<table>
<thead>
<tr>
<th>Centre name:</th>
<th>College View Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000128</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Clones Road, Cavan.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>049 437 2929</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:collegeviewnursinghome@eircom.net">collegeviewnursinghome@eircom.net</a></td>
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<tr>
<td>Type of centre:</td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>College View Limited</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Thérése McGarvey</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>PJ Wynne</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>None</td>
</tr>
<tr>
<td>Type of inspection:</td>
<td>Unannounced</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>67</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
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About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.
Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, 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 monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times
From: 24 November 2015 09:00  To: 24 November 2015 17:00
26 November 2015 09:15  26 November 2015 14:30

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

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Our Judgment</th>
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<tbody>
<tr>
<td>Outcome 01: Statement of Purpose</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 02: Governance and Management</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 03: Information for residents</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 04: Suitable Person in Charge</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 05: Documentation to be kept at a designated centre</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 06: Absence of the Person in charge</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 07: Safeguarding and Safety</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 08: Health and Safety and Risk Management</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 09: Medication Management</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 11: Health and Social Care Needs</td>
<td>Non Compliant - Moderate</td>
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<tr>
<td>Outcome 13: Complaints procedures</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 14: End of Life Care</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 15: Food and Nutrition</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 18: Suitable Staffing</td>
<td>Substantially Compliant</td>
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</table>

Summary of findings from this inspection
This report set out the findings of an unannounced monitoring inspection. This inspection took place over two days. The inspector reviewed progress on the action plan from the previous inspection carried out in September 2014. Notifications of incidents received since the last inspection was also considered and reviewed on this visit.

The physical environment meets the needs of residents. The centre was clean, warm and well decorated with a calm atmosphere. Residents were complimentary of staff and satisfied with care services provided. The inspector found that residents were receiving responsive healthcare that met their assessed needs. The staff supported residents to maintain their independence where possible.
The inspector found there was an adequate complement of nursing and care staff with the proper skills and experience at the time of this inspection. Staff had access to ongoing education and a range of training was provided during the past year.

A total of 14 Outcomes were inspected. The inspector judged two Outcomes as moderately non compliant. These included Health, Safety and Risk Management and Health and Social Care Needs. Seven Outcomes were judged as compliant with the Regulations and a further five as substantially in compliance with the Regulations.

The areas of moderate non compliance primarily related to;

The cleaning system in place required review to break the cycle of infection and minimise the risk of cross contamination.

The care planning system requires review to improve linkage between assessments completed, care plans developed and reviews undertaken. Further work is required to develop care plans that are more person-centred and individualised.

The action plan at the end of this report identifies these and other areas where improvements must be made to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (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):**
No actions were required from the previous inspection.

**Findings:**
The Statement of Purpose was updated following registration and contained the conditions of registration and expiry date.

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

**Judgment:**
Compliant

### Outcome 02: Governance and Management

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

**Theme:**
Governance, Leadership and Management

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

**Findings:**
There was a defined management structure to ensure the effective delivery of care in accordance with the Statement of Purpose. The management system in place is suitable to ensure the service provided is safe, appropriate, consistent and effectively monitored.
There was evidence of quality improvement strategies and monitoring of the services. The inspector reviewed audits completed by the person in charge. A comprehensive audit of falls by residents was undertaken. The information collected was utilised to identify trends or patterns of risk. Changes were made accordingly. Three senior alarm mats were in place for resident identified as a high risk of falling.

However, the audit program requires expansion to ensure a defined set of criteria are reviewed regularly and systemically. The last audit of psychotropic medication and night sedation was 2013. An audit of residents’ weight was undertaken. However, the audit objective was not clearly defined. The data was only reviewed only a short time frame and was not qualitative to inform an evidence based judgement. An audit to identify the number of residents with a raised bedrail was not completed.

On the second day of inspection the person in charge had reviewed data and was able to provide details to the inspector on each of the aforementioned areas.

A quality of life and safety of care questionnaires was sent to all families and the information received reviewed and compiled to form a report. However, an annual report on the quality and safety of care was not compiled reviewing and providing information on all aspects of the service provision for the previous year.

Judgment:
Substantially Compliant

**Outcome 03: Information for residents**

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

Theme:
Governance, Leadership and Management

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

Findings:
The inspector found that all residents had an agreed written contract. The contract of care was revised as this was an area identified for improvement on the last inspection.

The cost of additional expenses incurred by residents was set out in the revised contract of care. This identified charges payable per items not included in the overall fee.

The Residents’ Guide was reviewed to correctly detail the name of the registered provider.

Judgment:
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 is a registered nurse and is noted on the roster as working in the post full-time. She was knowledgeable of residents care needs. She could describe in an informed way where residents had specific needs and how staff ensured that their care needs were met appropriately.

She has maintained her professional development and attended mandatory training required by the Regulations.

She has maintained her clinical skill up to date. Since the last inspection she has attended courses in specialist palliative care.

There is dedicated time allocated to manage the clinical governance and administration duties required by the post of person in charge.

Judgment:
Compliant

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

Theme:
Governance, Leadership and Management

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

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

Written operational policies, which were centre specific, were in place to inform practice and provide guidance to staff. Policies identified for improvement on the previous visit were in place and contained procedures to guide staff action and interventions.

A sample of five staff files were examined to assess the documentation available, in respect of persons employed. All the information required by Schedule 2 of the Regulations was available in the staff files reviewed. The provider had applied and was awaiting the outcome of Garda Siochana vetting for the two most recently recruited staff.

A directory of residents was maintained update. The inspector noted the details of the most recent admission were recorded in the directory.

Judgment:
Compliant

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

Theme:
Governance, Leadership and Management

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

Findings:
On the last inspection the deputising arrangement in the absence of the person in charge were not sufficiently robust.

Formalised arrangements to deputise for the person in charge were put in place. A key senior manager was notified to the Authority as required by the Regulations.

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

**Findings:**
The policy on adult protection was available. Protected disclosure procedures to guide staff in their reporting of a suspicion of abuse were documented in the policy. Residents spoken with stated that they felt safe in the centre. There was a visitors log in place.

No notifiable adult protection incidents which are a statutory reporting requirement to the Authority have been reported since the last inspection.

Staff spoken with were able to inform the inspector of what constituted abuse and of their duty to report any suspected or alleged instances of abuse. Staff identified a senior manager as the person to whom they would report a suspected concern. The inspector viewed records confirming there was an ongoing program of refresher training in protection of vulnerable adults.

There is a policy on the management of behaviour that is challenging. Staff spoken with were very familiar with resident’s behaviours and could describe particular residents’ daily routines very well to the inspector. The majority of nursing staff had completed training on caring for older people with cognitive impairment or dementia. However, all care assistants had not completed training in this area.

The financial controls in place to ensure the safeguarding of residents’ finances were examined by the inspector. There was a policy outlining procedures to guide staff on the management of residents’ personal property and possessions. An accountable system was in place for the management of money collected by the provider on behalf of residents and money was lodged into a sub account of the centre’s business account. The contract of care specified the arrangements for the payment or refund of money owed to the resident. An annual financial statement was provided to residents or their next of kin.

There was a policy on restraint management (the use of bedrails and lap belts) in place. Signed consent was obtained by the resident or their representative. A risk assessment was completed prior to using bedrails and regularly reviewed. However, the risk assessment tool used only took cognisance of a very limited range of issues. Risks from challenging behaviour, intermittent confusion or medical conditions were not explored in the assessment tool utilised. There was limited evidence of exploring alternative options and why alternatives trialled were unsuccessful.

**Judgment:**
**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 governance arrangements to manage risk situations were specified. The risk management policy contained the procedures required by the regulation 26 and schedule 5 to guide staff. Responsibility for health and safety procedures and an organisational safety structure was included in the risk management policy and health and safety statement.

Fire safety equipment including the fire alarm, fire fighting equipment, emergency lighting and smoke detectors were provided and were serviced annually. Illuminated fire exit signage was in place. Action notices detailing the procedures to take in the event of discovering a fire or on hearing the alarm were displayed. Escape route plans were displayed on corridors to show the nearest escape route.

There was a fire safety policy in place. This detailed the evacuation procedures for the service to include partial or full evacuation. Personal emergency evacuation plans require review to accurately reflect residents’ assessed needs. A risk assessment to identify the most appropriate aids suitable to residents capability to assist them safely evacuate in a timely manner both during the day and at night while resting in bed were not developed.

There was an ongoing program of refresher training in fire safety evacuation. Records indicated fire drill practices were completed. However, the fire drill records did not record the time taken for staff to respond to the alarm. The drills did not record the scenario/type of simulated practice. There was no documented evaluation of learning from fire drills completed to help staff understand what worked well or identify any improvements required.

The building, bedrooms and bathrooms were visually clean. A sufficient number of cleaning staff were rostered each day of the week. The cleaning system in place required review to break the cycle of infection and minimise the risk of cross contamination. Colour coded cleaning equipment and cloths were provided to clean bedrooms and communal areas. However, cleaning cloths were not changed at frequent intervals between cleaning each bedroom by all staff. There was variation in practice amongst staff. Mops to clean separate areas were stored together in direct contact on
the cleaning trolley posing a risk of possible cross infection.

There were arrangements in place for recording and investigating untoward incidents and accidents. The inspector noted that falls and near misses were well described. In the sample of accident report forms reviewed vital signs for residents were checked and recorded. Neurological observations were recorded where a resident sustained an unwitnessed fall or a suspected head injury.

The training records showed that staff had up-to-date refresher training in moving and handling. There was sufficient moving and handling equipment available to staff to meet residents’ needs. However, a validated evidenced based tool was not used to risk assess each resident moving and handling needs.

Hand testing indicate the temperatures of radiators or dispensing hot water did not pose a risk of burns or scalds. Restrictors were fitted to windows. Access to work service areas to include the kitchen and sluice room was secured in the interest of safety to residents and visitors.

Judgment:
Non Compliant - Moderate

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**Outcome 09: Medication Management**

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

**Theme:**
Safe care and support

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

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

Each resident’s medication was dispensed from individual packs. The drugs on arrival are checked against the prescription sheets in the signed kardex to ensure all medication orders received were correct for each resident.

The inspector reviewed a sample of drugs charts. Photographic identification was available on the drugs chart for each resident to ensure the correct identity of the resident receiving the medication. The prescription sheets reviewed were not clearly legible in all cases. On one kardex a lot of medication was signed as discontinued. A faint line was crossed through each prescribed drug. However, it was difficult to decipher in some instances. Some prescription sheets require rewriting to reduce the risk of medication error.
The medication administration sheets viewed were signed by the nurse following administration of medication to the resident and recorded the name of the drug and time of administration. The drugs were administered within the prescribed timeframes. There was space to record when a medication was refused on the administration sheet.

Drugs were being routinely crushed for some resident at the time of this inspection. While medication was prescribed as suitable for crushing in a generic statement at the top of the kardex each drug was not individually prescribed as suitable for crushing.

Medications that required strict control measures were kept in a secure cabinet which was double locked in keeping with the Misuse of Drugs (Safe Custody) Regulations. Nurses kept a register of controlled drugs. Controlled drugs were checked by two nurses at the change of each shift. Seven resident were administered a controlled drug. The inspector checked a selection of the balances and found them to be correct.

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):

Findings:
There were 67 residents in the centre during the inspection and three in hospital. There were 22 residents with maximum care needs. Twenty residents were assessed as highly dependent and 20 had medium dependency care needs. Many residents were noted to have a range of healthcare issues and the majority had more than one medical condition.

The inspector reviewed five resident’s care plans in detail and certain aspects within other plans of care. In the sample of care plans reviewed there was evidence care plans were in place for each identified need On admission a comprehensive assessment of needs was completed. Care plans were updated at the required intervals or in a timely manner in response to a change in a resident’s health condition. There was evidence of consultation with residents or their representative in care plans.
However, there was poor linkage between assessments completed, care plans developed and reviews undertaken. The majority of the information to guide care interventions was outlined in the nursing notes. These were periodically files away and not readily accessible to guide care intervention and provide details the overall situation being managed. The care plan reviews were repetitive and outlined the same detail on each review. In one file the same review note was outlined for each review for a three year period.

An overall conclusion or professional judgment of the care pathway being followed was not indicated in the evaluation column of care plan documentation. An evaluation was not documented to highlight changes or a professional judgment to the plan of care outlined.

There was a good emphasis on personal care and ensuring personal wishes and needs were met. However, further work is required to develop care plans that are more person-centred and individualised. As an example, care plans for residents with dementia, anxiety or behaviours that challenge required review to ensure they are more person centred. Many were generic and contained similar information. Care plans for residents with dementia did not identify where the resident is on their dementia journey. Information such as who the resident still recognised or what activities could still be undertaken to guide staff practice was not evident in the care plans.

Residents had access to general practitioner (GP) services. There was good evidence of medical reviews shortly after admission and when a resident became unwell. Access to allied health professionals to include speech and language therapist and dietetic service.

Where residents had specialist care needs such as mental health problems there was evidence in medical files of good links with the mental health services. The consultant psychiatrist and their team visit the centre as required to review residents. Medication was reviewed to ensure optimum therapeutic values.

There were three residents with pressure or vascular wounds at the time of this inspection. The inspector reviewed the care plan for two residents. A plan of care was in place and regularly updated to take account of reviews by a clinical nurse specialist in wound management.

A number of residents were provided with air mattresses. Care staff completed repositioning charts for residents with poor skin integrity.

Activity coordinators were employed each day of the week. However, the deployment of activity staff requires review. There was limited sensory stimulation for residents throughout the days of inspection in the smaller day sitting room.

**Judgment:**
Non Compliant - Moderate

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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

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

Findings:
The complaints policy and procedure were reviewed. This was an area identified for improvement in the action plan of the previous inspection report.

The person in charge explained issues of concern are addressed immediately at local level without recourse to the formal complaints procedure, unless the complainant wishes otherwise.

The complaints procedure was displayed in the entrance foyer for visitors to view. This provided direction where a person could raise an issue with if they had a concern.

The complaints procedure displayed met the requirement of Regulation 34. However, the complaints procedure displayed in the sample of bedrooms visited was not updated to reflect the revised policy.

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

Judgment:
Substantially Compliant

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

Theme:
Person-centred care and support

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

Findings:
There was an end-of-life care policy detailing procedures to guide staff. The policy of the centre is all residents are for resuscitation unless documented otherwise. A multi disciplinary approach was undertaken to include the resident where possible, their representative, the GP and the nursing team. Residents with a do not resuscitate (DNR)
status in place have the DNR status regularly reviewed to assess the validity of clinical the judgement on an ongoing basis. This was an area identified for improvement in the action plan of the last inspection.

The majority of staff had completed end-of-life training during 2014.

**Judgment:**  
Compliant

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

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

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

**Findings:**  
The inspector reviewed the menu and discussed options available to residents. There were nutritious snack options available between meals to ensure sufficient or optimum calorific intake particularly those for those on fortified diets. A trolley served residents mid morning and afternoon offering a choice of tea/coffee fruit, buns and biscuits.

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

Residents had care plans for nutrition in place. There was prompt access to allied health professionals for residents who were identified as being at risk of poor nutrition. There was ongoing monitoring of residents nutrition and skin integrity. Nutritional screening was carried out using an evidence-based screening tool at monthly intervals. Each need had a corresponding care plan.

All residents were weighed regularly. Food intake records were well completed where a need was identified. Fluid charts were maintained for 15 residents at the time of this inspection. Fluid charts were totalled to ensure a daily fluid goal was achieved.

**Judgment:**  
Compliant

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**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 judged there was an adequate complement of nursing and care staff with the proper skills and experience to meet the assessed needs of residents at the time of this inspection taking account of the purpose and size of the designated centre.

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

Information available conveyed that staff had access to ongoing education and a range of training was provided. The inspector found that in addition to mandatory training required by the regulations staff had attended training on cardio pulmonary resuscitation, infection control and food hygiene. The majority of nursing staff had completed training on caring for older people with cognitive impairment or dementia. However, all care assistants had not completed training in this area.

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:
PJ Wynne
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report¹

<table>
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<th>College View Nursing Home</th>
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<tbody>
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<td>Centre ID:</td>
<td>OSV-0000128</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>24/11/2015 and 26/11/2015</td>
</tr>
<tr>
<td>Date of response:</td>
<td>26/01/2016</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:
The audit program requires expansion to ensure a defined set of criteria are reviewed regularly and systematically.

1. 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

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:
We currently have audits in place but will expand on them and systematically review them

Proposed Timescale: 31/03/2016
Theme: Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
An annual report on the quality and safety of care was not compiled reviewing and providing information on all aspects of the service provision for the previous year.

2. 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 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:
To complete an annual report

Proposed Timescale: 29/02/2016

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

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risk assessment tool used only took cognisance of a very limited range of issues. Risks from challenging behaviour, intermittent confusion or medical conditions were not explored in the assessment tool utilised. There was limited evidence of exploring alternative options and why alternatives trialled were unsuccessful.

3. 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:
Review the audit tool to ensure it meets the requirements and explore alternative options documenting same.
Proposed Timescale: 31/03/2016

**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:**
A validated evidenced based tool was not used to risk assess each resident moving and handling needs.

4. **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 validated evidence based tool has been sourced and will be implemented

Proposed Timescale: 26/01/2016

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The cleaning system in place required review to break the cycle of infection and minimise the risk of cross contamination. Cleaning cloths were not changed at frequent intervals between cleaning each bedroom by all staff. Mops to clean separate areas were stored together in direct contact on the cleaning trolley posing a risk of possible cross infection.

5. **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 cleaning system in place has been reviewed and all housekeeping staff are made aware

Proposed Timescale: 26/01/2016

**Theme:**
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Personal emergency evacuation plans require review to accurately reflect residents’ assessed needs.

6. Action Required:
Under Regulation 28(2)(iv) you are required to: Make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and safe placement of residents.

Please state the actions you have taken or are planning to take:
PEEPS have been reviewed and accurately reflect residents’ assessed needs

Proposed Timescale: 26/01/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The fire drill records did not record the time taken for staff to respond to the alarm. The drills did not record the scenario/type of simulated practice. There was no documented evaluation of learning from fire drills completed to help staff understand what worked well or identify any improvements required.

7. Action Required:
Under Regulation 28(1)(e) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and residents are aware of the procedure to be followed in the case of fire.

Please state the actions you have taken or are planning to take:
All Staff complete a ‘Self Reflection’ following training to identify their own needs. Fire Drill records will include the above information.

Proposed Timescale: 26/01/2016

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:
The prescription sheets reviewed were not clearly legible in all cases. On one kardex a
lot of medication was signed as discontinued. A faint line was crossed through each prescribed drug. However, it was difficult to decipher in some instances.

8. **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 Staff Nurses aware of the requirements in Medication Management. There are some difficulties with GP’s writing which have been addressed with the relevant GP.

**Proposed Timescale:** 26/01/2016

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
While medication was prescribed as suitable for crushing in a generic statement at the top of the kardex each drug was not individually prescribed as suitable for crushing.

9. **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:**
Each drug will be individually prescribed as suitable for crushing

**Proposed Timescale:** 26/01/2016

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

**Theme:**
Effective care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There was poor linkage between assessments completed, care plans developed and reviews. The care plan reviews were repetitive and outlined the same detail on each review. An evaluation was not documented to highlight changes or a professional judgment to the plan of care outlined.

10. **Action Required:**
Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident’s family.

Please state the actions you have taken or are planning to take:
All Staff Nurses made aware of the care plan development and review requirements.
Additional training planned in February 2016

Proposed Timescale: 31/03/2016
Theme: Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Further work is required to develop care plans that are more person-centred and individualised. Care plans for residents with dementia, anxiety or behaviours that challenge required review to ensure they are more person centred. Many were generic and contained similar information. Care plans for residents with dementia did not identify where the resident is on their dementia journey.

11. 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:
Additional care planning training planned for February 2016

Proposed Timescale: 31/03/2016
Theme: Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The deployment of activity staff requires review. There was limited sensory stimulation for residents throughout the days of inspection in the smaller day sitting room.

12. 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:
We currently have 2 Activity staff employed who have a range of activities to suit the individual needs of the residents
The activities program has been reviewed and discussed with the activity staff
**Outcome 13: Complaints procedures**

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

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The complaints procedure displayed in the sample of bedrooms visited was not updated to reflect the revised policy.

13. **Action Required:**
Under Regulation 34(1)(a) you are required to: Make each resident and his/her family aware of the complaints procedure as soon as is practicable after the admission of the resident to the designated centre.

*Please state the actions you have taken or are planning to take:*
All bedrooms have an updated revised policy

**Proposed Timescale:** 26/01/2016

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**Outcome 18: Suitable Staffing**

**Theme:**
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
All care assistants had not completed training on caring for older people with cognitive impairment or dementia.

14. **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:*
Training is on-going for all staff. Staff who are employed have completed care of the Older person module which includes caring for residents with cognitive impairment and dementia. Refresher training will be provided for staff

**Proposed Timescale:** 31/03/2016