

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Atlanta Nursing Home
Centre ID:	OSV-0000010
Centre address:	Sidmonton Road, Bray, Wicklow.
Telephone number:	01 286 0398
Email address:	atlantanursing@eircom.net
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Atlanta Nursing Home Limited
Provider Nominee:	Noeleen Cahill
Lead inspector:	Deirdre Byrne
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	43
Number of vacancies on the date of inspection:	0

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 2 day(s).

The inspection took place over the following dates and times

From:	To:
28 September 2016 09:30	28 September 2016 18:30
29 September 2016 09:30	29 September 2016 18:00

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	Non Compliant - Moderate
Outcome 03: Information for residents	Substantially Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Substantially 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	Non Compliant - Moderate
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	Non Compliant - Moderate

Summary of findings from this inspection

The provider had applied to renew the registration of the designated centre. This report sets out the findings of the inspection. The inspector reviewed documentation submitted to the Health Information and Quality Authority (HIQA) by the provider to renew the registration of the designated centre.

As part of the inspection, the inspector met with residents, relatives and staff

members. The inspector observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files.

The inspector found that the provider demonstrated a willingness to comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and the National Standards for Residential Care Settings for Older People in Ireland. The inspector met one of the directors who also worked full time in the centre and the person in charge.

Atlanta Nursing Home is located in an urban area. The centre has capacity to accommodate 43 residents and the service provides long term care to adults.

There were suitable governance and management systems in place, with some improvements identified in relation to the system of monitoring of the service to ensure gaps in care delivery and risk were identified. An annual review of the quality and safety of the service had been developed.

There were good recruitment arrangements in place, and staff had completed all mandatory training areas. The staff were familiar with the residents and knowledgeable of their health-care needs, with area of improvement identified in the review and documentation of care plans.

The centre was maintained in good standard of hygiene and repair, with a assistive equipment provided to support residents. It was nicely decorated and furnished in a homely style. However, there were deficits in the premises that required attention.

Other areas of improvement identified were in relation to outcomes on- health safety and risk management, complaints, residents' rights and workforce.

There were 14 actions required from this inspection and they are outlined in body of the report and the action plan at the end.

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 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 inspector was satisfied a written statement of purpose and function was developed for the centre. It met the requirements of regulation 3 and Schedule 1 of the regulations.

The statement of purpose outlined the aims, mission and ethos of the service. It provided a clear and accurate reflection of facilities and services provided.

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):

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

Findings:

There was a clearly defined management structure that outlined the lines of authority and accountability in the designated centre. There were systems in place to review the safety and quality of care of residents living in the centre however, these required improvement. The action from the previous inspection regarding the annual review had

been addressed.

The centre is operated by Atlanta Nursing Home Limited. There is a senior management team was in place that consisted of two directors. One of the directors is the person nominated to represent the provider (the provider). The provider was present throughout the inspection. This person also worked in the centre full time in a management capacity. The directors had delegated clear lines of authority and accountability of roles were in the centre. Both directors were registered nurses and were rostered to work in the centre. They worked closely with the person in charge. There were monthly governance meetings between the directors and person in charge to report on the operation of the centre. The agenda included information on staffing matters, accidents and incidents, restrictive practices, medicine management, and HIQA. There were meetings held every quarter with the senior staff of each department. It was noted the minutes were not available.

There were good systems in place to monitor the quality and safety of care provided to residents. There was a calendar of audits in place. The inspector read a sample of audits from 2015 and 2016. The audits were completed on a monthly or quarterly basis for a number of key performance indicators (KPIs) such as falls, wound care, bedrails, restrictive practices, medicine management and nutrition. A resident satisfaction survey had also been completed in 2015. The results of the audit findings were discussed at the governance meetings. However, some issues identified during the inspection that had not been addressed or resolved through the audit process. For example, areas of risk (Outcome 8 risk management), care planning (Outcome 11 health and social care needs) and premises deficits (Outcome 12 premises). The provider described a new quality management system that was going to replace the current auditing system and would further enhance the monitoring of the quality and safety of care provided to residents. She anticipated it would be fully implemented by the end 2016.

An annual report on the review of the safety and quality of care provided to residents was seen by the inspector. This was an action from the previous inspection and was addressed. It included detailed findings and actions to bring about improvements in the centre. The provider stated more comprehensive audits would be developed for 2016 in conjunction with the implementation of the new quality management system.

Judgment:

Non Compliant - Moderate

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):

No actions were required from the previous inspection.

Findings:

The inspector found that each resident had an agreed written contract and a guide to the centre was provided on their admission. An area of improvement regarding the residents' guide was identified.

A residents' guide was read. It was a nicely colour printed brochure and included detailed information on the visitor's policy, services provided and the emergency procedures. However, the procedures respecting complaints process and the terms and conditions of residency were not included.

A sample of residents' contracts of care was reviewed. Each contract was signed within one month of entering the centre. The contract included the services provided and the fees charged.

The contract of care stated there was a fixed monthly charge for the social programme payable regardless of residents' participation in activities. This was discussed with the provider who said residents were informed prior to their admission about the additional charges. The provider stated that the programme was available to all residents irrespective of their dependency levels. This was evidenced during the inspection as outlined in Outcome 11

Judgment:

Substantially 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 inspector was satisfied that the centre was managed full time by a registered nurse with experience in care of older people.

The person in charge is a qualified nurse. She has many years experience in the area of care of older people and in the management of the centre. She demonstrated a good understanding of the regulations and was familiar with her responsibilities. This was demonstrated during the inspection in terms of her knowledge of reporting and information to be held for residents.

She had kept her own continuous development up-to-date and attended training in various areas such as restrictive practices, safeguarding, and various health care areas.

She had completed a course leading to a certificate in management in 2014.

The person in charge was knowledgeable of the residents and their health and social care needs. It was evident she very familiar with the residents, and was observed stopping to spend time and talk with residents. The residents and family members in turn told the inspector the person in charge was always available to them and she regularly stopped by to talk to them.

Judgment:
Compliant

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

Theme:
Governance, Leadership and Management

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

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

Findings:

The inspector found the records listed in schedules 2, 3 and 4 of the regulations were maintained in a manner to ensure completeness, accuracy and ease of retrieval. The two actions from the previous inspection regarding policies were fully addressed.

An area of improvement was identified in the completion of records of fire drills. For example, the time they took place at, the length of time the drill took and the findings were not included.

All policies and procedures were in place as required by schedule 5 of the regulations. A sample of policies read were up-to-date, centre specific, and guided practice. The inspector spoke to staff who were sufficiently knowledgeable of key operational policies. The safeguarding policy and the medicine management policy had been reviewed and updated since the last inspection. These were found to contain sufficient information to guide staff practice.

There was documented evidence to confirm the centre had up-to-date insurance against loss or damage to residents' property, along with insurance against injury to residents.

A directory of residents was read and it contained the information required by the

regulations.
Judgment: Substantially Compliant

<i>Outcome 06: Absence of the Person in charge</i> <i>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.</i>
Theme: Governance, Leadership and Management
Outstanding requirement(s) from previous inspection(s): No actions were required from the previous inspection.
Findings: The provider was aware of the requirement to notify HIQA of any proposed absence of the person in charge for a period of more than 28 days. The provider had notified HIQA of the planned absence and return of the person in charge in 2016. There were appropriate contingency plans put in place during her absence - the two directors who were registered nurses deputised for the person in charge.
Judgment: Compliant

<i>Outcome 07: Safeguarding and Safety</i> <i>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.</i>
Theme: Safe care and support
Outstanding requirement(s) from previous inspection(s): No actions were required from the previous inspection.
Findings: The provider ensured there were systems in place to protect residents from being harmed or suffering abuse. A positive approach to manage responsive behaviours was promoted in the centre. Restrictive practices carried out, were done in accordance with

the regulations and national policy.

There was a detailed policy on the protection of vulnerable adults. It had been updated since the last inspection to reference the Health Service Executive's (HSE's) Safeguarding Vulnerable Persons at Risk of Abuse, National Policy & Procedures of 2014. The policy included information on the types of abuse, the reporting arrangements and the procedures to investigate an allegation of abuse.

There had been an allegation of abuse notified to HIQA since the last inspection. There was evidence that appropriate action had been taken at that time. The person in charge was familiar with the procedures on how to investigate an allegation, suspicion or disclosure of abuse. Records read confirmed all staff had up-to-date training in the safeguarding of vulnerable adults. Staff spoken to were knowledgeable of the different types of abuse and the reporting arrangements in place. The provider and a senior care assistant facilitated training for staff in the centre.

The inspector spoke to residents who said that they felt safe living in the centre. Residents attributed this to the management and staff who they said they were caring and trustworthy. There was a secure entrance to the centre, which was alarmed if the front door opened. A visitors' book was provided and all persons visiting the centre were required to sign it.

The provider was a pension agent on behalf of a number of residents. The arrangements in place to collect pensions for these residents were reviewed. It was noted residents' pensions were paid into a central account and not into an individual interest earning account in their own name. This was brought to the provider's attention during the inspection with regard to the Department of Social Protection guidelines.

There were systems in place to safeguard residents' personal monies. All transactions were recorded and double signatures maintained to ensure accountability. The inspector reviewed these practices and found them to be satisfactory.

The inspector read a policy on the management of responsive behaviours which guided staff practice. At the time of inspection a small number of residents presented with responsive behaviours. There were regular assessments completed and care plans were developed. Staff informed the inspector how they would handle certain situations with residents. Nurses spoken with were clear they needed to consider the reasons people's behaviour changed. They used evidenced based tools to record incidents when required. Where psychiatric or psychological services had been referred to or appointments made, there were records on file of visits from these professionals and their recommendations.

There was a policy on the use restrictive practices. The use of restrictive practices was limited to the use of bedrails. There was evidence these were routinely risk assessed, alternatives trialled, and care plans developed to guide care to be delivered. The national policy Towards a Restraint Free Environment (2011) was being implemented in the centre and a restraint free environment was promoted in the centre. For example, there was very low number of bedrails in use. There were no residents prescribed an "as required" (PRN) medicine at the time of the inspection

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):

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

Findings:

The inspector found there were systems in place to protect and promote the health and safety of residents, visitors and staff. The identification and assessment of risk required some improvement.

There was a risk management policy that met the requirements of the regulations. This was an action from the previous inspection and was addressed. It now included the procedures to prevent the risk of abuse. However, the implementation of the policy in practice required improvement. Two areas of risk were identified:

- an oxygen cylinder was stored in a resident's bedroom between use.
- a restrictive opening device for a window on the first floor was not working.

These issues were immediately addressed by the provider when brought to their attention, and an updated risk assessment was submitted to HIQA after the inspection. The identification of risk was an issue at the previous inspection also. A risk register had been developed which contained risk assessments for a range of hazards identified along with the control measures to manage them. There were individual risk assessments completed for residents also. The risk register was updated to reflect the revised assessments. A health and safety officer carried out bi-monthly inspections in the centre. There was an up-to-date safety statement for the centre.

There were arrangements in place for the investigation of adverse events involving residents. However, the review of medicine error incident reports required improvement. For example, the reports did not consistently include the action taken and if the errors had been discussed with nursing staff for learning or improvement. This was discussed with the person in charge.

The inspector observed residents to be actively mobile. Staff were observed following best practice moving and handling techniques. There was evidence that all staff had up-to-date training in this area. There were systems in place for the prevention of falls. A physiotherapist who worked in the centre three days per week had completed a monthly analysis of all falls occurring in the centre. The reports outlined the number of falls, the

location, time of day and if there were injuries sustained. The report included the actions required to bring about improvement. There was safe floor covering and handrails throughout the centre.

A comprehensive emergency plan was in place. It included the alternative locations should an evacuation be required. Staff knew how to respond in the event of an emergency.

There were suitable measures and policies in place to control and prevent infection. An infection prevention policy was in place. There was access to supplies of gloves and disposable aprons and staff were observed using the alcohol hand gels which were available throughout the centre.

There were suitable fire precautions in place. The inspector saw fire procedures were centre specific, guided staff practice and were prominently displayed throughout the centre. Service records confirmed the emergency lighting and fire alarm system was serviced every quarter and fire equipment was serviced annually. It was noted that the fire panels were in order, and fire exits, which had daily checks, were unobstructed.

Training records read confirmed all staff had attended annual fire safety training. Staff were knowledgeable of the procedure to follow in the event of a fire. Regular fire drills were conducted, with the most recent in September 2016. The action regarding the completion of drills at night time to assess staff knowledge of the procedures had been addressed. There had been two drills with the night shift staff since the January 2016. Records read confirmed these had taken place. The inspector discussed drill practices with the provider, who described the drills that took place, along with the action to take if improvements were identified. An area of improvement was identified as outlined in Outcome 5-Documentation.

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

Findings:
The provider ensured residents were protected by the centre's policies and procedures for medicine management.

The action from the previous inspection was addressed regarding the information

available to staff on prescription sheets regarding the administration of PRN ("as required") medicines.

There were operational policies relating to the ordering, prescribing, storage and administration of medicines. As reported in Outcome 5, the medicine management policy had been revised to include prescribing procedures.

The inspector reviewed the system in place for the safe administration of medication. Nursing staff spent time with the inspector and were familiar with the procedures in place.

All nursing staff had completed medicine management training. There were regular reviews of the residents' medicines by the GP and the pharmacy service. The person in charge ensured regular audits of medication practices were carried out. The pharmacy service also carried out detailed audits of the medicine management practices in the centre.

Medicines that required strict control measures (MDAs) were carefully managed and kept in a secure cabinet in keeping with professional guidelines. Nurses kept a register of the MDAs. The stock balance was checked and signed by two nurses at the change of each shift. The inspector checked the balance of a sample of medicine and found it to be correct.

All medicines were stored securely within the centre, and a fridge was available for all medicines or prescribed nutritional supplements that required refrigeration, and the temperature of this fridge was monitored and recorded on a daily basis.

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 was satisfied that a record of all incidents was maintained and where required were notified within the specified time frame to HIQA.

The inspector reviewed the records of accident and incidents. The person in charge was familiar with the different incidents that were notifiable to HIQA within three working days. The person in charge also submitted a quarterly report outlining other incidents to HIQA.

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:

The inspector found nursing staff had a good knowledge of the residents' health care needs. Residents received timely intervention when concerns around clinical risks were identified. However, the documentation, review and consultation of care plans required improvement.

The nursing staff were familiar with the residents and spoke knowledgeably of their health care needs. However, the documentation and review of care plans require improvement.

1. The care plans for some residents did not fully reflect the care to be delivered to residents. For example, end-of-life care, catheter care, diabetes management, responsive behaviours and psychotropic medicines.
2. Some care plans had not been reviewed at a minimum every four months. For example, there were gaps of up to 11 months between the review of one resident's care plan.
3. There was inconsistent documented evidence of consultation with residents in their care plan reviews.

These matters were discussed with the person in charge and provider who assured the inspector appropriate action would be taken to address the issues identified.

Residents were comprehensively assessed on admission to the centre. There were recognised tools used to assess residents clinical and health-care needs on a four monthly basis. There was information on each resident documented clearly on a daily basis in their nursing notes or within the vital signs were carried out on a monthly basis for example, body-mass-index (BMI), weight, blood pressure, temperature.

Residents' health care needs were supported by good access to GP services and an out-of-hours GP service was available. If preferred, residents could retain the services of their own GP. There

There was good access to allied health professionals including dietician, speech and language therapist and psychiatric services. The action from the previous inspection was addressed and the dietician's recommendations were incorporated into residents' care plans. This was seen to be implemented in practice. For example, care plans included recommendations on fortified meals and weight monitoring. A physiotherapist was employed by the service and provided valuable support. Letters of referrals and appointments to these services were seen on residents' files.

The inspector found there were systems in place to ensure the social care needs of residents. There were social care assessments completed for each resident. A care plan was developed outlined the residents level of ability and what activities they would like to take part in. A range of activities was undertaken including art, bingo, quizzes and group exercise programmes. The inspector observed that the residents who could participate enjoyed these activities immensely. An aroma therapist was present in the centre and provided massage.

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):

No actions were required from the previous inspection.

Findings:

The centre was clean, warm and well maintained. However, there were deficits in the design and layout of the centre that did not meet the requirements in the regulations. The matters had also been an issue at the previous registration inspection of July 2013 and were not fully addressed. The provider's response stated a comprehensive project was taking place to ensure compliance by February 2015. This was not evident at this inspection

There were three floors with bedrooms located on each floor. There were two main

staircases accessing all floors, one at each end of the centre. A number of bedrooms were located on the return of the stairs on each floor. These bedrooms included five twin bedrooms and one single bedroom that could only be accessed by negotiating a number of steps. A movement and handling assessment reviewed for each resident living in these rooms stated all were independently mobile, with some requiring support of one staff on the stairs. A number of these residents spoke to the inspector and were observed to mobilise up and down the stairs. However, the inspector found there was no definite contingency plan in place for the transfer of these residents if they became less mobile. The provider told the inspector residents would be moved to rooms accessed by a lift if their needs changed. She said there were long term plans to put chair lifts in place but formal plans were not available.

There were sufficient number of toilets, and accessible bathrooms in the centre. However, there was no assisted bathroom or shower on the second and third floors. Residents who needed an assisted bathroom were required to use one located the ground floor. These matters were also issues at the previous inspections of August 2012 and July 2013.

The provision of a staff room requires consideration. As outlined in Outcome 16, some staff reported that they used the visitors' room to have breaks in. Staff were also observed to use the residents' dining room to have their breaks.

There was one multi-occupancy three-bedded room in the centre The inspector spent time in the three-bedded room and found that there was adequate storage and screening provided to all three beds. All other bedrooms were either single or twin. The premises consisted of eight single bedrooms all with full assisted en suite shower, toilet and wash-hand basin, three single bedrooms and one single room all with en suite toilet and wash-hand basin, four twin bedrooms all with en suite toilet, ten twin bedrooms and the three-bedded room with no en suite facilities. There were two additional assisted toilets and showers on the ground floor. There was an additional toilet, wash-hand basin and shower on the second and third floor but no assisted facilities. There was a small staff changing room, kitchen, laundry, smoking room and dining room.

A call system, with an accessible alarm facility, was provided in each bedroom. There was an accessible, well maintained garden with seating areas. An outdoor smoking area was located in the garden also.

A fully equipped dirty utility room that included a bedpan washer was provided. Assistive equipment was provided to meet the needs of residents, these included pressure relieving mattresses and mobility aids.

There were records to demonstrate that equipment was regularly serviced including the hoist and lift. The inspector visited the kitchen and found that it was clean, spacious and well organised.

Judgment:
Non Compliant - Moderate

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 complaints procedure was displayed at the main entrance to the centre and it described how to make a complaint. A policy on complaint's management was in line with legislative requirements. There were some improvements identified in the information required to be kept by the regulations.

The inspector read a sample of complaints records for 2016. The nature of each complaint was documented. There was a response to each complainant about the action. However, the investigation carried out and each complainant's satisfaction was not documented. This was discussed with the provider who was also the complaint's officer.

The complaint's policy listed also details of the nominated complaints officer within the centre and an independent person was available for appeals.

It was noted there was no system of recording verbal complaints for trending and learning purposes. The person in charge stated that verbal complaints would be resolved by staff at local level and escalated to her if not.

The inspector spoke to residents and family members who were very happy with the complaint's process. It was noted that some residents and relatives spoken to were not satisfied that the complaint they had made had been resolved. This was brought to the provider's attention also who assured the inspector action would be taken.

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 a policy on end-of-life care which was guided practice and there was evidence of good practice in this area.

The person in charge stated that the centre maintained links with the local palliative care team. Residents at this stage of life would be offered a single room where possible. No resident was receiving end-of-life care at the time of inspection.

Care plans were developed for residents regarding their preferences and wishes if they were to approach end of life. This is discussed in more detail in Outcome 11.

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:

The person in charge ensured residents were provided with a choice of meals that were of adequate quantities, wholesome and met their nutritional needs.

The inspector spent time with residents in the centre's dining room during the lunchtime meal. During the meal there was an adequate number of staff available to support residents who required assistance. The person in charge was also present to supervise the meal. However, staff informed inspectors they were scheduled to take breaks during mealtime, which could reduce the numbers available to supervise residents by half. It was noted that nurses did not formally supervise the meals as they administered medicines during this time. Therefore improvements in the supervision of mealtimes required improvement. This is discussed in Outcome 18 (Workforce). There were no negative outcomes for residents observed during the mealtime.

There was a variety of choice available at each mealtime. This was confirmed by residents who spoke to the inspector. The inspector sat for a while with residents who spoke about the good quality food they were served. The meals looked wholesome and were nicely presented. There were good practices to support residents who required assistance and staff were observed discreetly and respectfully assisting some residents

with their meals.

The residents on a modified consistency diet received their prescribed diet, and systems were in place for nursing staff to communicate their needs with the catering staff and healthcare staff. Where residents required monitoring due to weight loss the person in charge described the systems in place to record their food and fluid intake. There were no residents being monitored at the time of the inspection.

Residents were offered refreshments and snacks during the day. The inspector saw residents being offered water, fruit juices and hot drinks. There was fresh fruit, cakes, soup and sandwiches provided between meals.

The inspector visited the kitchen and met the chef. There was a system for communicating up-to-date information on residents' assessed needs and dietary requirements. There was plenty of food in stock to ensure residents received meals and snacks in quantities and at a regularity that met their assessed needs.

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:

The inspector found residents' privacy and dignity was respected. However, improvement was required to ensure that residents were consulted with about how the centre was run.

There was no residents' committee in place for the last 12 months to consult with residents about how the centre was planned and run. The inspector was told the last meeting was over 12 months ago. This was discussed with the provider who said the reason was due to lack of residents' interest . However, improvement in this area was still required.

The provider outlined details of independent advocacy services that were available to the residents. The advocate regularly met residents on an individual basis when

requested to. The inspector met the advocate who outlined their role as advocate for residents in the centre.

There was an open visiting policy and evidence of regular contact with relatives. A room was provided for residents to meet loved ones in private. Some families told the inspector they were not aware there was a room available to meet in private. The inspector was told by staff it was used for their breaks. This was discussed with the person in charge and director who said they would ensure the room was available when requested.

Residents' religious and civil rights were supported. Mass and prayer services were held on a regular basis. Each resident had a section in their care plan that set out their religious or spiritual preferences.

Staff said and residents confirmed they had been offered the opportunity to vote at the recent elections.

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:
The inspector was satisfied that there were adequate arrangements in place to protect residents' possessions. Residents also had control over their own possessions.

There was suitable storage space for residents' clothing and their personal possessions. A lockable drawer was available in each resident's bedroom. On admission, a list of personal possessions was drawn up for each resident. It was kept up-to-date.

There were suitable laundry facilities available in the centre. A member of staff spoke to the inspector, and outlined the laundry arrangements that were in place. Each piece of clothing was labelled by the staff if requested. After clothing was laundered it was then returned 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):

No actions were required from the previous inspection.

Findings:

The inspector found that there were sufficient staff levels and skill mix to meet the assessed needs of residents. However, the deployment and management of staff to ensure appropriate supervision of residents at certain times of the day required improvement. This has already been referred to in outcome 15.

There was an actual planned roster seen by the inspector that confirmed an adequate number of staff and skill mix met the needs of residents. However, the delegation of staff to ensure adequate supervision of residents at certain times of the day required improvement. For example, as outlined in Outcome 15, care staff took their breaks during the main meal of the day which could result in up to three out of the six staff off the floor during this time. This left just three staff to provide care for residents in the centre at the main meal. This issue was commented on by family members during the inspection who reported due to staff taking breaks together there was no listening to requests for assistance by residents. This was brought to the attention of the provider and the person in charge, who took action during inspection. The inspector was informed that staff rosters would be adjusted during the mealtimes to ensure there was an adequate staff level at all meal times.

There was at least one nurse on duty on each in the centre in a 24 hour period. Two nurses were allocated to work from 7.30am to 7.30pm and one nurse was rostered to work overnight from 7.30pm to 7.30am. There were an adequate number of healthcare assistants assigned to support the nursing staff. The person in charge and the two directors (registered nurses) were also rostered to work and the days and times of their shifts were recorded.

A sample of staff files reviewed contained the information required by regulations. The sample of files reviewed confirmed staff had An Garda Síochána vetting.

All nurses had up-to-date personal identification numbers that confirmed registration with An Bord Altranais agus Cnáimhseachais na hÉireann (Nursing and Midwifery Board

of Ireland) for 2016.

There was a training programme in place for all staff. Records read by inspectors confirmed all staff had up-to-date mandatory training and received education and training to meet the needs of residents. Records confirmed staff had attended a range of training in areas such as dementia care, dysphagia and nutrition.

Judgment:

Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Deirdre Byrne
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:	Atlanta Nursing Home
Centre ID:	OSV-0000010
Date of inspection:	28/09/2016
Date of response:	27/01/2017

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 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 systems in place to ensure care was continuously and monitored required improvement for example, how to bring about improvement or changes in the care delivered to residents.

1. Action Required:

Under Regulation 23(c) you are required to: Put in place management systems to

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

ensure that the service provided is safe, appropriate, consistent and effectively monitored.

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

A new Quality Management System (QMS) is in the process of being introduced. Through the collection of data and scheduled audits we will be in a position to monitor the levels of our service delivery and thereby identify and improve any areas that need change. As required this will ensure that the care is "continuously".

Proposed Timescale: 29/09/2016

Outcome 03: Information for residents

Theme:

Governance, Leadership and Management

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

The residents' guide did not include the terms of residency in the centre.

2. Action Required:

Under Regulation 20(2)(b) you are required to: Prepare a guide in respect of the designated centre which includes the terms and conditions relating to residence in the centre.

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

The Residents Guide has been updated and includes the conditions relating to residence in Atlanta.

Proposed Timescale: 25/01/2017

Theme:

Governance, Leadership and Management

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

The residents' guide not include a summary of the complaint's process.

3. Action Required:

Under Regulation 20(2)(c) you are required to: Prepare a guide in respect of the designated centre which includes the procedure respecting complaints.

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

The Residents Guide has been updated and includes the procedure in respect of complaints and as required "respects complaints"

Proposed Timescale: 25/01/2017

Outcome 05: Documentation to be kept at a designated centre

Theme:

Governance, Leadership and Management

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

The completion of fire drill records requires some improvement for example, the time, length of time and findings were not included.

4. Action Required:

Under Regulation 21(4) you are required to: Retain the records set out in paragraphs (6), (9), (10), (11) and (12) of Schedule 4 for a period of not less than 4 years from the date of their making.

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

In addition to complying with Regulation 21(4) as to the records set out in paragraphs (6), (9), (10), (11), and (12), all fire drills will contain the time, length of time and findings.

Proposed Timescale: 25/01/2017

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:

The arrangements in place to lodge residents' pensions into a central account require review.

5. Action Required:

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

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

Every reasonable step is taken to protect residents from abuse. While it is clear that no financial abuse was had taken place, we are currently putting in place all the necessary paperwork in order to open individual bank accounts for residents. This will ensure that our system exceeds HIQA's previous findings of a robust financial management system for residents' funds being in place.

Proposed Timescale: 28/02/2017

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:

Two areas of risk had not been identified and assessed-the storage of oxygen cylinders and restrictive opening devices on an upper floor window.

6. Action Required:

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

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

While these were included in our Risk Assessments as to bedrooms, we will, for the purposes of clarity, break them out to into individualised assessments

Proposed Timescale: 25/01/2017

Theme:

Safe care and support

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

The review of incidents in the centre did not include an overview of improvements and actions for learning purposes.

7. 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:

In addition to our current arrangements, we will ensure that we clearly set out an overview of improvements and actions for learning purposes as part of our Risk Management process.

Proposed Timescale: 25/01/2017

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:

Care plans for residents' identified needs did not consistently guide the care to be delivered.

8. 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:

Through continuous training, staff development and auditing, we will ensure that all our care plans consistently guide the care that we deliver. This process will be enhanced through the introduction of a new QMS.

Proposed Timescale: 25/01/2017

Theme:

Effective care and support

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

Some care plans were not reviewed at a minimum every four months.

Consultation with residents in their care plan review requires improvement

9. Action Required:

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

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

All care plans will be reviewed every 4 months or as required. Through a new QMS we will carry out audits and take any corrective actions identified, discuss the findings at management and staff meetings and provide any additional training required.

A system has been developed whereby the PIC will meet with families at least twice a year or more often if required and subject to the residents wishes will discuss the care plans with the families.

Proposed Timescale: 25/01/2017

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:

There were six bedrooms on floors that were not accessible by a lift.

There were no assisted showers on the second and third floor for residents who required full assistance resided.

10. 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:

A comprehensive plan with all supporting documentation was previously submitted to, and approved by, the Chief Inspector in relation to Schedule 6. This is a matter of record on our file with HIQA. Compliance in this regard has been extended by the Minister for Health until 2021. All work, including inter alia, new assisted bathroom (AB) outside Room 27, revamped wet room O/s Room 20, revamped AB o/s Room 19, New wet room beside Room 9a and new wet room in the new conservatory have all been completed.

It is planned to install stair lifts during the first half of 2017. All residents residing in rooms that do not have lift access are fully assessed by our physiotherapist on an ongoing basis as to their mobility. In the event of a change in their mobility the resident will be moved to another room.

The only overhang issue from Project 2015 is the installation of the chair lifts. It is planned to install and commission these on a phased basis between now and 30th June 2017.

Proposed Timescale: 30/06/2017

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:

There was no record of complaint investigations and the satisfaction of a complainant with a particular outcome.

Some families and residents had not received feedback if their complaint was resolved.

11. Action Required:

Under Regulation 34(1)(f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.

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

A record is kept of all complaints and all complaints are fully investigated and evidence

in this regard is evident from copies of investigation reports submitted to HIQA previously. We will ensure that where relevant, appropriate feedback will be given and the satisfaction or dissatisfaction of the family or the resident, or both, with the outcome of any investigation is clearly recorded. We will include this criteria in our QMS.

Proposed Timescale: 25/01/2017

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:

The system of consulting with residents in how the centre is organised requires improvement.

12. Action Required:

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

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

A schedule of family / residents meetings has been put in place. An agenda will be prepared for each meeting and minutes taken and circulated.

Proposed Timescale: 25/01/2017

Outcome 18: Suitable Staffing

Theme:

Workforce

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

The allocation of staff during mealtimes requires improvement to ensure adequate supervision of residents' healthcare needs.

13. Action Required:

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

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

Having carried out a comprehensive review, assessment and evaluation of the numbers and skill mix at meal times, break times for HCAs has been changed to allow 3 additional HCAs supervise during meal times.

Proposed Timescale: 25/01/2017