<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Araglen House Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000705</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Loumanagh, Boherbue, Mallow, Cork.</td>
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<tr>
<td>Telephone number:</td>
<td>029 76 771</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:araglenhouse@gmail.com">araglenhouse@gmail.com</a></td>
</tr>
<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>Araglen House Nursing Home Limited</td>
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<tr>
<td>Provider Nominee:</td>
<td>Edward Noel Naughton</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>John Greaney</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Anna Delany; Breeda Desmond</td>
</tr>
<tr>
<td>Type of inspection:</td>
<td>Unannounced Dementia Care Thematic Inspections</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>57</td>
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<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>0</td>
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About Dementia Care Thematic Inspections

The purpose of regulation in relation to residential care of dependent Older Persons is to safeguard and ensure that the health, wellbeing and quality of life of residents is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer and more fulfilling lives. This provides assurances to the public, relatives and residents that a service meets the requirements of quality standards which are underpinned by regulations.

Thematic inspections were developed to drive quality improvement and focus on a specific aspect of care. The dementia care thematic inspection focuses on the quality of life of people with dementia and monitors the level of compliance with the regulations and standards in relation to residents with dementia. The aim of these inspections is to understand the lived experiences of people with dementia in designated centres and to promote best practice in relation to residents receiving meaningful, individualised, person centred care.
This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor compliance with specific outcomes as part of a thematic inspection. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times
From: 24 February 2016 09:15  To: 24 February 2016 19:30

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

<table>
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<th>Outcome</th>
<th>Provider's self assessment</th>
<th>Our Judgment</th>
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<td>Outcome 01: Health and Social Care Needs</td>
<td>Substantially Compliant</td>
<td>Non Compliant - Moderate</td>
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<tr>
<td>Outcome 02: Safeguarding and Safety</td>
<td>Compliance demonstrated</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 03: Residents' Rights, Dignity and Consultation</td>
<td>Substantially Compliant</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 04: Complaints procedures</td>
<td>Compliance demonstrated</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 05: Suitable Staffing</td>
<td>Compliance demonstrated</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 06: Safe and Suitable Premises</td>
<td>Compliance demonstrated</td>
<td>Compliant</td>
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</table>

Summary of findings from this inspection
This inspection report sets out the findings of a thematic inspection which focused on six specific outcomes relevant to dementia care. The purpose of this inspection was to focus on the care and quality of life for residents with dementia living in the centre. Twenty nine of the fifty seven residents who were living in the centre on the day of the inspection had a diagnosis of dementia. Eleven of these residents were accommodated in a dementia specific unit.

The provider had submitted a completed self assessment on dementia care to the Authority with relevant policies and procedures prior to the inspection. The judgments from the self assessment and inspection findings are set out in the table above.

Overall, residents' healthcare and nursing needs were met to a high standard.
Residents had access to medical, allied health and psychiatry of later life services. The management of complaints was fully compliant with regulations. Appropriate policies and procedures were in place to protect residents from any form of abuse and residents had access to advocacy services. Inspectors found that staffing arrangements facilitated continuity of care and supported a consistent positive approach to the behaviours and psychological symptoms of dementia (BPSD).

The location, layout and design of the centre was suitable for its stated purpose and met the needs of the resident in a comfortable and homely way. The centre was clean, spacious and decorated to a high standard throughout. All areas were bright and well lit, with lots of natural light.

Some improvements, however, were required, particularly in relation to assessment and care planning. For example, some assessments did not accurately identify issues such as communication needs and not all residents were reassessed at four monthly intervals. In relation to care planning, while many were comprehensive and provided adequate guidance on the care to be delivered, others were generic in nature and they were not always updated following changes to the resident's condition. Other required improvements included the provision of activities to residents based on their interests and capacity.

There were systems in place to support residents with dementia and their representatives to participate in the assessments, care plans and the organisation of the centre. The centre had a stable workforce of long term staff, with low levels of absenteeism. Staff had comprehensive training, including training to work with people with dementia and behaviours that challenge.

The action plan at the end of this report identifies where improvements are needed to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.
Outcome 01: Health and Social Care Needs

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:
This outcome sets out the inspection findings relating to healthcare, nursing assessments and care planning. The social care of residents with dementia is comprehensively covered in Outcome 3.

Inspectors focused on the experience of residents with dementia and they tracked the journey of a number of residents with dementia. They also reviewed specific aspects of care such as nutrition and restrictive practices in relation to other residents.

There were systems in place to optimise communication between the resident/families, the acute hospital and the centre. Prospective residents and their families were invited to visit the centre and meet other residents and staff before making the decision to live there. The person in charge also visited prospective residents in hospital prior to admission. This gave the resident and their family information about the centre and also to ensure that the service could adequately meet the needs of the resident.

Residents' files held a copy of their hospital discharge letter and the files of residents admitted under ‘Fair deal’ also held the Common Summary Assessment Report (CSAR), which detailed the assessments undertaken by a geriatrician, a medical social worker and a comprehensive nursing assessment. Inspectors examined the files of residents who were transferred to hospital from the centre and found that appropriate information about their health, medications and their specific communication needs were included with the transfer letter.

Records of residents' assessments reviewed by inspectors included comprehensive biographical details, medical history, nursing assessments and life histories. Inspectors primarily focused on the experience of residents with dementia and they tracked the journey of a number of residents with dementia. They also reviewed specific aspects of care such as nutrition, access to activities and restrictive practices in relation to other residents.

Residents had access to general practitioners (GPs) of their choice, and to allied
healthcare services including dietetics, speech and language, chiropody and occupational therapy. GPs visited the centre regularly and there was evidence that residents were reviewed regularly. Out-of-hours GP services were also available. A physiotherapist visited the centre for one afternoon each week to carry out individual assessments, where required, and also facilitated group classes. An occupational therapist was available in the centre for one afternoon every three weeks, a dietician visited the centre every three months or more frequently if required and a speech and language therapist visited the centre every three to four months, or more frequently if required. Residents also had access to mental health of later life services, which was available in the local hospital as was a consultant geriatrician.

Comprehensive nursing assessments were carried out that incorporated the use of validated assessment tools for issues such as risk of falling, risk of developing pressure sores and for the risk of malnutrition. Care plans were developed for issues identified on assessment. Improvements, however were required in relation to the assessment and care planning process. For example, the assessment for one resident identified that the resident had no communication deficits, however, it was identified elsewhere in the residents notes that he/she had difficulty hearing. Residents were not always routinely reassessed at four-monthly intervals as required and reassessments ranged from three to six monthly intervals. While many care plans were personalised and addressed issues identified on assessments, a number of deficits were identified, such as:

- inspectors were informed that one resident presented with responsive behaviour and the resident's notes reflected this, however, the assessment tool used to assess the resident's behaviour did not reflect what was known about the resident
- the care plan for one resident that was identified as being at high risk of falls had not been updated for 18 months prior to the date of this inspection, even though the resident had fallen and suffered a significant injury in the interim
- most residents had risk assessments completed prior to the use of bedrails, however, this was not done for all residents
- care plans were not in place for all residents for issues identified on assessment, for example, early dementia
- some care plans were generic and did not provide adequate detail of the care for individual residents.

There were written policies and procedures in place for end-of-life care and for the management of residents' resuscitation status. Staff provided end of life care to residents with the support of their GP and the community palliative care team. There were no residents at active end-of-life stage on the day of the inspection. Religious preferences were documented and there was evidence that they were facilitated. The centre had a large oratory that was furnished to a high standard and was available to residents and family members. In the event of the death of a resident, other residents were notified and funeral arrangements were displayed for visitors, residents and staff. Records indicated that end-of-life preferences were discussed with residents and/or their relatives and these were documented in residents' records. A specific "Order for Life Sustaining Treatment" form was completed for residents to indicate the type of care they would like in the event of an acute illness ranging from transfer to hospital for full medical intervention to remaining in the nursing home for comfort measures only. However, this form was not always completed properly for all residents, for example,
the medical rationale supporting the decision was not included on the form for one resident. Additionally, the form was signed by a relative in the signature line designated for the resident. The centre had end-of-life packs that included specially designed handover bags for returning residents' property to family members, signage for doors to indicate to staff and visitors that a resident was approaching end of life and designated linen for beds. The majority of residents were accommodated in single rooms, so the option of a single room was usually available. Family and friends were facilitated to remain with the resident and there was a family room with two large comfortable reclining armchairs, should family members wish to remain overnight.

There were a number of policies and procedures to guide practice in relation to the management of nutrition, including the provision of therapeutic and modified diets, management of hydration, enteral feeding and meals and mealtimes. There were systems in place to ensure residents' nutritional needs were met, and that they did not experience poor hydration. Residents were assessed for the risk of malnutrition on admission and at regular intervals thereafter. Residents' weights were checked on a monthly basis, and more frequently when indicated. There was an effective system of communication between nursing and catering staff to support residents with special dietary requirements. Inspectors found that residents on weight reducing, diabetic, high protein and fortified diets, and also residents who required modified consistency diets and thickened fluids received the correct diet and modified meals were attractively served. Residents that were identified as having unintentional weight loss were assessed by a dietician and advice to increase calorific intake had been appropriately communicated to catering staff.

Most residents had breakfasts in their bedrooms but had their lunch and supper in the dining rooms, of which there was one large and three small, however, residents that chose to dine in their bedrooms were facilitated to do so. Breakfast was served for most residents from 07:30hrs to 09:00hrs, lunch was served from 12:00hrs to 13:30hrs, and supper was served from 17:00hrs to 17:30hrs. Residents that chose to have their meals outside of these hours were facilitated to do so. Fluids were available throughout the day and tea/coffee and snacks were served at 10:30hrs, 19:00hrs and 21:00hrs.

On the day of the inspection there were adequate numbers of staff on duty to assist residents with their meals. Residents requiring assistance were assisted by staff in a respectful and dignified manner. Personal protective equipment was colour coded to identify when staff were assisting with food related activities from health/general activities for infection control purposes.

There were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents which were implemented in practice. Inspectors found that practices in relation to prescribing and medication reviews met with regulatory requirements and staff were observed to follow appropriate administration practices.

This outcome was judged to be substantially compliant in the self assessment, and inspectors judged it as non-compliant - moderate.

Judgment:
Outcome 02: Safeguarding and Safety

Theme:
Safe care and support

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

Findings:
Inspectors found that measures were in place to protect residents from harm or suffering abuse and to respond to allegations, disclosures and suspicions of abuse.

There was an elder abuse policy in place that covered prevention, detection, reporting and investigating allegations or suspicion of abuse. All staff spoken with knew what action to take if they witnessed, suspected or had abuse disclosed to them. They also clearly explained what they would do if they were concerned about a colleagues behaviour. The person in charge and the provider were also very clear of their role if there were any investigations. Records that were reviewed confirmed that staff had received training on recognising and responding to elder abuse.

All residents spoken with said they felt safe and secure in the centre, and felt the staff were supportive. Relatives of residents spoke highly of the care provided by the staff and their caring attitude.

There were policies in place about meeting the needs of residents with challenging behaviour (also known as behavioural and psychological signs and symptoms of dementia) and restrictive practices. Policies were seen to give clear instruction to guide staff practice. Training records reviewed by inspectors indicated that staff were facilitated attend training related to the care of people with dementia.

There were care plans that set out how residents should be supported if they presented with responsive behaviour. Inspectors saw that they described the ways residents may respond in certain circumstances, and that action should be taken, including how to avoid the situation escalating. Staff spoken with were knowledgeable of individual residents behaviour including how to avoid the situation escalating.

There were residents who required the use of bed rails. Risk assessments had been completed for most, but not all of these residents. The alternatives to bed rails had been considered for example low beds.

Inspectors reviewed incident reports in relation to resident’s behaviour and records confirmed the information given to inspectors that there were no recent significant behavioural related incidents.
The centre was not managing the finances of residents, however, petty cash was held on behalf of residents to cover day-to-day expenses such as the cost of prescription charges, personal hygiene items and for services such as hairdressing and chiropody. Improvements were required in relation to records of transactions as it was not always specified what item or service each transaction related to. Other improvements required included:

- residents' signatures were not obtained from residents that were able to do so
- many receipts were not dated, so it was not always possible to match a receipt with a transaction
- there were not always two staff signatures verifying transactions.

This outcome was judged to be compliant in the self assessment, and inspectors judged it as substantially compliant. The improvement relates to the maintenance of records of financial transactions.

**Judgment:**
Substantially Compliant

### Outcome 03: Residents' Rights, Dignity and Consultation

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

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

**Findings:**
Residents confirmed that their religious and civil rights were supported.

The preferences of all religious denominations were respected and facilitated. There was a large oratory available in the centre that was decorated to a high standard. Religious ceremonies were celebrated in the centre that included daily prayers and weekly mass for Catholic residents. Outside of religious ceremonies, the oratory was available as a quiet space for residents to pray and reflect. Each resident had a section in their care plan that set out their religious or spiritual preferences.

Residents were facilitated to vote in local and national elections and the returning officer had visited the centre the week prior to this inspection to facilitate residents to vote in the general election. Recently admitted residents that were not registered to vote in the centre would be supported to attend the local polling station to vote.

There was an in-house advocate available to residents. Contact details were also available of an independent external advocate that was available to the residents. There were no residents presently requiring the service, however, referrals would be made on the residents behalf if required.
There were residents meetings held in the centre, however they were held infrequently. Based on a review of records, meetings were scheduled to take place approximately every two to three months, however, in practice they were only held approximately every four to five months. For example, the minutes of a residents' meeting held in April 2015 indicated that the next meeting would be held in June 2015 but it did not take place until August. The next meeting held following this was in January 2016.

Resident surveys were carried out annually and records of the most recent survey in July 2015 highlighted predominantly positive feedback on care and the environment.

Inspectors observed the majority of staff interacting with residents in an appropriate and respectful manner, however, some improvements were required. For example, inspectors observed some staff use terms of endearment such as "darling" or "my friend", which does not support the individuality or dignity of residents. Inspectors also observed that not all staff knocked on bedroom doors before entering.

Residents had access to a number of private areas and meeting rooms whereby they could meet with family and friends in private, or could meet in their rooms. Most residents had private bedrooms and where bedrooms were shared there was adequate screening between beds to support privacy.

There was a pet dog that spent his days in the centre and appeared to be very popular with the residents. Inspectors were informed that the presence of the dog had a positive effect on residents.

Residents choose what they liked to wear and inspectors saw residents looking well dressed, including jewellery and makeup. A number of residents were observed having their hair done in the hairdressing salon on the day of inspection.

Positive interactions between staff and residents were observed during the inspection, predominantly when tasks were being undertaken, such as when residents were being assisted to the dining room or when mid-morning and mid-afternoon snacks were being served. Staff appeared to be very busy and there were very little opportunities for staff to socially engage with residents. As part of the inspection, inspectors spent a period of time observing staff interactions with residents. Inspectors used a validated observational tool (the quality of interactions schedule, or QUIS) to rate and record at five minute intervals the quality of interactions between staff and residents in two communal areas. The scores for the quality of interactions are +2 (positive connective care), +1 (task orientated care, 0 (neutral care), -1 (protective and controlling), -2 (institutional, controlling care). An overview of these observation periods is detailed below.

Observations were recorded in the sitting room in the dementia unit and also in the sitting room of the main part of the centre. The total observation period was 130 minutes, which comprised three 30 minute periods and one forty minute period. For rating purposes, there were 26 five minute observation periods. 15 scores of +2 were given predominantly when staff were seen to assist residents to the dining room or when snacks were being served. Staff were knowledgeable of individual residents needs and preferences, addressed residents by their name and conversed with them on issues
that appeared to be of interest or relevant to the resident. Staff were also seen to sit with residents and chat with them while making good eye contact but this was more evident in the dementia unit than in the main sitting room and it was only for short periods. Visitors were seen to come and go, and all were made welcome by staff and addressed them by name. Seven scores of +1 were given when there were minimal staff in the sitting room and residents were being assisted with minimal interaction. Two scores of 0 were given when there were either one or no staff in the sitting rooms and residents were left without any stimulation. Two scores of -2 were given for when staff were observed transferring a resident to a wheelchair without giving any instruction to the resident and using terms of endearment such as "good girl" rather than the resident's name.

Each resident had a "Key to Me" completed which detailed residents interests and provided an overview of significant events in each resident's life. Residents also had a meaningful activities assessment and activity plan completed. An activities co-ordinator was available in the centre each day from Monday to Friday and a range of activities were available each day such as games, music and reading. There were also one-to-one activities for residents that do not participate in group activities. The activities co-ordinator was supported by another member of staff who facilitated exercise related activities for a period of time each day she was on duty. A number of improvements, however, were required. For example, it was not evident that the programme of activities was developed based on the interests of each resident and records of participation in activities were not kept up-to-date. A number of residents stated that they were at times bored. This was supported by the observations of inspectors who observed residents spending significant periods of time without stimulation.

Residents were seen to be wearing glasses and hearing aids, to meet their needs.

This outcome was judged to be compliant in the self assessment, and inspectors judged it as non-compliant - moderate.

Judgment:
Non Compliant - Moderate

Outcome 04: Complaints procedures

Theme:
Person-centred care and support

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

Findings:
There was a system in place to ensure that the complaints of residents or their representative were listened to and acted upon. There was a complaints policy that
identified the person responsible for managing complaints and also included an appeals process. The complaints procedure was on prominent display in the centre, and summarised in the residents guide.

Throughout the inspection it was clear that residents were familiar with all members of management including the provider nominee, the director of clinical operations, the person in charge, and clinical nurse managers. It was apparent to inspectors that residents would find staff easy to approach with any concerns or complaints.

Inspectors viewed the complaints log that contained details of complaints, the investigation of each complaint, the outcome of the investigation and whether or not the complainant was satisfied with the outcome of the complaint.

Records were also maintained of cards and letters received from residents and family members complimenting staff for the care received.

This outcome was judged to be compliant in the self assessment, and inspectors judged it as compliant.

Judgment:
Compliant

Outcome 05: Suitable Staffing

Theme:
Workforce

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

Findings:
Inspectors found that staff delivered care in a timely and safe manner. During the inspection, residents were seen to receive attention from staff based on their care requirements, for example, responding to the call bell, and supporting people from the sitting area to the dining room or to their own rooms.

Residents appeared to be familiar with staff. At meal times staff were seen to be speaking to residents, and where support to eat and drink was being provided, it was done in a discreet way. Where residents were able to eat themselves they were supported to do so, for example, some residents had adapted equipment to help them hold items such as cups with handles.

An actual and planned roster was maintained in the centre with any changes clearly indicated. The person in charge was supported by a director of clinical care, who was also a nurse and was the former person in charge. There were also three clinical nurse managers. Inspectors reviewed staff rosters which showed there was a nurse on duty at
Either the person in charge, the director of clinical care or a clinical nurse manager were on duty each day, including weekends. There was a regular pattern of rostered care staff. The staffing complement included the activities coordinator, catering, housekeeping, administration and maintenance staff. The centre did not use agency staff as it had sufficient numbers of staff to provide cover.

Residents and staff spoken with felt there was adequate levels of staff on duty. However, the provider and person in charge were requested to keep staffing under review as the needs of residents change. This was particularly relevant at night time when there were two nurses and two care assistants on duty for 57 residents in a large spread out environment.

There was a varied programme of training for staff. Records viewed by inspectors confirmed all staff had completed mandatory training in areas such as safeguarding and prevention of abuse; and fire safety and evacuation. Staff also had access to a range of education, including training in specific dementia related courses that explained the condition, the progression of the disease and effective communication strategies. Training completed by staff included “Living Well with Dementia”, “Quality of Life in Dementia” and “Communicating with People with Dementia”.

Inspectors reviewed a sample of staff files and found that some improvements were required. For example, two written references were not available for all staff and a full employment history was not available for all staff with satisfactory explanations for any gaps in employment.

This outcome was judged to be compliant in the self assessment, and inspectors judged it as substantially compliant.

Judgment:
Substantially Compliant

Outcome 06: Safe and Suitable Premises

Theme:
Effective care and support

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

Findings:
Araglen House Nursing Home is a purpose-built residential centre with accommodation for 57 residents. The location, layout and design of the centre was suitable for its stated purpose and met the needs of the resident in a comfortable and homely way. The centre is situated on a large, well maintained, landscaped site with ample parking facilities. All resident accommodation and communal space is provided on the ground
floor, with staff facilities, including a staff education centre, situated on the first floor and only staff members have access to this area.

The centre was clean, spacious and decorated to a high standard throughout. Inspectors observed that all of the areas allowed for freedom of movement. All areas were bright and well lit, with lots of natural light in the day, and electric lighting when dark. Corridors had grab rails, and were seen to be clear of any obstructions. Residents were seen to be moving as they chose within the centre.

Resident accommodation comprises 41 single and eight twin-bedded rooms, all of which are en suite with shower, toilet and wash-hand basin. The centre is divided into four sections: honeysuckle suite (14 beds), daffodil suite (16 beds), primrose suite (16 beds), and the designated dementia unit, bluebell suite (11 beds).

All bedrooms were spacious and were seen to be personalised. Some residents had brought their own furniture as well as pictures and ornaments. It was observed that there was adequate room in the bedrooms for furniture including a bed, a chair and storage. The rooms also had enough space for equipment such as hoists to be used, with sufficient space to access the beds from either side.

The doors to the bedrooms in the dementia unit were all different colours to support residents identify their own room. Additional visual cues, such as dried flowers or crosses, were placed in frames outside of the doors to each room, also to support residents identify their bedroom. Contrasting colours were also used throughout the unit and in the bedrooms to support residents identify areas such as their bathroom.

Communal space in bluebell comprised a sitting room, a sensory room, a dining room and there was also a small kitchen for use by residents. Along the main corridor in bluebell was a memorabilia cupboard, an old style phone booth and a couch.

Communal areas in the main part of the centre included a large reception area with comfortable seating, two sitting rooms, a main dining room and two smaller dining rooms, an oratory, a family room and two quiet rooms. There are a number of secure gardens, including a sensory garden, that are accessible from a number of corridors and from some bedrooms.

There are two sluice rooms, five assisted toilets, one assisted bathroom and a visitors’ toilet. The main nurses’ station, treatment room and the office of the person in charge are located beside the reception.

Access to rooms such as the treatment room and cleaners’ room were all secure on the day of inspection, however, the door to one of the sluice rooms did not close properly on the morning of the inspection. This was immediately rectified.

There was a wireless call bell system, so residents have access to a call bell in communal areas. Windows have restrictors applied and each room has its own thermostatic control.

There was a large well-equipped kitchen with adequate hand hygiene and changing facilities for staff. There was evidence of good practice in relation to the management of
clinical and domestic waste.

There were up-to-date records of the maintenance of equipment such as beds, clinical equipment, speciality chairs and hoists.

This outcome was judged to be compliant in the self assessment, and inspectors judged it as compliant.

**Judgment:**
Compliant

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**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:**

John Greaney  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority
Provider's response to inspection report

Centre name: Araglen House Nursing Home
Centre ID: OSV-0000705
Date of inspection: 24/02/2016
Date of response: 23/03/2016

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 01: Health and Social Care Needs

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Improvements were required in relation to the assessment process. For example:
• the assessment for one resident identified that the resident had no communication deficits, however, it was identified elsewhere in the residents notes that he/she had difficulty hearing
• inspectors were informed that one resident presented with responsive behaviour and the resident's notes reflected this, however, the assessment tool used to assess the

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
resident's behaviour did not reflect what was known about the resident
• most residents had risk assessments completed prior to the use of bedrails, however, this was not done for all residents.

1. Action Required:
Under Regulation 05(2) you are required to: Arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person’s admission to the designated centre.

Please state the actions you have taken or are planning to take:
• All staff have been informed of the importance of completing resident’s Assessments correctly.
• This has been corrected.
• Bedrail Assessment now completed for all residents

Proposed Timescale: 07/03/2016

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Improvements were required in relation to the assessment process. For example:
• residents were not always routinely reassessed at four-monthly intervals as required and reassessments ranged from three to six monthly intervals
• the care plan for one resident that was identified as being at high risk of falls had not been updated for 18 months prior to the date of this inspection, even though the resident had fallen and suffered a significant injury in the interim.

2. 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:
• New management system of allocation of responsibility for Assessments has been developed.
• This was immediately corrected. The particular residents’ assessments had been regularly reviewed. The resident has fully recovered from the injury following on-going rehabilitation from staff.

Proposed Timescale: 30/06/2016

Theme:
Safe care and support
The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Improvements, however were required in relation to the care planning process. For example:
• care plans were not in place for all residents for issues identified on assessment, for example, early dementia
• some care plans were generic and did not provide adequate detail of the care for individual residents
• end of life preferences were not always included in care plans.

3. 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:
• A full audit has been commenced on all Care Plans in order to address this issue.
• Staff have been re-trained on person centre care plans.
• End of Life preferences has been addressed in care plan.

Proposed Timescale: 30/06/2016

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A specific "Order for Life Sustaining Treatment" form was completed for residents to indicate the type of care they would like in the event of an acute illness. However, this form was not always completed properly for all residents, for example:
• the medical rationale supporting the decision was not included on the form for one resident
• the form was signed by a relative in the signature line designated for the resident.

4. Action Required:
Under Regulation 05(2) you are required to: Arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person’s admission to the designated centre.

Please state the actions you have taken or are planning to take:
• This particular residents’ medical rationale has been reviewed.
• Clerical Error - addressed.

Proposed Timescale: 07/03/2016
Outcome 02: Safeguarding and Safety

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Petty cash was held on behalf of residents to cover day-to-day expenses such as the cost of prescription charges, personal hygiene items and for services such as hairdressing and chiropody. Improvements were required in relation to records of transactions as it was not always specified what item or service each transaction related to. Other improvements required included:
• residents' signatures were not obtained from residents that were able to do so
• many receipts were not dated, so it was not always possible to match a receipt with a transaction
• there were not always two staff signatures verifying transactions.

5. Action Required:
Under Regulation 08(1) you are required to: Take all reasonable measures to protect residents from abuse.

Please state the actions you have taken or are planning to take:
• These items have been corrected and the Electronic System updated.

Proposed Timescale: 31/03/2016

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Based on a review of records, resident meetings were scheduled to take place approximately every two to three months, however, in practice they were only held approximately every four to five months.

6. Action Required:
Under Regulation 09(3)(d) you are required to: Ensure that each resident is consulted about and participates in the organisation of the designated centre concerned.

Please state the actions you have taken or are planning to take:
• This occurred due to change of staff personnel. However there is daily interaction with residents about their preferences within the organisation.
• Residents next meeting planned for March 2016
Proposed Timescale: 07/03/2016

Theme: Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors observed the majority of staff interacting with residents in an appropriate and respectful manner, however, some improvements were required. For example, inspectors observed some staff use terms of endearment such as "darling" or "my friend", which does not support the individuality or dignity of residents. Inspectors also observed that not all staff knocked on bedroom doors before entering.

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

Please state the actions you have taken or are planning to take:
- Staff training on this matter has occurred and will be on-going

Proposed Timescale: 07/03/2016

Theme: Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A number of improvements were required in relation to the provision of activities. For example, it was not evident that the programme of activities was developed based on the interests of each resident and records of participation in activities were not kept up-to-date. A number of residents stated that they were at times bored. This was supported by the observations of inspectors who observed residents spending significant periods of time without stimulation.

8. 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:
- There are a wide range of activities throughout the day.
- An Improved Planned Activity Level will be carried out following individual assessment for each resident. This will be based on Exploratory, Sensory and Reflective Levels of ability. The activity interest of the resident's life will be incorporated in their Activities Care Plan.
- The Person Centred approach will be re-enforced to staff in order for them to recognise the ability of a person with cognitive impairment to engage in activity.
**Outcome 05: Suitable Staffing**

**Theme:**
Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Inspectors reviewed a sample of staff files and found that some improvements were required. For example, two written references were not available for all staff and a full employment history was not available for all staff with satisfactory explanations for any gaps in employment.

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

**Please state the actions you have taken or are planning to take:**
This matter has been rectified for all staff.

**Proposed Timescale:** 07/03/2016