Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	Amberley Home and Retirement Cottages
Centre ID:	OSV-0000189
Centre address:	Acres, Fermoy, Cork.
Telephone number:	025 40 900
Email address:	info@amberleyhome.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Amber Health Care Limited
Provider Nominee:	Liam Fitzgerald
Lead inspector:	Caroline Connelly
Support inspector(s):	John Greaney
Type of inspection	Unannounced
Number of residents on the date of inspection:	69
Number of vacancies on the date of inspection:	1

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:	To:
20 January 2016 09:00	20 January 2016 19:00
21 January 2016 09:20	21 January 2016 16:00

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

Outcome	Our Judgment
Outcome 02: Governance and Management	Non Compliant - Moderate
Outcome 04: Suitable Person in Charge	Compliant
Outcome 07: Safeguarding and Safety	Non Compliant - Moderate
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 09: Medication Management	Non Compliant - Moderate
Outcome 10: Notification of Incidents	Non Compliant - Moderate
Outcome 11: Health and Social Care Needs	Non Compliant - Major
Outcome 12: Safe and Suitable Premises	Compliant
Outcome 13: Complaints procedures	Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Compliant
Outcome 18: Suitable Staffing	Non Compliant - Moderate

Summary of findings from this inspection

This report sets out the findings of an unannounced monitoring inspection that took place over two days. This was the ninth inspection of Amberley Nursing Home by the Health Information and Quality Authority's Regulation Directorate.

As part of the inspection the inspectors met with residents, relatives, the provider, the person in charge, the general manager, two new CNM's, nurses, care staff, administration staff, and numerous other staff members. The inspectors observed practices and reviewed documentation such as care plans, governance reports, complaints log, accident and incident logs, policies and procedures and staff files. During the inspection the inspectors were informed that the person in charge had resigned from her post and was due to finish in the centre later in the week. The authority had not received notification in relation to this.

The inspectors saw many families visiting during the inspection and there were

photos of events which involved relatives such as garden and Christmas parties. The inspectors spoke to a number of residents and relatives during the inspection and reviewed feedback received by the centre via the resident/relative survey. They found that feedback was generally positive and satisfaction was expressed about the facilities, services and care provided. However there were some concerns expressed in relation to staffing levels which will be discussed further in the report. Residents' comments are found throughout the report.

Overall, the findings of this inspection indicated that residents' health and social care needs were generally addressed in pleasant and comfortable surroundings. The centre was clean, suitably decorated, had sufficient communal space including two enclosed outdoor areas. The centre had a nine bedded dementia specific unit which had been decorated and enhanced appropriately since the last inspection.

Issues identified and actions required at the previous inspection were looked into during the inspection and the inspectors were satisfied that these had been addressed however they were not all rectified. There were a number of issues that required action identified on this inspection in relation to governance, notifications, medication management, assessment, care planning, staffing and the system for reviewing and improving the quality and safety of care. These improvements are required to comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland. The provider was required to complete an action plan to address these areas:

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

Findings:
The inspectors found that there was a clearly defined management structure which outlined the lines of authority and accountability for the centre. Housekeeping staff, care assistants, administration staff, staff nurses and the clinical nurse managers (CNM) reported to the person in charge, who in turn reported to the provider. The person in charge reported to the provider through structured weekly meetings and the provider was also available in the centre on a regular basis for informal consultation.

The weekly management meetings were also attended by the general manager, clinical nurse managers and key senior management. All areas of the running of the centre were discussed and included issues such as accidents and incidents, staffing levels, ongoing maintenance and budgetary matters.

There were two new CNM's appointed in January in addition to a CNM who had been in the centre for a number of years who had responsibility for specific units of the centre. There was always a CNM on duty at the weekend therefore providing managerial cover seven days per week.

Since the last inspection the person in charge had implemented a further system of audit. The audit process included consultation with residents and relatives through residents' and relatives' forums. These will be discussed in more detail in Outcome 17 of this report. Audits had been carried out on issues such as health and safety, medication management and residents' care plans, wound care, however, a number of improvements were required. For example, where an audit identified required improvements, there was not always an associated action plan specifying the person responsible and time lines for completion. Additionally, the audit process was not sufficiently comprehensive to monitor the quality and safety of care in the centre on an

ongoing basis. This is supported by the findings of this inspection that identified deficits in a number of areas including medication management, risk management, and assessment and care planning, all of which will be discussed in further detail under the relevant outcomes of this report.

The inspectors also found that there was no 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.

Judgment:
Non Compliant - Moderate

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 inspectors interacted with the current person in charge throughout the inspection process. There was evidence that the person in charge was engaged in the governance, operational management and administration of the centre on a day-to-day basis. Inspectors were satisfied that she was a registered nurse, was suitably qualified and had a minimum of three years experience in nursing of the older person within the previous six years, as required by the regulations.

During the inspection the inspectors were informed that the person in charge was leaving the centre to take up another post in a number of days. The provider informed the inspector that they were in the process of appointing a new person in charge who would be taking up post in a number of weeks. This will be the centres fifth person in charge since the Authority undertook its first inspection of the centre in 2009 and the inspectors expressed concern in relation to the ongoing changes to person in charge.

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:
Inspectors were satisfied with the measures in place to safeguard residents and protect them from abuse. Inspectors reviewed the centre's policy on suspected or actual abuse which had an implementation date of 2013 and was reviewed in January 2015. Inspectors reviewed staff training records and saw evidence that staff had received up to date mandatory training on detection and prevention of elder abuse. Staff interviewed were familiar with the policy and knew what to do in the event of an allegation, suspicion or disclosure of abuse, including who to report incidents to.

Inspectors reviewed the systems in place to safeguard resident's finances which included a review of a sample of records and were satisfied that adequate records were maintained, including where the provider acted as an agent for residents' pensions and for safeguarding valuables and money. The centre maintained day to day expenses for a number of residents and inspectors saw evidence that complete financial records were maintained. Each financial transaction which involved the receipt or return of monies was signed by the resident and was countersigned by two staff. Inspectors were satisfied that the system in place to safeguard residents' finances was transparent.

A policy on managing responsive behaviours was in place. Efforts were made to identify and alleviate the underlying causes of behaviour that posed a challenge. The support of the community psychiatry service was availed of as appropriate to residents needs. The records of a resident who presented with responsive behaviours were reviewed by the inspectors who found there was not a care plan in place to direct care for management of such behaviours and to ensure consistency of approach. This will be discussed further under outcome 11.

Inspectors reviewed the practices in place in relation to restraint and found that there were good assessments and ongoing regular checks on residents who were using bed rails and lap-belts. However the staff were inappropriately classing the use of a number of bed-rails for residents who were unable to release then, as enablers and not as restraints. The inspectors saw that alternatives to restraint were in place such as low beds, alarm and sensor mats and efforts were in place to reduce restraint usage.

Judgment:
Non Compliant - Moderate

Outcome 08: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Safe care and support

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

Findings:
The centre had policies and procedures relating to health and safety. There was an up-to-date safety statement. There was a risk management policy and associated risk register that addressed risks such as aggression and violence, accidents and injuries to residents and staff, and self harm. The policy was updated since the last inspection to adequately address all of the items listed in the regulations including the risk of abuse, the unexplained absence of a resident, and it set out the arrangements that were in place for investigating and learning from serious incidents/adverse events involving residents.

The person in charge informed the inspectors that accidents and incidents were reviewed on an on-going basis and were discussed at management meetings and staff meetings. There was some documentary evidence of the evaluation of incidents to identify trends for safety, learning and quality improvement purposes however this could be developed further.

There was an emergency plan that addressed emergencies such as fire, loss of power, loss of water, loss of laundry facilities and also provided for the safe placement of residents in the event of a prolonged evacuation and this was found to be comprehensive.

There was a policy in place for the prevention and control of infection and staff members were observed to comply with best practice in relation to the use of personal protective equipment (aprons and gloves). Hand hygiene gel dispensers were located at suitable locations throughout the premises. On the previous inspection a number of issues were identified for improvement in relation to infection prevention and control. Bedpan washers were located in sluice rooms, which also contained taps and sinks for use by housekeeping staff. Inspectors were not satisfied that there was a suitable process in place to minimise the risk of cross contamination caused by the co-location of cleaning equipment and sluicing facilities in the one room. On this inspection the inspectors saw there had been a separation of these facilities with cleaners having their own separate room. However the inspectors saw a cleaning trolley that contained chemicals attached to the side left unsupervised on the corridor when cleaning staff were in a bedroom with the door closed. This was not safe practice in the storage of chemicals which allowed easy access to them by a resident with cognitive impairment.

There were reasonable measures in place to prevent other accidents in the centre, including safe floor covering, wide spacious corridors and handrails.

Suitable fire equipment was provided and there were records available indicating that

bedding and furnishings were fire safe. Records indicated that fire safety equipment, including emergency lighting and the fire alarm, were serviced at suitable intervals. Fire drills were held at least at six-monthly intervals and fire safety training was facilitated annually, however, there was not documentary evidence of learning from fire drills to ensure improvements in practices. Staff members spoken with were knowledgeable of the evacuation procedure in the event of a fire.

A small number of residents smoked and there was a process in place to supervise access to cigarettes and lighter/matches, however as identified on the previous inspections, improvements continued to be required. For example, the risk register indicated that all residents would be supervised while smoking, however, the care plan for one resident indicated that they could smoke unsupervised. Individual risk assessments had not been completed for all of the residents, including a system of on-going review, to identify the safe level of access to cigarettes and lighter/matches and the level of supervision required when smoking.

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

Findings:
There was a centre-specific up-to-date medication management policy detailing procedures for safe ordering, prescribing, storing and administration of medicines and handling and disposal of unused or out-of-date medicines. Nursing staff with whom the inspector spoke demonstrated best practice regarding administration of medicines. Photographic identification was in place for all residents as part of their prescription/drug administration record chart. Controlled drugs were maintained in line with best practice professional guidelines. Medication trolleys were securely maintained within the locked nurses' offices. A nurses' signature sheet was in place as described in professional guidelines.

Medication management audits were completed and these were evidenced during inspection last audit by the pharmacist August 2015. Medication reviews were completed at three monthly intervals and this was evidenced on residents' prescriptions. The pharmacist attended the centre on a regular basis to do a complete review of residents' medication management as well as education sessions with staff. The pharmacist also attended relative meetings and had commenced the process of meeting with the residents to discuss their individual medications.

Medications were delivered in single dose units and these were checked by nursing staff to verify that what was delivered corresponded with prescription records. Inspectors reviewed prescription and administration records and also observed nurses administering medications which were completed in accordance with best practice guidelines. Based on a sample of records reviewed, the inspectors saw that nurses were transcribing medications. However although the transcribing nurses name was on the chart it was not signed by the nurse or checked and countersigned by a second nurse as required by best practice guidelines. The medication policy also required review to reflect best practice in medication transcription.
The inspectors also identified that there were large stocks of paracetamol in the centre some of which were not in their original container therefore the expiry date was not know. On another large container of paracetamol there was a sticker over the expiry date which made it impossible to see the expiry date, these practices could lead to medication errors.

Judgment:
Non Compliant - Moderate

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:
A record of all incidents occurring in the centre was maintained and most notifiable events were notified to the Chief Inspector as required. However there were two incidents of pressure sores that were not notified within the correct time frame to the Authority.
As stated previously the person in charge had resigned and was due to leave the centre at the end of the week however the provider had not notified the authority of the proposed absence of the person in charge as required by legislation.

Judgment:
Non Compliant - Moderate

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

Findings:
There were a number of different General Practitioner (GP) practices providing a service to the residents and they visited on a regular basis. Residents' health status was reviewed regularly, at least every three months, by the GP including their medication. Full medical and nursing records were seen by inspectors, residents received regular checks of their weight, blood pressure and pulse.

Residents' additional healthcare needs were met. Physiotherapy services were available once a week. If additional physiotherapy is required this is paid for privately. The chiropodist visited regularly and saw all residents as required. Dietician, speech and language and tissue viability services were provided by professionals from a nutritional company who were also contactable by telephone for advice as required. All residents have regular nutritional screening and regular weight monitoring. All supplements were appropriately prescribed by a doctor.

Optical assessments were undertaken on residents in-house by an optician from an optical company. Audiology services were provided on a referral basis. Dental services were provided by a visiting dentist or by residents going out to visit their own dentist. Mental health services were provided by community psychiatric nurses who visited the centre. The inspectors were satisfied that facilities were in place so that each resident's well being and welfare was maintained by appropriate medical and allied health care. Residents, where possible, were encouraged to keep as independent as possible and inspectors observed residents moving freely around the corridors.

There was evidence of pre- admission assessments undertaken by the person in charge and residents generally had assessments completed on admission which included; dependency level, moving and handling, falls risk, pressure sore risk assessment, nutrition, and mental test score examination. These assessments were due to be repeated on a four- monthly basis or sooner if the residents' condition had required it. However the inspectors found that many of the assessments were not updated according to legislative time-lines and a number were very out of date.

The person in charge and staff demonstrated an in-depth knowledge of the residents and their physical, social and psychological needs. However this was not fully reflected in the care plans seen by the inspectors. Many of the care plans did not reflect personalised care administered to residents. Care plans were developed for some issues identified on assessment, however, some of these were generic and did not provide an adequate level of guidance on the care to be provided. There were a number of residents exhibiting responsive behaviours however this was not reflected in their care

plans and there were no plans to direct care for these residents. Likewise there were a number of residents who were at end of life and their care plans had not been updated to reflect these changes and there was not specific care plan set out to direct the care in relation to specific treatments required. The care planning system was the subject of audit and the inspectors identified as did the audit undertaken that there was little evidence of the assessments and care plans having been updated and agreed with residents and/or relatives as is required by legislation. These non compliances were also identified on the previous inspection and had not been rectified.

Wound care was also looked at by the inspectors who found that a number of improvements were required. There were a number of residents who had pressure sores in the centre and although there had been some scientific assessment of the wounds with photographs of same the reassessment was again found to be inconsistent so it was difficult to establish if the wound had improved or deteriorated. There was no staging of the wounds evident and no assessment by a tissue viability nurse. Training on wound care was limited and wound care plans were found not to be updated or specific to residents needs.

Judgment:
Non Compliant - Major

Outcome 12: Safe and Suitable Premises
The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:
Effective care and support

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

Findings:
Amberley Home was purpose built and provided adequate private accommodation and communal space for residents. Residents' accommodation comprised 62 single bedrooms and four twin bedrooms, all of which were en suite with shower, toilet and wash hand basin. The rooms were spacious, had adequate storage for personal property and possessions, and many were personalised with residents personal items. The centre was in a good state of repair and appeared to be clean throughout. Residents had access to two enclosed, well-maintained gardens containing a number of garden benches. There was a functioning call bell system throughout the centre.

The centre was subdivided into the East Wing, the West Wing and the Secure Unit. While the East Wing and West Wing were spacious with wide corridors throughout, enabling residents to move freely around the centre. On the previous inspection the

inspectors identified that sign age and visual cues required improvement to orient residents and to easily locate bedrooms, dining room and communal rooms. On this inspection improvements were seen particularly in the secure dementia unit when sign posts were painted on the walls along with other picturesque scenes. The Secure Unit comprised nine single bedrooms, a sitting room and a dining room. The secure unit had not been part of the original design and was created by sectioning off a portion of the centre and securing access with electronic locking mechanisms on the doors. Residents of the dementia unit had access to one of the secure garden areas. On the previous inspection a number of limitations were identified in the Secure Unit which the inspectors found had been address on this inspection. The unit now had its own nurses office which was now located so as to provide direct supervision of the residents, doors to the sitting room were held open by hold backs which were part of the fire system and closed when the fire alarm went off. The unit had been decorated with wall paintings adding colour and diversion including visual cues and landmarks to help orient residents. Access to the electronic care plans was now available in the unit. Although the management team had sourced a system for staff members who may be on their own, to alert other staff when assistance was required, the system wasn't currently operational and required replacement. Staff were currently alerting other staff through the nurse call system.

Records were available demonstrating the preventive maintenance of hoists, wheelchairs and beds, however, the records showed servicing of hoists only took place annual and not at six monthly intervals as required. The manager was to contact the manufacturers to establish servicing requirements.

Judgment:
Compliant

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

Theme:
Person-centred care and support

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

Findings:
Written operational policies and procedures were in place for the management of complaints. The complaints process was displayed in a prominent place in the foyer of the centre and residents were aware of it. Residents expressed confidence in the complaints process and stated they had no difficulty in speaking with staff and felt their concerns or queries would be dealt with.

The complaints log was examined and the nature and detail contained in the record complied with the requirements of regulations.

The inspectors saw that the actions required from the previous inspection had been completed and there was evidence that all complaints were followed up upon. The person in charge was the person nominated to deal with complaints and she maintained details of the complaint, the results of any investigations and the actions taken. An independent person was available if the complainant wished to appeal the outcome of the complaint.

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):

Findings:
There was evidence of consultation with residents through regular residents' meetings. Based on the records of the meeting held in January 2016, issues relevant to the day to day life of residents such as food, activities and religious services were discussed, and records indicated that issues raised were addressed or in the process of being addressed. Consultation with the families of residents was ongoing with regular meetings held. The last meeting was held in December 2015 which was attended by the person in charge, the CNMs, the pharmacist and staff. All aspects of the running of the centre and care was discussed.

There were adequate facilitates to allow residents to meet with visitors in private and there were no restrictions on visits. Residents' religious preferences were ascertained and facilitated. Residents had access to radio, television and newspapers and voting in local and national elections was facilitated.

The privacy and dignity of residents was respected during care provision and staff members were seen to interact with residents in a respectful manner. Staff were familiar with the various communication needs of residents, however, these were not always reflected in care plans. There was a programme of group activities including physiotherapy exercise classes, music, bingo and art. One to one activities were also facilitated.

Closed circuit television cameras (CCTV) were located at various locations throughout the premises, both internally on corridors and externally. There was sign-age in place

alerting residents and visitors to the use of CCTV cameras and there was a policy in place.

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

Findings:
Residents and relatives spoke positively of staff and indicated that staff were caring, responsive to their needs and treated them with respect and dignity. There had been changes to the management structures since the last inspection in that there is now a clinical nurse manager assigned to each of the three units in the centre. This is to ensure comprehensive management and full supervision of the staff. However two of the Clinical nurse managers were new and the person in charge was leaving so therefore this system will take time to be fully operational.

On the previous inspection the inspectors expressed concern in relation to nurse cover as there were three nurses on duty and each one was responsible for the care of residents in one of the three areas of the centre. However, the nurse responsible for the care of residents in the secure unit was also responsible for a number of residents in one of the other wings and was frequently not present in the unit. On this inspection the inspectors saw that this had been rectified and during the day there was a nurse and two care staff allocated to the secure unit who did not have to cover other units. However at night time there were two staff nurses and three healthcare assistants on duty in the centre with one of the healthcare assistants usually on her/his own in the secure unit. At the time of the inspection there was a resident in the secure unit who regularly did not sleep at night and was up and about, this resident was a high falls risk so required staff with her at all times. Relatives of other residents in the unit expressed concerns for the care of the other residents at night if the staff member could not leave the other resident. The person in charge told the inspector they were keeping this under review and had brought in extra staff on a couple of occasions including the previous night to cover. The inspectors required that staffing levels be kept under constant

review particularly in the evening night time as relatives also reported to the inspectors and it was identified on staff surveys that it was difficult to find staff in the evening and residents had to wait for staff. Relatives reported difficulty in getting in and out of the building particularly in the evening when they had to wait for staff to be around to let them in or out. Other findings from this inspection that support the inadequate staffing levels include the large number of residents' that were overdue reassessment and care plan reviews as outlined in outcome 11.

A review of a sample of personnel records indicated that the documents required by the regulations were present such as evidence of identity, vetting disclosure and relevant current registration. Improvements were seen in these records since the previous inspection.

Training records viewed by the inspectors confirmed the provision of ongoing professional development training. Mandatory training was in place for fire, protection of vulnerable adults and resident moving and handling. The inspector saw evidence of further training booked including responsive behaviour training on the 02 February with 40 staff scheduled to attend. Although a number of staff had attended dementia training this needs to be rolled out to all staff in the centre particularly staff working in the secure dementia unit. And as identified in outcome 11 wound care training was required for nursing staff to ensure they provided evidenced based care.
There was evidence of regular staff meetings taking place and the inspectors saw minutes of same.

Judgment:
Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Caroline Connelly
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Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	Amberley Home and Retirement Cottages
Centre ID:	OSV-0000189
Date of inspection:	20/01/2016
Date of response:	25/02/2016

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:
There was no 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.

1. Action Required:

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

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:
An annual review will be completed in accordance with the relevant legislation.

Proposed Timescale: 18/04/2016

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The audit process was not sufficiently comprehensive as there was limited documentary evidence of the actions identified on audits being implemented this was particularly relevant in relation to care plan documentation and wound care.

2. 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:
Action plans are being developed which will identify the steps necessary to correct the problem highlighted within the audit process.
The auditing and quality control mechanisms will be expanded in order to ensure a comprehensive monitoring & learning process.
The action plans will clearly specify a time frame for completion of the changes required and the procedure to be undertaken.
A follow up auditing process and secondary action plans will apply.

Proposed Timescale: 18/04/2016

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 staff were inappropriately classing the use of a number of bed-rails for residents who were unable to release then as enablers and not as restraints.

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:
All residents who have bed rails have been re-assessed and the restraint register has now been updated to reflect the current numbers.
The term enabler is no longer used to describe bedrails.

Proposed Timescale: 25/02/2016

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was not a plan in place to respond to residents who were presenting with responsive behaviours.

4. Action Required:
Under Regulation 07(2) you are required to: Manage and respond to behaviour that is challenging or poses a risk to the resident concerned or to other persons, in so far as possible, in a manner that is not restrictive.

Please state the actions you have taken or are planning to take:
Clinical nurse managers now meet with the nurses on both wings and the dementia unit on a daily basis to discuss and record incidences of responsive behaviour.
Responsive behaviour is also discussed at the weekly management meeting.
Responsive behaviour care plans are developed after consulting the Action Behaviour Consequences records.
Antecedents are now considered when updating responsive behaviour care plans.

Proposed Timescale: 18/04/2016

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 number of issues were identified in relation to fire practices in the centre.

There was not documentary evidence of learning from fire drills to ensure improvements in practices.

Individual risk assessments had not been completed for all of the residents that smoked, including a system of on-going review, to identify the safe level of access to

cigarettes and lighter/matches and the level of supervision required when smoking.

5. 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:
Refresher fire drills are being organised for some existing as well as all new staff.
Unannounced fire drills are planned post training and will be carried out with no general notice given.
Staff will be appraised on their performance and any lessons to be learnt will be recorded for training purposes at a later date.

The risk register has been updated to include all smokers.
Smokers care plans have been updated and are no longer in conflict with the risk register.
All access to lighters and matches is closely monitored.
All of the above will be reviewed on at least a three monthly basis or where required.

Proposed Timescale: 25/02/2016

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:
Medication management practices required review to ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned. Issues identified included:
Transcriptions of medications not being signed for by transcribing nurse and the centres policy required review in relation to transcribing to ensure it reflected best practice guidelines.
Expiry dates of medications were not clear on all medications .

6. Action Required:
Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.

Please state the actions you have taken or are planning to take:
All medication charts are currently being audited.
All charts will be co- signed by second nurse without exception as required by best

practice guide lines.
The medication policy will be amended to also reflect best practice within this area.
Excess of paracetamol has been returned to pharmacy as per returns protocol.
Storage of other medication will be audited on a regular basis in order to ensure best practice is maintained.

Proposed Timescale: 18/04/2016

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:
There were two incidents of pressure sores that were not notified within the correct time frame to the Authority.
As stated previously the person in charge had resigned and was due to leave the centre at the end of the week however the provider had not notified the authority of the proposed absence of the person in charge as required by legislation.

7. 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:
There is a new manager in place and ALL pressure sores will be reported to the authority immediately if and when they are identified.

Proposed Timescale: 25/02/2016

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:
Residents assessments and care plans were not reviewed on a four monthly basis or sooner as their condition required.

8. 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:
An Audit of all nursing care plans and assessment tools will be completed no later than the 30th of April in order to establish where improvements need to be made.
Where deficits are highlighted these will be updated with the intention of maintaining assessments at no less than three monthly intervals or as the need arises.

Proposed Timescale: 16/05/2016

Theme:
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all residents had care plans to direct care for a number of areas of care that they required. Care plans were not updated and changed as the needs of the residents changed.

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

Please state the actions you have taken or are planning to take:
All care plans will be updated and made bespoke to individual residents needs no later than 16th of May.
All care plans will be regularly reviewed on an individual basis in order that they can be personal to the resident's needs.
Nurses will be allocated to residents care on a named primary and secondary nursing basis.

Proposed Timescale: 16/05/2016

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Wound care in the centre was not provided to a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

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

Please state the actions you have taken or are planning to take:
A weekly wound audit will be conducted throughout all of the units. All wounds, regardless of size or type, will be recorded and progress of each wound will be updated, monitored and recorded.
A monthly wound audit will be conducted in order to establish any pattern that may be a contributory factor to the healing process.
A daily communication book will be commenced for carers who will be required to log their concerns for nurses within same.
Where a pressure area is detected and reported nurses will be required to consult a wound care algorithm which will be designed to guide them through the process of care delivery step by step. The process will also highlight recording and reporting procedures.

Proposed Timescale: 16/05/2016

Outcome 18: Suitable Staffing

Theme:
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Staffing levels required to be kept under constant review particularly in the evening and night time.

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

Please state the actions you have taken or are planning to take:
As acknowledged by the inspector within the report staffing levels are reviewed on a daily and weekly basis. This process will continue with the relevant adjustments to staffing levels made as required.

Proposed Timescale: 25/02/2016

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some staff working in the secure dementia unit did not have dementia training and wound care training was required for nursing staff.

12. 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 training matrix is currently being reviewed and additional training will be provided as required. As part of this process nurses will have completed wound care training by April 11th

Proposed Timescale: 11 April 2016

Proposed Timescale: