

**Health Information and Quality Authority
Regulation Directorate**

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



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| Centre name: | Portumna Retirement Village |
| Centre ID: | OSV-0000378 |
| Centre address: | Brendan's Road, Portumna, Galway. |
| Telephone number: | 090 97 59170 |
| Email address: | info@prv.ie |
| Type of centre: | A Nursing Home as per Health (Nursing Homes) Act 1990 |
| Registered provider: | Tony Williams |
| Provider Nominee: | Tony Williams |
| Lead inspector: | PJ Wynne |
| Support inspector(s): | None |
| Type of inspection | Announced |
| Number of residents on the date of inspection: | 58 |
| Number of vacancies on the date of inspection: | 5 |

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.

Please note the definition of the following term used in reports: responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration renewal decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

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|-----------------------|-----------------------|
| From: | To: |
| 18 October 2016 08:55 | 18 October 2016 18:00 |
| 26 October 2016 08:30 | 26 October 2016 17:00 |

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

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

Summary of findings from this inspection

This report set out the findings of an announced registration renewal inspection, which took place following an application to the Health Information and Quality Authority (HIQA), to renew registration of the designated centre.

In applying to renew registration of the centre the provider has applied to

accommodate a maximum of 63 residents who need long-term care, or who have respite, convalescent or palliative care needs. This is the same level of occupancy the centre is currently registered to accommodate.

The provider and person in charge are fully involved in the management of the centre. They are easily accessible to residents, relatives and staff. There was evidence of a commitment to providing quality, person-centered care. All of the actions identified in the report from the last inspection were satisfactorily completed.

A number of questionnaires from residents and relatives were received prior to the inspection. The inspector spoke to residents during the inspection. The collective feedback from residents and relatives was one of satisfaction with the service and care provided.

The building was well maintained, warm and comfortably decorated. The design ensured good natural daylight was available in all areas. There is a choice of spacious sitting rooms available for use by residents. Bedrooms accommodation comprises of 53 single and five twin bedrooms. Bedrooms are equipped to meet the comfort and privacy needs of residents.

The safety of residents was promoted and protected. Staffing levels on each work shift, skill mix and supervision arrangements were adequate to meet the needs of residents. Staff had the required qualities, skills and experience.

There were opportunities for all residents to participate in activities. Residents were well supported to practice their religious beliefs.

Twelve outcomes were judged as compliant with the regulations and a further five outcomes as substantially in compliance with the regulations. One outcome was moderately non-compliant with the regulations, namely Health and Social Care Needs. The action plan at the end of this report identifies these and other areas where improvements must be made to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.

Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

Outcome 01: Statement of Purpose

There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The statement of purpose detailed the aims, objectives and ethos of the centre. It outlined the facilities and services provided for residents and contained all information in relation to the matters listed in schedule 1 of the regulations.

The provider understood that it was necessary to keep the document under review and notify the Chief Inspector in writing before changes could be made which would affect the purpose and function of the centre.

The statement of purpose was revised in September 2016. The inspection evidenced the service provided was reflective and as described within the statement of purpose.

Judgment:

Compliant

Outcome 02: Governance and Management

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

Theme:

Governance, Leadership and Management

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

Findings:

The governance arrangements in place are suitable to ensure the service provided is safe, appropriate and consistent.

There was a clearly defined management structure that identifies the lines of authority and accountability. The governance arrangements specify roles and details responsibilities for each area of the service. The person in charge is responsible for the clinical governance and reports to the general manger who manages the administration and maintenance staff. The general manger oversees the daily operations of all aspects of the service and reports to the registered provider.

During the inspection the provider demonstrated knowledge of the legislation and of his statutory responsibilities. Records confirmed that he was committed to his own professional development. The provider is a qualified nurse and deputies in the absence of the person in charge.

There were sufficient resources to ensure the delivery of care in accordance with the statement of purpose. There was evidence of capital investment for enhancing the facilitates and services, the professional development of staff and ensuring sufficient staff are deployed to meet residents' care needs.

There were systems in place to capture statistical information in order to review the quality of care and identify trends for areas of improvement. A medication audit was completed in conjunction with the pharmacist. Further audits were planned in this area. Data on the usage of psychotropic or night sedative medication was being collated. A nutritional audit was completed at regular intervals to identify any risk to residents and an action plan was implemented.

The audit program requires further development to inform learning and ensure enhanced outcomes for residents. The falls audit requires review to identify trends within the data collected. The review did not assist to identify repeat falls by individual residents. There was no correlation between the times falls occurred and staff levels. The audit was not completed at regular intervals during the year to identify any corrective action at the earliest stage possible.

An annual report on the quality and safety of care was compiled. Copies of the report are available to the residents or their representative for their information. The report contained a good level of detail on all aspects of the service. Plans for 2016 were outlined. Residents' satisfaction with the care was ascertained through questionnaires and the findings were reported in the annual review.

Judgment:

Substantially Compliant

Outcome 03: Information for residents

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

for that resident and the fees to be charged.

Theme:

Governance, Leadership and Management

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

Findings:

Interviews with residents and relatives during the inspection were positive in respect of the provision of information on services and the care provided.

There was a residents' guide developed containing all the information required by the regulations. This detailed the visiting arrangements, the term and conditions of occupancy, the complaints procedure and a copy of the most recent inspection report by HIQA.

All residents accommodated had an agreed written contract. The contract included details of the services to be provided and the fees payable by the residents. The inspector reviewed a sample of three contracts of care. All contracts were signed by relevant parties.

The contract of care included details of the services to be provided and the fees payable by the residents. Expenses not covered by the overall fee and incurred by residents for example, chiropody, escort to appointment, hairdressing and dry cleaning were identified and outlined in the contract of care.

Judgment:

Compliant

Outcome 04: Suitable Person in Charge

The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The centre was being managed by a suitably qualified and experienced nurse who meets the criteria required by the regulations. She has appropriate qualifications, sufficient practice and management experience to manage the residential centre and meet its stated purpose, aims and objectives.

The person in charge has not changed since the last inspection and holds a full-time post. She was well known by residents. She had good knowledge of residents care needs. She could describe in an informed way where residents had specific needs and how staff ensured that their care needs were met appropriately.

She maintained her professional development and attended mandatory training required by the regulations. During the inspection she demonstrated that she had good knowledge of the regulations and standards pertaining to the care and welfare of residents. She is supported by a team of nurses.

The person in charge is additionally supported by a team of care assistants, kitchen and housekeeping staff, who report directly to her. The person in charge reports to the general manger.

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

Judgment:

Compliant

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

Theme:

Governance, Leadership and Management

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

Findings:

The documentation to be kept at the designated centre was available for inspection and well maintained.

Records listed in Schedules 2, 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People Regulations 2013 (as amended) were available. Samples of records were reviewed by the inspector. These included records relating to fire safety, staff recruitment and residents' care, as well as the centre's statement of purpose.

A record of visitors was maintained. The directory of residents contained all information required by schedule three of the regulations and was maintained up to date. The details of the most recent transfer of a resident to hospital and death were updated in the directory.

The centre's insurance was up to date and a certificate of insurance cover was available.

A sample of staff files were reviewed and found to be compliant with the regulations.

The inspector also reviewed operating policies and procedures for the centre, as required by Schedule 5 of the regulations. Policies listed in Schedule 5 were in place, including those on health and safety of residents, staff and visitors, risk management, medication management, end of life care, management of complaints and the prevention, detection and response to abuse. Policies read had been reviewed by the person in charge and were maintained up to date.

Judgment:
Compliant

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

Theme:
Governance, Leadership and Management

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

Findings:
Management arrangements were in place and described in the event of any unexpected absences.

The provider was aware of the requirement to notify the Chief Inspector of the proposed absence of the person in charge for a continuous period of 28 days.

The provider is the person notified to HIQA to deputise in the absence of the 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):

No actions were required from the previous inspection.

Findings:

There were effective and up to date safeguarding policies and procedures in place. Risks to individuals were managed to ensure that people had their freedom supported and respected.

Measures were in place to protect residents. There was a policy and supporting documents which provided guidance for staff to protect vulnerable adults. The management team demonstrated their knowledge of the designated centre's policy. No notifiable adult protection incidents which are a statutory reporting requirement to HIQA had been reported since the last inspection.

The training records identified staff had opportunities to participate in training in safeguarding vulnerable adults. Staff members spoken to understood how to recognise instances of abusive situations. They were aware of the appropriate reporting systems. Staff identified a senior manager as the person to whom they would report a suspected concern. Staff spoke confidently of being able to relay any issues and confirmed they are listened to and their concerns are acted on.

The financial controls in place to ensure the safeguarding of residents' finances were examined. Transparent systems were in place. The centre's management team was not an agent to manage a pension on behalf of any resident. There was a policy outlining procedures to guide staff on the management of residents' personal property and possessions. A petty cash system was in place to manage small amounts of personal money for residents. A record of the handling of money was maintained for each transaction. Two signatures were recorded for each transaction.

Residents spoken with stated that they felt safe in the centre. The front entrance door was secured. There was a visitors log in place.

Staff training, supervisions and appraisals were completed. A member of the management team is a qualified trainer in adult protection. Staff had the knowledge, skills and experience they needed to carry out their roles effectively. The inspector observed that residents were treated well with safety and support provided appropriately.

Policies and procedures were in place in relation to responsive behaviours and use of restraint. Because of medical conditions, some residents showed behavioural and psychological signs and symptoms of dementia (BPSD). Specific details such as possible

triggers and interventions were recorded in their care plans. Staff spoken with were very familiar with appropriate interventions to use. Behaviour logs were available to detail episodes of BPSD. During the inspection staff approached residents in a sensitive and appropriate manner to which residents responded positively.

Staff had received training in responsive behaviours, which included caring for older people with cognitive impairment or dementia. Care plans for residents with dementia outlined information such as, who the resident still recognised or what activities could still be undertaken.

There was a policy on physical restraint management (the use of bedrails and lap belts) in place. At the time of this inspection there were 25 residents with two bedrails raised. Sixteen were considered an enabler and nine a restraint measure in the best interest of the resident's safety. Fifteen residents had one bedrail raised or a half rail in place. A risk assessment was completed prior to using bedrails in each sample reviewed. Signed consent was obtained.

In line with national policy on promoting a restraint free environment further work is required. While assessments were supported with a care plan the documentation did not outline or describe well how the raised bedrail supported the resident and ensured an enabling function in each case.

The use of tables attached to chairs which restricted the free movement of residents was not risk assessed. This practice was in the minority. There were only two residents noted with this type of seating during this inspection. However, a restraint risk assessment, rationale for the use and review of the practice was not undertaken to evidence it was necessary and in the resident's best interest.

Chemical restraint, the prescribing of antipsychotic and anti anxiety medication was well managed. The rationale for any prescribed medication was outlined in a care plan and clarified the therapeutic benefit of administration.

Judgment:
Substantially Compliant

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

Findings:
The health and safety of residents, staff and visitors in the centre was promoted and

protected.

The action plan from the previous inspection to complete risk assessment for residents who smoke was completed. At the time of this inspection there were a small number of residents who smoked accommodated at the centre. Suitable safety precautions were in place including fire retardant aprons, assistance and supervision. The fire policy detailed the procedures should the clothes of a resident catch fire as required by the regulations.

The centre had policies and procedures relating to health and safety. The health and safety statement and risk management policy included all matters set out in regulation 26.

Policies for infection control and prevention, absconding, incident reporting, smoking and fire safety with supporting protocols were also available and implemented in practice. There were policies and procedures in place for responding to major incidents to include serious disruption to essential services or the emergency evacuation of the centre if deemed necessary.

Suitable arrangements were in place in relation to promoting fire safety. The fire policy provided guidance to reflect the size and layout of the building and the evacuation procedures. Fire safety and response equipment was provided. A personal emergency evacuation plan was completed for each resident. Each resident's evacuation needs was identified on their bedroom door. Emergency evacuation sheets were provided on each resident's bed.

Fire exits were identifiable by illuminated signage. Corridors were clear of equipment. Exits were unobstructed to enable means of escape. The fire alarm system was serviced on a quarterly basis and fire safety equipment was serviced every six months. Internal routine checks were undertaken to ensure fire exits were unobstructed, automatic doors closer were operational and fire fighting equipment was in place and intact.

Staff had completed training in fire safety evacuation procedures. Records indicated fire drill practices were completed. However, the procedures to complete and record fire drills require review. The fire drill records did not record the scenario or type of simulated practice, to include the time taken to respond to the alarm, for staff to discover the location of a fire and safely respond to the simulated scenario. There was no documented evaluation of learning from fire drills completed to help staff understand what worked well or identify any improvements required.

There were procedures in place for the prevention and control of infection. Hand gels were located along the corridor. A hand washing sink is provided in the foyer and hand hygiene is promoted by reception staff. Audits of the building were completed at intervals to ensure the centre was visibly clean. There were a sufficient number of cleaning staff rostered each day of the week. There was a colour coded cleaning system to minimise the risk of cross contamination. There is a sluice room on each floor of the building. A separate cleaning room is provided.

Training records evidenced that staff had up-to-date refresher training in moving and handling. There was sufficient moving and handling equipment available to staff to meet

residents' needs. Each resident's moving and handling needs were identified to include the type of hoist and sling size. These were documented and available for reference by staff in each resident's bedroom.

Falls were documented. In the sample of accident report forms reviewed vital signs for residents were checked and recorded. Neurological observations were not recorded where a resident sustained an unwitnessed fall or a suspected head injury in all cases. A post incident review was not completed in the immediate aftermath of a fall to identify any contributing factors for example, changes to medication or onset of an infection.

The arrangements in place for recording and investigating incidents and near miss events require review. Near miss events were not documented in the accident register. Some residents had dressings for minor grazes or skin tears. There was no incident report completed Therefore an investigation as to the possible cause or action to minimise the risk of a repeat occurrence was not in place as a result. Action to prevent a near miss event becoming an incident was not undertaken.

Hand testing indicated the temperatures of radiators or dispensing hot water did not pose a risk of burns or scalds. Access to work service areas to include the kitchen, sluice rooms and stairwells was secured in the interest of safety to residents and visitors.

There was a contract in place to ensure hoists and other equipment to include electric beds and air mattresses used by residents was serviced and checked by qualified personnel to ensure they were functioning safely.

Judgment:
Substantially Compliant

Outcome 09: Medication Management
Each resident is protected by the designated centre's policies and procedures for medication management.

Theme:
Safe care and support

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

Findings:
Policies and procedures were in place to guide staff in the management of residents' medication. They included information on the prescribing, administering, recording, safekeeping and disposal of unused or out of date medicines. Practices were satisfactory to ensure each resident was adequately protected by all medication management procedures.

There was good evidence of pharmacy input to support medication management practice. Advice from pharmacy of reviews to guide nursing staff on contraindications

and other forms of a drug for those with swallowing difficulty or blood screening for residents on a particular drug over a prolonged timeframe was provided.

A risk assessment tool to guide staff in decision making to facilitate residents who may wish to self medicate was available. There were no residents self medicating at the time of this inspection.

All medication was dispensed from blister packs. These were delivered to the centre on a weekly basis by the pharmacist. On arrival, the prescription sheets from the pharmacist were checked against the blister packs to ensure all medication orders were correct for each resident.

Photographic identification was available on the drugs chart for each resident to ensure the correct identity of the resident receiving the medication and reduce the risk of medication error in the sample reviewed. The prescription sheets reviewed were legible. The maximum amount for (p.r.n) medication (a medicine only taken as the need arises) was indicated on the prescription sheets examined.

The medication administration sheets viewed were signed by the nurse following administration of medication to the resident and recorded the name of the drug and time of administration. The drugs were administered within the prescribed timeframes. There was space to record when a medication was refused on the administration sheet.

Medicines were being stored safely and securely in the clinic room which was secured. The temperature ranges of the medicine refrigerator was being appropriately monitored and recorded.

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

Judgment:
Compliant

Outcome 10: Notification of Incidents

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

Theme:
Safe care and support

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

Findings:

The inspector reviewed a record of incidents or accidents that had occurred in the centre and cross referenced these with the notifications received from the centre. Quarterly notifications had been submitted to HIQA as required.

One incident identified as a statutory notification was not submitted. This was discussed with the management team. The person in charge immediately submitted the required notification retrospectively.

Judgment:
Compliant

Outcome 11: Health and Social Care Needs

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

Theme:
Effective care and support

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

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

Findings:

There were 58 residents in the centre during the inspection. There were 21 residents with maximum dependency care needs. Eighteen were assessed as highly dependent and 12 had medium dependency care needs. Six residents were assessed as low dependency. All residents were residing in the centre for continuing care. Residents were in advanced old age with many complex medical conditions. Twelve residents required either full or partial assistance with all their meals. Fifteen of the residents required the use of a hoist to meet all their moving and handling needs safety.

The arrangements to meet residents' assessed needs were set out in computerised based care records. There was a good emphasis on personal care and ensuring personal wishes and needs were met. Staff were knowledgeable of resident's preferred daily routine, their likes and dislikes.

On admission a comprehensive assessment of needs was completed. Recognised assessment tools were used to evaluate residents' progress and to assess levels of risk for deterioration, for example vulnerability to falls, dependency levels, nutritional care, the risk of developing pressure sores, continence needs and mood and behaviour. Risk assessments were regularly revised.

There were plans of care in place for each identified need. In the sample of care plans reviewed there was evidence care plans were updated at the required four monthly

intervals or in a timely manner in response to a change in a resident's health condition. Care plans were person-centred, individualised and described well the current care to be given. There was good linkage between risk assessments and care plans.

There was ongoing verbal discussion with residents and their representatives. However, there was limited documentary evidence of residents or their next of kin agreeing to their care plans when renewed or updated. The person in charge explained a new record facility on the computer system was now assigned to record all conversations and outline agreement on care pathway planned with residents

The daily nursing notes while documented twice in 24 hours as required by Schedule 3 (4) (C) do not provide a clear account of the resident's health, condition and treatment. The daily nursing records describe physical care needs only, personal or psychosocial needs were not well documented in all cases.

A number of residents were provided with air mattresses. Checks were completed to ensure the mattress type and setting was suitable to each residents assessed needs.

There were two residents with wounds being dressed. A plan of care was in place. However, improvements were required in the recording of the clinical practice in relation to wound assessments and documenting management of wound care.

Wound assessment records were not completed each time dressings were changed. Nursing notes did not outline a clinical evaluation of the progress of the wound and it was difficult to determine healing progress. Notes stated 'dressing changed and cleaned' infrequently. While photos were taken they were at irregular intervals, in some cases two months apart. There was no evidenced based reporting as to the progress of the adequacy of the type and frequency of the care interventions, dressings applied and assessment of pain. There was access to a clinical nurse specialist in wound management. However, reviews were not sought for long term wounds being dressed.

Residents had timely access to allied health professionals to include speech and language therapy and dieticians. Where residents had specialist care needs such as mental health problems there was evidence in care plans of good links with the mental health services. Referrals were made to the consultant psychiatrist to review residents and their medication to ensure optimum health.

The services of general practitioners to some residents was variable. In accordance with regulation 6 (1) and (2), an improvement in timely medical assessment and clinical reviews as residents' needs indicate is required. Newly admitted residents were not seen by the GP shortly after admission or on returning from hospital in all cases.

Medical notes evidenced GP reviews when a resident became unwell at the request of nursing staff. However, the system to review each resident's medication requires further development. In some files examined residents were on a comprehensive list of medications. Some GPs did not attend the centre to see each resident prior to renewing long term medication. There was evidence of a reliance on phone conversations, faxed advice or prescriptions.

Judgment:

Non Compliant - Moderate

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):**Findings:**

The location, design and layout of the centre was suitable for its stated purpose and met residents' individual and collective needs in a comfortable and homely manner. The premises takes account of the residents' needs and abilities, and was maintained in line with Schedule 6 of the regulations.

The building was well maintained, warm and comfortably decorated. The design ensured good natural daylight was available in all bedrooms and communal areas. There is a choice of spacious sitting rooms available for use by residents and smaller quieter sitting rooms on each floor. The dining rooms are suitable in size to meet residents' needs. Two separate sittings are accommodated at each meal time. Other facilities include a visitors' room, smoking room, hair salon and a chapel

Bedrooms accommodation comprises of 53 single and five twin bedrooms. Bedrooms are adequate in size and equipped to meet the comfort and privacy needs of residents. All bedrooms have ensuite facilities including toilet, wash hand basin and shower. There was suitable ventilation provided to all internal bathrooms.

Grab rails were provided alongside all bathroom facilities. There was a call bell system in place at each resident's bed and in the ensuites. Emergency call facilities were provided in the day sitting rooms. Suitable lighting was provided and switches were within residents reach in bedrooms.

Suitable staff facilities were provided. Separate toilets facilities were provided for care and kitchen staff in the interest of infection control. Suitable storage arrangements were available throughout the building.

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):

No actions were required from the previous inspection.

Findings:

There was a written operational policy and procedure relating to the making, handling and investigation of complaints. The person in charge explained issues of concern are addressed immediately at local level without recourse to the formal complaints procedure, unless the complainant wishes otherwise.

The procedure identified the nominated person to investigate a complaint and the appeals process. This was displayed in a prominent position. Residents and relatives that communicated with the inspector said they were aware of the process and identified the person whom they would communicate with if they had an issue of concern. However, the version of the complaint procedures on display and outlined in the residents' guide and statement of purpose was not the same.

The independent appeals process if the complainant was not satisfied with the outcome of their complaint was not fully meeting the requirements of the regulations. The independent appeals procedures referred complainants to a local external third party, an individual not part of the centre's governance structure.

Records of investigation details into the matters complained of and actions taken on foot of a complaint were recorded in addition to and distinct from a resident's care records. The complaints records detailed the outcome of any issue raised and the complainant's satisfaction with the outcome.

Judgment:

Substantially Compliant

Outcome 14: End of Life Care

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

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

There was an end-of-life care policy detailing procedures to guide staff. The policy of the centre is all residents are for resuscitation unless documented otherwise. Eight of the residents have a do not attempt resuscitation (DNAR) status in place.

Resident's end-of-life care preferences or wishes are identified and documented in their care plans titled planning for the future. Decisions concerning future healthcare interventions were outlined. Resident's preferences with regard to transfer to hospital if of a therapeutic benefit were documented. The wishes of residents who did not wish to discuss end of life care were respected and detailed in care plans.

The management team confirmed they had good access to the palliative care team who provided advise to monitor physical symptoms and ensure appropriate comfort measures. There were five residents while under the care of the palliative team each was stable at the time of this inspection.

Judgment:

Compliant

Outcome 15: Food and Nutrition

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

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

All residents were appropriately assessed for nutritional needs on admission and were subsequently reviewed regularly. Records of weight checks were maintained on a monthly basis and weekly where significant weight changes were indicated. At the time of this inspection 18 residents were prescribed supplements to help maintain a healthy nutritional status.

Meals were an unhurried social experience with appropriate numbers of staff available to support residents. There was a good level of independence observed amongst the resident profile at mealtimes. Approximately only ten residents required either full or partial assistance with all their meals. The majority of residents attended the dining room for both their dinner and evening meal. The inspector observed practices and saw that staff were using appropriate techniques when assisting residents with their meals.

Residents spoken with were complimentary of the food and told the inspector they could have a choice at each mealtime. Requests for an option other than those on the menu were facilitated.

Each resident had a nutritional care plan. The instructions for foods and liquids that had to have a particular consistency to address swallowing problems were outlined in care plans and available to catering and care staff. Access to dietician and a speech and language therapist was available when required to obtain specialist advice to guide care practice.

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):
No actions were required from the previous inspection.

Findings:
There was evidence that residents were consulted with and had opportunities to participate in the organisation of the centre. Questionnaires were completed to elicit the views of residents and their next of kin.

Access to information in relation to independent advocacy services was available to residents. Residents' independence and autonomy was promoted. For example, the inspector saw residents choosing to participate in activities or not. In the main, residents were able to make choices about how they lived their lives in a way that reflected their individual preferences or abilities. Resident's consent was respected and documented in their care files.

Residents' privacy and dignity was respected. Personal hygiene and grooming were well attended to by care staff. Personal care was provided in their bedrooms with doors closed.

There were opportunities for all residents to participate in activities. There was a structured program of activities in place which was facilitated by the activities coordinator. The inspector spoke with the activity coordinator who confirmed the range

of activities in the weekly program. The activity schedule provided for both cognitive and physical stimulation. Residents spoken with expressed satisfaction with the choice and variety of activities. Residents were facilitated to engage in hobbies that interested them such as reading newspaper, art, quizzes, bingo games and live music weekly.

Residents were well supported to practice their religious beliefs. Mass was celebrated twice a week in the chapel. Pastoral care for end of life was provided and resident's spiritual needs were well met.

Closed circuit television (CCTV) cameras were in operation throughout the building. Notices were on display along the corridor. There was a policy to guide the practice. There was one small sitting room mainly used for family visiting with CCTV. The use of a camera in this area requires review to ensure privacy by visiting families. The notice to advise of CCTV was not visible as it was located behind the door. There was another small sitting room which did not have CCTV. This was not highlighted to residents and visitors to give options to residents when they spend their entire day and have a reasonable expectation for privacy while in a communal area for example, while engaging in leisure activities or spending time with their visitors.

Residents spoken with expressed satisfaction with the choice and variety of activities and the support for their religious ethos. Questionnaires completed by residents and relatives submitted to HIQA prior to the inspection confirmed satisfaction with the quality and safety of care provided by the service.

Judgment:
Substantially Compliant

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

Theme:
Person-centred care and support

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

Findings:
There were arrangements in place for regular laundering of linen and personal clothing, and the safe return of clothes to residents. Residents and relatives were satisfied with the arrangements in place.

Each resident was provided with their own wardrobe. The centre provided the service to laundry all residents' clothes and families had the choice to take home clothes to launder if they wished.

A staff member was assigned to the laundry each day of the week. A clear system was in place to ensure all clothes were identifiable to each resident.

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):

Findings:

The inspector examined the staff duty rota, communicated with residents and relatives. During this inspection staffing levels on each work shift, skill mix and supervision arrangements were adequate to meet the needs of residents.

There are two nurses rostered over each 24 hour period supported by a part time clinical nurse manager role. The person in charge works full time over five days of the week. There are 10 care assistants rostered until 2.00pm and eight until 8.00pm each day. In addition, there is catering, cleaning, laundry, an activity coordinator and a receptionist employed. The planned staff rota matched the staffing levels on duty.

There was a detailed policy for the recruitment, selection and vetting of staff. It was reflected in practice. Staff had the required qualities, skills and experience to undertake their duties associated with their role. Staff who communicated with the inspector confirmed that they were supported to carry out their work by the provider and person in charge. This was also evidenced by a review of staff files. Recently recruited staff confirmed in conversations to the inspector they undertook a lengthy interview, were requested to submit names of referees. Staff explained they commended work only after an induction period.

There is a training and development program to ensure that staff maintain competence in all areas relevant to their role. This includes specialist training in relation to the care of the older person in areas such as dementia, end of life care, nutrition and safe feeding practices. Mandatory training required by the regulations for all staff was met

and updated on an ongoing basis

All nursing staff were facilitated to engage in continuous professional development and had completed training on medication management. Attendance at cardio pulmonary resuscitation training was facilitated.

Judgment:
Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

PJ Wynne
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

**Health Information and Quality Authority
Regulation Directorate**

Action Plan



Provider's response to inspection report¹

| | |
|----------------------------|-----------------------------|
| Centre name: | Portumna Retirement Village |
| Centre ID: | OSV-0000378 |
| Date of inspection: | 18/10/2016 |
| Date of response: | 24/11/2016 |

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:

The audit program requires further development to inform learning and ensure enhanced outcomes for residents. The falls audit requires review to identify trends within the data collected. The review did not assist to identify repeat falls by individual residents. There was no correlation between the times falls occurred and staff levels.

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(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:

The audit tool currently used will be enhanced to log all aspects of a fall, and will include the time and the staffing level at that time. In the event of multiple falls of a single resident over a period, this will be analysed separately.

Proposed Timescale: 01/01/2017

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:

In line with national policy on promoting a restraint free environment further work is required. While assessments were supported with a care plan the documentation did not outline or describe well how the raised bedrail supported the resident and ensured an enabling function in each case.

The use of tables attached to chairs which restricted the free movement of residents was not risk assessed. A restraint risk assessment, rationale for the use and review of the practice was not undertaken to evidence it was necessary and in the resident's best interest.

2. 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:

We are pleased that the inspector has acknowledged that restraint assessments supported by the relevant care plan are already in place. The assessment template will be enhanced to include any relevant comment regarding enablement.

The current risk assessment for the use of a mobile chair will be revised to include assessment of the use of any fitted table.

Proposed Timescale: 01/01/2017

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:

Neurological observations were not recorded where a resident sustained an unwitnessed fall or a suspected head injury in all cases. A post incident review was not completed in the immediate aftermath of a fall to identify any contributing factors for example, changes to medication or onset of an infection.

3. Action Required:

Under Regulation 26(1)(c)(iii) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control accidental injury to residents, visitors or staff.

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

A new Post Fall Assessment Form will be introduced and the information gleaned from that form will be collated to establish trends and identify any learning. A copy of the form will be sent to HIQA when available.

Proposed Timescale: 01/01/2017

Theme:

Safe care and support

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

Near miss events were not documented in the accident register. Some residents had dressing for minor grazes or skin tears. There was no incident report completed Therefore an investigation as to the possible cause or action to minimise the risk of a repeat occurrence was not in place as a result. Action to prevent a near miss event becoming an incident was not undertaken.

4. Action Required:

Under Regulation 26(1)(d) you are required to: Ensure that the risk management policy set out in Schedule 5 includes arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.

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

The incident report template will be revised to include near misses and the importance of recording and learning from near misses emphasised to nurses and care staff.

Proposed Timescale: 01/01/2017

Theme:

Safe care and support

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

The procedures to complete and record fire drills require review. The fire drill records

did not record the scenario or type of simulated practice, to include the time taken to respond to the alarm, for staff to discover the location of a fire and safely respond to the simulated scenario. There was no documented evaluation of learning from fire drills completed to help staff understand what worked well or identify any improvements required.

5. Action Required:

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

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

A Post Fire Drill report will be introduced so that following on from fire drills and all staff (not just those involved in the fire drill) will be provided with a report that will detail the scenario and report on what worked well, and what didn't go well so that staff learning from fire drills are documented.

Proposed Timescale: 01/01/2017

Outcome 11: Health and Social Care Needs

Theme:

Effective care and support

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

There was limited documentary evidence of residents or their next of kin agreeing to their care plans when renewed or updated.

6. 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:

It is acknowledged that it can be difficult to view the evidence of consultation within the myriad of care plans. To clarify this, a specific consultation plan will be added to the current suite of care plans to ensure that it is clear to any reader as to the extent of the consultation that took place.

Proposed Timescale: 24/11/2016

Theme:

Effective care and support

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

Wound assessment records were not completed each time dressings were changed. Nursing notes did not outline a clinical evaluation of the progress of the wound and it was difficult to determine healing progress. There was no evidenced based reporting as to the progress of the adequacy of the type and frequency of the care interventions, dressings applied and assessment of pain.

While there was access to a clinical nurse specialist in wound management further reviews were not sought for long term wounds being dressed.

7. 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 documented wound assessment will now be conducted each time dressings are changed and this assessment will include any required referral to our newly recruited in-house specialist tissue viability nurse.

Proposed Timescale: 24/11/2016

Theme:

Effective care and support

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

The services of general practitioners to some residents was variable. In accordance with regulation 6 (1) and (2), an improvement in timely medical assessment and clinical reviews as residents' needs indicate is required.

Some newly admitted residents were not seen by the GP shortly after admission or on returning from hospital in all cases.

8. Action Required:

Under Regulation 06(2)(c) you are required to: Provide access to treatment for a resident where the care referred to in Regulation 6(1) or other health care service requires additional professional expertise.

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

It is acknowledged that the service received from GP's was variable and one GP in particular was inconsistent. Meetings have now been scheduled with each of the GPs attending residents to agree a minimum quarterly visit to any of their patients that they have not otherwise attended to. In addition, GP's will be requested to attend all new admissions and re-admissions from hospital within three working days.

Proposed Timescale: 06/01/2017

Theme:

Effective care and support

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

The daily nursing notes as required by Schedule 3 (4) (C) do not provide a clear account of the resident's health, condition and treatment. The daily nursing records describe physical care needs only, personal or psychosocial needs were not well documented in all cases.

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:

All nurses advised of the need and importance of commenting on the resident's personal and psychosocial needs in daily notes

Proposed Timescale: Immediate – implemented post inspection

Proposed Timescale: 24/11/2016

Outcome 13: Complaints procedures

Theme:

Person-centred care and support

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

The independent appeals process if the complainant was not satisfied with the outcome of their complaint was not fully meeting the requirements of the regulations. The independent appeals procedures referred complainants to a local external third party, an individual not part of the centre's governance structure

The version of the complaint procedures on display and outlined in the residents' guide and statement of purpose was not the same.

10. Action Required:

Under Regulation 34(1) you are required to: Provide an accessible and effective complaints procedure which includes an appeals procedure.

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

The referral to the local external party has been deleted and the text used in the Statement of Purpose has now been amended to reflect the Residents' Guide and the display notices.

Proposed Timescale: 24/11/2016

Outcome 16: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

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

The use of a CCTV cameras require review to ensure privacy for residents and visiting families. A notice to advise of CCTV was not visible as it was located behind a door. There was another small sitting room which did not have CCTV. This was not highlighted to residents and visitors to give options for privacy.

11. 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:

The use of CCTV has been reviewed with input from residents and relatives. A Privacy Impact Assessment has been conducted. The notice that was partially hidden from view because of an open door has been moved. The availability of the room without the CCTV is now highlighted to residents and visitors by way of the Residents' Guide and a notice outside the room door.

Proposed Timescale: 24/11/2016