

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Dargle Valley Nursing Home
Centre ID:	OSV-0000031
Centre address:	Cookstown Road, Enniskerry, Wicklow.
Telephone number:	01 286 1896
Email address:	darglevalleynh@eircom.net
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Bluebell Care Limited
Provider Nominee:	Deirdre MacDonnell
Lead inspector:	Louise Renwick
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	24
Number of vacancies on the date of inspection:	6

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.

Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, 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

From:	To:
30 March 2015 10:00	30 March 2015 18:00
31 March 2015 09:30	31 March 2015 18:00

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

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

Summary of findings from this inspection

As part of the inspection, the inspector spoke with residents, family members, and staff. The inspector observed practices and reviewed documentation such as care plans, medical records, accidents and incident logs, policies, procedures and staff files. The inspector reviewed questionnaires that had been completed by both residents and their family members about the designated centre.

Overall the inspector found a good level of compliance with the 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. The inspector followed up on any outstanding actions generated from the most recent inspection report, and found that they had been adequately addressed. Areas

identified for improvement were in relation to:

- Governance and management
- staff training and documentation
- Documentation
- Accidents and incidents

There was evidence of good access to allied health care professionals, and clear documentation in relation to the assessed needs of residents. Care plans had improved since previous inspections, with any identified need for a resident effectively planned out and met.

The designated centre was nicely decorated, with a homely feel throughout. The building and the grounds were safe and secure, and maintained to a good standard. There were two twin rooms which are small in size and in need of address by the provider. Questionnaires from residents and families reflected satisfaction with the services and facilities on offer in the designated centre.

The findings of this monitoring inspection are detailed within the 18 outcome headings in the body of this report.

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):

No actions were required from the previous inspection.

Findings:

There was a statement of purpose in place in the designated centre, which clearly outlined the services and facilities on offer to residents. The inspector was satisfied that the statement of purpose was a true reflection of what the designated centre provided.

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:

Due to the size and current occupancy of the designated centre, the management structure in place consisted of the provider and the person in charge. The person in charge was supported in her role by the nursing team and the care assistants. There was also the assistance of administrative support staff who looked after staff files, human resources and other such duties. The inspector found that staff, residents and families were aware of the management structure, and who was the person in charge of

the designated centre.

The inspector determined that management systems in place in the designated centre were in need of improvement to ensure the services offered were being effectively monitored. There was evidence of clinical governance meetings having been continued since the last inspection, which were minuted and included actions plans and named persons responsible. There was also system of audits in place to review clinical aspects of care such as medication management, falls, wounds and pressure care. However, gaps were identified in relation to the review of accidents and incidents to prevent re-occurrence and to ensure learning was gained. This had resulted in a number of incidents involving residents not being sufficiently investigated or followed up. This will be further discussed under outcome 8.

The inspector spoke with the provider and found that an annual review of the designated centre had not been carried out as is required by the Regulations.

Judgment:

Non Compliant - Moderate

Outcome 03: Information for residents

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The inspector found that there was a policy in place for the provision of information to residents available in the centre. There was a written residents' guide in the centre which met the requirements of the Regulations, and was available to residents and visitors. This offered a true reflection of the services on offer.

On review of a sample of residents' files, the inspector found that all residents had written contracts which outlined the terms and conditions of their stay, and any additional fees to be charged such as hairdressing, taxis and newspapers.

Judgment:

Compliant

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The person in charge had been appointed to her role on 4th March 2015. The inspector had not received complete information in relation to the person in charge at the time of the inspection, and was awaiting this documentation prior to a judgment on suitability. The inspector noted that the person in charge was knowledgeable on the needs of the residents in the centre, and demonstrated a good understanding of her responsibilities and role in the centre.

Judgment:

Substantially Compliant

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The inspector was satisfied that the records listed in Part 6 of the Regulations were maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The provider had an online data system in place, and staff had been trained in its use. The inspector found that documentation in relation to residents was well organised on the online recording system and was evidenced as being up dated regularly.

The inspector reviewed staff files and found that improvements were required in this

area to ensure consistent documentation was obtained for all staff in line with the requirements of Schedule 2 of the Regulations. For example, some staff files did not contain the required two written references.

The designated centre had all of the written operational policies as required by Schedule 5 of the Regulations. However, the inspector found that the policy in relation to the recruitment of staff was not fully implemented in practice, as will be discussed under outcome 18 Staffing. The inspector also determined that the policy in relation to the review and learning from accidents and incidents was not fully implemented in practice, and was in need of review to ensure recording, and reviewing of adverse events was consistently in line with the centre's own policy.

Adequate insurance cover was in place for the centre.

Judgment:

Substantially Compliant

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The provider was aware of the requirement to notify the Chief Inspector of any proposed absence of the person in charge for a period of more than 28 days. There were appropriate plans in place to manage any such absence, with the provider nominee identified as the persons to deputise for any short term absences, along with additional nursing support.

Judgment:

Compliant

Outcome 07: Safeguarding and Safety

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

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

The inspector found that there was a policy in place as required by Schedule 5 of the Regulations in relation to the prevention, detection and response to abuse. This policy was included in the training sessions delivered to staff. The inspector spoke with staff and found them to be knowledgeable on the different types of abuse, their indicators and how to report any allegations or suspicions. The inspector was concerned however, that issues arising between residents, some of which had resulted in injury, had not been viewed as abusive, or dealt with through the protection policy. This was evident on review of a number of incidents involving residents, one of which was referred to the Gardai. The inspector discussed with the provider and person in charge, as the recording, reporting and investigating of these incidents had been weak, and did not ensure all residents were protected from harm. On review of the training records the inspector found gaps in the delivery of training on the prevention, detection and reporting of abuse for all staff members. For example, four staff had not received any training in this area.

The inspector found that overall residents who may present with behaviours that were challenging had clear care plans in place to guide staff, which were person centred. For example, guidance on topics of discussion when a resident became upset, or items of clothing that assisted a resident to feel more relaxed. However, the recording of behavioural incidents when they did occur required some improvement to ensure consistency with the centre's own policy. For example, the use of ABC charts was not always completed following incidents.

The inspector found that the use of physical restraints in the centre were well documented, monitored, reviewed and there was documentary evidence of clear rationale for their use. This had been done in consultation with the resident and/ or family representatives. The inspector determined that the use of chemical restraint was in need of review, to ensure any usage was in line with national policy. For example, the inspector found no evidence recorded of alternatives tried prior to the use of chemical restraint, and unclear protocols for their use. This was in need of improvement.

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):

No actions were required from the previous inspection.

Findings:

The inspector found that there were policies and procedures in place to guide practices in relation to health and safety, infection control, falls management, fire, responding to emergencies and risk. There was an up to date health and safety statement available.

There were adequate systems in place to prevent, detect and alert fire in the designated centre, which were checked and maintained on a regular basis by a suitably qualified professional. There was evidence of fire drills being carried out regularly, the evacuation plan was on display in various locations around the building. While staff had access to regular training in the area of fire safety and evacuation, not all staff had received this training at the time of the inspection. This was in need of address. Staff could discuss with the inspector what to do in the event of the alarm sounding.

The risk management policy and procedures were comprehensive and fully meet the requirements of the Regulations. Both environmental and clinical risks were identified and well managed within the centre. Risk assessments were updated as required.

The inspector reviewed the log maintained of any adverse event, accident, incident or near misses in the designated centre. While there was a recording system in place, the inspector was not satisfied that processes around reporting, reviewing and learning from adverse events were clear or effective. For example, the same incident between two residents had been recorded by a number of staff members, with conflicting facts. Such as outlining the left hand was injured in one report, and that it was the right hand in another. On review of the corresponding daily notes/ nursing notes for these incidents, the inspector again found discrepancies in the recording of facts and details, which differed across various reports. This was something that was in need of improvement. The inspector also found that where incidents had been recorded, there was a lack of appropriate investigation or follow up carried out, to prevent the likelihood of a reoccurrence, and to show learning gained and what had changed to reduce any risks for residents. This was discussed at feedback with the provider and the person in charge.

Judgment:

Non Compliant - Moderate

Outcome 09: Medication Management

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

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

The inspector found that residents were protected by safe medication management practices in the designated centre.

The inspector observed practices in relation to the cycle of medication management, and found there to be safe practice in this regard, which was guided by a centre specific policy in line with the Regulations. There was a system in place for the documenting and investigating of medication errors should they occur, and the inspector noted a low occurrence of medication errors in the centre in the past 6 months. Medication management was audited on a routine basis by the person in charge. The inspector reviewed evidence of these audits during inspection.

Judgment:

Compliant

Outcome 10: Notification of Incidents

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

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

The inspector found that there was a log of all adverse events, accidents, incidents and near misses in the designated centre. On review of this log, the inspector requested the person in charge to submit a number of notifications that had not been considered for submission to the Chief Inspector. These were submitted in the days following inspection.

Judgment:

Substantially Compliant

Outcome 11: Health and Social Care Needs

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

Theme:

Effective care and support

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

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

Findings:

The inspector found that residents' health needs were met through timely access to allied health care professionals and treatment. For example, on review of residents' medical notes, the inspector found good access to their General Practitioner, dietician, community psychology, audiology and speech and language therapy.

The inspector reviewed a sample of residents' care plans, and found clear and up to date documentation in place. Care plans had been reviewed since the previous inspection by the new person in charge, and the inspector found them to be concise, easy to follow and person centred. Residents' had appropriate pre-admission and continuous assessments to capture their individual needs, and care plans drawn up meet these needs. This had been improved upon since the previous inspection. The inspector noted resident and family involvement in the creation and review of care plans.

The inspector found that any identified need or risk, had an up to date care plan in place to address it. The inspector spoke with staff, and found them to be knowledgeable on individual needs of residents and the contents of their care plans. The inspector found that care plans were reviewed as residents' needs changed, for example following a fall.

The inspector found that any clinical risk for individual residents had been appropriately assessed and managed. For example risk of malnutrition, and risk of falls. Care plans in relation to residents with dementia, or residents with behaviours that could be challenging were person centred and guided staff in supporting residents in a non-restrictive way.

The inspector reviewed the weekly timetable and spoke with residents, and found that residents had more opportunities to participate in activities that were meaningful and purposeful to them since the previous inspection, which was an improvement. Assessments had been completed in relation to residents wishes and interests and included in their documentation. Residents in general expressed satisfaction with what was available to them in the centre.

Judgment:

Compliant

Outcome 12: Safe and Suitable Premises

The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:

Effective care and support

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

No actions were required from the previous inspection.

Findings:

The inspector found that the premises were in good condition, the interiors had been recently painted, and the building and furnishings were maintained to a good standard. The centre was located on grounds with mature trees, and peaceful surroundings. Residents commented to the inspector that it was a comfortable place to live. There was suitable outdoor space and garden furniture for residents use.

This designated centre comprised of 26 single rooms, and two twin rooms measuring 12.8 Meters Squared which were not in line with the Authority's Standards. At the time of inspection, one of these rooms only had one bed in it, and was currently vacant. The second twin room had two beds, but only one resident at the time of inspection. The provider had planned that these would remain as twin rooms should the centre be at full capacity. These rooms as twin rooms were smaller than as advised in the Authority's Standards, with each bed against a wall, a small wardrobe for each resident, and limited space for any additional furniture such as armchairs and comfort chairs. The inspector was concerned that these rooms were not of adequate size to ensure the privacy and dignity of residents at all times, as the usable floor space measured 5.62 Meters Squared. This was raised at previous inspections with the provider. The inspector noted that the plan to construct large bay windows as outlined in an action plan in relation to the rooms had not been carried out within the time frame set out by the provider.

Judgment:

Non Compliant - Moderate

Outcome 13: Complaints procedures

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

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

The inspector was satisfied that the complaints of each resident, his/her family, advocate or representative and visitors were listened to and acted upon. There was an operational complaints policy in place, and the procedure was clearly on display in the centre. The policy and practices in relation to complaints, met the requirements of the Regulations. The inspector spoke with family members who were clear on the reporting process if they had any complaints. On review of the complaints log, the inspector was satisfied that complaints had been acted upon and reviewed as an opportunity for further learning.

The inspector spoke with residents, who expressed that they would go to any of the staff if they had a complaint. Residents and families clearly named the person in charge as the person to go to if they wished to make a complaint.

The inspector was satisfied that there was a sufficient process in place guided by the centre's policy, were residents felt they could voice their concerns or complaints, and they would be acted upon and monitored.

Judgment:

Compliant

Outcome 14: End of Life Care

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

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

This outcome was inspected against during the thematic inspection in July 2014 and found to be compliant with the Regulations and Standards. On this inspection, the

inspector determined that the provider and person in charge had maintained compliance in relation to the end of life needs of residents.

As part of this inspection, the inspector reviewed the files of residents who had recently passed away, and found that appropriate care and support had been offered at the end of life to residents, in ensuring their physical, social, psychological and spiritual needs were met. Since the thematic inspection, improvements had been made in soliciting residents wishes and preferences in relation to end of life at an earlier stage. For example, residents wishes in this regard were now discussed shortly after admission, and the discussion revisited at each review opportunity.

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:

This outcome was inspected against during the thematic inspection in July 2014, where the inspector found the centre to be in compliance with the Regulations and Standards with regards to the provision of food and nutrition for residents.

At this inspection, the inspector found that this level of compliance had been maintained in the designated centre. There was a policy in place to guide staff in supporting residents with nutritional needs and the monitoring of same. The inspector reviewed care plans, and found that any resident with an identified need in this area, or who was at risk of malnutrition had a care plan in place, which was evident in practice. The meal time experience was observed to be relaxed, and un-rushed, with two sittings at lunch time to ensure all residents who required support or assistance with mealtimes had this provided to them. The inspector spoke with residents who expressed their satisfaction with the choice and quality of the meals on offer. The inspector met with the chef, and discussed the menus, the needs of residents and the provision of food. The inspector found that staff, including kitchen staff were aware of the needs of residents, and the supports required as outlined in health care professional assessments.

Judgment:

Compliant

Outcome 16: Residents' Rights, Dignity and Consultation
Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

Theme:

Person-centred care and support

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

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

Findings:

The inspector was satisfied that residents were consulted with and participated in the organisation of the centre, and that each residents' privacy and dignity was respected.

The inspector found that there was a system of consultation with residents where their feedback was sought and informed practice. The inspector reviewed minutes of the residents' meetings and found that they were held on a regular basis, and were well attended.

The inspector spoke with a number of residents, and reviewed questionnaires, and found that residents felt that they had choice and control over their daily routines. Over the two days of inspection, the inspector found that residents were supported and treated in a respectful manner, with positive interactions observed between staff and residents. There were arrangements in place for residents to receive visitors in private, with a number of smaller communal areas available. The inspector found that residents had access to radio, television, newspapers and information on current affairs and local events.

At the previous inspection, improvements were required in relation to the provision of meaningful activities for residents. The inspector found that there was now a documented schedule of activities on display for residents, which outlined what was available for both the morning and the afternoon in the designated centre. This was an improvement since the previous inspection. Over the two days of the inspection, the inspector saw musicians, religious personnel and reminiscence therapy in place for residents, and residents expressed their enjoyment at these. Each day a care assistant was assigned to carry out the morning activity with residents in the day room. On the first day of inspection this activity happened as outlined, with residents encouraged to take part in the timetabled activity. However, on the second day, the inspector observed no activity in place, and residents relaxing in the day room without any meaningful activity under after lunch time. While the inspector found that improvements had been made, and meaningful activities were now formalised and accessible for residents, this continues to be an area in need of constant attention to ensure meaning activation for residents are provided on a consistent basis.

Overall, the inspector was satisfied that residents' rights and dignity were respected, and they were appropriately consulted with in regards to the organisation of the designated centre.

Judgment:

Substantially Compliant

***Outcome 17: Residents' clothing and personal property and possessions
Adequate space is provided for residents' personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.***

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

The inspector found that there were systems in place to safeguard residents' clothing, personal property and possessions. There was a relevant policy in place to guide practice, which was updated as required. There was a log kept of all belongings of residents in line with the policy.

The inspector spoke with residents who said their clothing was well cared for, and returned to them safely. On review of the complaints log in the designated centre, there was no pattern of complaint in this regard. Residents were provided with lockable storage in their bedrooms for personal items, and were encouraged not to keep large amounts of valuables or money.

Judgment:

Compliant

Outcome 18: Suitable Staffing

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

Theme:

Workforce

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

No actions were required from the previous inspection.

Findings:

The inspector found that the number and skill mix of staff in the designated centre was adequate to meet the assessed needs of residents. The inspector reviewed the rosters and found there to be one nurse on duty during the day, along with the person in charge, and the provider who were both registered nurses. There were also 3-4 care assistants on duty during the day time. This was meeting the needs of the current number of residents, and may be increased as resident vacancies were filled.

The inspector carried out observations over the course of the two day inspection, and found interactions between staff and residents to be person centred, respectful and positive. The inspector observed staff chatting with residents about things that were important to them and their individual needs and tastes, which was reflective in the documented care plans.

The inspector reviewed staff files and found that improvements were required in this area to ensure consistent documentation was obtained for all staff in line with the requirements of Schedule 2 of the Regulations. This has been previously discussed under outcome 5 Documentation. The inspector also determined that the process in relation to safe recruitment of staff required strengthening to ensure compliance with the centre's own policies. For example, some staff's Garda Vetting had not been applied for until a significant length of time in their new role, and likewise references obtained after employment had commenced. This was not in line with the centre's own policy or best recruitment practices. This was most notable in the absence of appropriate written references for the newly appointed person in charge, as discussed in previous outcomes.

The training records indicated that not all staff had received up to date training in the mandatory fields, such as manual handling, fire safety and prevention, detection and response to abuse.

Judgment:

Substantially Compliant

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:

Louise Renwick
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	Dargle Valley Nursing Home
Centre ID:	OSV-0000031
Date of inspection:	30/03/2015
Date of response:	03/06/2015

Requirements

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

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

Outcome 02: Governance and Management

Theme:

Governance, Leadership and Management

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

The provider had failed to complete an annual review of the quality and safety of the service.

Action Required:

Under Regulation 23(d) you are required to: Ensure there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8

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

of the Act and approved by the Minister under section 10 of the Act.

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

An external company completed a 2 days review of the services and care provided in our Centre in February.

The outcome of this review has been reviewed by the Management & Governance (Completed 5th May 2015)

Clinical audits on the various aspects of the quality and safety of care and services in the Centre are completed as per schedule. Results of these audits are maintained by the Director of Nursing.

The Director of Nursing reviews all audits and reports. The analysis & any trending from these audits will be presented to the Management & Governance Team for discussion and planning.

All findings from the audits and review of audits shall continue to be used to improve our service, care & practice, improve quality and guide change where required.

Ongoing review and monitoring of the outcome of the annual review, analysis of action plans and outcome are on the Agenda for the monthly Management & Governance Meeting (Next meeting 12th June 2015)

There is a plan in place to review other elements of the service provided over the next 6 months. (30th November 2015)

Proposed Timescale: 30/11/2015

Theme:

Governance, Leadership and Management

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

Management systems were failing to effectively monitor adverse events to ensure the service provided is safe.

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:

We have reviewed the Terms of Reference of the Management & Governance Organisational Structure (Completed 5th May 2015).

We are updating of the Terms of Reference and Organisational Structure and this will be further reviewed and finalised at the next scheduled Management & Governance

Meeting scheduled for 12th June 2015

We have reviewed our Quality Manual and our Quality Improvement Program (Completed 22nd May 2015)

Over the next 6 months we will further develop our Quality Improvement Program and Management System to maximise the quality and safety of the services provided for our residents. Our Quality Improvement Programme shall be further developed and will include a full review and updating of the Home's Quality Manual, policies and procedures to reflect requirements under Regulation 23 (c).(30th November 2015)

The annual Resident Satisfaction Questionnaire is currently being reviewed. The revised questionnaire will be finalised at the next Management & Governance Team meeting on 12th June 2015.

Once finalised this questionnaire will be distributed or forwarded to residents and their relatives/representatives. (To be completed by 30th June 2015).

The timeframe for return of completed surveys/questionnaire will be 1 calendar month. (To be completed by 31st July 2015)

When an element of the service we provide is reviewed and updated, all revised PPGs will be disseminated to all relevant staff, relevant to their role and responsibility. Ongoing weekly policy discussions, led by the PIC shall then focus on discussion of revised policies and procedures to further enhance staff knowledge, ensuring that all staff are kept informed of new and reviewed PPGs. The weekly policy discussion group. (Ongoing)

Proposed Timescale: 30/11/2015

Outcome 04: Suitable Person in Charge

Theme:

Governance, Leadership and Management

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

The provider had failed to ensure all documentation was in place as required by Schedule 2 of the Regulations for the person in charge. For example, written references from the most recent employer

Action Required:

Under Regulation 14(5) you are required to: Ensure that the documents specified in Schedule 2 are provided by the person in charge.

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

All current employees HR files shall be reviewed and audited against the Regulations Regulation 04(1) & Schedule 2 [Audit] (to be completed 31st May 2015)

All prospective employees will not start employment until all required documentation as per Schedule 2 have been obtained & verified by Registered Provider/Person in Charge.

A written reference from an employee which was outstanding on the day of the inspection is now on her. (Completed 4th April 2015)

A reference for the Person in Charge from her most recent employer was initially sent directly to the Inspectorate by her most recent employer. We now have the required reference now on her file and a copy of this has been forwarded to the Inspectorate. (Completed 20th May 2015)

Garda Vetting Application forms for prospective employees are now submitted promptly via NHI. The current waiting period is circa 8-10 weeks.

Where a prospective employee has completed a Garda Vetting Application form, and only when this has been submitted for certification via NHI, and the prospective employee has signed a declaration stating disclosure of any and all relevant information regarding his/her criminal record, only then shall that person be deemed suitable to be employed.

Where rostered this person, until an acceptable Garda Clearance Certification is received by the employer, shall work under strict supervision until such time as the Garda Vetting Clearance Certification has been processed by NHI and returned the employer.

A "new employee" shall not be confirmed in post until such a time that an acceptable valid Garda Clearance Certification has been returned to the employer.

Proposed Timescale: 31/05/2015

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:

The policy in relation to the recruitment of staff was not fully implemented in practice.

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:

We have reviewed our Staff Recruitment and Selection Policy (Completed 22nd April 2015)

Following this review an update of the Policy and Guidelines have been drafted and shall be further reviewed and finalised at the next scheduled Management & Governance Meeting scheduled for 12th June 2015

The Administrator continues to work closely with the Person in Charge, the Management & Governance Team and the Registered Provider to ensure that all policies and procedures are adopted and implemented as per Centres PPGs and as per Regulatory requirements and Standards.

Proposed Timescale: 31/08/2015

Theme:

Governance, Leadership and Management

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

Complete documentation as outlined in Schedule 2 in relation to staff was not in place.

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:

The 2 staff files found not to have 2 references in place on the days of the inspection now have the required references in place.

A full audit of all staffs HR File shall be completed against the Regulations Regulation 21(1) & Schedule 2, 3 and 4 [Audit] (to be completed 31st May 2015 & will continue monthly until all staffs' files are complete as per Schedule 2 requirements)

Where a current employee's HR file fails to meet the regulatory Standard 21(1) Schedule 2, and the employee has not obtained or does not have a valid certification for mandatory training the employee shall not be rostered for duty until such a time that all certifications and requirements are in place.

In the case of 2 employees who are currently on long term sick leave, prior to their return to work, they shall be required to complete all outstanding mandatory training.

Proposed Timescale: 30/06/2015

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:

Chemical restraint was not managed in line with best practice.

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:

On the day of the inspection 1 resident had a prescribed medication order which was a "chemical restraint".

Following the inspection this medication order was reviewed on 6th April 2015, and the medication ordered was discontinued by the resident's GP.

There are currently no residents prescribed Chemical restraint in the Home.

Proposed Timescale: 07/04/2015

Theme:

Safe care and support

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

Not all staff were training in the detection, prevention of and responses of abuse.

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:

4 members of staff that did not have current Elder Abuse training at the time of the inspection.

2 of these staff members are on long term sick leave.

The other 2 staff members were sick in March 2015 when the training was completed.

The 2 working staff members have completed Elder Abuse training (20th May 2015)

In the case of 2 employees who are currently on long term sick leave, prior to their return to work, they shall be required to complete all outstanding mandatory training.

There are now 2 X TTT Elder Abuse trainers on the staff.

Going forward all staff shall be appropriately trained in the following "Elder Abuse: Prevention, Recognising, Responding to and Reporting"

- 1) During their induction if a new employee (Reviewed and updated Staff Recruitment and selection Policy). (12th June 2015) or
- 2) Within 1 year from the date when they last completed the mandatory training. (ongoing)

Proposed Timescale: 12/06/2015

Theme:

Safe care and support

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

Recorded incidents of peer to peer assault, had not been investigated by the person in charge.

Action Required:

Under Regulation 08(3) you are required to: Investigate any incident or allegation of abuse.

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

The incidents of peer to peer abuse that occurred in February 2015, i.e. Peer to Peer Abuse have subsequently been investigated.

The new Person in Charge has been in post since 4th March 2015.

She is fully aware of the requirements regarding the investigation of any incident or allegation of Elder Abuse.

The new Person in Charge is fully aware that it would be unacceptable not to investigate an incident or allegation of Elder Abuse.

The failure to investigate any incident or allegation of Elder Abuse shall not happen again. (ongoing)

Proposed Timescale: 01/04/2015

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:

Not all staff had completed training in Fire safety.

Action Required:

Under Regulation 28(1)(d) you are required to: Make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes,

location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.

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

Annual Fire Training including fire prevention, safety & risk, use of equipment (instructional and practical), evacuation protocol and evacuation drill is due for all staff for 2015.

Dates for this training for all staff, full time, part time and relief/bank will commence week commencing 15th June 2015.

There will be 2 sessions whereby all staff will be required to attend the training. Any staff member that is unable to attend these sessions will receive one on one instruction and training from the Centre's safety officer.

The Centre continues to have weekly fire alarm activation and all staff on duty as required to respond to this activation.

Following this activation, the PIC or her deputy speaks with all staff present on a specific topic relating to "Fire prevention and emergency procedures" (Ongoing)

Analysis of these tests, drills and training will be reviewed on a monthly basis and will be on the agenda at the Management & Governance meeting. (Ongoing)

Proposed Timescale: 30/06/2015

Outcome 10: Notification of Incidents

Theme:

Safe care and support

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

A notification had not been submitted to the Chief Inspector as required.

Action Required:

Under Regulation 31(1) you are required to: Give notice to the chief inspector in writing of the occurrence of any incident set out in paragraphs 7(1)(a) to (j) of Schedule 4 within 3 working days of its occurrence.

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

The new Person in Charge has been in post since 4th March 2015.

She is fully aware of the requirements regarding Notifiable Events within 3 working days of its occurrence.

We have a policy in place as part of our Governance & Management Policies, which describes internal and External Communication Requirements, including Notifiable Events to HIQA.

The new Person in Charge is fully aware that it would be unacceptable to fail to report

a Notification of any incident set out in paragraphs 7(1)(a) to (j) of Schedule 4 within 3 working days of its occurrence.

The failure to notify the inspectorate of any Notifiable Event as set out in paragraphs 7(1) (a) to (j) of Schedule 4 within 3 working days of its occurrence shall not happen again. (ongoing)

Proposed Timescale: 01/04/2015

Outcome 12: Safe and Suitable Premises

Theme:

Effective care and support

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

Two twin bedrooms did not have sufficient space to meet the needs of residents.

Action Required:

Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

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

Plans have previously been submitted to the Inspectorate for the proposed extension to both twin rooms by a minimum of 2 meters squared usable floor space (excluding ensuite facilities). When completed each of the two twin bedrooms will have a minimum of 7.4 meters squared per resident.

The two twin rooms are now unoccupied (Completed 7th May 2015)

The plan for the extension work to be carried out to both twin rooms has gone out to tender. (Completed 30th April 2015)

We shall keep the inspectorate informed of the outcome of the tender (TBC decision to be finalised by 30th June 2015)

The timeframe for completion of the extension project will be notified to the Inspectorate as soon as the contract has been agreed with the successful contractor.(TBC)

The two twin bedrooms shall not be occupied until the required extension work to accommodate in each room: "2 residents, with the minimum 7.4 metres squared usable floor space per resident" has been completed. (4 beds shall remain unoccupied until such time that extension work is completed) (Ongoing)

Proposed Timescale: 30/09/2015

Outcome 16: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

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

The provision of meaningful activities for residents was not consistent.

Action Required:

Under Regulation 09(2)(b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests and capacities.

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

The development of appropriate activities for all our residents is our priority.

All residents have had a PAL assessment completed (31st March 2015)

We have reviewed our existing activity program. (Completed 8th May 2015)

A number of our existing available activities have been modified to meet the needs of our residents, e.g.

The company facilitating the weekly "resident group programme" have been rescheduled to the morning from 1120-1220 for this activity.

The fortnightly Physiotherapist MDT sessions are now scheduled from 1000-1300.

These changes to the time for these activities have enhanced the level of participation and enjoyment for our residents. More of our residents are actively engaging positively in these activities.

We have established a working group, facilitated by a Fetac Level 6 Activities student. The members of this group include 4 residents, a HCA, and a Registered Nurse. (completed 8th May 2015)

A full review of the activities programme shall be carried out to identify areas for improvement.

This shall include a review of resident's preferences and will be cognisant of the needs and abilities of the residents. We shall further develop our activities program in line with the needs of our residents.

The outcome will be a new activities program that provides opportunities for each resident to participate in activities appropriate to his/her interests and capacities. (30th June 2015)

Following the new proposed activities program, a number of activities will be trialled and observational assessment of activities will be executed to support the development of a comprehensive, appropriate programme that will best suit the residents in our home. (31st July 2015)

A new policy and procedure on developing and managing the activities programme shall be developed. (30th June 2015)

The activities programme will be reviewed and updated on a quarterly basis by the Director of Nursing. (Ongoing)

Proposed Timescale: 31/07/2015

Outcome 18: Suitable Staffing

Theme:

Workforce

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

Not all staff had accessed training in Manual Handling.

Action Required:

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

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

The 2 members of staff that did access the Manual Handling Training are scheduled to complete this training on Wednesday 27th May 2015. (27th May 2015)

If either staff member does not complete the scheduled training he/she shall not be rostered until such time as they are certified as having attended this training. (27th May 2015)

Going forward all staff shall require an up to date certification on manual handling prior to the expiry of their existing certification (Ongoing)

The training schedule will allow for and facilitate all staff to have access to all mandatory training in advance of their current certification expiring. (Ongoing)

Proposed Timescale: 27/05/2015