Health Information and Quality Authority
Regulation Directorate

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	Abbot Close Nursing Home
Centre ID:	OSV-0004682
Centre address:	St. Marys Terrace, Askeaton, Limerick.
Telephone number:	061 601 888
Email address:	info@abbotclose.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Abbot Close Nursing Home Limited
Provider Nominee:	Denis McElligott
Lead inspector:	Caroline Connelly
Support inspector(s):	John Greaney
Type of inspection	Unannounced
Number of residents on the date of inspection:	56
Number of vacancies on the date of inspection:	5

About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

▪ Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
▪ Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

▪ to monitor compliance with regulations and standards
▪ to carry out thematic inspections in respect of specific outcomes
▪ following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
▪ arising from a number of events including information affecting the safety or wellbeing of residents.

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was following receipt of unsolicited information. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
09 February 2016 18:45	09 February 2016 22:30
10 February 2016 09:20	10 February 2016 17:50

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 05: Documentation to be kept at a designated centre	Non Compliant - Moderate
Outcome 07: Safeguarding and Safety	Compliant
Outcome 08: Health and Safety and Risk Management	Non Compliant - Major
Outcome 09: Medication Management	Non Compliant - Major
Outcome 10: Notification of Incidents	Compliant
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 12: Safe and Suitable Premises	Substantially Compliant
Outcome 13: Complaints procedures	Compliant
Outcome 15: Food and Nutrition	Compliant
Outcome 18: Suitable Staffing	Non Compliant - Moderate

Summary of findings from this inspection

This report sets out the findings of an unannounced two day follow up triggered inspection of Abbot Close Nursing Home which is registered to deliver care to 61 residents. The Authority had received a number of concerns in relation to staffing and safeguarding issues in the centre. Provider led inquiries were requested from the centre for a number of issues raised and were received by the Authority and included the required evidential documentation. A further concern in relation to staffing in the evening was received by the authority in February 2016 and as a result this triggered inspection was undertaken.

The inspectors arrived unannounced to the centre at 18.45 and were met by two nursing staff and a full complement of care staff. The centre was warm and comfortable and residents were up and around enjoying evening drinks. The issues raised were looked into during the inspection and are discussed under the relevant

outcomes but overall the inspectors did not identify evidence to substantiate the concerns raised.

During the inspection the inspectors reviewed documentation which included policies and procedures, resident's records and plans of care, minutes of staff meetings, staffing rosters, training records, incidents, allegations and investigations and other relevant documentation and practices were observed. Over the course of the inspection, inspectors met with residents, relatives, numerous staff members, the person in charge and the provider. Issues identified and actions required at the previous inspection were looked into during the inspection.

On the previous inspection inspectors found that there was requirement for significant improvement across a number of outcomes, and of the 18 outcomes inspected, 6 were found to be at the level of major non compliance. In response to two serious non compliances identified under outcome 8: Health & Safety and Outcome 18: Staffing, two immediate actions were issued and an appropriate response from senior management was issued to inspectors before the close of the inspection. On the previous inspection areas of non-compliance ranging from substantially compliant to major non-compliant were identified in 12 of the 18 outcomes: On this inspection inspectors inspected against the 12 outcomes of non-compliances identified on the previous inspection. On this inspection there were five outcomes compliant, one substantially compliant four moderate non-compliant and the inspectors identified major non-compliance in two outcomes previously found. This included one of the outcomes where an immediate action plan had been issued in health and safety and the other was in medication management which are two high risk areas. The inspectors reinforced to the provider and person in charge, about the seriousness of these continual major non compliances and the provider assured the inspectors they would address them immediately.

There were a number of other issues that required action identified on this inspection in relation to governance, care planning and staffing. These non compliances are discussed throughout the report and in the action plan at the end of the report. These improvements are required to comply 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.

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

Outcome 01: Statement of Purpose
There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:
Governance, Leadership and Management

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

Findings:
On the previous inspection this outcome was found to be major non compliant. The statement of purpose consisted of a statement of the aim, objectives and ethos of the designated centre. However, the provider was providing services which were not set out in the statement of purpose. The designated centre was providing day services such as meals and activities to some persons not residing in the designated centre. Services also included significant nursing interventions such as phlebotomy, liaising with doctors and responding to emergency calls from persons not residing in the designated centre. The centre also accommodated requests from persons not residing in the designated centre to intermittent overnight stays. None of these services were set out in the statement of purpose.

On this inspection the inspectors found that the centre was no longer providing any nursing interventions or organisational services for people not residing in the centre. The statement of purpose had been updated to reflect that some people from the retirement village did attend the centre for meals and some activities but this was organised by a member of staff designated to the retirement village. Staff spoken to including the person in charge stated this change was greatly beneficial to the residents in the centre as they had more time to spend on the residents and no longer had to provide care to non residents.

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

Findings:
On the previous inspection there was a clearly defined management structure that identified who was in charge, who was accountable and what the reporting structure was. Staff who spoke with the inspector were familiar with the structure. However on this inspection the inspectors found that there was no person designated as a key senior manager who would act up for the person in charge when she was on leave and this role was currently being fulfilled by the provider who is a registered nurse. As the provider is the provider for four other nursing homes this arrangement was not sustainable. The person in charge said they were actively recruiting for a new assistant director of nursing or a clinical nurse manager but had not been successful to date. There was evidence that the lack of a key senior clinical manager had impacted on areas of clinical oversight such as medication management and care planning as will be discussed further in the related outcomes.

As on the previous inspection there were audits completed for a range of areas such as pressure sores, falls, cleaning practices and complaints. There was evidence that the compiled data was analysed so as to improve quality and safety of care. Again on this inspection the inspectors found that there was scope to improve these audits and further audits on comprehensive medication management, fire practices and care planning documentation had not been undertaken. The inspectors found non compliances in these areas as were found on the previous inspection. Also two competent administration staff had full responsibility for the residents' accounts however there was no evidence of audit of these accounts by the person in charge or the provider. This is discussed further in outcome 7.

The provider was aware of his responsibility to conduct an annual review of the quality and safety of care delivered to residents in the designated centre and a very comprehensive annual review was forwarded to the inspector after the inspection, which included analysis of falls, complaints, pressure sores, activities, profiles of the residents. The report also contained the yearly overview and achievements for 2015. There was evidence of consultation with residents via the quarterly residents' forum.

Judgment:
Non Compliant - Moderate

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

Findings:
On the previous inspection there were a number of issues identified with residents' records which were looked into on this inspection and will be discussed further under outcome 11. On the previous inspection a number of policies required review required review. For example, the risk management policy did not meet the requirements of the regulations, in that it did not include all of the risks specified in the regulations. The medication policy required amendment to ensure it fully guided practice. On this inspection the inspectors found that the policies had been updated and the medication management policy was found to be comprehensive. However the risk management policy required further review as it did not state the procedures to be taken in the case of an allegation of abuse as specified in the regulations. Following the inspection the person in charge forwarded to the inspector an updated risk management policy that now met the requirements of regulation. It was also noted on this inspection that there was Closed-Circuit Television (CCTV) on the corridors and external perimeters of the building. There was a policy available but it was not sufficiently comprehensive as it did not state now long the CCTV was recorded for, who had access to the recordings and the purpose of the recordings. There was not sufficient sign-age to inform people that CCTV was in place as is required by data protection guidelines.

On this inspection a number of staff files were reviewed. The inspectors found that there were no references on file for a recently recruited nurse, there was no evidence of verification of references and a second member of staff had no reference from their last employer and no verified reference. This system of recruitment was found not to be sufficiently robust and did not meet the requirements of schedule 2 of the regulations.

Judgment:
Non Compliant - Moderate

Outcome 07: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe care and support

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

Findings:
The inspectors found that there was a policy in place for the prevention, detection and response to abuse. Staff who spoke with the inspector knew what constituted abuse and what to do in the event of an allegation. Staff confirmed that they would have no hesitation in reporting any concerning episodes and where concerns had arisen in the past, staff confirmed that they had been adequately supported by management to ensure they were protected if raising a concern in regards to safeguarding. The person in charge stated that she monitored systems in place to protect residents from abuse. She stated that a whistleblower policy was in place to protect those making a disclosure and she implemented this if necessary. She stated that the subject of abuse was discussed at staff meetings. Any incidents, allegations or suspicion of abuse were appropriately investigated and recorded.

Residents who spoke with the inspector stated that staff were very good, that they felt safe in the centre and stated that that they could speak with a number of staff if any concerns so arose. Relatives who spoke with the inspectors also confirmed that they felt their family member was well looked after in the centre.

The inspectors viewed the systems in place to safeguard residents' money and these were easily explained to the inspector. The centre was acting as an agent for some residents and record keeping was clear and up to date. There were two signatures for all transactions and receipts were generally maintained. A tally of a random selection of residents' property tallied with records. Two competent administration staff had full responsibility for the residents' accounts and there was no evidence of audit of these accounts by the person in charge or the provider. Internal and external audit would ensure a more robust system. This is included in the action around audit in outcome two.

There was a policy in place for managing behaviour that is challenging and for the use of restraint. Staff demonstrated good knowledge of residents' needs and discussed ways in which they responded to behaviours that challenge. On the previous inspection the

inspectors found that for residents who exhibited behaviours that challenge, there was no documentary evidence that efforts had been made to identify and alleviate the underlying causes of behaviour. There were no care plans in place in regards to positive behavioural support to ensure staff supported the resident in a consistent and appropriate manner. On this inspection the inspectors reviewed the care of a resident with responsive behaviours and found he had been reviewed on a regular basis was seen by psychiatry of old age and a comprehensive plan was in place which staff were following using distraction therapy and ensuring they were meeting the needs of the resident. Staff reported that this was all working well. However as on the previous inspection mandatory training for the management of behaviours that challenge was not up to date for all staff (this is actioned under outcome 18).

Since the last inspection the inspectors saw that the number of residents using bedrails had substantially reduced and efforts had been made to promote a restraint free environment via the purchasing of low low beds and alarm mats. There was evidence in residents' notes of an assessment completed for the need for restraint and other alternatives having been tried. The use of chemical restraint had also been reduced since the last inspection and there was evidence that alternatives were trialled prior to administering restraint. There was evidence of regular checks taking place and residents had signed consent forms where possible, and it was noted that the resident's wishes were documented on the consent form.

On the previous inspection environmental restraint was in place, however, it had not been identified as environmental restraint. On this inspection the inspectors saw that environmental restraint was acknowledged on the notification forms and appropriate assessments and checks were in place.

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:
On the previous inspection there were two major high-risk hazards identified and these had also been identified by an independent external health and safety consultant audit undertaken in the centre in 2014. The first related to fire doors (in this case bedroom doors) being wedged open which posed a risk to all residents in the centre should a fire occur as the doors were not being help open by an appropriate means and were

therefore prevented from working as they should when required. On that inspection the provider was required to take immediate action to address this hazard. At the time the provider confirmed that all wedges had been removed and undertook to ensure that any doors that would be held open in the future would be held open using safe and appropriate mechanisms only. On this inspection the inspectors found that the unsafe practice of holding back doors had continued and wedges had been replaced by waste-paper bins, chairs and other unauthorised mechanisms. In the very high risk area of the smoking room the inspectors found the smoking door held back by a hook despite the door having an automatic hold back that was connected to the fire alarm system which was not used. The inspectors requested the immediate removal of the hook mechanism and this was removed prior to the second day of inspection.

The second high-risk hazard identified related to residents smoking in their bedrooms. On the previous inspection the inspectors were informed that the provider and person in charge had made the decision to allow three residents to smoke in their bedrooms. Following the inspection residents were no longer allowed to smoke in their rooms as this was assessed as high risk to fire. However on this inspection on the first evening of the inspection the inspectors saw that one of the residents had continued to smoke in their room despite the provider and person in charge removing the residents' cigarettes and lighter. The resident was in a bedroom upstairs, the bedroom door was wedged open with a chair and there was no staff in the vicinity, as all staff were downstairs. Inspectors were not satisfied that the supervision of residents upstairs in the evenings was sufficiently robust as no member of staff had allocated responsibility. Numerous other issues were identified in relation to smoking in the centre. The inspectors were not satisfied that residents were being appropriately supervised when using the smoking room as there was no viewing pane to observe residents when smoking. The inspectors formed the opinion that the smoking room door was kept open to counteract the lack of observation if the door was closed, but the inspectors found that there was an unacceptable strong smell of smoke in the corridors and throughout the dementia specific unit which infringed on the rights of the residents living there. The risk assessments seen for residents who smoked were not sufficiently robust as they did not identify the supervision required. The inspectors were therefore not assured that the provider had taken adequate precautions against the risk of fire and thus ensured the safety of all residents, staff and visitors to the centre. The provider confirmed following the inspection that they had commenced the process of putting door guards on the residents' bedroom doors which will automatically release in the event of a fire.

On the previous inspection the inspectors found that the systems in place for the prevention and control of healthcare associated infections (HCAIs) required improvement. Since the last inspection significant improvements were seen in the centre in the provision of hand hygiene training and the provision of hand sanitisers and paper towels in residents' bedrooms. The provider had employed the services of an external consultant who undertook an infection control audit which identified a number of improvements required. The person in charge and staff were working through these and have purchased a new bed pan washer and planned to implement a new safer cleaning system which was on order from the manufacturer. Training will be provided in its implementation to cleaning staff. However the inspectors identified issues in relation to current infection control practices. There were no dedicated cleaning rooms in the centre. Slice rooms contained cleaning equipment and were being used for sluicing and

cleaning which can lead to cross contamination. Cleaning cloths were being used for numerous areas, and the sluice rooms were found to be unlocked and unsecured chemicals were stored inside.

On this inspection the inspectors also identified further hazards in the centre. The first part of the inspection was conducted during the evening the inspectors found the corridors very dark. The lighting system worked on a sensor detecting movement but if you stood still for any length of time the lights switched off and the inspectors found themselves in darkness which is not a suitable system for elderly people who often stop for a while to rest when walking. Other hazards included building materials and cans of paint stored on a corridor which was very dark and therefore there was a danger of being a trip hazard. The door to the garden off this corridor was open at night and as there were no light sensors if a resident went out the door in the dark they would not be seen. All the above issues were discussed with the provider and person in charge during the inspection and at the feedback meeting and the significant risks highlighted the centre remains major non compliant and required immediate actions to mitigate the risks identified.

Judgment:
Non Compliant - Major

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

Findings:
On the previous inspection the inspectors found that significant improvements were required in relation to medication management in the centre. On this inspection although some corrective action had been taken such as an updating of the medication policy, the provision of a medication fridge, provision of controlled access to the medication storage room and recording of returned medications, there remained significant improvements required with medication management and the centre remained major non-compliant in this area.

On the previous inspection the inspectors found that medications were not always administered as prescribed. On this inspection the inspectors found the same practices had continued and saw that an as required medication (PRN) and a short term medication were not signed by the GP but yet were administered to residents. There were numerous occasions and it was common practice in the centre for medications to be administered at a time different to the prescribed order (a medication prescribed for

09:00 was administered at 07:00 or prescribed for 22.00 given at 19.00 or 20.00). This practice is not in accordance with professional guidelines for nurses. In addition, the inspectors saw that the administration of a controlled PRN medication was only recorded in the daily nursing notes and was not recorded on the medication administration record, as required. The inspectors found that the recording of all PRN medications required review as it was difficult to establish what time, date they were administered at and the dosage was not always clear.

The inspectors observed a nurse administering medications and found that the round and the medication administration record were completed in line with An Bord Altranais guidance. However photographic identification was not present for all residents as is required.

The inspectors saw that access to the keys of the controlled drugs storage was being managed in line with An Bord Altranais guidance. The inspectors observed the night staff and day staff undertaking the count of controlled drugs which was completed, recorded and tallied with the actual number of controlled drugs.

The person in charge said the pharmacist had conducted an audit of medication management in the centre but the audit tool was not available at the time of the inspection. There was an audit tool used by the person in charge but the inspectors found a far more robust system for auditing all parts of the medication management cycle was required to prevent the reoccurrence of the numerous issues identified. The person in charge and provider were informed at the feedback meeting that medication management required immediate review and that major non-compliance was identified.

Judgment:
Non Compliant - Major

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

Findings:
On the previous inspection the inspectors found that the quarterly report provided to the Authority did not meet the requirements of Schedule 4 of the Regulations as it did not identify all episodes of restraint used in the centre. The inspectors reviewed all the notifications received from the centre since the last inspection and found that all notifications were received in accordance with the regulations and the quarterly notification now contained and identified all restraints used.

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

Findings:
As identified on the previous inspection residents' health care needs were met through timely access to medical treatment, this was evidenced in residents' records. Residents had access to allied health professionals such as occupational therapy, speech and language therapy, dietician and physiotherapy. Care was delivered to encourage the prevention and early detection of ill health, for example, monthly weights and observations such as blood pressure were recorded.

Since the last inspection the person in charge said they had moved to a system of computerised assessment and care planning and all staff were becoming familiar with this process. Health assessments were carried out for residents on a four monthly basis. These included such assessments as those to determine nutritional status, levels of dependence and falls risk amongst others. These were found to be up to date. However the inspectors found that a full assessment had not been undertaken in regards to activities of daily living and some relevant information was not available. Therefore problems/issues were mainly identified through the health assessments and not from a comprehensive assessment. The inspectors saw evidence that vital information was missing from some care plans and that although a plan of care was documented some were found to be insufficient to guide care and practice. Examples of this were seen by the inspectors in relation a resident who was diabetic and nutritionally compromised. There was no baseline assessment the residents' likes and dislikes and the care plan did not specify the residents' dietary requirements. The resident had been reviewed by the dietician who had documented a comprehensive assessment and recommendations, but the residents care plan had not been updated to reflect the professionals advice and therefore the care provided to the resident was inconsistent.

Issues identified on the previous inspection in relation to inconsistent care planning practices remained ongoing for example, the inspectors found that a resident with a

chronic pain issue did not have a care plan that sufficiently guided care. Although the person in charge and staff demonstrated an in-depth knowledge of the residents and their needs this was not fully reflected in the care plans seen by the inspectors. Although some care plans were much personalised many of the care plans did not reflect personalised care administered to residents, some of these care plans were generic and did not provide an adequate level of guidance on the care to be provided.

Wound care was also looked at by the inspectors who found that a number of improvements were required. There were a number of residents who had pressure sores in the centre and although there had been some scientific assessment of the wounds, the reassessment was again found to be inconsistent so it was difficult to establish if the wound had improved or deteriorated. The chronology of the dressing changes was disorganised and there were gaps in documentation. For example a resident was assessed as requiring daily dressing changes but in accordance with the residents notes there was no documented evidence that the dressing had been completed in the previous week. It wasn't evident what instruction was guiding nurses' practice in regard to appropriate dressing choices. The documentation of wound measurements was inconsistent and there was inconsistent staging of the wounds evident and no assessment by a tissue viability nurse. Training on wound care was limited and wound care plans were found not to be updated or specific to residents needs. There was little evidence of care being provided in accordance with a high standard of evidence based nursing care and this had also been identified as non compliant on the last inspection.

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

Findings:
The design and layout of the centre were in line with the statement of purpose. The centre was purpose built and promoted the residents dignity, independence and wellbeing. Overall, it was well maintained, since the last inspection some decorative upgrade had taken place. As identified on the previous inspection the centre had homely features, however, the wing dedicated to the care of residents with dementia lacked a

homely feel. This was an issue that had been identified by relatives prior to previous inspections, and although some work had been undertaken, such as a mural in the circulation corridor, there was still scope to enhance this area significantly and little further work had been undertaken.

As identified on the previous inspection, the communal space in the main part of the centre was limited. This was an issue that had already been identified by the provider and he told the inspectors at that time that works were due to commence in the summer months to build on a conservatory off the main sitting room. However on this inspection work on this conservatory had not commenced to date and the provider did not have a start date. There was an activities room in use, and as identified on the previous inspection the activities room was also being used as a store room for bedrails, walking frames and chairs which prevented a homely feel from the room. Residents' bedrooms were large, bright and airy and some personal touches were seen in residents' rooms.

Shared rooms had adequate space and furniture, and the inspectors saw that they had upgraded privacy screening since the last inspection which worked well for both residents individually.

On the previous inspection the inspectors saw that there were safe external grounds, however, some of the doors giving access to these areas were kept locked during the day and it wasn't evident as to why this was necessary. On this inspection the inspectors observed that residents had free and easy access to the gardens.

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

Findings:
On the previous inspection it was identified that the details for the person nominated to deal with appeals were not contained in the procedure details and that the procedure required amendment as it did not accurately reflect the role of the Authority where complaints arose. On this inspection this had been actioned and was completed.

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

Findings:
On the previous inspection good practices were observed around food and nutrition however it was not clear how the person in charge satisfied themselves that the menu was nutritionally balanced at all times. On this inspection the person in charge showed the inspectors a report compiled by the dietician confirming the nutritional components of the weekly menu's ensuring they were nutritionally balanced.

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

Findings:
On the previous inspection it was identified that the centre provided nursing services and an on call emergency response service for persons not residing in the designated centre. This resulted in occasions whereby up to two staff, one of whom may have been the only nurse on duty, were absent from their duty in the designated centre, for undetermined timeframes, so as to attend to the needs of the persons not residing in the designated centre. It also resulted in significant daily nursing and care resources being allocated to persons not residing in the designated centre. Inspectors were therefore not satisfied that the registered provider had ensured that the number and skill mix of staff was appropriate at all times, having regard to the needs of the residents and the size and layout of the designated centre. This resulted in an immediate action being issued to the provider prior to the close of the inspection, requiring a response before the inspectors left. On this inspection the inspectors saw and were informed by all staff members that they were no longer providing this service to the adjacent retirement village as dedicated staff were now employed to do so. Staff reported that this led to more time for residents in the centre.

On the last inspection and previous inspections the inspectors were not satisfied that there was an appropriate skill mix on duty at all times given the number and needs of the residents and the design and layout of the centre. The centre was large and spread out over two floors and a separate wing dedicated to the care of residents with dementia, However, only one nurse was rostered on night duty. The majority of staff who spoke with the inspector stated that they thought two nurses would be more appropriate. There remained only one nurse on night duty on this inspection. The provider and person in charge had recruited four new nursing staff who were currently working in the centre under an induction and familiarisation programme. They were unable to assume nursing duties until they received their registration with the Irish nursing board which they were currently waiting for. Once these nurses are registered the person in charge told the inspectors that she plans to have two nurses on night duty at all times.

On the previous inspection all staff were not up to date with mandatory training. For example, not all staff had received fire training. Not all staff were up to date with adult protection training or the management of behaviours that challenge. On this inspection the person in charge informed the inspector significant investment was put into training since the last inspection. The person in charge forwarded an updated schedule following the inspection demonstrating that protection training for the outstanding staff requiring this training had taken place as was seen scheduled on the inspection. The centre's training matrix indicated that a number of staff had received training in the care of those with dementia and responsive behaviours and hand hygiene to ensure they provided care that reflects up to date, evidence-based practice. However further staff require this training and a number of staff required update fire training and six staff required updated moving and handling training.

As outlined and actioned in outcome 5 The system of recruitment was found not to be sufficiently robust and did not meet the requirements of schedule 2 of the regulations.

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:

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Health Information and Quality Authority

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Action Plan

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Provider's response to inspection report[1]

Centre name:	Abbot Close Nursing Home
Centre ID:	OSV-0004682
Date of inspection:	09/02/2016
Date of response:	02/03/2016

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 02: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no person designated as a key senior manager who would act up for the person in charge when she was on leave and this role was currently being fulfilled by the provider who is a registered nurse. As the provider is the provider for four other nursing homes this arrangement was not sustainable.

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

1. Action Required:
Under Regulation 23(b) you are required to: Put in place a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

Please state the actions you have taken or are planning to take:
We have interviewed and appointed two CNM's. One is a current employee who has been promoted and the second was an outside candidate. It is intended to provide CNM cover over a seven-day week. This has been agreed with the Registered Providers and the Person In Charge.

The CNM's will be responsible for a wide range of clinical oversight including wound care and medication management. They will both be accountable to the Person In Charge and to their professional practice. In addition they will work with and link with other CNM's in our other nursing homes so that clearly defined roles are understood and shared difficulties are addressed.

In the absence of the Person In Charge they will assume managerial responsibility and work with the Registered Providers in ensuring that there is an accountable and visible managerial structure.

Proposed Timescale: 29/02/2016

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Audits on comprehensive medication management, fire practices and care planning documentation had not been undertaken. The inspectors found non compliances in these areas as were found on the previous inspection. Two administration staff had full responsibility for the residents' accounts and there was no evidence of audit of these accounts by the person in charge or the provider.

2. Action Required:
Under Regulation 23(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

Please state the actions you have taken or are planning to take:
WE have met with the Pharmacist week beginning February 22nd to outline to him the need to develop a clearer system for documentation, in particular the timing of medication administration including PRN medications. We emphasised to him his responsibilities around audit and having a real presence in the nursing home. We have scheduled a further meeting for Wednesday March 9th to put in place a protocol to address gaps in service. I have invited the Person In Charge and the CNM to this meeting. The Person In Charge has undertaken to review the Care planning process and met with a PIC colleague on Monday 29th February to look at audit tools used by

her and will introduce that system here at Abbot Close NH.

Our HR manager is attending a fire drill/evacuation tomorrow 3/3/2016 at another of our nursing homes and will feed back to me the outcomes so we can introduce it here. We are planning on having a fire drill and evacuation at Abbot Close NH within the next month.

The Person In Charge has carried out an audit on six random resident accounts in the last week and has reported full compliance with procedures and balances.

Proposed Timescale: 31/05/2016

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 CCTV policy was not sufficiently comprehensive as it did not state now long the CCTV was recorded for, who had access to the recordings and the purpose of the recordings. There was not sufficient sign-age to inform people that CCTV was in place as is required by data protection guidelines.

3. Action Required:
Under Regulation 04(3) you are required to: Review the policies and procedures referred to in regulation 4(1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.

Please state the actions you have taken or are planning to take:
The CCTV policy has been updated, a copy has been sent to HIQA inspector. Signage has been placed near all CCTV cameras.

Proposed Timescale: 20/02/2016

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
On this inspection a number of staff files were reviewed. The inspectors found that there were no references on file for a recently recruited nurse, there was no evidence of verification of references and a second member of staff had no reference from their last employer and no verified reference. This system of recruitment was found not to be sufficiently robust and did not meet the requirements of schedule 2 of the regulations.

4. 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:
We are continuing to review all our staff files. In the course of this review we discovered a part time (student nurse) member of staff was also non compliant with references. We have stopped assigning him duties until further notice subject to him providing references and attending fire training.

The two staff files that were reviewed have since been updated and comply with regulations.

Proposed Timescale: 29/02/2016

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 inspectors identified a number of hazards in the centre. The first part of the inspection was conducted during the evening the inspectors found the corridors very dark. The lighting system worked on a sensor detecting movement but if you stood still for any length of time the lights switched off and the inspectors found themselves in darkness, which is not a suitable system for elderly people who often stop for a while to rest when walking. Other hazards included building materials and cans of paint stored on a corridor which was very dark and therefore danger of being a trip hazard. The door to the garden off this corridor was open at night and as there were no light sensors if a resident went out the door in the dark they would not be seen.

5. 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:
Our electrician has adjusted the sensors to increase the length of time that the lights stay on and this is now satisfactory. Corridors where building materials were stored have now been cleared and the lighting has been adjusted and has greatly improved. The garden is now secure and a sensor light is being installed.

Proposed Timescale: 31/03/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority were not fully implemented by staff:
1. The systems in place in relation to environmental cleaning required review.
2. The systems in place to manage and control the spread of communicable/transmissible disease required improvement.
3. A separate cleaning room was required

6. Action Required:
Under Regulation 27 you are required to: Ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.

Please state the actions you have taken or are planning to take:
Our contracted cleaning company has delivered a new environmental cleaning system incorporating a colour coded microfiber mop system to meet all the requirements as recommended by our Clinical Nurse Specialist who completed the Infection Prevention and Control Audit in September 2015. Intensive training has been completed with PIC and cleaning staff on 2/3/2016.

A separate cleaning room has been identified.

Proposed Timescale: 31/03/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
As outlined in the report fire doors were being wedged open, numerous issues were identified with high risk smoking activities in the centre therefore the inspectors were not assured that the provider had taken adequate precautions against the risk of fire and thus ensure the safety of all residents, staff and visitors to the centre.

7. Action Required:
Under Regulation 28(1)(a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.

Please state the actions you have taken or are planning to take:
To date we have installed 26 door guards and plan to monitor and install as necessary. All residents, their families and staff have been made aware of fire risk. Residents are aware that there is zero tolerance to smoking in the bedrooms. The smoking room that was in the unit has been refurbished, redecorated and is no longer used as a smoking

room. An alternative facility, outside the building in line with Smoking In and Around Premises Regulations of July 2007, has been identified and costed for smokers. We have updated our Admissions Policy to indicate that we only accept non smokers for admission. Bed managers have been informed of this also.

Proposed Timescale: 31/03/2016

Outcome 09: Medication Management

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The inspectors found that medications were not always administered as prescribed and saw that an as required medication (PRN) and a short term medication were not signed by the GP but yet were administered to residents.

There were numerous occasions and it was common practice in the centre for medications to be administered at a time different to the prescribed order (a medication prescribed for 09:00 was administered at 07:00 or prescribed for 22.00 given at 19.00 or 20.00). This practice is not in accordance with professional guidelines for nurses. The inspectors saw that the administration of a controlled PRN medication was only recorded in the daily nursing notes and was not recorded on the medication administration record, as required. The inspectors found that the recording of all PRN medications required review as it was difficult to establish what time, date they were administered at and the dosage was not always clear.

There was no photographic ID on a number of medication charts.

8. Action Required:
Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.

Please state the actions you have taken or are planning to take:
As outlined in Outcome 2 by the Registered Provider we have engaged with the Pharmacist to update our MAR's to reflect more accurately the times of medication administration, both regular medication and PRN's. The pharmacist has agreed to put resident's pictures on the Kardex's, Mar's as well as on the Biodose trays.

Recording of medication has been highlighted to nurses and they have been instructed to complete the Medication Management Module authorised by NMBI which is available on the HSEland website. To date three nurses have completed the review. It is envisaged that our local policies will mirror best practice.

Proposed Timescale: 31/03/2016

Outcome 11: Health and Social Care Needs

Theme:
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was no evidence of a comprehensive assessment for a number of residents in the centre.

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

Please state the actions you have taken or are planning to take:
Named nurses have been instructed to complete the Comprehensive Assessments on their assigned residents as available in our computerised charting system. As PIC I have earmarked residents that have not have these assessments fully completed and instructed their named nurse to complete in a timely fashion. Future admissions will have theses assessments completed also.

Proposed Timescale: 01/09/2016

Theme:
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There were inconsistencies in care planning practices. The inspectors saw evidence that vital information was missing from some care plans and that although a plan of care was documented some were found to be insufficient to guide care and practice.

10. 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 nurses have been directed by me to collate all vital information, liaise with allied professionals (PHN, GP's, dietician, SALT, etc.) to create a comprehensive care plan. In addition ongoing information gathering and documentation of same has also been emphasised to the nurses.

Proposed Timescale: 30/04/2016

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were a number of issues identified with inconsistencies in wound care. Training on wound care was limited and wound care plans were found not to be updated or specific to residents needs. There was little evidence of care being provided in accordance with a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.and this had also been identified as non compliant on the last inspection.

11. Action Required:
Under Regulation 06(1) you are required to: Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

Please state the actions you have taken or are planning to take:
A Tissue Viability Nurse had been engaged for a days training on March 30th with all nurses on Classification, Management and Prevention of Pressure Sores. I have engaged a TVN to attend and review a current resident. We have identified a nurse who will lead wound care going forward. A protocol is being developed which includes weekly photographing of wounds. Nurses have been reminded that all pressure sores greater that Grade 2 are reportable to HIQA in the Quarterly reports.

Proposed Timescale: 30/07/2016

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:
The wing dedicated to the care of residents with dementia lacked a homely feel.

The communal space in the main part of the centre was limited.

The activities room was also being used as a store room for furniture such as bed-rails, chairs and walking frames, which prevented a homely feel from the room.

12. 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 have begun the process of redecorating the unit. We have new soft furnishings ordered and we will replace items such as the curtains.

We are researching best practice in dementia care and its environment. We have ordered an outside storage shed and our maintenance man is commissioning it. This will house the equipment temporarily stored in our activities room.

Proposed Timescale: 01/05/2016

Outcome 18: Suitable Staffing

Theme:
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The inspectors were not satisfied that there was an appropriate skill mix on duty at all times given the number and needs of the residents and the design and layout of the centre particularly in light of there was only one nurse on duty at night time.

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:
We have recently appointed four Pre Reg nurses who are awaiting their PIN numbers. They are currently on an Induction and familiarisation programme. It is envisaged that our continuing recruitment drive and retention programme will facilitate a significant increase in staff nurse hours.

Proposed Timescale: 30/09/2016

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The training matrix confirmed that a number of staff required up dated training in fire safety, six staff required moving and handling training and numerous staff required dementia and responsive behaviour training.

14. Action Required:
Under Regulation 16(1)(a) you are required to: Ensure that staff have access to appropriate training.

Please state the actions you have taken or are planning to take:
To date all staff have been trained in Recognising Elder Abuse. A Patient Moving and Handling Course has been scheduled for Friday March 4th . Nine members of staff have been scheduled to attend. Following my meeting with another PIC of the group last Monday she has agreed to provide training in Dementia and Responsive behaviours. A date is imminent.

Proposed Timescale: 30/04/2016