

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Melview Nursing Home
Centre ID:	OSV-0000250
Centre address:	Prior Park, Clonmel, Tipperary.
Telephone number:	052 612 1716
Email address:	davina@sonas.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Sonas Nursing Homes Management Co. Limited
Provider Nominee:	John Mangan
Lead inspector:	Louisa Power
Support inspector(s):	Kieran Murphy;
Type of inspection	Announced
Number of residents on the date of inspection:	33
Number of vacancies on the date of inspection:	3

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 following an application to vary registration conditions. This monitoring inspection was announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 11 December 2014 09:15 To: 11 December 2014 17:45

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 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 18: Suitable Staffing

Summary of findings from this inspection

The inspection was an announced and took place over one day following an application to vary conditions of registration. The providers had applied to increase the maximum number of residents that can be accommodated to 38.

This was the sixteenth inspection of the centre by the Authority. As part of the inspection process, inspectors met with residents, relatives, visitors and staff members. Inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures, risk management documentation and staff records. The documentation submitted by the providers as part of the application process was also reviewed prior to the inspection.

Overall, inspectors found that the person in charge ensured that residents' medical and nursing needs were met to a good standard. Residents looked well and cared for, engaged readily with inspectors and provided positive feedback on the staff, care and services provided. The previous inspection findings of 02 and 03 April 2014 had identified significant improvements in the areas of quality improvement, care

planning and provision of medical and nursing care. Inspectors saw evidence that these improvements had been sustained.

Inspectors found that the original part of the premises continued to pose numerous challenges in the provision of care due to the lack of private and communal space and facilities for residents. The premises and fittings were not adequately maintained. The majority of residents were accommodated in multi-occupancy rooms. There was no communal space provided on the first floor. Sanitary facilities on the top floor did not meet the needs of residents accommodated. In contrast, the new part of the premises comprises a majority of single rooms, was finished to an adequate standard and the decor was bright. The providers outlined to the inspectors the plan for the next phase of renovation and upgrading of the centre in order to comply with the Regulations and Standards.

The other required improvements are set out in detail in the action plan at the end of this report and include:

- Hazard identification
- manual handling practices
- care planning for residents with epilepsy
- staff files
- documentation in relation to bed rail safety checks.

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 consisted of the aims, objectives and ethos of the designated centre and statement as to the facilities and services that were to be provided for residents. The inspectors noted that the statement of purpose was made available for residents, visitors and staff to read. The statement of purpose had been reviewed in November 2014 and contained all items listed in Schedule 1 of the Regulations, including the information set out in the Certificate of Registration.

The statement of purpose described that care was provided in a "friendly and happy atmosphere". Inspectors observed that the ethos as described in the centre's statement of purpose was actively promoted by staff.

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 evidence of a clearly defined management structure that identified the lines

of authority and accountability, specified roles, and details of responsibilities for all areas of service provision. The person in charge was supported by a clinical nurse manager who had a strong clinical role. Inspectors observed a good working relationship between the person in charge and the clinical nurse manager.

In addition, inspectors saw evidence that directors of the company, including the provider nominee, had a regular presence and provide support to the person in charge. Minutes of regular meetings attended by the person in charge and the directors were made available to the inspectors which included discussions on human resources, health and safety, training needs and premises. The person in charge stated that she attended group management meetings. Inspectors was satisfied that the management system in place ensured that service provided was safe, appropriate, consistent and effectively monitored.

Staff with whom inspectors spoke were clear about the management structure and the reporting mechanisms. Inspectors saw evidence of continued investment and expansion of the centre to ensure effective delivery of care in accordance with the statement of purpose.

The person in charge informed the inspectors that she was working with the provider nominee to co-ordinate a plan to complete the annual review of quality and safety of care.

Inspectors saw evidence that a robust system was in place to review and monitor the quality and safety of care and the quality of life of residents. The person in charge monitors a number of clinical indicators on a weekly basis such as vaccination rates, pain, pressure areas, psychotropic medications, catheterisation rates, falls, weight loss, hospital admissions and antibiotic use. Audits had been completed in pertinent areas such health and safety, falls, infection control, nutrition, wound care and food preparation. The provider nominee had completed a comprehensive overall audit in November 2014. The audits identified areas for improvement and audit recommendations. Improvements were brought about as a result of learning from audits such as improved communication with catering staff, storage and improved documentation.

There was evidence of consultation with residents and their representatives. A residents' survey is completed on an annual basis. Meetings of the residents' committee take place on a quarterly basis. Items discussed include activities, upcoming events and outings. Suggestions made are actioned on in a timely manner by the person in charge. An advocacy service is available to residents. An advocate attends residents' committee meetings and is also available to meet with residents individually.

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 centre was managed by a suitably qualified and experienced nurse with clear lines of authority, accountability and responsibility for the provision of service.

The person in charge had been in post since August 2012. The person in charge was employed full time and was a nurse with more than three years experience in the area of nursing of the older person within the previous six years.

The person in charge provided evidence of ongoing professional development appropriate to the management of a residential care setting for older people, including short courses on safeguarding vulnerable adults, therapeutic activities and management of challenging behaviour. The person in charge had also attended a 'Train the Trainer' course on restraint.

While speaking with the inspectors, the person in charge demonstrated comprehensive knowledge of residents, their care needs and a strong commitment to ongoing improvement of the quality of the services provided. She was seen and reported to be visible, accessible and effective by staff, residents and relatives. Inspectors observed residents and relatives to be relaxed and comfortable in her presence.

The person in charge demonstrated good knowledge of the relevant legislation and her statutory responsibilities. Inspectors noted that the improvements seen in the most recent inspection had been sustained. The person in charge is engaged in the governance, operational management and administration of the centre on a regular and consistent basis.

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

<p>Outstanding requirement(s) from previous inspection(s): The action(s) required from the previous inspection were satisfactorily implemented.</p> <p>Findings: Only the component in relation to staff documentation was considered as part of this inspection. An inspector reviewed a sample of staff files and found that staff files were generally complete and well maintained. However, one staff file did not contain documentary of the relevant qualifications and accredited training for this staff member.</p>
<p>Judgment: Non Compliant - Moderate</p>

<p><i>Outcome 06: Absence of the Person in charge</i> <i>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.</i></p>
<p>Theme: Governance, Leadership and Management</p>
<p>Outstanding requirement(s) from previous inspection(s): No actions were required from the previous inspection.</p> <p>Findings: There had been no periods where the person in charge was absent from the centre for 28 days or more since the last inspection and there had been no change to the person in charge. The provider nominee was aware of the obligation to inform the Chief Inspector if there is any proposed absence of the person in charge and the arrangements to cover for the absence.</p> <p>The clinical nurse manager is identified as the person to act as the person in charge in her absence. Inspectors observed that the clinical nurse manager was an experienced nurse who had retained a strong clinical role and demonstrated a good understanding of her responsibilities when deputising for the person in charge. Inspectors were satisfied that suitable arrangements were in place for the management of the designated centre in the absence of the person in charge.</p>
<p>Judgment: Compliant</p>

<p><i>Outcome 07: Safeguarding and Safety</i> <i>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</i></p>
--

Theme:

Safe care and support

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

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

Findings:

Inspectors found that systems were in place to protect residents from being harmed or suffering abuse. Residents were provided with support that promoted a positive approach to behaviour that challenges.

There was an organisational policy in place in relation to the protection of vulnerable adults and response to allegations of abuse, which had been reviewed in June 2012. The policy was comprehensive, evidence based and would guide staff effectively.

Staff training was provided in relation to the detection and prevention of and responses to abuse. However, training records confirmed that three members of staff had not attended training. Staff with whom inspectors spoke were knowledgeable of what constitutes abuse and of steps to take in the event of an incident, suspicion or allegation of abuse. Residents with whom inspectors spoke confirmed that they felt safe in the centre and that they knew who to talk to if they needed to report any concerns of abuse. There was a nominated person to manage any incidents, allegations or suspicions of abuse. Residents and staff were able to identify the nominated person.

There were transparent systems in place to safeguard residents' money and improvements had been made in relation to documentation. Inspectors reviewed the system in place to safeguard resident's finances. Day to day expenses were maintained for five residents and each financial transaction was signed by the resident and two nurses.

A centre-specific policy in relation to the management of behaviour that is challenging was made available to inspectors, which had been reviewed in August 2013. The policy was comprehensive and evidence based. Records confirmed that training was provided to staff in the response and management of behaviour that is challenging but training was outstanding for one member of staff providing care to residents. The person in charge confirmed that no residents were actively demonstrating challenging behaviour.

In relation to restraint practices, inspectors observed that while bedrails were in use, their use followed an appropriate assessment. Inspectors noted that signed consent from residents was secured where possible and the use of bedrails was discussed with residents' representatives as appropriate. Multi-disciplinary input was sought when planning the use of bedrails. There was a centre-specific policy on the use of resident restraint, which had been reviewed in July 2013. This policy included a direction to consider all other options prior to using restraint. A risk-balance tool was completed for residents prior to the use of a bedrail; a comprehensive care plan was developed and reviewed every four months. The clinical nurse manager outlined that the resident's

safety was being monitored closely when the bed rails were in place. Documentary evidence of these checks were not provided to the inspectors on the day of inspection. However, a policy outlining the procedure for checking bedrails was submitted to the Authority following the inspection which stated that documentary evidence of hourly checks on all residents is clearly outlined in the daily occupancy & resident's roll call.

Judgment:

Non Compliant - Moderate

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:

In relation to manual handling practice, an inspector observed two healthcare staff assisting residents who needed to access the bathroom after lunch in the dayroom on the top floor. The incident observed was not in line with correct moving and handling practices. One resident was being transferred from her chair to a wheelchair. It appeared that staff were going to assist the resident to stand up initially with support from a walking frame and, then from this position, to assist her to sit in the wheelchair. However, no instructions were given to the resident that she was going to be lifted, where she was going to be lifted to or when she was going to be lifted. Staff did not have the resident's own walking frame and were using another resident's walking frame which was not familiar to the person being assisted. Initially staff were using a contemporary device around the residents waist to transfer the resident. There wasn't any assessment of the working environment as other residents chairs were in close proximity, with one resident becoming agitated while the lift was being undertaken. When this lift was unsuccessful, the staff brought in a standing hoist to assist the resident. However, staff were unable to put the correct attachments in place on the standing hoist. Finally staff, using the contemporary device, lifted the resident from her chair into the wheelchair. However, the brakes were not put on the wheelchair before assisting the resident to sit.

The risk management policy was up to date and there were measures to control hazards including abuse, unexplained absence of a resident, injury, aggression and self harm. There was an organisation safety statement with an accompanying risk register. This register contained risk assessments in relation to access/egress, bedrooms, common areas, ground floor, kitchen, nurses' station, laundry and service facilities. However, risk assessments were not available for:

- An unrestricted window on the emergency exit on the middle floor
- trip hazard from all door saddles on top floor

- door to the sluice on the top floor left unopened
- a radiator in one bedroom on the top floor felt hot to touch

There was an incident reporting policy and records indicated that there had been 17 reported incidents from January 2014 to November 2014; 16 of these related to resident falls and one related to aggressive behaviour by a resident. There was evidence that all appropriate immediate action had been taken following each incident. In addition each incident had been reviewed by the person in charge and learning was applied in particular in relation to the management of resident falls.

Inspectors saw evidence of agreement with a local transport company and a local sports club in relation to transfer and accommodation of residents in the event of an emergency requiring evacuation. Personal emergency plans were available for each resident. Each emergency plan contained details of what supports a resident required if they were a) in bed and b) out of bed.

In relation to infection control, an infection prevention and control policy reviewed in February 2014 was made available to inspectors. The policy was centre-specific, comprehensive and evidence-based. A colour-coded cleaning system was in place. Household staff with whom inspectors spoke were knowledgeable about cleaning practice. There was evidence of good communication in relation to healthcare acquired infections (HCAI) and cleaning staff were aware of appropriate cleaning requirements for any HCAI.

However, inspectors observed a cleaning sponge drying on a radiator in a resident's room. The person in charge explained these sponges were used for providing personal care and were not single use. This practice could lead to potential cross infection from a used sponge.

Staff confirmed that bedpan washer in the sluice on the top floor was not operational. While this is also covered in more detail in Outcome 12, the healthcare assistants told inspectors that in the absence of a working bed pan washer staff were manually disinfecting portable male urinals. Staff said that while they used disposable gloves when cleaning these urinals they were not using disposable gowns. An inspector observed a healthcare assistant carrying a portable male urinal to a resident and the urinal was dripping on the floor.

Inspectors saw evidence that suitable fire prevention equipment was provided throughout the centre and the equipment was adequately maintained by means of:

- Servicing of fire alarm system and alarm panel August 2014
- fire extinguisher servicing and inspection March 2014
- declaration of conformity for emergency lighting January 2014

Inspectors reviewed training records which indicated 62 staff had received training in the use of fire extinguishers in 2014. Evacuation maps and procedures were visible throughout the premises. Inspectors saw evidence that fire drills were being done with the most recent in December 2014. A fire alarm test was undertaken weekly. There was a schedule of review of escape routes and a review of automatic door releases the most recent of which took place on 9 December 2014.

There were a number of residents who smoked and inspectors reviewed a sample of smoking risk assessments for these residents. A new smoking shelter was in the final stages of completion and was located in an internal courtyard. Inspectors observed that fire precautions were available in this area.

Judgment:

Non Compliant - Moderate

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 centre-specific policy on medication management was made available to the inspectors which had been reviewed in August 2014. The policy was comprehensive and evidence based. The policy was made available to staff who demonstrated adequate knowledge of this document.

Medications for residents were supplied by a local community pharmacy. There was evidence of appropriate involvement by the pharmacist in accordance with guidance issued by the Pharmaceutical Society of Ireland including quarterly review of prescribed medicine therapy in conjunction with nursing staff and the resident's doctor, most recently in November 2014.

Inspectors noted that medications were stored in a locked cupboard or medication trolley. The temperature of the medication refrigerator was noted to be within an acceptable range; the temperature was monitored and recorded twice daily. Medications requiring refrigeration were stored appropriately. Handling and storage of controlled drugs was safe and in accordance with current guidelines and legislation.

The practice of transcription was in accordance with professional guidance issued by An Bord Altranais agus Cnáimhseachais. Where medications were to be administered in a modified form such as crushing, this was individually prescribed by the medical practitioner on the prescription chart.

Residents were encouraged to be responsible for their own medication following appropriate assessment. The assessment was reviewed every four months or more frequently if a residents' condition changes. Inspectors were satisfied that adequate supervision was in place to ensure compliance and concordance.

Records confirmed that appropriate and comprehensive information was provided in relation to medication when residents were transferred to and from the centre.

Inspectors saw that medication incidents were identified and reported in a timely manner. There was evidence that learning from medication incidents was implemented. A medication management audit was completed on a quarterly basis and there was evidence that actions identified in the audits were implemented.

Inspectors noted that medication prescription sheets were current and contained all of the required elements and maximum daily doses were specified for 'pro re nata' (PRN) medication. However, there was no oxygen prescription available for a resident who was receiving oxygen on a regular and ongoing basis. Therefore, it was not clear if oxygen was administered at the prescribed flow rate or for the prescribed duration.

Medication administration sheets identified the medications on the prescription sheet, contained the signature of the nurse administering the medication and allowed space to record comments on withholding or refusing medications. The times of administration matched the prescription sheet. The medication administration sheets clearly stated the times and dates for medications to be administered.

An inspector observed medication administration practices and found that the nursing staff did adhere to professional guidance issued by An Bord Altranais agus Cnáimhseachais.

Medications which are out of date or dispensed to a resident but are no longer needed were stored in a secure manner, segregated from other medicinal products and are returned to the pharmacy for disposal. A record of the medications returned to the pharmacy was maintained which allowed for an itemised, verifiable audit trail.

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):

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

Findings:

Inspectors noted that a comprehensive record of all incidents was maintained. Notifications to the Authority were made in line with the requirements of the Regulations.

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):

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

Findings:

There was evidence that timely access to health care services was facilitated for all residents. The person in charge confirmed that a number of GPs were currently attending to the need of the residents and an "out of hours" GP service was available if required. The records confirmed that residents were assisted to achieve and maintain the best possible health through regular blood profiling, quarterly medication review and annual administration of the influenza vaccine. Residents were referred as necessary to the acute hospital services and there was evidence of the exchange of comprehensive information on admission and discharge from hospital. In line with their needs, residents had ongoing access to allied healthcare professionals including optical, chiropody, physiotherapy and dietetics.

Inspectors reviewed a selection of care plans. There was evidence of a pre-assessment undertaken prior to admission for residents. After admission, there was a documented comprehensive assessment of all activities of daily living, including mobility, nutrition, communication, personal care, mood and sleep. There was evidence of a range of assessment tools being used and ongoing monitoring of falls, pain management, mobilisation and, where appropriate, fluid intake. Each resident's care plan was kept under formal review as required by the resident's changing needs or circumstances and was reviewed no less frequently than at four-monthly intervals, in consultation with residents or their representatives. However, a specific care plan developed for a resident with epilepsy was generic and there were no clear instructions or protocol to guide staff in the event of an epileptic seizure.

Wound management was seen to be in line with national best practice. Wound management charts were used to describe the cleansing routine, emollients, dressings used and frequency of dressings. Wounds were examined on a daily basis. The dimensions of the wound were documented and photographs were used to evaluate the wound on an ongoing basis. There was evidence of appropriate input being sought from specialist tissue viability services.

There was a strategy in place to prevent falls whilst also promoting residents' independence. An evidence-based assessment tool was used to assess residents' risk of falls on admission and at least every four months thereafter. A physiotherapist visited the centre twice a week. A weekly physiotherapy schedule is agreed in advance with the person in charge. The physiotherapist completes a comprehensive treatment form after each consultation.

The incidence of falls is monitored on an ongoing basis. A falls audit is completed on a quarterly basis and inspectors saw that there was a significant reduction in the number of falls due to implementation of a falls team who complete a review after each fall and recommend preventative measures.

There was a range of activities offered including gentle exercise, arts and crafts, quizzes and live music. Inspectors found that, for those residents with dementia, activities such as bingo had been modified to enhance interaction and communication.

Residents were facilitated to attend activities external to the centre. A number of residents enjoyed going into the town centre to visit the library or to socialise. Residents with whom inspectors spoke often went out with family and friends for lunch.

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:

Melview House is almost 200 years old; it was originally built as a private dwelling and in later years was used as a convent and medical facility by a religious order. It has operated as a nursing home in private ownership since about 1985. Melview House is an architecturally significant listed building. It is a three-storey over-basement structure; resident accommodation is provided on the ground, first and second floors. Two lifts are in operation. There was a "report of a thorough examination" of the lift from September 2014. A number of defects had been identified which had a timeframe of six months to remedy.

The main entrance provides access to the ground floor of the main building; the entrance retains the original three limestone steps. A ramp is provided, leading to a small lobby area or porch and the main reception area.

The basement is accessed from the ground floor by means of a restricted stairwell and accommodates the main kitchen and ancillary stores, offices for the person in charge, quiet room, staff changing, dining and sanitary facilities. Separate changing and toilet facilities are provided for catering staff.

The ground floor accommodation consists of a sitting room and dining room for residents, and seven bedrooms. Five of the bedrooms are en suite with toilet, wash-hand basin and assisted shower. Three of the en suite bedrooms are part of the initial refurbishment phase. There is a bathroom with toilet, wash-hand basin and low level bath with electric seated insert, and a further single toilet provided for residents' use. Sluice and toilet facilities are also accommodated on the ground floor.

The first floor is accessed by means of a stairwell from the ground floor that leads directly to the nurses' station; a further stairwell leads to a large central landing area, residents bedrooms, and the lift and lobby area. There are nine bedrooms; five single rooms ensuite, two two-bedded rooms and two four-bedded rooms. The multi-occupancy rooms are not ensuite. One of the two-bedded rooms was originally the oratory. The single rooms on this floor are part of the refurbishment project and two of these bedrooms were examined on this inspection on foot of an application to vary conditions of registration. There was a bathroom with toilet, wash-hand basin and assisted shower and a second separate toilet and wash-hand basin provided for residents. There are no communal or dining facilities on the first floor but inspectors observed that residents were encouraged to frequent communal facilities on the ground floor for meals and activities.

A further stairwell leads up to the second (top) floor; again there is a main central landing with a residents' sitting/dining room and three bedrooms, one single room, one twin bedroom and two four-bedded rooms. These bedrooms are not en suite; a bathroom with a toilet, wash-hand basin and assisted shower and a separate toilet and wash-hand basin are again provided.

Laundry facilities were temporarily provided in an area of the original 'Orchard Wing' part of the building. The person in charge confirmed that only personal linen was laundered on-site. Towels and bedding were collected and laundered by an external laundry provider. The facilities were seen to be adequate for this arrangement and the area was linked to the fire system.

The design and layout of the refurbished area of the building was adequate and the inspectors saw that the size of the rooms was sufficient to meet residents' needs.

However, inspectors found that the original premises continued to pose numerous difficulties in the provision of care due to the lack of private and communal space and facilities for residents. The centre required a number of actions to ensure it met the requirements of legislation. The majority of the residents were accommodated in multi-occupancy rooms which afforded little space, privacy or room for personal storage or the

use of specialist equipment. In many cases, lockers and wardrobes were quite small and did not accommodate sufficient clothing to allow residents to exercise choice. There were no communal or dining facilities available for residents on the first floor.

Inspectors noted that there was inadequate ventilation in toilet and bathroom facilities. The premises was not adequately maintained with evidence of broken tiles, broken skirting board, peeling and stained paintwork. Inspectors found the floor covering to be inadequate and in particular there was a trip hazard due to a gap between door saddle and carpet in lobby area on top floor. Floor covering was observed to be torn in a number of locations.

As outlined in outcome 8, the sluice facilities on the top floor were not adequate and the bed pan washer was not operational. There weren't a sufficient number of toilets designed to provide access for residents in wheelchairs. An inspector observed one resident who had to use a commode in a shared bedroom as her wheelchair would not fit in the narrow bathroom on the top floor. This did not safeguard the resident's privacy and dignity and also did not respect other residents' privacy

The kitchen was visibly clean and organised and inspection reports issued by the relevant Environmental Health Officer (EHO) were made available to the inspectors.

The issues noted by the inspectors were discussed at length with the person in charge and a director nominated to represent the company. The inspectors were assured that these areas will be rectified as a matter of urgency under the ongoing general maintenance programme and a timeline had been previously provided to the Authority for completion of the renovation project in September 2015.

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):

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

Findings:

A centre-specific comprehensive complaints policy was in place, last reviewed in August 2013. The complaints policy identified the nominated complaints officer and also included an independent appeals process as required by legislation. A summary of the complaints procedure was displayed prominently and was included in the statement of purpose.

Inspectors reviewed the complaints log detailing the investigation, responses, outcome of any complaints and whether the complainant was satisfied. Complaints were seen to be investigated promptly.

Residents with whom the inspectors spoke were able to identify the complaints officer, stated that any complaints they may have had were dealt with promptly and were satisfied with the complaints procedure.

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:

There was a planned roster in place. Based on observations, a review of the roster and these inspection findings, inspectors was satisfied that the staff numbers and skill-mix were appropriate to meeting the assessed needs of the complement of residents accommodated.

There was a registered nurse on duty at all times and a record is maintained of current registration details of nursing staff. Inspectors saw that there was a selection of healthcare reading materials and reference books stored in the nurses' station. Copies of both the Regulations and the Authority's Standards were available. Staff were also able to articulate adequate knowledge and understanding of the Regulations and the Authority's Standards.

Staff training records were reviewed and there was evidence of ongoing education and training by staff. However as outlined in outcome 8, a number of staff were not appropriately trained in lifting and handling techniques to enable them to provide care in accordance with contemporary evidence based care.

Inspectors noted that regular meetings took place for nursing and care staff. Topics discussed include documentation, falls prevention, nutrition, wound management and shift patterns. Staff were supervised appropriate to their role and a formal system of

annual appraisal had been implemented. Effective recruitment procedures were in place including the verification of references.

Judgment:
Non Compliant - Moderate

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

Louisa Power
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	Melview Nursing Home
Centre ID:	OSV-0000250
Date of inspection:	11/12/2014
Date of response:	08/01/2015

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:

A staff file did not contain documentary evidence of relevant qualifications and accredited training completed.

Action Required:

Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by

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

the Chief Inspector.

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

Training was completed but the certified documentation was misplaced. Copy of certification being sought from the education establishment.

Proposed Timescale: 01/02/2015

Outcome 07: Safeguarding and Safety

Theme:

Safe care and support

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

Training in relation to the management of challenging behaviour was outstanding for one member of care staff.

Action Required:

Under Regulation 07(1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.

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

Training booked for the 13th of January 2015.

Proposed Timescale: 14/01/2015

Theme:

Safe care and support

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

Training in relation to the detection and prevention of and responses to abuse was outstanding for three members of staff.

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:

Training booked for the 14th of January.

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:

Poor manual handling practices were observed.

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:

Manual handling update training will be completed on the 7th of January. Nursing staff will supervise all manual handling techniques on a daily basis.

Proposed Timescale: 08/01/2015

Theme:

Safe care and support

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

A number of risks had not been identified nor were these risks assessed:

- An unrestricted window on the emergency exit on the middle floor
- trip hazard from all door saddles on top floor
- door to the sluice on the top floor left unopened
- a radiator in one bedroom on the top floor felt hot to touch.

Action Required:

Under Regulation 26(1)(a) you are required to: Ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.

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

- restrictor's in place on the window to emergency door in the middle floor.
- saddle boards removed from the top floor 20/01/2015.
- all staff communicated the importance of keeping the sluice room door closed.
- temperature on radiator restricted on top floor bedroom.

Proposed Timescale: 01/02/2015

Theme:

Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in

the following respect:

Potential cross contamination from the re-use of sponges for personal care

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:

Sponges replaced with wipes.

Proposed Timescale: 08/01/2015

Theme:

Safe care and support

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

Male urinals were not managed, decontaminated and maintained appropriately to prevent the spread of HCAI.

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:

Male urinals decontaminated in bed pan washer.

Proposed Timescale: 08/01/2015

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:

An oxygen prescription was not available for a resident receiving oxygen on a regular and ongoing basis.

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:

All residents on oxygen have been prescribed by the GP.

Proposed Timescale: 08/01/2015

Outcome 11: Health and Social Care Needs

Theme:

Effective care and support

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

Care plans for epilepsy were generic and protocols had not been developed for the management of epileptic seizures.

Action Required:

Under Regulation 05(3) you are required to: Prepare a care plan, based on the assessment referred to in Regulation 5(2), for a resident no later than 48 hours after that resident's admission to the designated centre.

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

All residents who have a diagnosis of epilepsy have a care plan that complies with best evidence based practice.

Proposed Timescale: 08/01/2015

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:

Sluicing facilities were inadequate to meet the needs of the residents on the top floor of the premises.

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:

Service on bed pan washer on top floor has been organised.

Proposed Timescale: 20/01/2015

Theme:

Effective care and support

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

Floor covering was not safe as there was a trip hazard due to a gap between door saddle and carpet in lobby area on top floor. Floor covering was observed to be torn in a number of locations.

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:

Floor covering will be replaced when building is being refurbished.
Door saddles have been removed on the top floor.

Proposed Timescale: 01/09/2015

Theme:

Effective care and support

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

Toilet facilities on the top floor do not provide adequate access for residents in wheelchairs.

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:

Toilets on top floor will be redesigned to provide adequate access as part of the refurbishment work.

Proposed Timescale: 01/09/2015

Theme:

Effective care and support

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

There was inadequate ventilation in toilet and bathroom facilities used by residents.

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:

Adequate ventilation will be provided in bathroom and toilet as part of the refurbishment works.

Proposed Timescale: 01/07/2015

Theme:

Effective care and support

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

Parts of the centre were poorly maintained and in need of repair.

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:

Parts of the centre in poor repair will be upgraded as part of the planned refurbishment works.

Proposed Timescale: 01/09/2015

Theme:

Effective care and support

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

Communal facilities were limited on the first floor.

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:

All residents on this floor use communal facilities on the ground or top floor in agreement with residents and family.

Proposed Timescale: 08/01/2015

Theme:

Effective care and support

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

Storage for residents' personal belongings was limited in multi-occupancy bedrooms.

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:

As part of the planned refurbishment the multi-occupancy rooms will be downsized which will make more space available for storage of personal belongings.

Proposed Timescale: 01/01/2016

Outcome 18: Suitable Staffing**Theme:**

Workforce

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

A number of staff were not appropriately trained in lifting and handling techniques to enable them to provide care in accordance with contemporary evidence based care.

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:

Manual Handling Training booked for the 7th of January.

Proposed Timescale: 08/01/2015

