropriate standards of privacy and dignity
Two rooms, 12 and 12A had natural light provided by sky lights in the ceiling but had no windows that residents could look out of.
Room 13 (shared by two residents) was also undersized measuring 13.6 square metres instead of recommended minimum of 14.8 square metres and the usable space in some rooms restricted the use of equipment.
There was no treatment room where residents could meet with health professionals in private,
A secure outdoor garden space was not available
The laundry area was confined making the segregation of clothing difficult to manage safely..

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:
Deficits in the structure of the building are being addressed by the new renovation plans that have been developed and fully costed. Phase 1 of the development is now complete which includes extensive ground works and improvements to residents views and privacy. Phase 2 of the development is going to planning stage with a proposed commencement of works in Spring 2015 and an expected conclusion to works circa July 2016.

Proposed Timescale: 31/07/2016