

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Glenashling Nursing Home
<b>Centre ID:</b>	OSV-0000040
<b>Centre address:</b>	Oldtown, Celbridge, Kildare.
<b>Telephone number:</b>	01 627 2694
<b>Email address:</b>	gavigang@iol.ie
<b>Type of centre:</b>	A Nursing Home as per Health (Nursing Homes) Act 1990
<b>Registered provider:</b>	Garry Gavigan
<b>Provider Nominee:</b>	Garry Michael Gavigan
<b>Lead inspector:</b>	Ann Wallace
<b>Support inspector(s):</b>	Shane Walsh
<b>Type of inspection</b>	Announced
<b>Number of residents on the date of inspection:</b>	73
<b>Number of vacancies on the date of inspection:</b>	2

## **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 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 1 day(s).

**The inspection took place over the following dates and times**

From: 01 August 2017 09:00 To: 01 August 2017 18:30

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

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

**Summary of findings from this inspection**

This was an announced inspection by the Health Information and Quality Authority (HIQA). The purpose of the inspection was to inform an application to renew registration of the centre.

As part of the inspection the inspectors met with residents, relatives, the provider, the person in charge (PIC), the clinical nurse managers (CNM) and members of staff who were present in the centre during the inspection. The inspectors also observed practices and reviewed documentation such as policies and procedures, staff files, clinical governance and audit documents, care plans, medical records and the records from allied healthcare and specialist practitioners.

During the inspection residents were seen to be offered choice in how they went about their day and where they spent their time in the centre. Inspectors found that residents were encouraged and enabled to maintain their independence in their day to day lives at the centre. Both the provider and the person in charge were involved in the centre on a daily basis and were seen to be easily accessible to residents,

relatives and staff. The person in charge was supported in her role by the provider and the CNMs.

Inspectors found that there were adequate staffing levels and skill-mix to meet the residents' assessed needs. Residents had good access to medical and allied health care professionals including specialist services where required however inspectors found that one resident had been waiting several weeks for a specialist mental health service.

There were effective governance and management arrangements in place to ensure the quality and safety of the service provided in the centre. Standards were regularly reviewed through the centre's audit calendar, an annual resident survey and monitoring of incidents and complaints. The inspectors found evidence of improvements being introduced as a result of audits and other feedback.

The centre was seen to be clean and tidy on the days of the inspection. Communal areas were well used by residents and their visitors which gave the centre a homely, welcoming atmosphere. The nicely laid out grounds and garden areas provided secure and peaceful outdoor spaces for residents. Residents' bedrooms were decorated with photographs and artifacts from home giving them a personal feel.

Some areas for improvement were identified in relation to risk assessments for residents who continued to smoke, fire drills, care plans and resident meetings. These are discussed under the relevant outcomes within the body of the report.

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

***Outcome 02: Governance and Management***

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

**Theme:**

Governance, Leadership and Management

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

No actions were required from the previous inspection.

**Findings:**

The inspectors found that there were effective management arrangements in the centre and that there were effective systems in place to monitor the quality and safety of the service.

The centre had a defined management structure in place which was known to staff. The person in charge [PIC] works full time in her management role and is supported by two clinical nurse managers (CNM) one of whom was new in post but had prior experience of working with older persons in her previous role. The CNMs provided direct support and supervision for nursing and care staff including weekends. The CNMs deputized in the absence of the PIC. The provider is also on site most days and was present on the day of the inspection. Residents and families who spoke with the inspectors said that they regularly saw the provider and PIC and that they were approachable.

There was a full time administrator based in the centre who took responsibility for resident finances and maintenance of staff files and residents' non-clinical records.

The inspectors found that there were clinical governance systems in place which included an audit programme and regular staff and management meetings. Records showed that the audit programme included key areas such as medication management, nutrition and weights, falls, dependencies, restraints, infection control, moving and handling and pressure relief equipment, staff training, complaints and care plans. Clinical governance meetings were held monthly with the provider, the person in charge and the clinical nurse managers.

The person in charge met regularly with the housekeeping, activities staff and the catering team. Nursing and care staff meetings were held four monthly and minutes were kept and circulated to the relevant groups. Documents showed that issues such as complaints, incidents, staff performance and changes to policy or working systems were

discussed.

Staff handover meetings were held at the beginning of each shift. The PIC told the inspectors that these had been developed to include staff training and updates on items including policy development, incident reviews and the results of audit findings.

Following feedback from the last inspection the centre had carried out a resident and family survey and feedback from the survey was currently being analyzed. The results would be used to inform the annual survey which was due for completion at the end of August 2017.

**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:**

There was a full time person in charge of the designated centre who was a qualified nurse and who had the relevant experience and qualifications required to carry out the role. During the inspection they demonstrated a good understanding of the regulations and standards and had effective systems in place in the centre to make sure that these were being met.

The person in charge was seen to be accessible to staff and residents. The focus of their work was ensuring the quality and safety of the care and services provided for residents.

The person in charge was supported in their role by the provider and two clinical nurse managers (CNM). The CNMs acted for the person in charge in her absence.

**Judgment:**

Compliant

***Outcome 07: Safeguarding and Safety***

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

***is promoted.***

**Theme:**

Safe care and support

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

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

**Findings:**

Inspectors found that procedures were in place to safeguard and protect residents from abuse. Inspectors found evidence that the provider was working towards a restraint-free environment.

There was a policy in place that set out clear procedures for the prevention, detection and response to elder abuse. The provider informed the inspectors that all staff working in the centre were Gardaí vetted. This was a requirement from the previous inspection.

The staff training records documented that all staff had attended training on safeguarding and elder abuse during induction and ongoing training in the centre. This was a requirement from the previous inspection.

Inspectors spoke with staff and found that they were able to articulate the policy and procedure to follow in the event of an allegation, suspicion or disclosure of abuse. Staff were also clear about who to go to report concerns regarding abuse. The inspectors reviewed the documentation relating to a recent investigation that had been carried out in the centre and found that the allegation was appropriately managed and that the safety of residents was protected. There was evidence of learning from the investigation. Inspectors were satisfied that the person in charge knew how to respond to an allegation of abuse if it was reported to them.

Residents who spoke with the inspectors said that they felt safe at the centre.

Inspectors reviewed the centre's policy on the management of responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). The policy described the types of responsive behaviours and the approaches that should be used for identifying causes of responsive behaviours. Staff had attended training on the management of responsive behaviours. This was a requirement from the previous inspection.

Staff who spoke with inspectors knew the residents who might display challenging behaviours and were able to describe the triggers for such behaviour and the most appropriate way to respond to reassure and support the resident. This information was documented in individual resident's care plans. Residents with responsive behaviours had good access to specialist services such as community mental health teams and psychiatry of later life however inspectors noted that one resident was waiting several weeks for a psychology assessment following referral.

During the inspection staff were observed using a positive approach to calm and support residents who became agitated. Inspectors noted that care provided was person centred.

There was a comprehensive policy in place for managing restraints within the centre. Risk assessments had been completed for residents who required equipment such as bed rails, floor and bed sensor mats and bracelet alarms. Resident's records showed that these restraints were reviewed regularly and that resident/family consent was obtained. The centre was working towards a restraint free environment in line with national best practice guidance.

The centre had transparent systems in place in relation to resident's finances. Money and valuables kept on behalf of a resident were stored securely. For those residents for whom the centre was a pension agent individual residents' accounts were in place in line with the Department of Social Protection guidance.

**Judgment:**

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):**

No actions were required from the previous inspection.

**Findings:**

There were procedures in place to promote the health and safety of staff, residents and visitors within the centre. The centre had comprehensive fire safety policies and procedures in place however some improvements were required in relation to care plans for residents who continued to smoke and fire drills.

There was a health and safety statement in the centre that had been signed by the provider in July 2017. The centre had a policy in place on risk management which outlined clinical, environmental and occupational risk. It outlined who was responsible for risks and how risk could be evaluated and how to put controls in place. A risk register had been completed and this outlined identified generic risks in the centre including fire risks, medication errors, falls, risk of absconding and responsive behaviours. Residents also had individual risk assessments in place. Residents who smoked had had a risk assessment completed which clearly outlined the actions that were to be taken to mitigate risks for example the use of smoking aprons and levels of supervision required for individual residents. However inspectors found that one resident who smoked did not have a risk assessment completed.

There were comprehensive emergency policies and procedures in place for the evacuation of the centre in the event of a fire or unforeseen event. The fire evacuation procedure was displayed within the centre. Each resident had a personal evacuation plan (PEEP) which described their needs in relation to support and supervision in the event of an emergency.

The centre was compartmentalised by fire doors throughout the corridors. The doors were on magnetic self closing mechanisms that would automatically close if the fire alarm sounded. All the doors had hot seals and smoke seals in place to slow the spread of fire and smoke. Four of these fire doors were tested by the inspectors and all closed with no noticeable gap between them. There were fire safety equipment, emergency lights and smoke/heat detectors throughout the centre. The inspectors reviewed the servicing records of all and found that they had been serviced in line with fire safety requirements.

Staff who spoke with the inspectors were able to articulate the fire emergency procedures. Records showed that all staff had received training in fire safety within the last year. The PIC informed the inspectors that the last fire drill had been done in February 2017 as part of the fire safety training provided. There was no record of what scenario occurred in the drill or how long it had taken. There was no evidence of another fire drill occurring within 12 months prior to the drill recorded in February 2017. This was not in accordance with the centre's own fire safety policy which stated that all staff in the centre would take part in a fire drill twice a year. This was discussed with the PIC who told the inspectors that a fire drill was planned in August 2017 but that the date had not yet been confirmed.

Inspectors observed that staff in the centre followed appropriate infection control policies and procedures. There were handwash basins with soap and paper towels and hand sanitisers placed at regular intervals along corridors and in clinical areas. Staff were observed to use personal protective equipment (PPE) such as gloves and aprons appropriately. Laundry staff who spoke with the inspectors were able to articulate the procedure which needed to be followed for managing soiled or infectious laundry.

**Judgment:**

Non Compliant - Moderate

***Outcome 09: Medication Management***

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

**Theme:**

Safe care and support

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

No actions were required from the previous inspection.

**Findings:**

There were appropriate management systems in place to ensure safe medication practices.

There was a comprehensive medication policy in place which gave clear guidance to nursing staff on the procedures to follow for ordering, monitoring, documenting, administering and the disposing of un-used and out-of-date medications. The policy included the procedure to follow in the event of medication errors. The PIC completed monthly medication administration audits and a comprehensive pharmacy audit of all areas relating to medications was completed every three months.

A sample of medication records was reviewed. Inspectors found that the records included the name of the drug and the time of the administration and that the nurse signed the medication record after each administration. The drugs were administered within the prescribed timeframes. If a resident refused medication this was recorded correctly. Drugs being crushed were signed by the general practitioner (GP) as suitable for crushing and liquid alternatives had been sourced where possible. Staff administering medication were seen to follow appropriate medication management practices in line with relevant professional best practice guidance. Residents' medication was reviewed regularly by their GP.

Medications were stored securely. Controlled drugs were stored in a locked cupboard within a locked cupboard in the medications room. Nurses kept a register of controlled drugs. They were checked by two nurses at the change of each shift. The inspector checked a selection of controlled drug medication balances and found them to be correct. Medications that needed to be stored in the fridge were stored as directed. Opened medication was labelled with date of opening. Inspectors found that the temperature of the drugs fridge on one unit had not been recorded daily in line with best practice guidance and the centre's own medication policy.

There was an effective system in place to manage the return of out-of-date and un-used medications with records providing a clear audit trail.

**Judgment:**

Substantially 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:**

A record of incidents that have occurred in the centre was maintained and any incidents

required to be notified to HIQA had been.

A record was kept of accidents and incidents in the centre. A falls summary was maintained in the centre which outlined the time and location of the fall and if an injury had occurred. All falls that had resulted in an injury had been notified to HIQA. All other notifiable incidents had been reported to HIQA. A quarterly report had been provided to HIQA each quarter.

**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):**

No actions were required from the previous inspection.

**Findings:**

Each resident had a comprehensive assessment of their needs and a written care plan that described how their needs were to be met. Care plans were devised with input from residents and or their families.

There was a comprehensive policy in place that set out the processes that should be used to assess each individual resident prior to admission and on admission to the centre. The policy also described the review processes in place to ensure that resident's needs were reviewed four monthly or more often if there was a change in their health or wellbeing and that their care plan was updated accordingly. The policy stated that each resident must receive a comprehensive assessment prior to their admission to the centre to ensure that the centre would be able to meet their ongoing needs.

A selection of residents' records was reviewed. The inspector found that each resident had a pre-admission assessment completed prior to coming into the centre. Following admission, nursing staff worked with the resident and or their family to complete a comprehensive assessment of the resident's needs including actual and potential risks such as weight loss, falls or responsive behaviours. Where health or social care needs were identified, a care plan was drawn up and agreed with the resident and or their family. Most care plans were found to provide clear information to staff providing care and support for residents and were found to reflect the resident's current needs. However inspectors found that some improvements were needed as one care plan did

not give clear directions about the resident's communication needs and another resident's record did not have a clear end of life care plan in place.

Care plans were person centred and often included residents' preferences for care and support, for example, what time they liked to get up and retire at, and what activities they preferred. Clinical risk assessments were completed for skin integrity, falls, nutrition, continence, moving and handling needs and responsive behaviours. Risk management plans were seen to promote residents' independence and self-care abilities where possible.

Inspectors found that residents had good access to GP services and a range of allied health care professionals and specialist teams such as the palliative care team, community mental health services and psychiatry of later life. Inspectors found that one resident who had been referred by the centre for specialist psychiatric assessment had been waiting several weeks due to resource issues. This had been followed up by the provider and an appointment date had been received for the resident.

Referrals were made appropriately, and where allied professionals had made recommendations for care these were found to have been implemented. For example; modified diets as recommended by the dietitian or speech and language therapist.

Residents and their families reported high levels of satisfaction with the care and support provided in the centre and said that they were kept informed about any changes in their care or services.

Where residents were temporarily absent from the centre, records showed that relevant information was sent with them. Also, when residents returned from another care setting to the centre there was a clear summary of the resident's needs and plan of care.

**Judgment:**

Substantially Compliant

***Outcome 12: Safe and Suitable Premises***

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

**Theme:**

Effective care and support

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

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

**Findings:**

Inspectors found that the design and layout of the centre met the needs of the residents. The centre was clean and well maintained however one action from the last inspection relating to radiator covers was ongoing due to repeated damage by wheelchairs. Most of the requirements of Schedule 6 were met; however some improvements were needed in relation to the availability of hand rails in communal bathrooms and showers.

The centre is based in a quiet area close to a small town with local shops and amenities and good transport links. The building is organised into three units which are mostly laid out over one ground floor containing the Main Floor and Millennium Wing and a partial first floor extension containing the New Building. There is a passenger lift to the first floor extension.

Communal areas are bright and homely and comfortably set out for residents. There are two large communal rooms in the New Building and a spacious communal lounge in the Main Floor. Other communal spaces include an activities room, a number of smaller quiet seating areas, a smoking room and an oratory. There is a main dining room and two smaller dining areas available for residents who prefer a quieter atmosphere or who require more supervision at meal times.

There is plenty of outside space including an enclosed patio garden with seating and potted flowers which is accessed off the main lounge area. There is a second landscaped garden area which surrounds the centre and can be accessed from each of the three units. During the inspection residents were observed using the garden areas to mobilise with their visitors or staff.

Residents told the inspectors that they enjoyed visiting the centre's donkeys that were in a field adjoining the centre. Another resident took responsibility for feeding the local cat.

The centre has 51 single bedrooms and 12 twin bedrooms. Forty four bedrooms have en-suite facilities. Inspectors observed that there were sufficient communal bathrooms and toilets to meet the needs of residents. Bedrooms are personalised with resident's possessions and there is suitable storage for belongings in the rooms. There is a call bell in place in each of the bedrooms. Inspectors noted that there was suitable screening in place in the twin bedrooms.

On walkabout the inspectors found that the premises was well lit, comfortably heated, clean and well maintained. The requirements from the previous inspection in relation to maintenance of the centre had been resolved apart from damaged radiator covers which inspectors found in one communal toilet and along a corridor.

All bedrooms, en-suite facilities and communal bathroom/toilets have call bells in place. There are handrails in place along corridors and on both sides of staircases. The inspectors noted that a number of communal bathrooms and toilets did not have grab rails installed at the sink or the shower. This was brought to the attention of the PIC during the inspection.

Inspectors found that there was suitable amount of assistive equipment for residents such as hoists and wheelchairs. These were stored in designated areas off the corridors. Records showed that all equipment had been serviced within the last year.

**Judgment:**

Substantially 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:**

The centre had a policy and procedure in place for receiving and responding to complaints. This was found to be implemented in practice.

The complaints procedure was displayed in various locations throughout the centre. The procedure outlined that the person in charge was responsible for the management of complaints. The provider of the centre was nominated as a person to oversee that complaints were managed correctly. There were also details for an independent appeals person, and for the office of the ombudsman.

Both verbal and written complaints were recorded. The person in charge had a record of the complaints which outlined the details of the complaint, the actions taken and the outcome/satisfaction of the complainant.

A copy of any written complaints was also maintained. So far any written complaints in 2017 had been dealt with informally. This was following the centres policy, however the person in charge explained to the inspectors that she was aware a formal resolution may be required depending on the circumstance.

**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:**

Inspectors found that residents are consulted in how the centre is run. Their privacy is promoted and their rights are respected.

Residents meetings scheduled every three months and the minutes for the last meeting were on display near the front entrance to the centre. The centre produced a regular newsletter and a copy of the most recent newsletter was displayed near the nurses' station in the New Building. The newsletter included details of residents' birthday and of any events that had occurred in the centre.

Following a recent change in the provision of advocacy services the provider was in the process of trying to access a suitable advocacy service for residents. The inspectors reviewed ongoing correspondence between the centre and national and local advocacy services. The correspondence confirmed the centre's plans to organize independent advocacy services for residents as soon as possible.

The inspectors spoke with the activities coordinator. The activities programme in the centre was developed with feedback from residents. The programme was reviewed every three to four weeks. On the day of the inspection residents were observed to be asked if they wished to participate in activities. Staff offered gentle encouragement and support to residents before and during activities. When residents did not want to take part in the activities on offer this was respected by staff. The activities planned for the week of the inspection included, darts, a quiz, card games, bowling, sonas and cookery.

The activities coordinator described to the inspectors how the 'key to me' resident assessment tool was used to inform the development of the centre's activities programme based on residents' identified life skills and interests. The inspectors were informed that other activities grew organically such as the breakfast club, which was a social event where 10 to 15 residents could meet up and have breakfast and a chat together over a leisurely breakfast. The club had started with six residents and had grown in popularity over the following months. It was now a popular addition to the activities programme.

Residents' participation in activities was recorded by the activities co-ordinator. Most records reviewed were up to date however inspectors noted that one-to-one activities with residents were not consistently documented.

The centre had an open visiting policy and inspectors observed a number of visitors in the centre throughout the day of the inspection. Visitors told the inspectors that they were made welcome at the centre. Residents could meet with their visitors in private in the smaller communal rooms or in their bedrooms.

Weekly Mass was held in the centre. Most of the residents were Roman Catholic so they could attend if they wished. Residents of other faiths were facilitated to attend services outside of the centre or receive members of their church.

Residents who wished to vote could register to vote in the nursing home. For those who wished to attend the local polling station transport was arranged for them.

Residents had access to various media including television, radio, newspapers and Wi-Fi.

Residents informed the inspectors that they were supported to make choices about how and where to spend their time each day and that their rights and choices were respected by staff in the centre.

**Judgment:**

Substantially 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):**

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

**Findings:**

Inspectors found that there were appropriate numbers of staff with the necessary skills and experience to meet the needs of residents.

Inspectors reviewed the staffing levels, actual and planned staff rosters, staff training records and spoke with staff, residents and visitors. Inspectors found that there were sufficient staff with the required skills to deliver safe and effective care to meet the assessed needs of the residents who lived at the centre. The planned rosters took into account the layout of the centre and the levels of care and supervision required. Staff levels were reviewed regularly in response to changing resident dependencies and care requirements.

There was also sufficient housekeeping, laundry, catering and administration staff to ensure that the centre was run effectively for the benefit of the residents who lived

there. Staff were seen to be respectful and cooperative in their dealings with each other and with the residents and their visitors. Residents and their families expressed high levels of satisfaction in their relationships with the staff team at the centre often commenting on their cheerful and helpful manner and their kindness and courtesy.

Training records showed that all staff had been provided with mandatory training in moving and handling and prevention of abuse and fire safety. Following an action required from the previous inspection staff had received training in infection control, managing responsive behaviours, dementia care and infection control. Some staff had attended specialist End of Life Care training. The provider who is a qualified nurse had completed a HSE Safeguarding Trainer Course and was now an accredited trainer in safeguarding for the centre.

The provider informed the inspectors that all staff and volunteers working in the centre were Gardaí vetted. The inspectors reviewed a selection of staff files and found that they contained the information relating to each member of staff as required in Schedule 2 of the regulations. Records showed that nursing staff were registered with the Irish Nursing and Midwifery board.

**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:***

Ann Wallace  
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 report<sup>1</sup>

<b>Centre name:</b>	Glenashling Nursing Home
<b>Centre ID:</b>	OSV-0000040
<b>Date of inspection:</b>	01/08/2017
<b>Date of response:</b>	12/09/2017

### 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 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:

One resident did not have a smoking risk assessment recorded.

#### 1. Action Required:

Under Regulation 26(1)(a) you are required to: Ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.

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

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

The resident in question now has a smoking risk assessment in place.

A system is in place to ensure all risk assessments are completed within 48 hours of admission and appropriate care plans are developed to address the identified risks. This is monitored by the PIC.

**Proposed Timescale:** 01/08/2017

**Theme:**

Safe care and support

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

Fire drills were not occurring at regular intervals and did not encompass the inclusion of all staff. Records of fire drills did not contain sufficient detail on what scenario occurred in the drill or how long it had taken.

**2. 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:**

Fire Safety and Evacuation Training incorporating fire drills have been occurring once yearly with an outside fire Marshall present and all staff members attending signed the register. Training sessions have taken place for all staff twice yearly. The training records are in place and show all staff where possible have attended fire training twice yearly. The details on the scenarios and the duration of the fire drills can be documented and will be documented going forward in future training sessions.

Proposed Timescale: Fire drill completed 31.08.17. Next fire drill is scheduled for September 29th 2017.

**Proposed Timescale:** 29/09/2017

**Outcome 09: Medication Management**

**Theme:**

Safe care and support

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

The temperature of the drugs fridge on one unit had not been recorded daily in line with best practice guidance and the centre's own medication policy.

**3. Action Required:**

Under Regulation 29(4) you are required to: Store all medicinal products dispensed or supplied to a resident securely at the centre.

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

Prior to the inspection this error had already been identified. Daily records are now in place as per the centres own medication policy.

Proposed Timescale: ongoing

**Proposed Timescale:** 12/09/2017

**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:**

One care plan did not give clear directions about the resident's communication needs and another resident's record did not have a clear end of life care plan in place.

**4. 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:**

The resident in question's care plan has been reviewed and updated to suit their needs. The resident's communication needs have been addressed and staff members specifically identified best equipped to deal with these needs. This is reflected in the care plan.

End of life care plans are in the process of being reviewed and updated to suit individual's needs and preferences.

**Proposed Timescale:** 30/11/2017

**Theme:**

Effective care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement**

**in the following respect:**

One resident had been waiting several weeks for specialist assessment by a clinical psychologist.

**5. 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:**

The inspectors were informed on the day of the inspection of the appointment date for the psychiatric appointment in relation to this resident. This appointment took place and the resident was assessed on 03.08.2017.

An appropriate referral was made for this resident, followed up and an appointment received all within an appropriate time scale.

**Proposed Timescale:** 03/08/2017

**Outcome 12: Safe and Suitable Premises**

**Theme:**

Effective care and support

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

A number of radiator covers were noted to be broken. This was also a finding from the last inspection.

**6. Action Required:**

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

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

The previous inspection stated the radiator cover was broken in the bathroom this cover had been repaired. Subsequently residents have hit off other radiator covers and caused minor damage.

All radiator covers will be checked and repaired accordingly.

**Proposed Timescale:** 30/11/2017

**Theme:**

Effective care and support

**The Registered Provider is failing to comply with a regulatory requirement in**

**the following respect:**

Grab rails were not in place in all communal bathrooms/toilets at the sink and/or shower.

**7. Action Required:**

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

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

Grab rails are currently being installed in communal bathrooms and toilets at the sink or in the shower area where required. This is part of an ongoing bathroom refurbishment programme.

**Proposed Timescale:** 30/11/2017

**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:**

Residents' participation in activities was recorded by the activities co-ordinator. However inspectors noted that one-to-one activities with residents were not consistently documented.

**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:**

All staff have been retrained in recording daily interactions with residents this includes all one on one activities.

This documentation already exists in our computer system, all staff have been made aware of how to access the record, how to fill it out and when to use it.

This is being monitored daily by the PIC to ensure best practice.

**Proposed Timescale:** 12/09/2017