<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Garbally View Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000343</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Brackernagh, Ballinasloe, Galway.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>090 964 2622</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:garballyview@gmail.com">garballyview@gmail.com</a></td>
</tr>
<tr>
<td>Type of centre:</td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>Tony Whyte and Teresa Whyte Partnership T/A Garbally View Nursing Home</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Tony Whyte</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Marie Matthews</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>None</td>
</tr>
<tr>
<td>Type of inspection:</td>
<td>Announced</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>32</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>5</td>
</tr>
</tbody>
</table>
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:
15 March 2017 10:00 15 March 2017 19:00
16 March 2017 09:00 16 March 2017 17:00

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

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

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

The centre accommodates 37 residents requiring long-term care, or who have respite, convalescent or palliative care needs. The centre was originally a domestic
house which was extended when the centre was established in 1993. It was clean and generally well maintained and provided a comfortable environment. There were 32 residents accommodated at the time of this inspection. A further two residents were in hospital.

The inspector met with the provider and the person in charge who displayed a good knowledge of the Authority's Standards and regulatory requirements. A number of questionnaires from residents and relatives were received prior to the inspection and the inspector spoke to residents during the inspection. The collective feedback from residents and relatives was one of satisfaction with the service and care provided. The inspector reviewed progress on the action plan from the previous monitoring inspection carried out in September 2015. Seven of the eight actions were addressed.

The person in charge was aware of her responsibilities under the regulations. She was accessible to residents, relatives and staff and had a good knowledge of each of the residents care needs. A general manager also worked in the centre and there was evidence of a commitment to providing quality, person-centered care.

There was evidence of individual residents’ needs being met. The inspector found a good standard of evidence-based care and appropriate medical and allied health care access. Residents spoken with stated that they felt safe in the centre. Most residents came from the Ballinasloe area and were known to staff and there were strong links with the local community. Documentation such as care plans, medical records, policies and procedures and staff personnel files were reviewed. The inspector found that residents’ health care needs were appropriately assessed and addressed. There was good access to general practitioners, pharmacists and allied health professionals.

The inspector identified some aspects of the service that needed improvement. Audits were completed by the person in charge but there was no quality improvement strategies developed to address any deficits and improve the quality of the service. Some care plans also required review make them more person centred and to reflect the advice of specialists. There was also inadequate storage space available for all assistive equipment and some minor refurbishment of the premises was required to repair damage from equipment.

The action plan at the end of this report identifies these and other areas where improvements must be made to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.
**Outcome 01: Statement of Purpose**

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

**Theme:**
Governance, Leadership and Management

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

**Findings:**
There was a written statement of purpose which set out the aims, objectives and ethos of the centre and which detailed the facilities and services provided for residents. It required minor review to include details of the number of residents accommodated and the arrangements for consultation as required in schedule 1 of the Regulations. These were both addressed during the inspection and a revised copy submitted to the Chief Inspector.

**Judgment:**
Compliant

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**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:**
There was a clear management structure in place and appropriate systems were in place to ensure the service provided was safe appropriate to residents needs and consistently
monitored. The general manager and the person in charge worked closely together to ensure the service provided was safe and appropriate to the needs of residents. The provider nominee told the inspector that he visited the centre two to three days per week and this was confirmed by the person in charge.

The person in charge completed various clinical audits of areas such as complaints, accidents or falls sustained by residents, medication management, nutrition and weight loss, restraint use and wound care but these audits were not completed annually and there was no quality improvement plan developed where decencies were identified. There was no evidence of consultation of residents in the reviews completed.

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

**Findings:**
There was a written contract of care provided to all residents on admission to the centre which detailed the services to be provided and the fees payable by the residents. The inspector reviewed a sample of the contracts of care and found that they were signed by the resident or their next of kin and they clearly specified the amount paid.

The contract of care outlined the range of services included in the fee and those which incurred an additional charge were included in an attached schedule. Additional expenses included chiropody and hairdressing. The contract indicated whether the resident had a single or shared bedroom which was an action from the last inspection.

There was a residents’ guide available which included a summary of the complaints procedure.

**Judgment:**
Compliant

### Outcome 04: Suitable Person in Charge

The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.
**Theme:**
Governance, Leadership and Management

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

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

The person in charge had completed training in various clinical areas to maintained her clinical skills including training on falls management, cardiac, wound care, medication management and infection control.

**Judgment:**
Compliant

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**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.

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**Theme:**
Governance, Leadership and Management

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

**Findings:**
The directory of residents was reviewed and contained all the information required by schedule three of the regulations. Written operational policies, which were centre-specific, were in place to inform practice and provide guidance to staff.

Appropriate insurance cover was in place with regard to accidents and incidents and residents’ personal property.
Medical records and other records, relating to residents and staff, were also maintained in a secure manner. Some care records reviewed required further review to ensure they were person centred and accurately reflect the residents' needs care.

A review of a sample of staff files found them to contain all the information required by Schedule 2 of the regulations. However, codes were used on the staff roster without any key to explain them and times were not recorded in a 24 hour format.

**Judgment:**
Substantially Compliant

<table>
<thead>
<tr>
<th><strong>Outcome 06: Absence of the Person in charge</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

**Theme:**
Governance, Leadership and Management

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

**Findings:**
A senior nurse who deputised in the absence of the person in charge was on leave. A second nurse was trained by the person in charge to ensure a contingency arrangement. The provider was aware of the requirement to notify the Chief Inspector of the proposed absence of the person in charge for a continuous period of 28 days.

**Judgment:**
Compliant

<table>
<thead>
<tr>
<th><strong>Outcome 07: Safeguarding and Safety</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

**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 for the prevention, detection and response to abuse. Residents who spoke with the inspector said they felt safe and secure in the centre. A policy on protecting residents from abuse was available however it required review to reflect the revised reporting and safeguarding arrangements in the new Health Service Executive (HSE) policy on Protection of Vulnerable adults.

The inspector spoke with several staff members and with the person in charge. All those spoken with indicated that any form of abuse would not be tolerated and were aware of the signs to look out for. Staff identified that they would report any suspicions to the person in charge as the person. Training records reviewed confirmed that all staff members had completed training in protection of vulnerable adults.

Five residents had bedrails in place. Three of these were at the request of the resident to either assist them or reassure them. The inspector saw that the enabling function was recorded on the assessment completed. A risk assessment was completed prior to using bedrails and signed consent was obtained. There was evidence of multi disciplinary involvement in the decision making process.

Where residents had behaviours and psychological symptoms of dementia (BPSD) a log of the behaviours was maintained to help identify possible triggers. The residents’ dementia was noted in care records and guidance included to staff to help alleviate anxiety. There was a policy in place for behaviour that is challenging, and staff had received training on understanding and managing behaviours. Staff were observed to be aware of the interventions to use to help manage the behaviours including redirection and engaging with the residents. There was evidence in care plans of links with the mental health services.

There was a policy outlining procedures to guide staff on the management of residents’ personal property and possessions. The person in charge acted as an agent for one resident. A record of all transactions was maintained and two signatures were recorded for each transaction. The ongoing balance was clear from the records. Small amounts of money were also stored safely on behalf of some residents.

_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):_
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 environment was maintained in a safe manner and all corridors were unobstructed. The inspector saw that a safety statement was available which included a register of all the identified risks in the centre including those specified in the regulations. The risk management policy required review as it did not provide guidance on the management these risks identified.

Arrangements were in place for the prevention and containment of fire. All bedroom doors were fitted with self closing devices and suitable fire fighting equipment was provided including fire extinguishers, smoke detector alarms, emergency lighting and alarm equipment. There were service records of the equipment maintained that confirmed regular servicing took place and they were in good working order. All fire exits were unobstructed and records were read of the daily checks completed nursing staff.

Fire evacuation procedures were prominently displayed in the centre. All staff had been trained in fire safety management, which they completed on an annual basis. The staff were knowledgeable of their role and the evacuation of residents in the event of a fire. All immobile residents had an evacuation sheet fitted to their bed. Instruction on the use of fire extinguishers was provided as part of fire training and the person in charge stated that the fire alarm was activated regularly however, these drills were not comprehensively recorded. For example, the location of the drill and duration was not documented or the names of the staff or residents who took part was not recorded.

There were measures in place in to prevent the risk of injury to residents and there were systems in place to manage and document any accidents and incidents that occurred. Communal areas were well supervised during the inspection and the number of falls occurring was low. The inspector reviewed the accidents and incident log. The records included details of the incident and the actions taken and learning to prevent reoccurrence. Residents who sustained a fall were reviewed by a physiotherapist. Where a fall was unwitnessed or the resident had a head injury neurological observations were recorded.

Staff had all up-to-date training in movement and handling and in the use of assistive equipment such as hoists. Call bells were provided in communal areas and beside residents’ beds. There were non-slip safe floor surfaces. Handrails were provided on along hallways and in bathrooms to support residents.

There were polices on the prevention of infection in the centre. Hand gel dispensers and disposable gloves and aprons were provided. All cleaning equipment, chemicals and items which could be ingested by residents with a cognitive impairment were securely contained in a locked area.

An emergency plan was read that included the procedures in place to manage potential risks such as flood, fire or water shortage. There was alternative accommodation available locally if an evacuation from the centre was required however there was no reference to the availability of an alternative power source for use in the event of a power failure.
Judgment:
Non Compliant - Moderate

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

Theme:
Safe care and support

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

Findings:
The inspector found that there were suitable policies and processes in place in relation to the safe management of medications. Medication was supplied by a local pharmacy in the original packaging. All medication was checked for completeness following delivery. The person in charge said that where possible residents were facilitated with their choice of pharmacist. There was a system for the return of unused medication to the pharmacy. GP’s reviewed each resident’s medication every three months or more frequently should a change in residents’ health occur.

The inspector reviewed a sample of medication charts. Photographic identification was evident on each chart to ensure the correct identity of the resident receiving the medication and reduce the risk of medication error. The prescription sheets reviewed were legible. The maximum dose over a 24 hour period was stated for all PRN or as required medication.

The inspector saw that controlled drugs were stored safely in a double locked cupboard and stock levels were recorded at the end of each shift and recorded in a register in keeping with the Misuse of Drugs (Safe Custody) Regulations, 1982. In the sample checked by the inspector the balance in stock was the balance recorded.

Judgment:
Compliant

Outcome 10: Notification of Incidents
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:
Safe care and support
Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
The inspector reviewed a record of incidents or accidents that had occurred in the centre and cross referenced these with the notifications received from the centre. Quarterly notifications had been submitted to the Authority as required but some of these had not been received in the required time frame. The person in charge said they had experienced some issues with the Authorities system for submission of notifications.

Judgment:
Substantially 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:
There were 30 residents accommodated on the day of the inspection and a further two residents were in hospital. Six residents were assessed as having maximum or high dependency care needs, eight were assessed as having high level needs and 17 were assessed as having medium dependency needs.

Residents had a mixture of age related medical conditions and six residents had a formal diagnosis of dementia however others were described as having some form of cognitive impairment. The inspector found that residents were appropriately monitored to detect changes in their health and they received appropriate care to enable them to remain well.

Nine General Practitioners (GP s) supported the centre and there was evidence of regular review by GPs in the files reviewed. Support services such as physiotherapy, speech and language therapy, dietetics and occupational therapy were contracted in by the provider and the inspector saw that residents requiring review were seen promptly and their recommendations were been followed by the staff. There was also good access to geriatrician and psychiatry of older age services in the area also.

The person in charge visited residents prior to admission in order to determine their care
needs. Evidence based assessment tools were used following admission to determine residents’ care needs and to assess their vulnerability to the risk of falls, developing pressure wounds, weight loss, and moving and handling requirements. Arrangements to meet residents’ care needs were set out in individual care plans.

Four resident’s care plans were reviewed during the inspection and aspects of other care plans were reviewed. The inspector saw that residents were closely monitored and were seen by a GP when required or in some cases went to hospital for further assessments.

Most care plans reviewed were person centred and contained a good level of detail. However, aspects of some care plan documentation required improvement. For example: - the recommendations of some health professionals whilst been implemented in practice were not always incorporated into a small number of care plans. For example, a dietician’s advice to help prevent weight loss wasn’t included in the one residents care plan. Whilst assessments were reviewed every four months, there wasn’t always any narrative note recorded detailing any changes in the residents care needs. The inspector also reviewed the care of one resident who had a cardiac condition and who had repeated respiratory tract infections. There was no written care plan in place to guide staff to provide the appropriate and ensure these care needs were addressed in a consistent manner.

Consultation with residents or their families in care plan reviews was not always evident. The person in charge said families and residents were regularly updated on any changes made to their care plans and this was confirmed by the residents and relatives who completed questionnaires however limited documentation was available to demonstrate this.

The inspector reviewed the care of residents with dementia. There was guidance provided in various care plans to assist staff to help care for these residents however this information was not cohesive and wasn’t consistently recorded. For example, one residents care was described in a care plan on confusion and another’s was included in a care plan on communication. However, there was no specific dementia care plan to support the resident which described the stage of their dementia, the memory and abilities they retained or the family members the resident still recognised.

**Judgment:**
Non Compliant - Moderate
Effective care and support

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

**Findings:**
The centre was originally built as a single storey domestic house and adapted by the addition of various extensions over the years. It was clean, warm and well maintained. The building was safe and secure. There was a key code required to enter or exit the building. There were two communal areas available and residents could choose where they spent their time. A large dining room was located in older part of the house. The kitchen was inspected and found to be adequate to serve the centre.

Bedroom accommodation comprised of 6 single bedrooms with ensuite bathroom facilities and four without; 12 double rooms (one with ensuite facilities) and one triple room. Bedrooms had been personalised to reflect the residents’ tastes. The inspector saw that there was adequate storage provided for residents and screening and appropriate screening was provided around the beds in shared bedrooms. A call system was provided in each bedroom.

There was an accessible, well maintained garden available to the rear of the premises. None of the current residents smoked but a smoking area was provided.

There were four accessible bathrooms available. One bathroom had a hydrotherapy pool that was well used by residents. This room had a ceiling tracker hoist provider overhead. There were handrails provided on all corridors and in bathrooms and toilets to support residents.

Some refurbishments were required in areas. For example some showers required a sealant to allow effective cleaning and some skirting boards had become damaged from equipment impact. There was also inadequate storage space available for wheelchairs and commodes. The inspector observed that some showers had had a raised step around the shower tray.

A cleaning room and a dirty utility room were provided and both were observed to be kept locked to protect residents. Various assistive equipment was provided to meet the needs of residents including mobility aids, wheelchairs and pressure relieving mattresses. There were records to demonstrate that equipment was regularly serviced.

**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 complaints procedure was displayed at the main entrance to the centre and it described how to make a complaint. A policy on complaints' management was in line with legislative requirements.
The inspector read a sample of the complaints recorded for 2016 and 2017. The nature of each complaint was recorded. There was evidence of a response by the person in charge to each complainant and the complainant's satisfaction was documented. The complaint's policy listed also details of an independent appeals person.

Most complaints were dealt with immediately by staff and only more serious complaints were escalated to the person in charge. There was however no clear process for monitoring all verbal complaints to help identify trends or any learning.

Residents and family members who completed satisfaction questionnaires stated they were very happy with the complaints process.

### Judgment:
Substantially Compliant

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### 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 families of residents receiving end of life care were facilitated to be with their loved ones. There was evidence of good involvement with the local palliative care team. The resuscitation status of residents was noted at the front of their medical file and the inspector saw that this decision was regularly reviewed with the resident by the General Practitioner.

The person in charge stated that residents at this stage of life would be offered a single room wherever possible. No resident was receiving end-of-life care at the time of
Care plans were developed for residents regarding their preferences and wishes if they were to approach end of life. Some of these contained a good level of detail regarding the residents’ end of life preferences but some were generic and had not been adapted to reflect the specific choices of the resident. An action has been included under outcome 11 to address this.

**Judgment:**
Substantially 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 inspector found that wholesome and nutritious food which was provided in adequate quantities to meet each resident's needs. Each resident was screened for nutritional risk on admission using a recognised assessment tool. Where a resident was identified as being at risk nutritionally they were referred to a dietician and those who had an impaired swallow were reviewed by a speech and language therapist.

The inspector observed the centre’s dining room during the lunchtime meal. There was an adequate number of staff available to support residents who required assistance. There was a choice available at each mealtime. This was confirmed by the residents who spoke with the inspector. The meals looked wholesome and were nicely presented. There were good practices to support residents who required assistance and the inspector observed that kitchen staff visited each resident who wanted to remain in their room to get their preferences. Staff were observed discreetly and respectfully assisting some residents with their meals. Residents with an impaired swallow were seated in an upright position in accordance with the advice of the Speech and Language therapist to prevent aspiration.

Those on special diets, for example modified consistency or high calorie diets, received their prescribed diet and systems were in place to communicate their needs with the kitchen and healthcare staff. The inspector saw residents being offered water, milk and hot drinks. There was a variety of homemade cakes and scones and fruit provided between meals.
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.

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

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**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:**
Comments in the residents’ questionnaires confirmed that residents were happy and that their rights, privacy and dignity were respected. The inspector observed staff interacting with residents in a friendly and courteous manner. Questionnaires completed by residents and relatives submitted to HIQA prior to the inspection also confirmed satisfaction with the quality and safety of care provided by the service.

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. There were good links with the local community and some residents went home regularly with their families. The residents’ liaison group held every two months which was chaired by one of the staff nurses. The minutes of the meetings included a note that actions from the previous meeting were addressed. There were no relatives or an independent advocate actively attending the meetings but residents who were unable to attend the meetings were visited separately by the nurse who chaired the meetings and consulted about the service. A new initiative called Garbally view newsletter had been introduced to help keep residents informed and the inspector saw that first newsletter was available.

Residents were facilitated to exercise their civil, political and religious rights. Mass was held in the centre once a week and residents religious or spiritual preferences were
recorded on admission and in their end of life care plan. The person in charge ensured that each resident was included on the electoral register and some residents spoken with residents confirmed they had voted at the last election. There was good range of organised activities to keep residents engaged in a meaningful way. An activity coordinator was employed and the activities programme covered the full week including the weekend. A range of activities were provided included an exercise class held three times a week, pet therapy, baking, word games and quizzes, music and movies.

There were both individual and group therapeutic programmes provided three times a week for residents with dementia. The residents spoken with said that they were able to exercise choice regarding the time they got up and were able to have breakfast at a time that suited them. Staff were observed knocking on bedroom, toilet and bathroom doors and waiting for a response before entering.

Judgment:
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. There were suitable laundry facilities available in the centre. A member of staff spoke to the inspector, who outlined the arrangements that in place to launder clothing. Appropriate infection control procedures were in place. Each piece of clothing was labelled. After clothing was laundered it was returned to each resident. On admission, a list of personal possessions was drawn up for each resident and this was kept up-to-date by the laundry staff member.

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:**
There were appropriate staffing levels and skill mix to meet the assessed needs of residents. There was an actual planned roster available. There was always at least one nurse on duty 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 8.30pm to 8.30am. There were an adequate number of healthcare assistants assigned to support the nursing staff. The person in charge was also rostered to work and was included on the rota.

The provider confirmed that all staff working in the centre had been vetted by an Garda Síochána. The sample of files reviewed by the inspectors confirmed this. 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:**
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:

Marie Matthews
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

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Garbally View Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000343</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>15/03/2017</td>
</tr>
<tr>
<td>Date of response:</td>
<td>25/04/2017</td>
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</tbody>
</table>

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:
Clinical audits were done infrequently and there was no quality improvement strategies was developed to improve the service where decencies were identified. There was no report completed on the quality and safety of care as required by the regulations.

1. Action Required:
Under Regulation 23(d) you are required to: Ensure there is an annual review of the

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.

Please state the actions you have taken or are planning to take:
Clinical Audits will now be done more frequently and a report on the quality and safety of care will be completed as required by the regulations.

Proposed Timescale: 31/07/2017

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:
Some care records reviewed required further review to ensure they were person centred and accurately reflect the residents needs care.
Working times on the staff rota were not recorded in a 24 hour format and codes were used without any key to explain them

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

Please state the actions you have taken or are planning to take:
The Staff Roster will now be done in 24 hour format and relevant codes explained. Care plans are now under review to be more person centered.

Proposed Timescale: Roster changes completed April 2017
Care Plan reviews to be completed May 31st

Proposed Timescale: 31/05/2017

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:
The risk management policy required review as it did not provide guidance on the management the risks specified in the regulations.

3. Action Required:
Under Regulation 26(1) you are required to: Ensure that the risk management policy set out in Schedule 5 includes all requirements of Regulation 26(1)

Please state the actions you have taken or are planning to take:
Risk Management will be reviewed to include the management of risks specified in the regulations

**Proposed Timescale:** 31/07/2017

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The emergency plan did not reference to the availability of an alternative power source for use in the event of a power failure.

**4. Action Required:**
Under Regulation 26(2) you are required to: Ensure that there is a plan in place for responding to major incidents likely to cause death or injury, serious disruption to essential services or damage to property.

Please state the actions you have taken or are planning to take:
Local Plant hire company was contacted and can provide a generator for rental if required, emergency plan has been updated to reflect this with name and number of the company.

Proposed Timescale: Completed March 23rd

**Proposed Timescale:** 23/03/2017

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The location and duration of the fire drill was not documented or the names of the staff or residents who took part was not recorded.

**5. Action Required:**
Under Regulation 28(1)(d) you are required to: Make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.

Please state the actions you have taken or are planning to take:
The staff and residents who are involved in relevant training will now be recorded at each fire drill including the location and duration of time it takes.

**Proposed Timescale:** 07/04/2017

**Outcome 10: Notification of Incidents**

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Quarterly notifications had been submitted to the Authority as required however some of these had not been received in the required time frame

6. **Action Required:**
Under Regulation 31(3) you are required to: Provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of any incident set out in paragraphs 7(2) (k) to (n) of Schedule 4.

**Please state the actions you have taken or are planning to take:**
All notifications will be submitted in the required timeframe going forward

**Proposed Timescale:** Immediate April 2017

**Proposed Timescale:** 30/04/2017

**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:**
A resident who had a cardiac condition and repeated respiratory tract infections did not have any written care plan in place to guide staff to provide the appropriate and ensure these care needs were addressed in a consistent manner.

there were no specific dementia care plans developed which described the stage of their dementia, the memory and abilities they retained or the family members the resident still recognised.

There was a policy on end-of-life care which was guided practice and there was evidence of good practice in this area. The families of residents receiving end of life care were facilitated to be with their loved ones. There was evidence of good involvement with the local palliative care team. The resuscitation status of residents
was noted at the front of their medical file and the inspector saw that this decision was regularly reviewed with the resident by the General practitioner.

The person in charge stated that residents at this stage of life would be offered a single room wherever possible. No resident was receiving end-of-life care at the time of inspection.

Some end of life care plans were generic and had not been adapted to reflect the specific choices of the resident.

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

*Please state the actions you have taken or are planning to take:*
All care Plans will be updated to reflect specific end of life wishes

Proposed Timescale: Update Care Plans May 31st

Cardiac care plan for specific resident completed 18th March 2017

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**Proposed Timescale:** 31/05/2017

**Theme:**
Effective care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Consultation with residents or their families in care plan reviews was not always evident.

8. **Action Required:**
Under Regulation 05(5) you are required to: Make the care plan, or revised care plan, prepared under Regulation 5 available to the resident concerned and, with the consent of that resident or where the person-in-charge considers it appropriate, to his or her family.

*Please state the actions you have taken or are planning to take:*
All Care Plans will have family consultation.

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**Proposed Timescale:** 31/05/2017

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**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 was inadequate storage available for assistive equipment such as wheelchairs and commodes and bathrooms were used to store this equipment.

Some skirting boards had become damaged from equipment impact.

9. 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:
We are in consultation with our builder to provide a storage space for assisted equipment.

Proposed Timescale: 30/11/2017

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 clear process for monitoring verbal complaints to help identify trends or any measures required for improvement in the service.

10. Action Required:
Under Regulation 34(1)(h) you are required to: Put in place any measures required for improvement in response to a complaint.

Please state the actions you have taken or are planning to take:
A new informal complaint s book has been introduced and all daily complaints will be recorded.

Proposed Timescale: 04/04/2017