<table>
<thead>
<tr>
<th><strong>Centre name:</strong></th>
<th>Hillview Private Nursing &amp; Retirement Residence</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Centre ID:</strong></td>
<td>OSV-0000141</td>
</tr>
<tr>
<td><strong>Centre address:</strong></td>
<td>Rathfeigh, Tara, Meath.</td>
</tr>
<tr>
<td><strong>Telephone number:</strong></td>
<td>041 982 5698</td>
</tr>
<tr>
<td><strong>Email address:</strong></td>
<td><a href="mailto:jjcahill@hillviewcare.ie">jjcahill@hillviewcare.ie</a></td>
</tr>
<tr>
<td><strong>Type of centre:</strong></td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
</tr>
<tr>
<td><strong>Registered provider:</strong></td>
<td>Hillview Private Nursing &amp; Retirement Residence Partnership</td>
</tr>
<tr>
<td><strong>Provider Nominee:</strong></td>
<td>John James Cahill</td>
</tr>
<tr>
<td><strong>Lead inspector:</strong></td>
<td>Catherine Rose Connolly Gargan</td>
</tr>
<tr>
<td><strong>Support inspector(s):</strong></td>
<td>Brid McGoldrick</td>
</tr>
<tr>
<td><strong>Type of inspection</strong></td>
<td>Announced</td>
</tr>
<tr>
<td><strong>Number of residents on the date of inspection:</strong></td>
<td>23</td>
</tr>
<tr>
<td><strong>Number of vacancies on the date of inspection:</strong></td>
<td>3</td>
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</table>
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, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 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**

<table>
<thead>
<tr>
<th>From:</th>
<th>To:</th>
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<tbody>
<tr>
<td>26 November 2014 10:00</td>
<td>26 November 2014 15:30</td>
</tr>
<tr>
<td>27 November 2014 09:00</td>
<td>27 November 2014 16:30</td>
</tr>
</tbody>
</table>

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

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

**Summary of findings from this inspection**

This was the seventh inspection of the centre by the Authority and was completed in response to an application by the provider to renew registration. During the inspection the inspectors met with residents, relatives and staff members. Residents who could verbalize their views were complimentary about the meals provided, choices they were empowered to make, the staff team who cared for them and the level of recreational activity provided. The Inspector found that residents and relatives were also positive in terms of the service provided in the Authority’s pre-inspection feedback questionnaires given to inspectors on the days of inspection.

Inspectors found that satisfactory arrangements were in place to meet the needs of residents in receipt of end of life care. Residents were observed to enjoy the social
activities provided on the days of inspection. Some residents participated in a baking activity in a day-care facility adjoining the centre. Residents had access to healthcare professionals to support their needs. A day-care facility independent to the centre was provided to meet the activation needs of four adult residents with intellectual disability needs.

On this inspection, Inspectors found that governance and management arrangements required review to ensure systems were in place so that the service meets its stated purpose in relation to parts of the premises and risk management processes. The layout and design of some residents' bedrooms did not ensure their privacy and dignity needs were met as set out in the centre's statement of purpose and function.

In addition the layout of some residents’ bedrooms did not facilitate them to maintain control over their clothing and personal belongings.

Fire safety arrangements and risk management procedures were not adequate and findings constituted major non-compliance with the Legislation. A referral to Meath fire services was made by the Authority on 01 December 2014.

Nine actions from the last inspection in the centre in April 2013 were not satisfactorily completed and were found to be in repeated non-compliance with the legislation on this inspection. These actions are restated in the action plan at the end of this report in addition to new actions required to address further areas of non compliance with the Legislation.

Repeated areas of non compliance with the Legislation included missing information in the statement of purpose, some policies and procedures to inform best practice and information in relation to fees charged was not adequately stated in some residents’ contracts. Inspectors also found that not all notification of specified incidents were forwarded to the Authority as required.

Other findings constituting moderate non compliance with the legislation included improvement in facilitation of medical review of residents following a fall incident. Staffing levels and skill mix required review in terms of resident falls prevention. Medication management procedures did not meet required standards in respect of GP prescribing and nurse transcribing practices.

The Action Plan at the end of this report identifies improvements that 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.
Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National 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):**
Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**
There was a written statement of purpose and function forwarded as part of the renewal of registration application documentation forwarded to the Authority. Inspectors found on review of this document dated 03 June 2013 that it did not contain all information as required by schedule 1 of the Regulations. This finding is repeated and was the subject of an action plan from the last inspection on 23 April 2013. The provider was made aware of the requirement to ensure this document was reviewed and kept up to date. A revised Statement of Purpose document was forwarded to the Authority since the inspection and contains all information as required by the legislation.

**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:**
Inspectors found that management systems in place did not ensure that the service provided was safe and appropriate in terms of accommodation and safety to meet residents' needs in accordance with the centre’s statement of purpose on the days of inspection. Fire safety arrangements and risk management procedures were not adequate and findings constituted major non-compliance with the Legislation.

Inspectors found that there was a defined management structure in place within the centre that identified the lines of accountability and authority. There was a system of auditing of various aspects of the service in place to review and monitor the quality and safety of care and the quality of life of residents. Inspectors reviewed the documentation collated and observed that data was collated by auditing/surveying and analysed to identify areas for improvement. However, actions to be taken to improve the quality and safety of the service were not consistently stated or with timescales for completion in response to assessed concomitant risks. In addition, the findings by inspectors in relation to unidentified risks, inadequate fire safety arrangements, infection control and prevention procedures, inadequate access by residents to medical review post falls and incidence of resident falls at night-time reflected an ineffective and weak auditing process. The aforementioned findings are described throughout this report.

Judgment:
Non Compliant - Major

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

Findings:
Inspectors found that there was a residents' guide available in accessible format to inform residents of the services available to them. There was also information displayed at various points around the centre to keep residents informed.

A sample of agreed resident contracts was reviewed by inspectors. Inadequate information on resident contracts in relation to fees charged was the subject of an action plan from the last inspection in April 2013. The following information was found to be inadequate on this inspection and requires review;
- Additional charges to residents were of varying amounts and services and were not clearly specified
- The information reviewed indicated an additional charge for bedrails used by residents, clarity was required to ensure that use of bedrails for residents was in line with the
National Restraint Policy.
- Personal contribution to fees by residents was not stated in all contracts reviewed.

**Judgment:**
Non Compliant - Moderate

<table>
<thead>
<tr>
<th>Outcome 04: Suitable Person in Charge</th>
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<tbody>
<tr>
<td>The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.</td>
</tr>
</tbody>
</table>

**Theme:**
Governance, Leadership and Management

<table>
<thead>
<tr>
<th>Outstanding requirement(s) from previous inspection(s):</th>
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</thead>
<tbody>
<tr>
<td>No actions were required from the previous inspection.</td>
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</table>

**Findings:**
The person in charge of the centre is Rebecca Carolan. She was appointed in this role in June 2005. She is a registered general nurse with An Bord Altranais agus Cnáimhseachais na hÉireann. She has completed a postgraduate gerontology course and a course in acquired brain injury. She has experience in caring for older people as required by the Legislation.

The person in charge demonstrated that she was engaged in the governance, operational management and administration of the centre on a consistent basis. During this inspection the person in charge demonstrated that she was aware of the Regulations, the Authority’s Standards and her responsibilities as person in charge of the centre. The person in charge is supported in her role by an assistant director of nursing and a team of nursing staff, care assistants, catering, administrative and ancillary staff.

**Judgment:**
Compliant

<table>
<thead>
<tr>
<th>Outcome 05: Documentation to be kept at a designated centre</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

**Theme:**
Governance, Leadership and Management
Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
The inspectors found that records listed in Part 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) were not adequately maintained in the centre. All written operational policies as required by Schedule 5 of the Regulations were available. However, not all policies adequately informed practice in all respects. For example, medication management, risk management and protection of vulnerable adults. The safety statement was not reviewed annually. Not all records listed in schedules 2, 3 and 4 are completed and maintained in the centre. For example, all restraints used details of fire evacuation drills, resident fees, notifications were not complete, staff employment records and the duty rota were not complete.

Incomplete information on staff employment files was the subject of an action plan from the last inspection in April 2014 which was not satisfactorily completed on this inspection. A sample of staff employment records was reviewed and not all were complete as required by the regulations. Details missing included details of roles and responsibilities, contracted hours of work and other items.

There was evidence of current insurance to cover residents' property and against accidents or injury to residents, staff and visitors.

The directory of residents was reviewed and found to contain all required information.

Judgment:
Non Compliant - Major

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 and person in charge were aware of their responsibility to notify the Chief Inspector of the absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during her absence. The person in charge had not been absent from the centre for more than 28
days to date.

The deputy person in charge was working in the centre on the day of the inspection and was met by an inspector. She was knowledgeable about residents' care and social needs. The deputy person in charge had completed a postgraduate course in gerontological nursing.

**Judgment:**
Compliant

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

**Theme:**
Safe care and support

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

**Findings:**
The inspectors reviewed the policy documentation informing protection of vulnerable adults reviewed August 2014. This policy was reviewed on a two-yearly basis. Staff training in elder abuse prevention, recognition and management was also facilitated every two years. Some staff last completed this training in 2013. This finding was not in line with recommendations of the National Standards which indicates annual review of implementation of the policy should be taken. Inspectors were provided with a copy of the staff training record which confirmed that all staff on the duty rota had completed training in elder abuse prevention, recognition and management. All staff files reviewed on the days of inspection had evidence of completed appropriate vetting procedures. Staff knowledge of the policy documentation informing protection of vulnerable adults was not adequate on the last inspection of the centre in April 2013 and was the subject of an action plan which was not satisfactorily completed on this inspection. Inspectors found on this inspection that while staff spoken with were knowledgeable with regard to their role and responsibilities in protecting residents and reporting any suspicions or disclosures made to them to safeguard residents, some were unsure of the procedure if an allegation was made against a senior member of staff. This information was missing from the policy documentation.

Residents spoken with by inspectors confirmed that they felt safe in the centre and were complimentary of staff caring for them. Inspectors observed staff - resident interactions on the days of inspection which were found to be satisfactory. Access to the centre is by key code and controlled by staff. There was no evidence of unanswered or prolonged
ringing of call bells on the days of inspection.

There was policy documentation available to inform practices and procedures involving residents’ finances and personal possessions. A record of each resident's personal possessions was completed but not completed on a regular basis as required by the regulations. Inspectors reviewed management of residents' money kept in safekeeping for their use for day to day personal expenses. Transactions were double signed by staff and residents had access to this money at all times. All residents did not have access to a lockable facility in their bedroom to secure personal valuables they wished to keep on their person.

A policy document was in place to inform management of behaviour that challenges exhibited by residents with promotion of a positive approach to managing same whilst supporting the resident concerned. The person in charge informed the inspector that some of the residents currently residing in the centre exhibited mild behaviour that challenged. 68% of staff had attended training in dementia and managing challenging behaviour.

There were policies available to inform practices with use of bedrails and use of restraints for residents. The inspectors reviewed a list of residents using bedrails as provided by the person in charge. Eight residents were recorded on the list provided as using bedrails, five of which used same on only one side of their bed. Safety rationale was documented for use of bedrails by four residents. All bedrails were used by residents at night-time only and on their request. Two residents at risk of leaving the centre unaccompanied were fitted with alert bracelets. There was evidence to support that restraints were not used in line with the national restraint policy in relation to monitoring and ongoing review and assessment of need.

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:
The centre's safety statement was not reviewed on an annual basis. Inspectors observed that the document in place had been reviewed in 2013. A risk management policy was available to inform risk management activity in the centre. A health and safety committee meet in the centre however frequency varied from four to seven
months. This meeting is attended by the provider, person in charge and the staff member responsible for maintenance in the centre. The most recent meeting was convened on 10 September 2014 and was minuted.

The risk register was reviewed by the inspectors and found not to identify all risks with stated concomitant controls to mitigate level of risk to residents, staff and others. The following undocumented risks were found on inspection;
- missing handrails on one corridor to residents accommodation
- step in level of floor between kitchen and communal dining room
- control of hot water temperatures to residents was not adequately controlled
- bubbling of the floor covering in some areas used by residents
- slip risk on an external path posed by an extractor vent from the clothes drier in the laundry
- risk of slip on wet floors in showers with shower trays fitted
- a push-bar designated fire door was not alarmed if opened inadvertently while two residents were at risk of leaving the centre unaccompanied and wore bracelets for risk control.

Controls for identified risks as documented in the risk register were not implemented in relation to secure storage of hazardous chemicals. Inspectors found that hazardous chemicals were not safely secured in locked storage facilities as directed by safety data information sheet and listed as a control in the risk register. Unsupervised hazardous chemicals accessible to vulnerable residents and others were observed by inspectors on the cleaning trolley.

There was an emergency policy in place. The procedure for evacuation of residents in the event of a fire was documented as being to the next safe zone or to the assembly area. The centre was divided into eight fire zones. Inadequate fire safety arrangements were the subject of an action plan from the last inspection of the centre in April 2013 which was not satisfactorily completed on this inspection. The inspectors reviewed fire safety arrangements in the centre and found them to not be of an adequate standard. Inspectors' findings included;
- residents did not have personal evacuation assessments completed in terms of equipment and staff required to ensure their safe evacuation in the event of a fire in the centre. One resident was in receipt of continuous oxygen. There were no arrangements for a portable supply within close proximity to this resident if required to maintain continuity of therapy in the event of evacuation
- there was a record of fire safety training and drills completed by all staff according to staff training records. However, inspectors could not confirm if staff had participated in a twice yearly fire evacuation drill. Records of fire evacuation drills did not include any commentary referencing details of simulated evacuations, timescales to complete same or revisions made to the procedure from completion of test evacuations.
- the door of room 16 opens out into the corridor immediately into the route of a designated fire exit
- one designated fire exit had glass windows on either side and was fitted with a latch in addition to a push-bolt locking device. This device was removed by the provider on the second day of inspection
- there were no break glass key units located by any of the fire exits which were secured by a key.
- some bedrooms were fitted with wooden panel type doors as opposed to doors of the required fire retardant standard
- doors to residents' bedrooms were ajar on the days of inspection and were not fitted with self-closure units.
- There was no visible directional signage to the nearest fire exit on exiting a number of bedrooms.

Meath Fire Services were informed by the Authority of inspectors’ findings in relation to fire safety in the centre on 01 December 2014, as discussed with the provider during inspection feedback.

Fire alert and fire fighting equipment was serviced regularly as required. A checking schedule of fire preventative and safety procedures was routinely completed and documented. A declaration of fire safety compliance was received by the Authority as part of the application for renewal of registration documentation. The provider advised inspectors that a familiarisation visit had been completed by the fire services. There was a designated smoking area which was used by residents who smoked on the days of inspection. This practice was documented in the risk register, however individual resident risk assessments were not completed to ensure their safety needs were met while engaging in this activity. A wheelchair accessible bus was available to transport residents on outings and was assessed in terms of risks to residents in the risk register. Records of servicing and road worthiness were also available. The person in charge and the person with responsibility for maintenance of the centre were designated drivers of same supported by records of relevant driving permit documentation.

While there was a missing person policy available to inform procedures in the event of a resident leaving the centre unaccompanied, residents at assessed risk did not have missing person profiles completed to assist the emergency services to expedite their recovery and safe return to the centre.

There was a policy document to advice on prevention and management of resident falls. There was 36 resident falls documented from January 2014 up to the days of this inspection. The inspectors found that while some controls were implemented to mitigate risk of injury to residents assessed as being at risk of falling such as mattresses by their beds and fitting of hip protectors, there was scant evidence of learning for staff from reviews of resident falls information. There was evidence from a review of these records by inspectors of many incidents where residents were falling more than once and sustaining injury including head injury. One resident sustained a limb fracture from a repeated fall. While there was evidence that some residents who sustained head injuries from falls had neurological observations completed, the policy did not advice on the period of time these observations should be completed for. A physiotherapist attended the centre each week. There were no arrangements in place where the physiotherapist’s expertise was utilised in assessment and management of residents who were at risk or had fallen in particular residents who have fallen on repeated occasions.

The inspectors found that some practices and procedures in the centre were not consistent with the standards for the prevention and control of infection. The following areas of inadequate practice were found;
- a soiled sponge was observed in the hot press
- the treatment room was also used as the centre’s hair salon
- there was bottles of shampoo and shower gel for communal use in the bathroom/shower
- there was no extractor fan in a communal shower room
- bedpan disinfection unit was visibly soiled
- tagging of waste for disposal was not done before transportation from the centre.

**Judgment:**  
Non Compliant - Major

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### Outcome 09: Medication Management

**Each resident is protected by the designated centre’s policies and procedures for medication management.**

**Theme:**  
Safe care and support

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

**Findings:**  
Inspectors carried out a review of medication prescription and administration in the centre. Medication management competency assessments were completed with staff involved in medication management and all registered nurses had completed medication management training in 2014 as confirmed by staff training records. The medication management policy was dated as reviewed in 2013 however, did not adequately inform medication management practices in line with legislative and professional standards in all respects. The policy did not include adequate information to inform required prescribing standards. An inspector examined a sample of medication prescription sheets and administration records. The medication prescription sheets examined were current. However, the inspector saw that a number of the medication prescription sheets examined did not contain a signature for each medication order, maximum dose of PRN (as required) over each 24 hour period or instruction to crush to reference each medication for administration to residents who required this format. Therefore, these prescription orders were not complete authorisations to administer medications as per the Medicinal Products (Prescription and Control of Supply) Regulations (Amendment) 2007.

Medications for residents were supplied by a local community pharmacy in blister packs. There was inadequate evidence of appropriate involvement by the pharmacist in accordance with the regulation 29 and guidance issued by the Pharmaceutical Society of Ireland including quarterly review of prescribed medicine therapy in conjunction with nursing staff and the resident's GPs.

The inspectors noted that arrangements were in place for medication storage in a locked cupboard or medication trolley. Handling and storage of controlled drugs was safe and in accordance with current guidelines and legislation. Medications requiring refrigeration were stored appropriately.
The temperature of the medication refrigerator was routinely monitored as required.

The inspectors observed medication administration practices and found that the nursing staff observed, did not adhere to professional guidance issued by An Bord Altranais agus Cnáimhseachais in relation to transcription of medication prescriptions in terms of signatory records of the nurse transcribing and the nurse checking the transcription record and auditing of medication prescription transcribing procedures. Medication preparations for administration were prepared in the nurses’ station, this practice required review in respect of hygiene and safety. A medicinal product prescribed for a resident was not adequately stored as observed in a communal bathroom cupboard.

No residents were self-administering their medications at the time of inspection.

Judgment:
Non Compliant - Moderate

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**Outcome 10: Notification of Incidents**
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

**Theme:**
Safe care and support

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

**Findings:**
All notifications of incidents as required were forwarded to the Authority.

**Judgment:**
Compliant

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**Outcome 11: Health and Social Care Needs**
Each resident’s wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident’s assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

**Theme:**
Effective care and support
Outstanding requirement(s) from previous inspection(s):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
There were 23 residents accommodated in the centre on the days of inspection. Their assessed dependency levels were 8 residents with high dependency needs, 11 with medium dependency needs and 4 with low dependency needs. Most residents in receipt of long term care were over 65 years of age and had a variety of age related conditions, some of which were complex including dementia. Four residents with intellectual disabilities were cared for in the centre and attended day-care activation in an on-site facility three days each week. Each resident had a cognitive assessment completed. Three residents presented with intermittent episodes of challenging behaviour, one of which engaged in shouting and two residents were vulnerable and at risk of leaving the centre unaccompanied. These two residents wore alert bracelets which activated if the resident passed through the doors to go outside the centre. The inspector observed staff guiding, reminding and orientating residents with memory deficits to ensure they were involved in the daily life of the centre and were afforded opportunities to participate where able or desired.

Each resident had a care plan in place that set out the interventions to meet assessed needs. The inspector reviewed a sample of residents care plans and associated documentation in addition to speaking with residents on the days of inspection. The person in charge confirmed to the inspector that none of the residents had pressure related skin breakdown. All residents were assessed and seven identified as being 'at risk' had pressure relieving equipment in place including mattresses and cushions incorporated into their care to mitigate potential risk.

The inspector found that residents had access to allied health professionals. A physiotherapist attended the centre on a weekly basis and provided on-going rehabilitative physiotherapy for four residents as part of the terms and conditions of their contracts.
Some residents had assistive chairs.

Residents had access to GP services. The inspectors observed that residents' blood pressure was monitored on a monthly basis however; no other physiological parameters were recorded as part of this routine assessment. One resident received continuous supplemental oxygen therapy. There was no recording of respiration rate or oxygen saturation levels. Inspectors observed that there were 36 recorded resident falls since January 01 2014. Staff administered first aid where necessary or in the case of more serious injuries transferred residents to hospital. While residents' relatives were informed of fall incidents without delay, residents GPs were not informed to determine whether medical review was required in 99% of the resident fall incidents reviewed until some hours later or not at all, including incidents where a head injury was sustained. 54% of staff had attended cardiopulmonary resuscitation (CPR) training and an external automated defibrillator (AED) was available to staff in the centre in the event of a resident requiring emergency care. All residents were given opportunity to receive annual influenza vaccination, which the majority of residents had availed of.
The inspector observed a comfortable and relaxed atmosphere in the centre, on the days of inspection. This finding was enhanced by provision of a number of communal rooms for residents to relax in, entertain visitors in and enhanced space for residents to move around the centre. Activities were provided under the leadership of an activity co-ordinator in the day-room in the main premises and in the day centre for four residents facilitated by a staff member with responsibility to care for residents there. Activities provided were observed by the inspectors to interest and positively engage residents. An activity assessment was completed for each resident and a record was maintained of activities that each resident participated in. However recorded information did not indicate whether participation in activities had positive outcomes for each resident to inform provision of suitable activities to meet the interest and capabilities of each resident. Activities provided included a weekly outing to an event/place of interest to the residents. Health promoting activities including accompanied walks in the local area and in-house gentle physical exercises.

As the centre admits residents to the centre with dementia care needs, completion of a sensory based activity training programme by staff facilitating activities for residents with dementia would further support and underpin good practices observed with theoretical knowledge and in turn further benefit the quality of life of residents with dementia care needs. All communal areas were adequately supervised by staff on the days of this inspection. Some residents told the inspector that they enjoyed the activities arranged for them and that they could choose whether they wanted to participate or not.

Judgment:
Non Compliant - Moderate

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**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:
The designated centre was extended three years ago to provide additional communal accommodation for residents. The centre provides accommodation for twenty six residents in fourteen single and six twin bedrooms on ground floor level.
Inspectors found that the layout and design of residents' bedroom accommodation including en-suite facilities did not meet their stated purpose. The layout and design of a twin room was the subject of an action plan from the last inspection of the centre in April 2014 and was not satisfactorily completed. Inspectors found the following areas to be inadequate and not in compliance with the regulations;

- there was inadequate ventilation in a communal shower as no extractor fan was fitted in this facility
- some toilet bowls were at a low level and did not have adequate assistive support equipment fitted to promote independence and safety. Occupational therapy expertise was not sought to ensure these toilets met the needs of residents in accordance with the centre's statement of purpose and function.
- en-suite facilities were narrow, located within close proximity to beds and had doors fitted that opened into bedrooms and as such did not meet the needs of some residents accommodated in adjacent bedrooms
- most twin bedrooms accommodated by residents did not meet the needs of residents in terms of layout and design to ensure their independence and accessibility needs were promoted and met. There was inadequate space to carry out personal care in private and to have unrestricted access to personal belongings,
- privacy screen curtain rails were not fitted so as to enclose adequate personal space for each resident in twin bedrooms. A number of curtains extended across residents' beds
- some residents could not access the wash basin in their bedrooms
- not all residents had adequate space to move around their personal space safely and unobstructed
- not all residents had a their bedside locker within reasonable reach
- not all corridors had hand rails fitted.
- environmental temperatures were not monitored and residents were unable to control radiator temperatures in their bedrooms
- hot water temperatures were not adequately controlled so as not to exceed 43 degrees centigrade at the point of contact by residents
- although recently painted, areas of a wall along the top of a skirting board in a twin bedroom had evidence of dampness with disintegration of masonry surfaces.

Vulnerable residents could access an enclosed safe external area independently. This landscaped garden also contained raised vegetable planting areas but it was not directly accessible from the centre to all residents at will. Seating was available in the garden located to the front of the centre.

The communal sitting, dining and quiet room areas used by residents in the centre were visibly clean and bright on the days of inspection. Service records were available and inspectors found that servicing of equipment used by residents was completed.

A day-care facility called 'Teach Bríd' is attached to the facility at a lower ground level accessible to staff only via a stairs internally and accessible to residents and visitors by a designated front door to the back of the centre. A sloped pathway with handrails on both sides is in place to facilitate access for residents from the centre. This facility provides an activity room, quiet room, sitting/dining area, an accessible kitchen and a
wheelchair accessible toilet facility. Teach Bríd was visited by inspectors and observed to meet the needs of the four residents who attend the centre. However, this facility did not have adequate accommodation for any increase in this number of residents in terms of space available and safety.

**Judgment:**
Non Compliant - Major

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**Outcome 13: Complaints procedures**

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

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

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

**Findings:**
There was a policy available to inform management of complaints in the centre. The complaints procedure was displayed to advise residents and others of the procedures to follow if they were dissatisfied with any aspect of the service provided to them. The person in charge was the designated complaints officer in the centre. An appropriate appeals process was not stated. The policy directed the complainant if dissatisfied with the outcome of internal investigation to independently arrange an appeals process which would have to be agreed by the provider.

A record of complaints made was recorded. Inspectors observed two complaints were made in 2014. These complaints referenced dissatisfaction with the cleanliness of furniture used by residents. While the issue was addressed on both occasions with immediate reactive cleaning, findings did not support that there was learning from investigations of same as the issue was not proactively addressed to prevent recurrence. The evidence supported that the issue recurred and schedules or procedures for routine cleaning of communal furniture used by residents were not put in place.

Residents and their relatives were aware of whom they should make a complaint to and although they confirmed in feedback in the Authority’s pre-inspection questionnaires and on the days of inspection to inspectors that they never had to make a complaint, they said they felt they would be listened to if dissatisfied with any aspect of the service.

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

Theme:
Person-centred care and support

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

Findings:
Inspectors were told by the person in charge that there were no residents in receipt of end of life care on the days of this inspection. A review of residents' care plans evidenced that their end of life wishes were discussed and documented. Members of the local clergy from the various religious faiths provide pastoral and spiritual support to residents who are at the end stage of their lives. There was a policy document available to inform residents' end of life care in the centre. Palliative care services were available on referral to assist with promoting residents' comfort needs. Some staff had attended training on end of life care in 2014.

Settlement of fees was not initiated in respect of deceased residents until one month after their death. The centre provides accommodation and refreshments for relatives of residents at the end stage of their lives to facilitate residents to have their families with them at this time. The person in charge confirmed in a self assessment questionnaire issued by the Authority that residents would be provided with single room accommodation at the end stage of their lives.

Judgment:
Compliant

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

Theme:
Person-centred care and support

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

Findings:
There was satisfactory evidence that residents were provided with adequate fluid and dietary intake to meet their needs on the days of inspection. Fresh water was available
in each resident's bedroom and in communal areas. Plain water and water flavoured with an orange concentrate were available at mealtimes. Staff were observed to engage in monitoring and encouraging residents to take fluids. The inspectors found that each resident’s individual nutritional and dietary needs were generally met and that they were offered a nutritious and varied diet that provided them with choice of a hot dish at each mealtime. While the nutritional value of menus was evaluated by a dietician, further review would be of benefit to evaluate inclusion of milk as a mealtime drink and inclusion of palatable high fruit preparations such as smoothies. Some residents told inspectors that they had symptoms of skeletal conditions and some were assessed as being at risk of constipation. Increase in fruit juices availability for breakfast was an action initiated by residents from the most recent residents' meeting. The inspectors observed residents at mealtime and found that those that required assistance received same in a dignified and discrete way by adequate members of staff who were assigned to ensure residents were appropriately assisted if necessary.

There was a policy document available to support staff in all aspects of nutritional and hydration care. Residents’ weights were monitored and those identified as being at risk of unintentional weight loss had evidence of monitoring and review by dietetic services. The chef was aware of and accommodated residents with specific nutritional support needs, support plans and preferences. The chef had copies of the recommendations made by speech and language and dietetic therapy services. Care plans were in place to inform care of residents with nutrition and hydration needs which were satisfactorily linked to monitoring and treatment plans and were evaluated in daily progress notes.

The dining room was spacious, homely and comfortable. Residents spoken with told the inspectors that they enjoyed the food provided in the centre. The chef engaged in home-baking for residents which many spoke about in complimentary terms.

**Judgment:**
Substantially Compliant

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

**Findings:**
The inspector was satisfied that residents were enabled to make choices about how they lived their lives in a way that reflected their individual preferences and diverse needs. Residents' meetings were chaired by the activity coordinator which was minuted. There was evidence of action taken in response to issues raised by residents at this forum, for example, more juices were requested at breakfast and fresh jugs of water in bedrooms which was implemented on the days of inspection.

There were examples where residents were encouraged and facilitated to maintain their independence, for example residents who were assessed as able were accompanied on walks around the local community. However, the layout and design of some residents' bedrooms and en-suite facilities did not safely promote independence. Independent access to the garden was also not in place for vulnerable residents. This finding is discussed in outcome 12.

A volunteer advocate attended the centre every week and met with residents. Residents had got to know the centre's advocate well as an outcome of her frequent visits to the centre.

There was a communication policy in use to inform communication strategies especially with residents who had illnesses and medical conditions that resulted in them having communication deficits. The Inspector also observed that residents had access to local and national newspapers. Some residents were observed independently reading them and others who were unable to do so were informed of the contents as part of the communal activities facilitated by the activity coordinator. Residents had access to optical and auditory services and some residents wore glasses and hearing aids. Items of interest to residents were displayed in the centre.

The centre also had a telephone which residents could use if they wished to speak to relatives in private. Residents confirmed that they had regular visitors and could choose where they would like to meet them.

The layout and design of some residents' bedrooms did not ensure their privacy and dignity needs were met as set out in the centre's statement of purpose and function. One bedroom accommodating two residents had a large bay window which was overlooked by the communal dining room and was did not have privacy screening fitted to ensure the privacy of residents in this room was not compromised. These findings were the subject of two actions plans from the last inspection in April 2013, neither of which was satisfactorily completed. While there was a small local church nearby, inspectors were told it was not accessible to all residents due to steps and the absence of an accessibility ramp. The provider advised that he was negotiating with the local clergy in relation to same. Mass was celebrated in the centre's communal sitting once per month with weekly distribution of communion by the local priest. There were arrangements in place to ensure the needs of residents of non catholic faiths were also met in the centre.

**Judgment:**
Non Compliant - Moderate
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 found that residents had adequate space to store their clothes and personal belongings. However, due to the layout and design of twin rooms all residents could not retain control over their personal possessions. Some residents did not have access to their personal wardrobe space without entering the personal space of another resident in twin rooms including when bed screen curtains were closed.

There was a policy to inform management of residents' personal property and possessions available. A record of each resident’s property was completed but was not completed on a frequent basis to ensure possessions were recorded. The centre has a laundry on-site and residents clothing was laundered by designated staff member whom inspectors was well informed of appropriate laundering including infection control and prevention procedures. Linen collection skips were available that appropriately segregated used linen in line with the national policy. Residents spoken with told the inspector that their clothing was managed to their satisfaction. The staff member with responsibility for laundering residents' clothing also undertook minor repairs and button replacement. The inspector observed that clothing worn by residents was clean, in good condition and stored neatly in wardrobes and drawer units. Items of residents clothing viewed by the inspector had the residents identification on them.

Judgment:
Non Compliant - Moderate

Outcome 18: Suitable Staffing
There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

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

Findings:
The staffing rota confirmed that there was a registered nurse on duty in the centre at all times. The inspector was informed by the person in charge that staffing levels were reviewed on an on-going basis to meet the changing needs of residents and were increased where necessary to meet the needs of those assessed as requiring high levels of care. However, inspectors found from review of resident falls that there were periods where incidents of residents' falls were increased and as such adequacy of night-time staffing levels required review during these periods to ensure residents were adequately supervised. Inspectors found that 53% of resident falls occurred between 19:35hrs and 05:30hrs of which 41% occurred between 19:35hrs and 23:00hrs. In addition the records did not confirm that the adequacy of staffing levels to safely evacuate residents in the event of a fire was assessed by a simulated night-time fire drill.

The inspectors were provided with copies of the staff rotas and staff files as requested which were reviewed to assess compliance with the legislation in each case. The duty rotas given to the inspectors for review referenced the full name of staff working in the centre and hours of duty worked as required. However, the numbers of staff on the staff rota and training records did not correlate. The names and hours worked by the activity coordinator, physiotherapist or volunteer advocate were not included on the staffing rota.

There was a recruitment policy in place and the sample of some staff files reviewed did not contain all information required by regulation 21. A record of the current registration details of all staff nurses working in the centre was maintained and was up to date.

All care staff had Further Education and Training Awards (FETAC) Level 5 training. All staff had attended mandatory training in fire safety, protection of vulnerable adults and safe moving and handling procedures. Additional training was facilitated to support staff competency skills and professional development. Staff were observed by the inspectors to be responsive and effective in meeting residents' needs.

Residents spoken with spoke well of the staff in the centre and were complimentary of the respect and kindness shown to them. Comments from residents and relatives included 'kind and caring', 'chatty and cheerful' and 'give very good care'. Residents spoken with also spoke positively in relation to staff competence and skill in meeting their needs. Staff spoken with by inspectors were knowledgeable about residents' needs. Residents told the inspector that they felt safe said that call bells were answered promptly when they required help.

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:

Catherine Rose Connolly Gargan
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
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Regulation Directorate

Action Plan

Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Hillview Private Nursing &amp; Retirement Residence</th>
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<tr>
<td>Centre ID:</td>
<td>OSV-0000141</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>26/11/2014</td>
</tr>
<tr>
<td>Date of response:</td>
<td>09/04/2015</td>
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Requirements

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

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 02: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Management systems in place did not ensure that the service provided was safe and appropriate and adequately resourced in terms of accommodation and safety to meet residents' needs in accordance with the centre’s statement of purpose.

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

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Please state the actions you have taken or are planning to take:
The Health and Safety policy statement and risk assessments have been updated as of January 2015 and additional risks identified and control measures put in place. Additional fire safety measures have been put in place to manage identified risks, a new fire resistant door is in place to reduce the amount of residents that would require evacuation to the next safe zone in the event of a fire. Additional fire exit / escape signage have been displayed throughout the home and an up-to-date fire assembly point sign is now in place.

Infection control and prevention procedures are in place to ensure standards are met. Issues arising from the inspection have been dealt with and an audit tool for measuring compliance with the infection control and prevention procedures in place is in the process of being updated to include these issues highlighted. The incident/accident policy has been amended to ensure that medical review post falls is sought where applicable. In all cases the residents G.P. will be contacted to advise of fall and any treatment plan documented and implemented. A standard operating procedure in the event of a suspected head injury and a suspected limb injury is in the process of development to guide staff in the immediate care of a resident post same. The incident audit completed 3 monthly by the person in charge allows for analysis of incidents and learning from same is documented and measures implemented where applicable.

A full review of the room layout and overall accommodation of the home is now complete and a plan developed to ensure the accommodation needs of the resident are met as per regulations. Detailed drawing plans of which are enclosed. A number of rooms are now complete.

Proposed Timescale: 30/04/15 & 31/07/15

Proposed Timescale: 31/07/2015

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The system in place to review and monitor the quality and safety of care and the quality of life of residents was not adequate.

Action Required:
Under Regulation 23(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored.
Please state the actions you have taken or are planning to take:
Audit tools used to monitor the quality and safety of care and the quality of life of residents in Hillview are in the process of review, to ensure that identified risks and subsequent controls and improvements to be made are outlined with a clear plan for implementation.

**Proposed Timescale:** 31/05/2015

### Outcome 03: Information for residents

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Additional charges to residents were of varying amounts and services provided for same were not clearly specified. The information reviewed indicated an additional charge for bedrails for residents; clarity was required to ensure that use of bedrails for residents was in line with the National Restraint Policy.

**Action Required:**
Under Regulation 24(2)(b) you are required to: Ensure the agreement referred to in regulation 24 (1) relates to the care and welfare of the resident in the designated centre and includes details of the fees, if any, to be charged for such services.

**Please state the actions you have taken or are planning to take:**
All fees are now outlined in the residents contract and fully discussed with the resident, where applicable, and his/her family or representative. Where bed rails are used this is in line with national restraint policy and Hillview policy on the use of bedrails.

**Proposed Timescale:** 09/04/2015

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Personal contribution to fees by residents was not stated in all contracts reviewed

**Action Required:**
Under Regulation 24(2)(a) you are required to: Ensure the agreement referred to in regulation 24 (1) relates to the care and welfare of the resident in the designated centre and includes details of the services to be provided, whether under the Nursing Homes Support Scheme or otherwise, to the resident concerned.

**Please state the actions you have taken or are planning to take:**
All fees are now outlined in the residents contract and fully discussed with the resident, where applicable, and his/her family or representative.

**Proposed Timescale:** 09/04/2015

### 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:**
Not all policies included adequate information to inform practice in all respects. For example, medication management, risk management and protection of vulnerable adults.

The safety statement was not reviewed annually.

**Action Required:**
Under Regulation 04(1) you are required to: Prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.

**Please state the actions you have taken or are planning to take:**
The safety Statement has undergone a full review as of January 2015 and will be reviewed annually as per statement. Several policies including medication management, risk management and protection of vulnerable adults have been reviewed to inform best practice and relevant staff aware of same. All policies as per schedule 5 are in place.

**Proposed Timescale:** 09/04/2015

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Not all records listed in schedules 2, 3 and 4 are completed and maintained in the centre. For example, all restraints used, details of fire evacuation drills, resident fees, notifications were not complete, staff employment records and the duty rota were not complete and the centre's statement of purpose document did not include all required information.

**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 the Chief Inspector.
Please state the actions you have taken or are planning to take:
As per schedule 3 all records in respect of each resident are in place and maintained. Details of fire evacuation drills are now maintained and have been expanded to include commentary referencing details of the evacuation drill and learning from same. Details of resident fees are now outlined in the residents contract of care. As per schedule 2, the documents to be held in respect of the person in charge and each staff member are in place. Details of roles and responsibilities and contracted hours of work are included in the individual staff contract. The physiotherapist who attends our nursing home each week is not a paid member of staff but a contracted service. The hours worked by the activities co-ordinator were included on the duty roster – and are now clearly identified as such. The volunteer advocate, Physiotherapist and befriender who visits our home weekly are now identified on the duty roster and their hours of attendance documented on same.

Proposed Timescale: 09/04/2015

Outcome 07: Safeguarding and Safety
Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Restraints were not used in line with the national restraint policy in relation to monitoring and ongoing review and assessment of need.

Action Required:
Under Regulation 07(3) you are required to: Ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.

Please state the actions you have taken or are planning to take:
Hillview are committed to a restraint free environment and where restraint is used, will only be used as per our restraint policy and in accordance with national policy. 5 residents currently use a bed rail on one side of their bed only and by request, alternative methods will be researched and implemented in consultation with the resident. 1 resident uses a bed rail on both sides of her bed, this is at her request as she is an active sleeper and she is fully able to alert staff to have rails lowered at her request. All residents who use bedrails have a careplan reflecting same and bedrails are used in accordance with national policy.

Proposed Timescale: 30/04/2015
Theme:
Safe care and support
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some staff were unsure of the procedure if an allegation of abuse was made against a senior member 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:
The elder abuse policy has been amended to include the procedure to be followed if an allegation of abuse was made against a senior member of staff. This information has been disseminated to all staff and will be included in all elder abuse training.

Proposed Timescale: 09/04/2015

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:
All risks found on inspection were not identified with stated concomitant controls to mitigate level of risk to residents, staff and others.

Controls stated for identified risks as documented in the risk register were not implemented in relation to secure storage of hazardous chemicals.

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:
A lockable unit is now in situ on the cleaning trolley to house chemical products in use. The health & safety statement has been reviewed as of January 2015 with risks identified and concomitant controls stated to mitigate the level of risk.

Proposed Timescale: 09/04/2015

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents at assessed risk of leaving the centre unaccompanied did not have missing
person profiles completed to assist the emergency services to expedite their recovery and safe return to the centre.

**Action Required:**
Under Regulation 26(1)(c)(ii) 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 unexplained absence of any resident.

**Please state the actions you have taken or are planning to take:**
There is a missing persons profile sheet available as per our missing persons policy, that is partly completed with the details of 2 residents identified at risk, to assist the emergency services to expedite their recovery and safe return to the centre.
As the profile of a resident may change from day to day, this profile, as per policy, is then fully completed at the time of the event of a missing resident.

**Proposed Timescale:** 09/04/2015

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Some practices and procedures in the centre were not consistent with the standards for the prevention and control of infection. The following areas of inadequate practice were found;

- a soiled sponge was observed in the hot press
- the treatment room was also used as the centre's hair salon
- there was bottles of shampoo and shower gel for communal use in the bathroom/shower
- there was no extractor fan in a communal shower room.
- bedpan disinfection unit was visibly soiled
- tagging of waste for disposal was not done before transportation from the centre

**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:**
- The stained cushion foam was removed at the time of inspection.
- All bottles of shampoo and shower gel are labelled for individual resident use.
- An electronic extractor fan has been installed in both bath and shower room.
- The rust along the edging of the bedpan disinfection unit has been removed.
- tagging of waste for disposal is done by the clinical waste collection company on collection of waste.
The therapy room is now not used as a treatment room.
Proposed Timescale: 09/04/2015

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The inspectors reviewed fire safety arrangements in the centre and found them to not be of an adequate standard. Inspectors' findings included;

- the door of room 16 opens out into the corridor immediately into the route of a designated fire exit
- one designated fire exit had glass windows on either side and was fitted with a latch in addition to a push-bolt locking device.
- some bedrooms were fitted with panel type doors as opposed to doors of the required fire retardant standard
- doors to residents' bedrooms were ajar on the days of inspection and were not fitted with self-closure devices
- individual resident risk assessments were not completed to ensure the safety needs of residents who smoked were met while engaging in this activity.
- residents did not have personal evacuation assessments completed in terms of equipment and staff required to ensure their safe evacuation in the event of a fire in the centre.
- documentation in relation to fire evacuation drills was not adequate

Action Required:
Under Regulation 28(1)(a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.

Please state the actions you have taken or are planning to take:
Following an inspection of the nursing home by Meath County Council Fire Officer, all issues identified have been addressed, however, the push bolt has been removed from the designated fire exit identified on the day of inspection, this is a different door to the door identified as a fire exit with glass on either side, which on the day of inspection was marked as a fire door, however, this sign has been removed and this door is now marked as a fire exit.
- the door of room 16 now opens inwards.
- All residents who smoke now have a smoking risk assessment completed which dictates their careplan in this activity. The assessment is reviewed every 4 months or earlier as needed.
- A personal evacuation plan is now in situ for all residents and the procedure in the event of a fire has been updated to reflect this.
- The documentation maintained in relation to fire evacuation drills has been expanded to include commentary referencing details of the evacuation drill and learning from same.
- All bedroom doors are to be reviewed in respect of self - closure in the event of a fire as part of the full review of room layouts, in the interim, All staff have and will undergo
fire safety training, which includes the need to ensure doors are closed in the event of the fire alarm sounding.

Proposed Timescale: 31/07/2015

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:
There was inadequate evidence of appropriate involvement by the pharmacist in accordance with regulation 29 and guidance issued by the Pharmaceutical Society of Ireland including quarterly review of prescribed medicine therapy in conjunction with nursing staff and the resident’s GPs.

Action Required:
Under Regulation 29(2) you are required to: Facilitate the pharmacist concerned in meeting his or her obligations to a resident under any relevant legislation or guidance issued by the Pharmaceutical Society of Ireland.

Please state the actions you have taken or are planning to take:
There was evidence available to show that the pharmacist visits our nursing home on a quarterly basis, last visit before inspection date was 29/10/14 where a review and audit of prescribed medicine therapy is carried out with the nurse on duty. There was also evidence available to show that a quarterly review of prescribed medicine therapy is carried out by the G.P.
On admission, consent is obtained from a resident to use our pharmacist to supply their medicines – this consent is documented on the residents admission sheet.
The person in charge/or delegate carries out a quarterly audit of medication management and practices.
The medication management policy was reviewed and updated in December 2014 to inform medication management practices in line with legislation and professional standards.

Proposed Timescale: 09/04/2015

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A number of the medication prescription sheets examined did not contain a prescriber’s signature for each medication order, maximum dose of PRN (as required) over each 24 hour period or instruction to crush to reference each medication for administration to residents who required medications in this format.
Transcription of medications prescriptions was not in accordance with professional guidance issued by An Bord Altranais agus Chnáimhseachais.

**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 medication prescription sheets have a prescribers signature for each medication order. All PRN medications now have a maximum dose in a 24hr period documented. There were no medications being crushed at the time of inspection, and as per our medication management policy, all medications that require crushing will be prescribed as such by the residents g.p.
All medication prescriptions transcribed are now countersigned by 2 nurses. This action is now included on the quarterly medication management audit carried out by the person in charge/delegate as per An Bord Altrainis agus Chnáimhseachais guidelines to ensure ongoing compliance.

**Proposed Timescale:** 09/04/2015

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Medication preparations for administration were prepared in the nurses’ station, this practice required review in respect of secure storage, hygiene and safety.

A medicinal product prescribed for a resident was not adequately stored as observed in a communal bathroom cupboard.

**Action Required:**
Under Regulation 29(4) you are required to: Store all medicinal products dispensed or supplied to a resident securely at the centre.

**Please state the actions you have taken or are planning to take:**
Medication preparations for administration are prepared in the nurses station, an area has been identified and designated as solely for the preparation of medications. The medication trolley is secured when not in use. All medication storage units are locked and the keys are with the nurse in charge at all time. All medications are stored in the locked medication trolley, locked fridge or locked cupboard at all times. The room referred to is a nurses station and not a staff office. The medicated powder prescribed for a resident and inadvertently left in the bathroom was removed immediately.
**Proposed Timescale:** 09/04/2015

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

**Theme:**
Effective care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Recorded information did not indicate whether participation in activities had positive outcomes for each resident to inform provision of suitable activities to meet the interest and capabilities of each resident.

**Action Required:**
Under Regulation 05(1) you are required to: Arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2).

**Please state the actions you have taken or are planning to take:**
The interest and capabilities of all residents in activities is assessed on admission and a care plan is developed to inform the provision of suitable activities to meet their needs. This is updated every 4 months or as resident needs and abilities change. The record of participation and level of engagement is under review to fully reflect each resident’s interest, fulfilment and capability, this information will ensure there are positive outcomes for the resident meeting their assessed needs. A regular residents meeting also facilitates discussion around suitability of activities. An activity schedule is developed taking into consideration residents preferences and displayed throughout the home.

**Proposed Timescale:** 31/05/2015

**Theme:**
Effective care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Residents GPs were not informed to determine whether medical review was required in 99% of the resident fall incidents reviewed until some hours later or not at all, including incidents where a head injury was sustained.

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

**Please state the actions you have taken or are planning to take:**
As was advised and agreed on the previous inspection with the authority, it was
recommended that the clinical judgement of the nurse could determine if medical attention was necessary at the time of a fall, however, our incident policy has now been revised and amended to ensure that in the event of a fall, the residents g.p. is contacted in all cases to advise on treatment where necessary, this has been implemented immediately. A care pathway in the event of a fall and a subsequent injury is in the process of development and will ensure that medical attention is sought in a timely manner where applicable.

**Proposed Timescale:** 30/04/2015

<table>
<thead>
<tr>
<th>Outcome 12: Safe and Suitable Premises</th>
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<tr>
<td><strong>Theme:</strong> Effective care and support</td>
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**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The layout and design of residents' bedroom accommodation including en-suite facilities did not meet their stated purpose. Inspectors found the following areas to be inadequate and not in compliance with the regulations:

- some toilet bowls were at a low level and did not have adequate assistive support equipment fitted to promote independence and safety. Occupational therapy expertise was not sought to ensure these toilets met the needs of residents in accordance with the centre's statement of purpose and function.
- en-suite facilities were narrow, located within close proximity to beds and had doors fitted that opened into bedrooms and as such did not meet the needs of some residents accommodated in adjacent bedrooms.
- most twin bedrooms accommodated by residents did not meet the needs of residents in terms of layout and design to ensure their independence and accessibility needs were promoted and met, adequate space to carry out personal care in private and unrestricted access to personal belongings,
- privacy screen curtain rails were not fitted so as to enclose adequate personal space for each resident in twin bedrooms. A number of curtains extended across residents' beds.
- some residents could not access the wash basin in their bedrooms.
- not all residents had adequate space to move around their personal space safely and unobstructed.
- not all residents had their bedside locker within reasonable reach.

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

**Please state the actions you have taken or are planning to take:**
All toilets now have adequate assistive support rails in situ to promote independence and safety. Completed.
Privacy screen curtain rails have been assessed and where applicable new screens will be in place by 05/03/15

all residents now have a bedside locker within reasonable reach.

A full review of the room layout and overall accommodation of the home is now complete and a plan developed to ensure the accommodation needs of the resident are met as per regulations. Detailed drawing plans of which are enclosed. A number of rooms are now complete.

**Proposed Timescale:** 31/07/2015

**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 a communal shower as no extractor fan was fitted in this facility
- not all corridors had hand rails fitted.
- environmental temperatures were not monitored and residents were unable to control radiator temperatures in their bedrooms
- hot water temperatures were not adequately controlled so as not to exceed 43 degrees centigrade at the point of contact by residents
- although recently painted, areas of a wall along the top of a skirting board in a twin bedroom had evidence of dampness with disintegration of masonry surfaces.

**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:**
Extractor fans have now been fitted to communal shower room and bathroom. There is now a handrail in place in all corridors.
All rooms have a facility to control the temperature and where able to the resident is can do this independently. Temperatures are automatically set at Minimum Requirement.
Water temperatures are monitored regularly and do not exceed 43 degrees at the point of contact by residents.
This has been addressed and the masonry repaired and repainted.

**Proposed Timescale:** 09/04/2015
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<tr>
<th><strong>Outcome 13: Complaints procedures</strong></th>
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</thead>
<tbody>
<tr>
<td><strong>Theme:</strong> Person-centred care and support</td>
</tr>
<tr>
<td><strong>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</strong> An appropriate appeals process was not stated.</td>
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<td><strong>Action Required:</strong> Under Regulation 34(1) you are required to: Provide an accessible and effective complaints procedure which includes an appeals procedure.</td>
</tr>
<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong> A revised appeals process has now been added to our complaints policy and procedure, a copy of which is contained in the residents contract and displayed in a prominent place in our home.</td>
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<td><strong>Proposed Timescale:</strong> 09/04/2015</td>
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<tr>
<th><strong>Outcome 15: Food and Nutrition</strong></th>
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<tbody>
<tr>
<td><strong>Theme:</strong> Person-centred care and support</td>
</tr>
<tr>
<td><strong>The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:</strong> While the nutritional value of menus was evaluated by a dietician, further review would be of benefit to evaluate inclusion of milk as a mealtime drink and inclusion of palatable high fruit preparations such as smoothies.</td>
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<tr>
<td><strong>Action Required:</strong> Under Regulation 18(1)(c)(iii) you are required to: Provide each resident with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional assessment in accordance with the individual care plan of the resident concerned.</td>
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<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong> Milk as a mealtime drink was and continues to be available to all residents where appropriate. The addition of Smoothies will be discussed with our residents and added to our menus where appropriate.</td>
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<tr>
<td><strong>Proposed Timescale:</strong> 30/04/2015</td>
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</table>
**Outcome 16: Residents' Rights, Dignity and Consultation**

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

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The layout and design of some residents' bedrooms did not ensure their privacy and dignity needs were met as set out in the centre's statement of purpose and function.

One bedroom accommodating two residents had a large bay window which was overlooked by the communal dining room and was did not have privacy screening fitted to ensure the privacy of residents in this room was not compromised.

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

**Please state the actions you have taken or are planning to take:**
All shared rooms have curtain screens around each bed that can be pulled to ensure privacy for each resident, new curtains and rails have been ordered to replace existing and are due for fitting on 05/03/15, to ensure that each resident may undertake personal activities in private.

Privacy screening has now been installed in all rooms that are overlooked

**Proposed Timescale:** 05/03/2015

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

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

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Due to the layout and design of some twin rooms all residents could not retain control over their personal possessions.

**Action Required:**
Under Regulation 12(a) you are required to: Ensure that each resident uses and retains control over his or her clothes.

**Please state the actions you have taken or are planning to take:**
A full review of the room layout and overall accommodation of the home is now complete and a plan developed to ensure the accommodation needs of the resident are met as per regulations, including ensuring that each resident retains control over their personal possessions. Detailed drawing plans of which are enclosed. A number of rooms are now complete.
Outcome 18: Suitable Staffing

Theme:
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Staffing levels required review to ensure there was adequate staff on duty at night to meet the supervision needs of residents and to evacuate residents safely in the event of a fire.

Action Required:
Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

Please state the actions you have taken or are planning to take:
The addition of an extra fire resisting door has reduced the number of residents who would require evacuation to the next safe zone in the event of a fire. A fire drill has been completed to ensure that the safe evacuation of residents can be completed at night.
Staffing levels have been reviewed and are sufficient to meet the supervision needs of residents at night. Dependency levels and skill mix are assessed regularly to ensure safe and effective supervision and staff levels will be amended where applicable.

Proposed Timescale: 09/04/2015