Health Information and Quality Authority
Regulation Directorate

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	Innis Ree Lodge
Centre ID:	OSV-0000350
Centre address:	Ballyleague, Lanesborough, Roscommon.
Telephone number:	043 332 7300
Email address:	s.curran@allenfield.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Allenfield Care Homes Limited
Provider Nominee:	Eileen Burke
Lead inspector:	PJ Wynne
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	52
Number of vacancies on the date of inspection:	6

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:
02 December 2014 09:00	02 December 2014 17:15
03 December 2014 08:45	03 December 2014 16:00

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

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

Summary of findings from this inspection

This report set out the findings of an announced registration renewal inspection, which took place following an application to the Health Information and Quality Authority (the Authority) Regulation Directorate, to renew registration of the designated centre.

The inspector met with the person in charge who is also the provider nominee and staff team. All staff displayed a good knowledge of the Authority's Standards and regulatory requirements and were found to be committed to providing quality person-centred care to the residents.

The inspector was satisfied that the residents were well cared for and that their nursing and care needs were being met. Residents had good access to general practitioners (GP). The person in charge was fully involved in the management of the centre and was found to be easily accessible to residents, relatives and staff. This was evidenced in questionnaires completed by families and returned to the Authority.

There was evidence of individual residents' needs being met and the staff supported residents to maintain their independence where possible. There was a variety of social and recreational activities led by an activities coordinator.

The building is well maintained both internally and externally. It was found to be comfortable and welcoming. There was a good standard of décor throughout. The inspector was satisfied that the health and safety of residents, staff and visitors in the centre was promoted and protected. The person in charge had sufficiently prioritised the safety of residents in the event of fire.

The action plan at the end of this report identifies these and other areas where improvements must be made to meet the requirements of 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.

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 was revised since the last inspection. The Statement of Purpose set out the services and facilities provided in the designated centre and contained all the requirements of Schedule 1 of the Regulations.

Judgment:
Compliant

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

Theme:
Governance, Leadership and Management

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

Findings:
There was a management structure in place to ensure the effective governance of the service. The inspector found that the management structure was appropriate to the size, ethos, purpose and function of the centre.

There was evidence of quality improvement strategies and monitoring of the services. The inspector reviewed audits completed by the person in charge. A system of audits is planned on an annual basis to include clinical data over a wide range of areas namely medication management, nutrition and any accident/falls sustained by residents. The inspector found that this information was used to improve the service. Improvement plans to ensure enhanced outcomes for residents were developed.

Annual reviews of the quality and safety of care was undertaken by the provider and included feedback from residents and their families. Satisfaction surveys were completed by residents and their next of kin. A comprehensive report on the quality of life and safety of care was complied. The report is made available to residents and their families.

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

Findings:

There is a residents' guide available containing the information required by the Regulation.

The complaints procedure was displayed in the entrance foyer opposite the nurses' station for visitors to view. This provided direction to the person they could raise an issue with if they had a concern. A comments box was provided for residents or visitors to raise issues.

There was an information display area with relevant brochures to provide age appropriate information to residents in relation to protection, finances and bereavement support.

The inspector reviewed a sample of two contracts of care to include the contract for the residents mostly recently admitted to the centre. All contracts were signed by relevant parties. The inspector found that each resident had an agreed written contract which included details of the overall fee for services. The contract were revised since the last inspection to include details of the charges payable per all items not included in the overall fee for example, chiropody, hairdressing, physiotherapy and an escort to attend appointments.

Judgment:
Compliant

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 has not changed since the last inspection. She is a registered nurse and holds a full-time post. She was well known by residents. She had good knowledge of residents care needs. She could describe in an informed way where residents had specific needs and how staff ensured that their care needs were met appropriately. She maintained her professional development and attended mandatory training required by the Regulations. The person in charge is a qualified adult protection trainer and moving and handling instructor.

She had attended courses in nutrition in the elderly, end of life care, dementia care and infection control. The person in charge confirmed she assists in the delivery of clinical care in addition to her governance responsibilities ensuring she is appraised of each resident's care needs.

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 found that there were systems in place to maintain complete and accurate records. Records were stored securely and easily retrievable.

Written operational policies, which were centre specific, were in place to inform practice and provide guidance to staff.

The inspector found that medical records and other records, relating to residents and staff, were maintained in a secure manner. Appropriate insurance cover was in place with regard to accidents and incidents, out sourced providers and residents' personal property.

The directory of residents contained all the information required by schedule three of the regulations and was maintained up to date.

A sample of six staff files to include the files of the two most recently recruited staff were reviewed. The files were examined to assess the documentation available, in respect of persons employed. All the information required by Schedule 2 of the Regulations was available in the staff files reviewed.

The end-of-life policy food and nutrition policy required required minor review to reflect recent changes in care practice. This is discussed inmore detail under Outcome 14, End of Life care and Outcome 15, Food and Nutrition.

Judgment:
Compliant

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 the requirement to notify the Chief Inspector of the proposed absence of the person in charge for a continuous period of 28 days. The key senior manger is appointed to deputise while the person in charge is absent.

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 inspector was provided with a copy of the centre's policy on prevention, detection and response to elder abuse. The policy was specific to the centre. Protected disclosure procedures to guide staff in their reporting of a suspicion of abuse were documented in the policy.

Residents spoken with stated that they felt safe in the centre. There was a visitors log in place. One incident of adult protection was recorded and notified to the Authority since the last inspection. The incident was managed in line with the centre's policy. Responsive action to ensure the welfare and protection of residents was ensured.

Staff to whom the inspector spoke with were able to confirm their understanding of the features of protection of vulnerable adults and to whom they would report a concern. All

staff had up to date refresher training in protection of vulnerable adults.

Garda Síochána vetting had been applied for all staff members. This was evidenced by a review of returned Garda Siochana vetting forms examined by the inspector.

The financial controls in place to ensure the safeguarding of residents' finances were examined by the inspector on the last visit. There was a policy outlining procedures to guide staff on the management of residents' personal property and possessions. An accountable system was in place for the management of finances on behalf of residents.

There is a policy on the management of behaviour that is challenging and supportive strategies were in place. Psychotropic medications used were pertinent to specific behaviours. Medical records evidenced close monitoring by the prescribing clinician. There was regular review to ensure optimum therapeutic values. Risk assessments and care plans for challenging behaviour were completed.

Staff spoken with were very familiar with resident's behaviours and could describe the particular interventions well to the inspector. Staff had received training in behaviours that challenge to ensure they have up to date knowledge and skills to respond appropriately.

There was a policy on restraint management (the use of bedrails and lap belts) in place. The policy and practice was reflective of the national policy on promoting a restraint free environment. A multidisciplinary risk assessment was completed prior to using bedrails. Signed consent was obtained by the resident or their representative and the GP. The physiotherapist was involved in the decision making process. There were seven residents with two bedrails raised at the time of this inspection.

Other residents had one bed rail raised which was being used as an enabler, to assist the resident sit up or turn in bed. The rationale for each bed rail was outlined in the risk assessment documentation reviewed. In the documentation reviewed there were details of trialling alternative options and why there were unsuccessful, such as ultra low beds or an additional mattress on the floor by the bed.

Judgment:
Compliant

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 was satisfied that the health and safety of residents, staff and visitors in the centre was promoted and protected. The actions in the previous inspection which related to risk, health and safety were satisfactorily completed. The risk management policy was revised to include the arrangements to ensure learning for all staff to minimise the risk of repeat occurrences.

The outcomes of fire drills undertaken are now documented to ensure evaluation and learning from fire drills completed. There was evidence all staff participated in fire drills. As some staff only work night shifts simulated fire drills are undertaken to reflect a night time situation when staffing levels are reduced.

The inspector reviewed the fire safety register and training records. Staff to whom the inspector spoke confirmed their attendance at fire training and gave accounts of their understanding of fire procedures in the event of an outbreak of fire. All staff had completed refresher training in fire evacuation since the last inspection.

There were four residents who smoked at the time of inspection. A plan of care was in place to guide staff. Cigarettes and lighters were held in safe keeping by staff. A fire retardant apron was required for use by one resident following risk assessment. This was observed in use on the days of inspection. Fire safety equipment including the fire alarm, fire extinguishers, emergency lighting and smoke detectors were provided. These were serviced quarterly and annually as required. Fire exits were marked and the escape routes well identified. However, the procedures to follow on hearing the alarm and action to take on discovering a fire was only displayed in one location in the building opposite the nurses' station.

The Authority was provided with written evidence from a suitably qualified person confirming the building meets all the statutory requirements of the fire authority in relation to the use of the building as a residential centre for older dependent people in advance of this inspection. Similarly evidence of compliance with planning and development legalisation was submitted to the Authority.

The inspector viewed evidence staff were trained in the safe moving and handling of residents. The moving and handling assessments were updated as required from the last visit to include details of the sling type and size. There was a range of assistive equipment available to meet resident moving and handling needs in a safe manner.

The inspector viewed the infection control policy and found it provided appropriate guidance for staff when managing a range of infectious illness including norovirus and influenza. A copy of the Authority's standards on the prevention and control of associated healthcare infections was available for reference. The contact details for the local health office and the public health doctor were available. Hygiene measures including hand sanitizers and protective equipment were available throughout the building. Audits of the building were completed at intervals to ensure the centre was clean and identify any safety issues. A sufficient number of cleaning staff were employed and the building was visually clean on the day of inspection.

However, the current cleaning methods did not minimise the risk of cross contamination. The inspector noted cleaning staff did not change cleaning cloths at regular intervals

between bedrooms to break the cycle of infection. Separate designated equipment for cleaning a bedroom in the event of infection was not available.

Judgment:
Non Compliant - Minor

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:
There was a comprehensive medication management policy in place which provided guidance to staff to manage aspects of medication from ordering, prescribing, storing and administration. Residents had a choice of pharmacist.

The inspector reviewed a sample of drugs charts. Photographic identification was available on the drugs chart for each resident to ensure the correct identity of the resident receiving the medication and reduce the risk of medication error. The prescription sheets reviewed were legible and distinguished between regular and short term medication and antibiotic therapy.

The medication administration sheets viewed were signed by the nurse following administration of medication to the resident and recorded the name of the drug and time of administration. The drugs were administered within the prescribed timeframes. There was space to record when a medication was refused on the administration sheet.

Medication was being crushed for some residents. Alternaltive liquid or soluble forms of the drugs were sought where possible through consultation with the pharmacy. Drugs being crushed were signed by the GP. This was an area identified for improvement on the last inspection.

An assessment was not undertaken to ascertain if a resident had the capacity to manage their own medication if they expressed the desire. A risk assessment tool to guide staff in their decision making to facilitate residents who may wish to self medicate was not available.

Medicines were being stored safely and securely in the clinic room which was secured. The temperature ranges of the medicine refrigerator was being appropriately monitored and recorded.

Medications that required strict control measures were kept in a secure cabinet which

was double locked in keeping with the Misuse of Drugs (Safe Custody) Regulations. Nurses kept a register of controlled drugs. Controlled drugs were checked by two nurses at the change of each shift. The inspector checked a selection of the balances and found them to be correct.

Judgment:
Non Compliant - Minor

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 inspector reviewed a record of incidents/accidents that had occurred in the centre and cross referenced these with the notifications received from the centre. Quarterly notifications had been submitted to the Authority as required.

Judgment:
Compliant

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 centre can accommodate a maximum of 58 residents who need long-term care, or who have respite, convalescent or palliative care needs. There were 52 residents being accommodated for extended care at the time of the inspection. Many residents were noted to have a range of healthcare issues and the majority had more than one medical condition.

The arrangements to meet residents' assessed needs were set out in individual care plans. The inspector found a good standard of evidence-based care and appropriate medical and allied health care access. Recognised assessment tools were used to evaluate residents' progress and to assess levels of risk for deterioration, for example vulnerability to falls, dependency levels, nutritional care, the risk of developing pressure sores and cognitive functioning.

The inspector reviewed three resident's care plans in detail and certain aspects within other plans of care to include the files of residents with nutritional issues, forms of restraint in use, potential behaviour that challenges and residents under palliative care. The inspector found that all files reviewed were comprehensive. The range of risk assessments completed were used to develop care plans that were person-centred, individualised and described the current care to be given. In the sample of care plans reviewed there was evidence care plans were updated at the required intervals or in a timely manner in response to a change in a resident's health condition. There was evidence of consultation with residents or their representative in all care plans reviewed of agreeing to their care plan when reviewed or updated.

Residents had access to general practitioner (GP) services and there was evidence of medical reviews at least three monthly and more frequently when required. Medical records evidenced residents were seen by a GP within a short time of being admitted to the centre. A review of residents' medical notes showed that GP's visited the centre regularly. The GP's reviewed and re-issued each resident's prescriptions every three months. This was evidenced on reviewing medical files and drug cards.

Access to allied health professionals to include speech and language therapist, dietetic service and physiotherapy was available. There were no residents with pressure wounds on the day of inspection.

Judgment:
Compliant

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

Findings:

The building is designed to meet the needs of dependent older people. The building is well maintained both internally and externally. It was found to be comfortable and welcoming. There was a good standard of décor throughout and very high levels of personalisation evident in residents' bedrooms. Residents spoken with confirmed that they felt comfortable in the centre. The centre has a large well furnished and maintained reception which also serves as a sitting area. Sitting / dining rooms are also provided in each unit.

There are 54 single bedrooms and two twin bedrooms all with ensuite shower and toilet facilities. Rooms are large with adequate storage space and each is equipped with a fridge, washing machine and tea making facilities. All bedrooms have good natural light and ensuites were suitably ventilated.

Staff facilitates were provided with lockers for the storage of personal belongings Separate toilets and showering facilitates were provided for care and kitchen staff in the interest of infection control. A separate cleaning room and sluice room were available and access was restricted in the interest of safety to residents and visitors. There was sufficient storage space for equipment used by residents and corridors and communal rooms were clear of any obstructions.

The variation in floor surfaces between the dining and sitting areas in some units was identified as a hazard on the last inspection as the edges of the floor covering were damaged or may pose a trip hazard. Replacement covering had been provided in each unit to eliminate the trip hazard.

Judgment:
Compliant

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

Theme:
Person-centred care and support

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

Findings:
There was a comprehensive complaints policy in place. The person in charge explained issues of concern are addressed immediately at local level without recourse to the formal complaints procedure, unless the complainant wishes otherwise.

The complaints policy was revised as required by the action plan of the last inspection report. The inspector reviewed the complaints procedure and noted this displayed in the central foyer. A designated individual was nominated with overall responsibility to investigate complaints. A nominated person who would monitor that the complaints

process was followed and recorded (independent of the person responsible to investigate the complaint) was identified.

There were robust internal mechanisms within the centre's policy to resolve complaints. The timeframes to respond to a complaint, investigate and respond to complainant were outlined. There was an independent appeals process if the complainant was not satisfied with the outcome of their complaint.

No complaints were being investigated at the time of inspection. A complaints log was in place which contained the facility to record all relevant information about complaints. There was evidence complaints were resolved to the satisfaction of the complainant.

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

Findings:
End of life care formed an integral part of the care service provided at the centre.

There was an end-of-life policy in place. However, the policy required minor review to reflect recent changes in care practice. The policy did not include procedures to guide staff on documenting resident's wishes in relation to end of life in terms of advance care planning and information on referral to palliative care services for specialist input. Staff spoken with had an understanding of end of life care and staff had completed training in this area during 2014.

The policy of the centre is all residents are for resuscitation unless documented otherwise. The end of life plans included discussions in relation to life sustaining treatments. All residents were consulted regarding their future healthcare interventions, personal choices and wishes in the event that they became seriously ill and were unable to speak for themselves. A multi disciplinary approach was undertaken to include the resident where possible, their representative, the GP and the nursing team. End of life care plans were reviewed at required intervals.

Residents with a do not resuscitate (DNR) status in place have the DNR status regularly reviewed to assess the validity of clinical the judgement on an ongoing basis. This was evidenced on reviewing medical files. This was an area identified for review in the action plan of the last report by the inspector.

Where the need was identified and the resident consented or their next of kin, referrals were made to the palliative care team. Records reviewed evidenced good input by the palliative team to monitor and ensure appropriate comfort measures. Medication was regularly reviewed and closely monitored to ensure optimum therapeutic values. The person in charge had a validated pain assessment tool available. The pain assessment tool was frequently reviewed and detailed each resident's pain medication.

The person in charge stated that upon the death of a resident, his/her family or representatives were offered practical information (verbally) and on what to do following the death of their relative. An information leaflet on how to access bereavement and counselling services is available.

There was a protocol for the return of personal possessions. Property lists were maintained recording each resident's personal belongings. Property list were filed on the inside of each residents wardrobe. The record included space for families to record any item they brought in or took away belonging to the resident. A specially designed bag to return personal possessions to the families was available.

Care practices and the facility of the physical environment ensured that resident's needs were met and their dignity respected. Accommodation comprises 54 single rooms. Families are supported to be with their relative and facilitated to stay overnight. Refreshments are available to visitors. Residents' cultural and religious needs were supported. There is an oratory available to residents to meet their spiritual needs.

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:
There was a food and nutrition policy in place which was centre specific. However the policy required minor review to reflect changes in care practice to guide staff. All residents are weighed at a minium monthly and the policy states every three months. The policy does not outline the new practice required by staff to document all food and fluid intake for newly admitted residents for the first week of their stay to establish a baseline dietary pattern.

The inspector observed mealtimes. Residents confirmed they could choose where they wanted to eat. Residents are accommodated in dining rooms in each of the units if they wish. The majority of residents had their main meal in the large central dining room referred to as the day centre. This is where the group activites also took place.

Meal times were a social occassion and a calm enviroment was ensured. The dining areas are well decorated with a bright decor. The lunch time menu provided residents with two different options. The menu choices were clearly displayed on each table. Residents confirmed their menu choices for lunch and tea mid morning and alternaltives were available should they change their mind. Each residents' food likes and dislikes were doucmeted and made known to kitchen staff. Pictorial menus were available to help residents understand the food choices.

All food was cooked on the premises. The inspector reviewed the menu and discussed options available to residents with the chef. There were nutritious snack options available between meals to ensure sufficient or optimum calorific intake particularly those for those on fortified diets. A trolley served residents mid morning offering a choice of soup tea/coffee. In the afternoon residents were offered a fruit/smoothie option with biscuits, tea or coffee.

The instructions for foods and liquids that had to have a particular consistency to address swallowing problems were outlined in care plans and are available to catering and care staff. Staff interviewed could describe the different textures and the residents who had specific requirements.

Sufficient dining space was available in each area.Tables accommodated small groups of residents which supported social interaction. The inspector saw that there were adequate staff available to assist at mealtimes. Staff sat with residents who required assistance with meals, were respectful with their interventions and promoted independence by encouraging residents to do as much as they could for themselves.

Clinical documentation was of a good standard. Assessments, care plans and nursing evaluation notes were reviewed. Residents had care plans for nutrition and hydration in place. There was prompt access to the GP and allied health professionals for residents who were identified as being at risk of poor nutrition or hydration. There was evidence of reviews by the dietician and the speech and language therapist. Care plans were revised to reflect updates following reviews by allied health specialists. Two residents were documented for subcutaneous fluids by the GP.

There was ongoing monitoring of residents nutritional, hydration and skin integrity and oral hygiene. Nutritional screening was carried out using an evidence-based screening tool at three monthly intervals. Each need had a corresponding care plan which detailed the nursing care, medications/food supplements prescribed; specific care recommendations from visiting inter disciplinary team members and the GP.

Residents' weights and body mass index (BMI) were monitored. All residents were weighed monthly and those at risk on a weekly basis. Staff monitored the food and fluid intake of all residents following risk assessment. Each residents daily fluid goal was recorded and fluid charts were totalled and reviewed to ensure the recommended fluid

goal was achieved.

Detailed dietary monitoring records of food intake were implemented when appropriate. Food records maintained were detailed to a high standard. Staff had received training in relation to food and nutrition. They demonstrated and articulated good knowledge of how to provide optimal care for residents.

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:
There was evidence of a very good communication culture amongst residents, their families, the staff team and person in charge. There were regular residents' meetings to elicit the opinion of residents on the service and care provided. There was evidence of work by the management team to respond to request by residents in relation to menu choices, activities type and frequency. Regular staff meeting takes place and minutes indicated a good attendance and level of discussion on the service, polices, training requirements and care provided. A residents' forum was in place. Residents had access to an independent advocate who provided feedback to the person in charge.

Residents were dressed well and according to their individual choice. The inspector observed staff interacting with residents in a courteous manner and addressing them by their preferred name.

Residents were able to exercise choice regarding the time they got up and were able to have breakfast at a time that suited them. During the day residents were able to move around the centre freely. They had a choice of sitting rooms and could move to a smaller quieter room if they wished.

The majority of the bedrooms were single. There was seating in the communal areas inside the main entrance and the central foyer. However, there was not a visitor's room to allow residents meet with visitors in a suitable private area apart from their bedrooms.

There were opportunities for all residents to participate in activities. There was a structured program of activities in place which was facilitated by the activities coordinator, employed 23 hrs each week. The inspector spoke with the activity coordinator who confirmed the range of activities in the weekly program. The activity schedule provided for both cognitive and physical stimulation. There is live music sessions scheduled twice weekly.

Judgment:
Non Compliant - Minor

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 reviewed a policy for the managing of residents' personal property. It provided guidance to staff on the storage and care of residents' belongings. There was evidence that residents had adequate space for their belongings, including secure lockable storage. Each resident was provided with their own wardrobe. The centre provided a service to launder all residents' clothes and families had the choice to take home clothes to launder if they wished.

A property list was completed with an inventory of all residents' possessions on admission and updated periodically. The inspector noted that resident's bedrooms were personalised with many of the rooms decorated with pictures and photographs.

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):
No actions were required from the previous inspection.

Findings:
The provider employs a whole-time equivalent of 13 registered nurses and 29 care assistants. In addition, there is catering, cleaning an activity coordinator and administration staff employed. The inspector viewed the staff duty rota for a two week period. The rota showed the staff complement on duty over each 24-hour period. The person in charge at all times was denoted on the rota. The staff roster detailed their position and full name. The inspector noted that the planned staff rota matched the staffing levels on duty.

The inspector judged there was sufficient staff with the proper skills and experience to meet the assessed needs of residents at the time of this inspection taking account of the purpose and size of the designated centre.

There was a detailed policy for the recruitment, selection and vetting of staff. It was reflected in practice. This was evidenced by a review of staff files. Recently recruited staff confirmed to the inspector they undertook an interview and were requested to submit names of referees.

There was a training matrix available which conveyed that staff had access to ongoing education and a range of training was provided. The inspector found that in addition to mandatory training required by the regulations staff had attended training on caring for residents with dementia, infection control, nutritional care and end- of- life care. All nursing staff were facilitated to engage in continuous professional development and had completed basic life support training, as had12 care assistants.

There was a significant program of training facilitated by the management team and undertaken by staff in the past 12 months. The person in charge completes a staff appraisal annually with each staff member. However, there has been no review of the effectiveness of the training, and its implementation in practice. There has been no follow up with staff to assess their understanding of training completed and evaluation to ensure improved outcomes for residents. The person in charge confirmed she is

developing a training needs analysis matrix which will form part of each staff members professional development review. This will be used to assess training requirements and influence course content for training delivery.
Judgment: Non Compliant - Minor

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:

PJ Wynne
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	Innis Ree Lodge
Centre ID:	OSV-0000350
Date of inspection:	02/12/2014
Date of response:	12/01/2015

Requirements

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

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

Outcome 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 end-of-life policy required minor review to reflect recent changes in care practice. The policy did not include procedures to guide staff on documenting resident's wishes in relation to end of life in terms of advance care planning and information on referral to palliative care services for specialist input.

There was a food and nutrition policy required minor review. The policy does not

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

outline the new practice required by staff to document all food and fluid intake for newly admitted residents for the first week of their stay to establish a baseline dietary pattern.

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:
The End of Life policy will be updated to include documenting our residents wishes regarding resuscitation status, and when to introduce palliative care services.

The nutrition/food policy has been updated to reflect current practices.

Proposed Timescale: 15/01/2015

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:
The current cleaning methods did not minimise the risk of cross contamination. Cleaning staff did not change cleaning cloths at regular intervals between bedrooms to break the cycle of infection. Separate designated equipment for cleaning a bedroom in the event of infection was not available.

Action Required:
Under Regulation 27 you are required to: Ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.

Please state the actions you have taken or are planning to take:
A clear system is detailed in both cleaning rooms which specifies colour coded clothes, how frequently mop bucket water is changed and after how many rooms the cloths are changed. This is in line with best practice to minimise the risk of cross infection. Extra equipment will be stored in case of an outbreak.

Proposed Timescale: 21/01/2015

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The procedures to follow on hearing the alarm and action to take on discovering a fire

was only displayed in one location in the building opposite the nurses' station

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

Please state the actions you have taken or are planning to take:
The procedure will be displayed in each section and corridor.

Proposed Timescale: 21/01/2015

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:
A risk assessment tool to guide staff in their decision making to facilitate residents who may wish to self medicate was not available.

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:
A form will be devised and used to assess the risk regarding self administration of medication.

Proposed Timescale: 14/02/2015

Outcome 16: Residents' Rights, Dignity and Consultation

Theme:
Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was no visitor's room to allow residents meet with visitors in a suitable private area apart from their bedrooms.

Action Required:
Under Regulation 11(2)(b) you are required to: Make suitable communal facilities available for a resident to receive a visitor and a suitable private area which is not the resident's room, if required.

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

The meeting room will be redecorated to provide a calm and private area for residents to socialise with family and friends.

Proposed Timescale: 27/02/2015

Outcome 18: Suitable Staffing

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There has been no review of the effectiveness of the training, and its implementation in practice. There has been no follow up with staff to assess their understanding of training completed and evaluation to ensure improved outcomes for residents.

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

Please state the actions you have taken or are planning to take:
All staff will now be assessed to determine their training needs and a plan put in place.

Proposed Timescale: 14/03/2015