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:	Deerpark Nursing Home
Centre ID:	OSV-0000222
Centre address:	Deerpark, Lattin, Tipperary.
Telephone number:	062 55121
Email address:	deermairead@gmail.com
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Deerpark Nursing Home Limited
Provider Nominee:	Mairead Perry
Lead inspector:	Catherine Rose Connolly Gargan
Support inspector(s):	Mary O'Donnell
Type of inspection	Unannounced Dementia Care Thematic Inspections
Number of residents on the date of inspection:	27
Number of vacancies on the date of inspection:	3

About Dementia Care Thematic Inspections

The purpose of regulation in relation to residential care of dependent Older Persons is to safeguard and ensure that the health, wellbeing and quality of life of residents is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer and more fulfilling lives. This provides assurances to the public, relatives and residents that a service meets the requirements of quality standards which are underpinned by regulations.

Thematic inspections were developed to drive quality improvement and focus on a specific aspect of care. The dementia care thematic inspection focuses on the quality of life of people with dementia and monitors the level of compliance with the regulations and standards in relation to residents with dementia. The aim of these inspections is to understand the lived experiences of people with dementia in designated centres and to promote best practice in relation to residents receiving meaningful, individualised, person centred care.

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor compliance with specific outcomes as part of a thematic inspection. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
18 May 2016 07:50	18 May 2016 15:30

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

Outcome	Provider's self assessment	Our Judgment
Outcome 01: Health and Social Care Needs	Substantially Compliant	Non Compliant - Moderate
Outcome 02: Safeguarding and Safety	Substantially Compliant	Substantially Compliant
Outcome 03: Residents' Rights, Dignity and Consultation	Substantially Compliant	Non Compliant - Moderate
Outcome 04: Complaints procedures	Substantially Compliant	Compliant
Outcome 05: Suitable Staffing	Substantially Compliant	Compliant
Outcome 06: Safe and Suitable Premises	Substantially Compliant	Non Compliant - Major
Outcome 07: Health and Safety and Risk Management		Non Compliant - Moderate
Outcome 12: Notification of Incidents		Non Compliant - Moderate

Summary of findings from this inspection

This inspection report sets out the findings of a thematic inspection which focused on specific outcomes relevant to dementia care. The inspection also followed-up on progress with the completion of actions required to address non-compliances with the regulations from the previous registration inspection in December 2014. There were nine actions required in the action plan from this inspection and six were satisfactorily completed. Since the previous inspection the Health Information and Quality Authority (HIQA) received two pieces of unsolicited information relating to this centre. The provider and the investigation reports confirmed that the issues of concern were not substantiated following their investigation by the provider or by

inspectors during this inspection.

As part of the thematic inspection process, providers were invited to attend information seminars given by HIQA. In addition, evidence-based guidance was developed to guide the providers on best practice in dementia care and the inspection process.

Prior to the inspection, the person in charge completed the provider self-assessment and scored the service against the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland. The previous table outlines the self-assessment and inspectors' rating for each outcome.

Inspectors met with residents, relatives and staff members during the inspection. They tracked the journey of four residents with dementia within the service. They observed care practices and interactions between staff and residents who had dementia using a validated observation tool. Inspectors also reviewed documentation such as care plans, medical records and staff training records.

Deerpark Nursing Home is a purpose-built single-storey centre, which provides residential care for 30 people. Approximately 20% of residents have dementia. The atmosphere was homely, comfortable and in keeping with the overall assessed needs of the residents who lived there.

Each resident was assessed prior to admission to ensure the service could meet their needs and to determine the suitability of the placement. Residents had a comprehensive assessment undertaken and care plans were in place to meet their assessed needs. The health needs of residents were met to a high standard. Residents had access to general practitioner (GP) services, to a range of other health services and evidence-based nursing care was provided. Residents were treated with respect and dignity by staff. Six of the nine action plans from the previous inspection were completed. Improvements in relation to wafarin prescribing practices were not sustained. Major non-compliances relating to confined space in the dining room and multi-occupancy rooms would be resolved when the extension and reconfiguration of the premises were completed. Building and refurbishment work was under way and due for completion in August 2016. The provider forwarded an application to Health Information and Quality Authority (HIQA) to extend the date for completion of the works due to unforeseen delay to the start date.

Safe and appropriate levels of supervision were in place to maintain residents’ safety. There was appropriate staff numbers and skill-mix to meet the assessed needs of residents. There was a recruitment policy in place which met the requirements of the regulations.

There were policies and procedures in place around safeguarding residents from abuse. However, HIQA was not notified about an allegation of abuse. There were systems in place to ensure that residents' finances were robustly managed.

In order to ensure the design and layout of the premises will promote the dignity, wellbeing and independence of residents with dementia, the provider needs to complete the planned action in relation to the premises.

These are discussed further in the report and included in the Action Plan at the end of this report.

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

Outcome 01: Health and Social Care Needs

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:
Inspectors were satisfied that each resident's wellbeing and welfare was maintained by a high standard of nursing care and appropriate medical and allied healthcare. Some improvement was required to ensure that each resident was protected by the centre's procedures for medicines management, assessment of residents' pain with a validated tool and development of an associated care plan to direct care. Improvement was also required in documentation regarding consultation with residents or their representatives regarding review of care plans.

There were suitable arrangements in place to meet the health and nursing needs of residents with dementia. The person in charge outlined ongoing work to ensure the common summary assessment records developed in the community prior to admission were available in the centre. Pre-admission assessments were undertaken to ensure that the service could meet the needs of individual residents. Prospective residents and their families were also invited to visit the centre prior to deciding to live there. The person in charge had identified that the time of day residents were transferred from the acute services required improvement to ensure new admissions or current residents were transferred back to the care of the centre during office hours. This was to ensure disturbance to the daytime routine of residents with dementia was minimized, to ensure timely access to their GP if necessary and at a time when staffing levels were increased.

Comprehensive assessments were carried out and care plans developed in line with residents' changing needs. The assessment process involved the use of validated tools to assess each resident for risk of malnutrition, falls, their level of cognitive impairment and their skin integrity. Validated tools for the assessment of pain and behaviours that challenge were not in use. A care plan was developed within 48 hours of admission based on the resident's assessed needs. However, care plans for pain management and management of behaviour that challenges were not consistently developed to inform some residents' care needs. There was evidence that residents and their families, where appropriate, were involved in the care planning process. However, consultation with residents or their representatives was not consistently documented.

There were arrangements in place to meet the end-of-life needs of residents documented in end-of-life care plans which reflected the wishes of residents with dementia. However some residents did not have end-of-life care plans in place that referenced their wishes regarding their physical, psychological and spiritual care including their preferred place for receiving care. Residents had access to clergy of different faiths. Staff cared for residents with end-of-life care needs with the support of community palliative care services and residents' GPs.

Should admission to the acute services be required a detailed transfer form was completed to ease the transition process for the resident. This included details regarding their level of mobility, falls risk, communication needs, nutritional requirements and medications. Inspectors noted that for residents with dementia, the standard form was supplemented with an additional document and a copy of the nursing notes for the preceding five days. This included particular care needs, likes, dislikes and communication strategies. Inspectors noted that similar information was provided on discharge back to the centre including updates from members of the multidisciplinary team.

Inspectors reviewed the management of clinical issues such as wound care, diabetes and falls management and found they were well managed and guided by robust policies.

There were systems in place to ensure residents' nutritional and hydration needs were met. Residents were screened for nutritional risk on admission and reviewed on a four monthly basis thereafter. Residents' weights were also checked on a monthly basis or more frequently if required. Nutritional care plans were in place that outlined the recommendations of dieticians and speech and language therapists where appropriate. Inspectors also noted that individual preferences and habits around mealtimes were recorded. Details of residents' specialist dietary needs as recommended by dietician and speech and language services, in addition to individual food preferences, were copied to and posted for reference in the kitchen. Residents had a choice of a hot dish for lunch and could have a fried breakfast if they wished. Although menus were displayed, the text was small and could be improved with the addition of photograph representations of the various dishes available. This would assist residents with dementia in making a choice regarding what they would like to eat. Residents requiring assistance with eating were assisted discretely and sensitively. The majority of residents requiring assistance did eat their meals in the dining room on the day of inspection. Inspectors formed the view that this could be improved to ensure all residents had the opportunity to enjoy the social aspects of dining in the dining room. Residents were complimentary regarding their mealtime experiences and told inspectors that the food was 'very good'. Inspectors sampled the food and found that it was tasty and nutritious.

Residents had access to GP services and out-of-hours medical cover was also provided. A full range of other services was available on referral including speech and language therapy (SALT), dietetic services and mental health services. Physiotherapy services were available on site every Tuesday and Friday. The physiotherapist was also involved in mobility assessment and development of mobility treatment and care plans. Chiropody and optical services were also provided. Inspectors reviewed residents' records and found that some residents had been referred to these services and results of appointments were written up in the residents' notes. Inspectors noted that residents

could no longer access dental services on site and the practice of only brushing a resident's teeth in the morning was not in line with best practice.

Inspectors reviewed a sample of administration and prescription records and noted that some improvements were made. Some residents required their medication to be administered in crushed format. Revision of the prescription sheets since the last inspection in December 2014 ensured that instructions to crush medications for residents were individually signed by the prescriber. Improvement in response to an action plan from the last inspection in relation to telephone orders for anticoagulant medications where two staff listened to and confirmed phoned prescriptions for Wafarin was not sustained. This issue was discussed with the person in charge to ensure resident safety.

HIQA were notified of an increased incidence of residents developing pressure ulcers while in the centre over the past 12 months. The inspector reviewed the management of residents at risk of developing pressure related skin injury. There was evidence of regular assessment of risk with measures implemented to mitigate risks found including pressure relieving mattresses, cushions and repositioning schedules. The nutritional needs of residents with wounds were given particular attention to ensure healing was optimized. While care of residents' skin was outlined in care plan documentation, an inspector observed that the setting on one resident's pressure relieving mattress did not meet their assessed needs. Following inspection, the person in charge was requested to carry out a root-cause review of incidence of pressure ulcers that occurred in the centre to date to identify whether areas for improvement in prevention management required address. Wound care procedures were observed to be comprehensive regarding wound care management, procedures and documentation to track progress of wound healing and direct treatment procedures.

Judgment:
Non Compliant - Moderate

Outcome 02: Safeguarding and Safety

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 management of suspicions, allegations and incidents of abuse. Residents were provided with support that promoted a positive approach to the behaviours and psychological symptoms of dementia however, improvement was required in developing behaviour intervention plans. The person in charge advised inspectors that she was developing this area of care.

The person in charge had completed a 'train the trainers' programme in the prevention, detection and management of abuse. All staff had received training in the prevention, detection and management of abuse within the last two years. Staff spoken to by the inspectors confirmed that they had received recent training in this area and were familiar with the reporting structures and their reporting obligations.

There were systems in place to ensure allegations of abuse were fully investigated and that, pending such investigations, measures were in place to ensure the safety of residents. Inspectors found that an allegation of abuse by a staff member which was not substantiated following a preliminary investigation had not been notified to HIQA as required. Staff confirmed that there were no barriers to raising issues of concern. Inspectors spoke with some residents during the inspection who were satisfied with the overall level of care being provided, and stated that any concerns they raised were addressed. Interactions between staff and residents were observed to be respectful, supportive and kind. Residents were complimentary in their comments to inspectors regarding staff, the care they provided and the services in the centre. In conversation with several residents, all confirmed they were happy living in the centre. All were full of praise for staff working in the centre and felt safe and well cared for. Inspectors observed interactions between residents and staff were mutually respectful friendly and warm.

The provider managed some monies for four residents and inspectors found that a transparent and robust system was in place to support this arrangement. Residents had access to their money as they wished.

Bed rails were the only type of restraint in use. Forty percent of residents used bed rails for safety or as an enabler. Three-monthly audit reports showed a reduction in the use of bedrails. Inspectors noted that appropriate bed rail risk assessments had been undertaken. Staff spoken with confirmed the various alternatives that had been tried prior to the use of bed rails. Additional equipment such as low-low beds and sensor alarms were in use to reduce the need for bed rails. Two hourly checks were completed when bed rails were in use. The use of bed rails was recorded in the restraint register and notified to HIQA accordingly.

There was a policy in place to advise staff on managing behaviour that challenges. Staff had received training on understanding and managing behaviour that challenges as part of dementia care training. Staff spoken with by the inspectors were knowledgeable regarding interventions that were effective for individual residents in managing such behaviours including redirection, distraction and engagement. Residents had been regularly reviewed by their GP and there was access to psychiatric services for further specialist input as observed by inspectors. The behaviour support plans seen by inspectors were person-centred and included input from the psychiatric liaison support team, the resident and their families. However, positive behavioural support plans were not in place for all residents with behaviours that challenges.

Judgment:
Substantially Compliant

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:
Person-centred care and support

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

Findings:
Inspectors were satisfied that residents with dementia were consulted with about how the centre was run and were enabled to make choices about how to live their lives.

There was evidence of a culture of good communication between residents and the staff team. Inspectors observed staff interacting with residents in a courteous manner and respecting their privacy at appropriate times. Residents were able to exercise choice regarding the time they got up and were able to have breakfast at a time that suited them. Night staff served breakfast to three residents who enjoyed an early morning breakfast. During the day residents were able to move around the centre freely. However, signage and colour were not used effectively to support residents to find their way to bedrooms and bathrooms. Personal space was limited in multi-occupancy rooms and storage space for personal items and clothing was inadequate. There was inappropriate storage of residents' clothing which did not ensure residents in multiple occupancy bedrooms had adequate space to store their clothing and personal possessions.

Inspectors spent a period of time observing staff interactions with residents. Inspectors used a validated observational tool, the quality of interactions schedule (QUIS) to rate and record at five minute intervals the quality of interactions between staff and residents in three communal areas. The observations took place in the day room and the dining room at lunch time. Inspectors observed that staff knew the residents well. However, staff were not present in the sitting room to engage with residents for significant periods during the morning of inspection. Interactions were mostly task-focused; such as when drinks were offered. The arrangement of furniture around the perimeter of the room did not support staff to sit with residents and chat. There was evidence of wellbeing where some residents chatted together and read the daily newspaper; however, less able residents were not provided with reasonable opportunities for social interaction or sensory stimulation.

During the lunch time period staff were observed to offer assistance in a respectful and dignified manner. All staff sat beside the resident to whom they were giving assistance and were noted to patiently and gently encourage the resident throughout their meal. Independence was promoted and residents were encouraged to eat their meal at their own pace with minimal assistance to improve and maintain their functional capacity. Positive connective care was evidenced in the dining room. This included joking and laughter between staff and residents while assisting with the meal.

The provider explained that the activity person was on leave on the day of inspection. The staff duty roster showed that there is an activity co-ordinator on duty every afternoon including weekends. Inspectors found there was a varied activities programme with pampering, arts and crafts and exercise included. There were also a mix of group and individual sessions. Residents' life stories were in the process of being collated by staff and the activity programme was reviewed regularly to ensure that the programme was relevant to residents' past lives and interests.

There was a residents' committee in operation. Inspectors viewed the minutes of the previous meeting which had been held in April 2016. The feedback provided assurances that residents were happy with the food and services provided. There was evidence that there was a nominated person to act as an advocate for residents with dementia on this committee. This would ensure that any issues raised for residents with dementia are acknowledged, responded to and recorded, including the actions taken in response to issues raised.

Inspectors observed that some residents were spending time in their own rooms, and enjoyed reading and watching TV, or taking a nap. Residents could meet visitors in the quiet room or in the patio area. Residents did not have access to a secure outdoor area whilst building works were in progress; however, inspectors saw staff taking residents outside on the day of inspection.
Newspapers and magazines were available. Inspectors observed that one resident attended day care services in the local town. Some residents went home at the weekend with their relatives.

Staff informed inspectors that every effort was made to provide each resident with the freedom to exercise their choice in relation to their daily activities. Weekly Mass was held in the centre. Residents were facilitated to exercise their political and religious rights. Many voted in the recent election, including some residents with dementia. External advocacy services were available to residents and contact details in the residents' guide document.

Judgment:
Non Compliant - Moderate

Outcome 04: Complaints procedures

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 and procedure in place in the centre for the management of complaints. A copy of the procedure was displayed prominently within the centre.

Inspectors spoke to a resident and another resident's family member and found that they were aware of the complaints process. There was a nominated person to deal with complaints, who maintained records of complaints, and an independent person to deal with appeals was also named in the complaints procedure.

Inspectors viewed the complaints log and found evidence that all complaints were promptly investigated and fully documented. Records reviewed showed that the outcome of the complaint and the complainant's satisfaction with the outcome were recorded.

Judgment:
Compliant

Outcome 05: Suitable Staffing

Theme:
Workforce

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

Findings:
Inspectors found that the levels and skill-mix of staff on the day of the inspection were sufficient to meet the assessed needs of residents, including residents with dementia. This was confirmed by a planned staff roster. The staff roster also indicated that a nurse was on duty at all times in the centre.

Staff were observed to be supportive towards residents and responsive to their needs. Inspectors were satisfied that education and training was available to staff to enable them to provide care that reflected up-to-date, evidence-based practice. Inspectors also spoke to staff and found that they were knowledgeable in fire safety, evacuation procedures and moving and handling practices. Inspectors viewed records confirming that all staff attended mandatory training in moving and handling practices within the past two years. Training records for fire safety indicated that staff had received up-to-date training. The induction of a new healthcare assistant included a briefing on fire safety and she was due to attend fire training in June 2016.

Staff had also undertaken other training in 2016 including in managing behaviour that challenges and dementia, nutrition, pressure sore prevention, infection control and protection of vulnerable adults. Nurses confirmed that they had received recent training on medication management. The person in charge was completing a postgraduate course in dementia care. Inspectors viewed records of regular meetings in which all levels of staff were involved. Inspectors attended the handover meeting from night to day staff and found that relevant information about residents was shared between staff.

There was a comprehensive policy in place for the recruitment, selection and vetting of

staff. Inspectors examined a sample of staff files and found that all contained the documents as required by Schedule 2 of the regulations, including up-to-date An Bord Altranais professional identification numbers (PIN) for registered nursing staff.

Judgment:
Compliant

Outcome 06: Safe and Suitable Premises

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:
Residents with dementia integrated with the other residents in the centre. Following the last inspection of the centre in December 2014, the provider submitted plans to refurbish and extend the current premises to address findings of major non-compliance with the regulations and national standards regarding:
- the layout and space for residents in three bedrooms accommodating three residents in each and one bedroom accommodating four residents,
- inadequate space for all residents to dine in the dining room,
- needs of residents in the dining room,
- inadequate storage space for residents' personal belongings and equipment.

The provider proposed that these works would be completed by January 2016 which was accepted by the Chief Inspector and stated in a condition of registration of the centre. Inspectors found that proposed works to an extension external to the current centre accommodation were underway. The main kitchen has been extended and re-fitted and the laundry area has been refurbished and extended. The provider forwarded a revised completion date and application to vary the condition on the registration to take account of same.

Inspectors found that the layout and space available in three three-bedded and one four-bedded multiple occupancy bedrooms and the centre's dining room did not meet their stated purpose. Although storage facilities for resident equipment such as hoists had been improved, residents in multiple occupancy bedrooms did not have adequate space to store and display their personal possessions. Residents' clothing was stored in an en-suite toilet shared between a three- and a four-bed multi-occupancy bedroom. These findings did not provide a comfortable and therapeutic environment for all residents and particularly for residents with dementia.

The centre is a single-storey premises. The building is set on an elevated site with beautiful views of the surrounding countryside and mountains. Car parking is provided

to the front of the centre. Garden areas were not accessible due to building works underway; however, an internal secure area will be available to residents on completion of building work as well as access to the surrounding garden areas. Staff were observed assisting residents to walk outside on the day of inspection. There was a temporary main entrance to the centre through the dining room.

Communal sitting accommodation currently comprises of one large seated area. Seating was placed around the perimeter of the room which did not positively encourage social interaction. However, the sitting room was spacious, bright and decorated with some traditional memorabilia. A large screen television was available to support ease of viewing for residents with visual deficits.

The environment in the centre was generally bright and the many large windows provided good natural lighting to the centre. There was some use of signage to support residents with dementia, however this area needed improvement. Handrails on corridors were in a contrasting colour however, access for residents with dementia could be improved with fittings such as grab rails in toilets and showers in a contrasting colour to walls and in a contrasting colour on doors to toilets. Signage required improvement as much of the current signage needed replacing to ensure good visibility by residents. A room was provided for hairdressing in the centre. This room did not have a window to the outside of the building. This room required review to ensure there was adequate ventilation to remove fumes from hair products.

Judgment:
Non Compliant - Major

Outcome 07: Health and Safety and Risk 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:
Overall, inspectors found that the provider was committed to ensuring the health and safety of residents, visitors, and staff.

A room was available to residents who smoked which included a smoking apron and extinguisher directly outside the door. The room was adequately ventilated. Residents who smoked had a risk assessment completed and controls were in place to mitigate risk such as, supervision and use of the smoking apron.

While there were emergency exits for residents to evacuate the centre in the event of fire, one exit through the laundry was partially obstructed with linen bags and hoists in a storage area en-route. Another fire exit provided access to the new extension; however,

the flooring was unsafe due to building materials at various points. While there were evacuation drills completed, they required improvement to ensure the conditions at the time simulated were reflected. The detail on fire drill documentation also required improvement. Staff spoken with were aware of the procedures to evacuate residents safely. Personal evacuation plans (PEEPs) were completed for residents but did not distinguish between night and day-time evacuation requirements in terms of staff assistance and equipment needs.

Some environmental risks were not identified in the risk documentation with controls to mitigate the level of risk following assessment. For example, an uneven floor surface due to a space in the floor surface for a floor mat and a ramped incline on the corridor to the smoking room. Adequacy of ventilation to remove fumes from hair products used in the hairdressing room was not assessed in the absence of a window to the outside of the premises.

The centre was clean. Hand hygiene dispensers were located at various points throughout the centre and staff were observed to carry out hand hygiene procedures as appropriate. Personal protective equipment (disposable gloves and aprons) were also provided. Infection control practices were satisfactory in general and staff had attended training in infection prevention and control.

Judgment:
Non Compliant - Moderate

Outcome 12: Notification of Incidents

Theme:
Effective care and support

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

Findings:
Inspectors found that an allegation of abuse by a staff member which was not substantiated following a preliminary investigation had not been notified to HIQA as required.

All other specified notifications were forwarded to HIQA as required.

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:

Catherine Rose Connolly Gargan
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

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Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	Deerpark Nursing Home
Centre ID:	OSV-0000222
Date of inspection:	18/05/2016
Date of response:	22/06/2016

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 01: Health and Social Care Needs

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Care plans for pain management and management of behaviour that challenges were not consistently developed to inform some residents' care needs.

1. 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

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

that resident's admission to the designated centre.

Please state the actions you have taken or are planning to take:
Staff would be informed through the communication system in Deerpark. In epiccare. We will set up regular audits to confirm implementation of these care plans. They will be added to the admission list of care plans to remind staff they might be required.

Proposed Timescale: 30/09/2016

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was evidence that residents and their families, where appropriate, were involved in the care planning process. However, consultation with residents or their representatives was not consistently documented.

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

Please state the actions you have taken or are planning to take:
Care plans discussion are in place and are updated 4 monthly, these will now be documented in family communication on the epicare and will be continued to be done 4 monthly Residents will be involved if they are able to do so.

Proposed Timescale: 30/09/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors noted that residents could no longer access dental services on site and the practice of only brushing a resident's teeth in the morning was not in line with best practice.

3. 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:

Dentist is only available privately for residents. All carers have now been informed through verbal meetings at handover and written memo about the importance of cleaning teeth and dentures twice a day. Supervision and spot checks of implementation will be on-going by PIC.

Proposed Timescale: 30/09/2016

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some residents did not have 'end of life' care plans in place that referenced their wishes regarding their physical, psychological and spiritual care including their preferred place for receiving care.

4. Action Required:
Under Regulation 13(1)(a) you are required to: Provide appropriate care and comfort to a resident approaching end of life, which addresses the physical, emotional, social, psychological and spiritual needs of the resident concerned.

Please state the actions you have taken or are planning to take:
Most residents did have end of life care plans. The ones that were not available were residents that did not want to discuss these issues to date, and the others were new residents that have not been approached about this subject yet, but will be done in due course. Care planning will be dependent on speaking to either the resident or family members where possible.
All nurses do end of life in basic training, but we will incorporate it in this years training.

Proposed Timescale: 31/12/2016

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Improvement in response to an action plan from the last inspection in relation to telephone orders for anticoagulant medications where two staff listened to and confirmed phoned prescriptions for Wafarin was not sustained.

5. 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:

We commenced this from last inspection but unfortunately we had slipped back to one nurse. With immediate effect all nurses have been sent a memo regarding this, and changes to commence immediately. The PIC will monitor and maintain this process on-going.
It is already part of our medication audit.
All staff have been reminded again of this in our internal notification system in epiccare.

Proposed Timescale: 30/06/2016

Outcome 02: Safeguarding and Safety

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Positive behavioural support plans were not in place for some residents with behaviour that challenges.

6. Action Required:
Under Regulation 07(2) you are required to: Manage and respond to behaviour that is challenging or poses a risk to the resident concerned or to other persons, in so far as possible, in a manner that is not restrictive.

Please state the actions you have taken or are planning to take:
Positive behaviour support care plans have now been implemented. ABC charts will be used occasionally for challenging behaviour, and care plans will be developed to reflect on the outcome of the chart.

Proposed Timescale: 30/09/2016

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Personal space was limited in multi-occupancy rooms to ensure residents' privacy and storage space for personal items and clothing was inadequate.

7. Action Required:
Under Regulation 09(3)(b) you are required to: Ensure that each resident may undertake personal activities in private.

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

With completion of the new build residents will have adequate storage space for personal items, and activities.
In the interim, we have changed existing storage units to accommodate residents requirements, allowing for storage space and personal activity.

Proposed Timescale: 30/10/2016

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The arrangement of furniture around the perimeter of the room did not support staff to engage in social interaction. Less able residents were not provided with reasonable opportunities for social interaction or sensory stimulation.

8. Action Required:
Under Regulation 09(2)(a) you are required to: Provide for residents facilities for occupation and recreation.

Please state the actions you have taken or are planning to take:
Furniture has been moved for a more friendly/ communicative environment, with table between two chairs etc. Residents did not seem to like this, and have insisted on moving the chairs and tables back to the existing position.
Activities take place daily Monday to Sunday. In the future we will potentially look at increasing activities from early morning. In the interim we will encourage staff to interact for longer with the residents after they bring them to the dayroom. Also the kitchen staff do interact with the residents while giving out drinks etc...
Activities will be coordinated/arranged by the activities coordinator for them to continue when she is absent.

Proposed Timescale: 30/06/2016

Outcome 06: 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 layout and space available in three, three bed and one four bed multiple occupancy bedrooms and the centre's dining room did not meet their stated purpose.

9. Action Required:
Under Regulation 17(1) you are required to: Ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.

Please state the actions you have taken or are planning to take:
As seen on day of inspection new build is ongoing and changes will reflect regulation (17)1 when completed

Proposed Timescale: 30/12/2016

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Although storage facilities for resident equipment such as hoists was improved, residents in multiple occupancy bedrooms did not have adequate space to store and display their personal possessions.

Residents' clothing was stored in an en suite toilet shared between a three and a four bed multiple occupancy bedrooms.

Doors to key areas, for example, toilets and grab rail fittings in toilets and showers were not painted in contrasting colours to assist residents with dementia.

There was inadequate means of ventilation in place in the room used for the purpose of hairdressing to remove fumes from hair products safely

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

Please state the actions you have taken or are planning to take:
With new build more storage facilities will be available for residents equipment, and also more space for residents to display and store personal possessions.
As mentioned, previously, chest of drawers was removed.(Action Plan 6)
Extractor fan was already installed in the hairdressing room, providing ventilation, Also contrasting colours will be provided where needed for dementia residents. We will install contrasting colours in one toilet for dementia resident's use. (handrails and toilet seat)

Proposed Timescale: 30/12/2016

Outcome 07: 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:
Some environmental risks were not identified in the risk documentation with controls to mitigate level of risk following assessment.

11. 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:
Risk not identified was slope near old front door, physio has undertaken risk assessment and has put controls in place, and is available now for viewing.
Controls in place are:
Existing handrails on both sides already in place and we have placed non slip mat on the ramp.
Staff instructed to pull wheel chairs backwards up and down ramp, giving more control, complying with correct manual handling techniques,
A warning sign has been displayed to alert resident staff and visitors, regarding the ramp and the difference in floor level.
All staff have been advised in communication book and daily shift handover.

Proposed Timescale: 30/06/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
While there were evacuation drills completed, they required improvement to ensure the conditions at the time simulated were reflected. The detail on fire drill documentation also required improvement.

Personal evacuation plans (PEEPs) were completed for residents but did not distinguish between night and day-time evacuation requirements in terms of staff assistance and equipment needs.

12. 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:
Fire drill simulation (day time) has taken place 03.06.2016 and is available in fire drill folder for viewing. We are organising a night time simulation ASAP. Existing fire drill improved and updated.

With regard to PEEPS the physio has distinguished time of day and night as can been seen on PEEP, method of evacuation OUT OF BED, when the resident is out of bed and FROM THE BED, when the resident is in the bed and also documented is the equipment required to completed this process Staff are clearly able to identify the difference as clearly written.

Fire exits have all been reviewed, appropriate signs have been put up, and as the rails in the courtyard have now been installed, and ramps through the courtyard and out of the new building, we can use this as a method or evacuation as a safe exit route.

Proposed Timescale: 30/10/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Means of emergency escape required review to ensure residents could be safely evacuated.

A fire exit was partially obstructed.

13. Action Required:
Under Regulation 28(1)(b) you are required to: Provide adequate means of escape, including emergency lighting.

Please state the actions you have taken or are planning to take:
Staff have been made aware through memo and also verbally at handovers the importance of keeping fire doors clear. The exit through the laundry is now kept clear on a constant basis. Staff are reminded at all times on-going. We have moved some equipment (not in constant use) to another storage area, to allow more space.

Proposed Timescale: 30/06/2016

Outcome 12: Notification of Incidents

Theme:
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
An allegation of abuse by a staff member which was not substantiated had not been notified to HIQA as required.

14. Action Required:
Under Regulation 31(1) you are required to: Give notice to the chief inspector in writing of the occurrence of any incident set out in paragraphs 7(1)(a) to (j) of Schedule 4

within 3 working days of its occurrence.

Please state the actions you have taken or are planning to take:
Appropriate documentation has now been completed to and sent to HIQA via Portal system, regarding said incident. We will notify any further allegations to HIQA going forward.

Proposed Timescale: 30/06/2016