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:	Haven Wood Retirement Home
Centre ID:	OSV-0000236
Centre address:	Bishopscourt, Ballygunner, Waterford.
Telephone number:	051 303 800
Email address:	pdolan@havenwood.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Haven Wood Retirement Villages Limited
Provider Nominee:	Padraig Dolan
Lead inspector:	Gemma O'Flynn
Support inspector(s):	Breeda Desmond
Type of inspection	Announced
Number of residents on the date of inspection:	64
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

Please note the definition of the following term used in reports:
responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration renewal decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
31 January 2017 09:15	31 January 2017 18:30
01 February 2017 07:20	01 February 2017 15:55

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	Compliant
Outcome 03: Information for residents	Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Substantially Compliant
Outcome 06: Absence of the Person in charge	Compliant
Outcome 07: Safeguarding and Safety	Non Compliant - Moderate
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 09: Medication Management	Non Compliant - Moderate
Outcome 10: Notification of Incidents	Substantially Compliant
Outcome 11: Health and Social Care Needs	Compliant
Outcome 12: Safe and Suitable Premises	Compliant
Outcome 13: Complaints procedures	Compliant
Outcome 14: End of Life Care	Compliant
Outcome 15: Food and Nutrition	Substantially Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Compliant
Outcome 17: Residents' clothing and personal property and possessions	Compliant
Outcome 18: Suitable Staffing	Compliant

Summary of findings from this inspection

This report sets out the findings of an announced, two day inspection the purpose of which was to inform a registration renewal decision. The inspectors also followed up on the actions that resulted following the centre's previous inspection in October 2015. Of the three actions, two had been satisfactorily addressed and an action relating to fire safety training had not been satisfactorily addressed. An action relating to medication management had been partially addressed, however,

additional areas of non-compliance were identified on this inspection. The centre can accommodate a maximum of 64 residents. On the day of the inspection, there were 62 residents in the centre and two residents in hospital.

Over the course of the inspection the inspector met with residents, relatives, staff and management. Practices were observed and documentation was reviewed. Overall, there was evidence that residents received care that was evidence based and of a good standard. Care was delivered by staff who demonstrated an in-depth knowledge of residents' needs and histories. Residents reported that they felt very safe in the centre and said that staff couldn't do more for them. Residents were cared for in a well maintained, comfortable setting.

Based on the evidence seen over the course of the inspection, feedback from residents and relatives and conversations with staff, the inspectors formed the judgment that the centre was in compliance or substantial compliance with the majority of the outcomes monitored. Improvements were required in relation to documentation and to ensure that the centre's practices in relation to use of restraint were fully in line with the national policy on restraint at all times. Non-compliances in medication management were also identified and a review of the centre's infection control procedures was also required. Assistance given at meal times required review to ensure it was person centred in its approach at all times.

The inspector's judgments in respect of compliance are set out in the table above and discussed in detail throughout the body of the report and in the associated action plan at the end of the report.

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

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

Theme:
Governance, Leadership and Management

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

Findings:
The statement of purpose consisted of a statement of the aims, objectives and ethos of the designated centre and as statement as to the facilities and services which are to be provided for residents.

It contained all of the information required by schedule one of the regulations and had been reviewed in November 2016.

Inspectors were satisfied that the statement of purpose was implemented in practice.

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):
No actions were required from the previous inspection.

Findings:
There were sufficient resources in place to ensure the effective delivery of care as described in the statement of purpose. There were sufficient resources to ensure

residents' comfort and access to equipment to assist them with the activities of daily living in a holistic manner. Resources were in place to allow development of staff to ensure care was evidence based and up-to-date.

A clearly defined management structure that identified lines of accountability and set out what the reporting structure was. Residents, relatives and staff were familiar with same. There was a board of five directors, including the person in charge and the person nominated to represent the provider, who oversaw the governance of the centre. The chairperson of the board attended the centre on both days of the inspection and attended the feedback session at the close of the inspection. Residents, relatives and staff were supportive of management and confirmed that they were a presence in the centre on a regular and consistent basis.

There were management systems in place to ensure that the service provided was safe and appropriate. A regular audit programme was implemented that collected data on key quality indicators such as hand hygiene audits, activities; care plans; incidents and accidents; nutrition and a quality of care audit. Results of these audits were collated and compared to previous results to ensure ongoing improvements and identify areas for improvement. Actions plans were developed as required. Inspectors found that there was scope to develop these audits further to ensure that areas of non-compliance were identified in a timely manner such as medication management and infection control. These are an example of areas that resulted in findings of non-compliance on inspection.

An annual review of the quality and safety of care delivered to residents had been developed and plans were in place for the coming year. Some of the plans included increasing internet access in all areas of the centre and rolling out new safeguarding training for staff. The provider stated that additional plans would be added to the annual review 2017 plan following the inspection.

There was evidence of consultation with residents and relatives via regular surveys and residents' meetings. Residents were involved in the development of the centre's menus and participated in menu tasting sessions to allow meaningful input. Residents' feedback was seen to be listened to and changes arose as a result such as changing the time of the afternoon tea round.

Judgment:
Compliant

Outcome 03: Information for residents
A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

Theme:
Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:
There was a guide to the centre available to residents; a copy was kept in each resident's bedroom. This document met the requirements of the regulations.

A sample of contracts was reviewed on inspection and were found to meet the requirements of the regulations. A tracking system was in place for contracts that were to be returned for new residents to the centre.

Contracts of care set out all the fees being charged to the residents and included the services to be provided.

Judgment:
Compliant

Outcome 04: Suitable Person in Charge
The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:
Governance, Leadership and Management

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

Findings:
The person in charge was a qualified nurse and was suitably qualified and an experienced manager in the area of health care. Her post was full time, she worked Monday to Friday, a minimum of 39 hours per week. Staff confirmed that the person in charge was available to them at all times and night staff who spoke with the inspector confirmed that the person in charge could be contacted at any time.

All staff, residents and relatives who spoke with the inspector confirmed that the person in charge was approachable and that they wouldn't hesitate in bringing any concerns to her attention. Staff reported that she was a responsive manager.

In conversations with the inspector, the person in charge demonstrated an understanding of the legislation and sufficient knowledge of her statutory responsibilities. She demonstrated clinical knowledge and seen to participate in morning handover. She was engaged in the governance and management of the centre on a regular and consistent basis. She planned to undertake a health management course in February 2017 to complement her a management course she had completed in October 2016.

She stated that she planned to focus on the development of newly recruited nurses in 2017 and enhance the role of the newly appointed clinical nurse managers.

Judgment:
Compliant

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

Theme:
Governance, Leadership and Management

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

Findings:
Records were maintained in the centre and overall, these were found to be accurate and up-to-date. However, some non-compliance was identified in regards to complete documentation. For example, an incident involving a resident had not been documented in the nurses' daily narrative note. Wound care documentation was, at times, inconsistent. For example, a wound care plan did not specify that a wound should be dressed daily. Documentation confirming that the wound had been attended to was recorded either in the daily narrative note or the wound progress chart. Records in the daily note did not contain the same detail as those recorded in the wound progress chart.

Care plan documentation was, overall, person centred in its approach and reflected the knowledge of the staff. However, in some of the files reviewed, where a specific problem or need had been identified, a specific care plan was not in place. Instead, the interventions were recorded under a non-specific care plan which meant the problem or need wasn't always clearly identifiable. Therefore, it was determined that records required streamlining to ensure that key information relevant to the residents' care needs was easily identifiable and retrievable at all times.

Records were kept securely and were retrievable over the course of the inspection. There were policies in place in regards to retaining resident records and the person in charge was able to articulate her knowledge in this regard.

The policies required under schedule five of the regulations were available for review.

A directory of residents was maintained on the centre's electronic system.

Judgment:
Substantially Compliant

Outcome 06: Absence of the Person in charge
The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:
Governance, Leadership and Management

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

Findings:
There had been no incidences whereby the person in charge had been absent for 28 days or more. The person in charge was supported by an assistant director of nursing who was appointed to deputise for any absence of the person in charge. The assistant director of nursing was in the centre on both days of the inspection and demonstrated good knowledge of the systems of care in the centre and of the residents' needs. She was involved in audits of care and was able to discuss findings, trends and action plans for same. She demonstrated sufficient knowledge of the legislation.

Judgment:
Compliant

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

Theme:
Safe care and support

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

Findings:
There was a policy on, and procedures in place for, the prevention, detection and response to abuse. Staff had received training in this policy and were aware of where to access it if they so required. Staff had recently received updated training in safeguarding vulnerable adults, seven staff who were still awaiting this training had received elder abuse prevention training in 2016 as demonstrated by training records shown to inspectors.

Staff who spoke with inspectors were aware of what constituted abuse and what to do

in the event of an allegation or suspicion of abuse and who to report it to. The person in charge stated that she ensured there were no barriers to staff or residents reporting any concerns by ensuring she was a visible presence in the centre and reminding staff of the whistle blowing procedures.

Residents who spoke with inspectors said that they felt safe in the centre and relatives said that they were satisfied that staff treated their loved ones very well and that they were safe at all times in the centre. Residents and relatives confirmed that the provider and person in charge were a regular and consistent presence in the centre.

There were systems in place to safeguard residents' money. Following the centre's previous inspection in October 2015, a new signature system had been implemented when residents withdrew funds from the petty cash that the centre held for them. Funds were held in small amounts and for a small number of residents. Records tallied with random checks of funds held and three staff signatures were in place for residents unable to sign themselves as per the new protocol. The financial controller confirmed that the centre did not act as a pension agent for any resident.

The person in charge confirmed that there had been no allegations of abuse in the centre.

There was a policy and procedures in place for working with residents who required specific support to assist them with responsive behaviours (how people with dementia or other conditions may communicate or express thier physical discomfort with ther social or physical environment). Staff who spoke with inspectors were able to identify those residents who required additional support and were able to clearly and consistently set out triggers for responsive behaviours and the appropriate management strategies that were in place to support those residents effectively. Care plan documentation was in place to direct such care, however in some of the files reviewed, care plans required some additional development to ensure they reflected the knowledge of staff and included all known triggers and strategies.

There was a policy in place for the use of restraint, however, this required review to ensure it was in line with national policy 'Towards a Restraint Free Environment'. For example, the definition of restraint in the centre's policy was not in line with the definition set out in the national policy. The person in charge and staff demonstrated a commitment to promoting a restraint free environment. There was a relatively low incidence of the use of restraint in the centre, with approximately 12 per cent of residents utilising bed side rails. Staff and documentation indicated that the majority of these were requested by residents for reassurance purposes. Alternatives were in place such as low-low beds and sensor beams. For residents who had bed side rails in place, records demonstrated that alternatives had been offered or trialled.

Documentation required review to ensure it was fully in line with the centre's policy and the national policy for the use of restraint. For example, although documentation demonstrated that the risks of utilising such equipment were explained to residents, a formal comprehensive assessment to determine the suitability of implementing bed side rails was not in place. However, key staff who spoke with inspectors were able to demonstrate that they would consider key safety issues associated with the use of bed

side rails before implementation of same.

Care plans did not specify the frequency of safety checks that should be carried out once bed rails were in use, however, all staff who spoke with inspectors were very clear that checks were carried out hourly and records confirmed that they were completed. Inspectors were therefore satisfied that these were care plan documentation issues and hence, these issues will be actioned under outcome five; documentation.

The use of other forms of restraint, although in use to aid the functionality of specific equipment, for example, lap belts, did not have a specific care plan in place if a resident could not remove such a device themselves. Arrangements for the safe use of such equipment were not in line with the centre's own policy such as ensuring a minimum of ten minute opportunities for motion and exercise for every two hours of use. Inspectors acknowledge that this device was only in use in a room where there was constant supervision and pressure relieving repositioning was carried out three hourly. However, robust, specific arrangements pertaining to the use of such equipment were required to ensure safety. This was discussed in detail with the person in charge.

Judgment:
Non Compliant - Moderate

Outcome 08: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Safe care and support

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

Findings:
The centre had policies relating to health and safety. There was an up-to-date health and safety statement last reviewed in November 2016 available for review. The risk management policy met the requirements of the regulations. The centre maintained a register setting out hazards identified in the centre and the controls in place to minimise the associated risk.

Practices and procedures relating to infection control and, specifically prevention, required comprehensive review as inspectors found that cleaning regimes posed a risk of the spread of infection. For example, cleaning equipment was insufficient as household staff had an inadequate supply of cleaning cloths to ensure effective prevention of infection. In addition, the storage of such cloths on the trolley promoted cross contamination. Clean towels awaiting distribution to bedrooms were stored with cleaning equipment. Training records for staff carrying out housekeeping duties did not demonstrate that relevant training in infection control and prevention had been

delivered.

Appropriate action had been taken in the event of an outbreak of infection and appropriate agencies informed. Key staff were knowledgeable on what constituted an outbreak of infection and all grades of care staff who spoke with inspectors were able to discuss the measures that had or would be implemented in the event of an outbreak of infection. The person in charge had conducted a review of the management of an outbreak of infection in an effort to identify areas for improvement and development.

A record of incidents and accidents occurring in the centre was maintained and included good detail of the circumstances of the event, the treatment given, the outcome for the resident and any learnings for the staff in the centre. Data regarding falls management was reviewed by the onsite physiotherapists and there was a good communication system in place to advise staff of falls in each month, including the time and location of falls.

Staff were trained in safer people moving and handling techniques and a senior carer was a qualified in-house instructor. This staff member was supported in her role by physiotherapists who worked in the centre full time.

Overall, the provider took a proactive approach to fire safety management, however, non compliances were identified in fire training and fire drills.

Fire exits were unobstructed and there was sufficient means of escape. Fire evacuation procedures were displayed in prominent locations for residents and visitors, including high traffic areas and on the back of bedroom doors. Instructions for staff were contained in a folder at the nurses' station and staff who were asked about the location of such documentation were aware of its location. The provider was observed, on the second day of inspection, to remind staff of the arrangements in place should the fire alarm sound. Staff confirmed that these reminders were a regular occurrence at morning handover meetings.

Staff who spoke with inspectors were able to demonstrate a good knowledge of what to do in the event of the alarm sounding. Records demonstrated that mandatory annual training in fire safety, delivered by a competent person, was not up to date for at least 28 members of staff and was outstanding since 2013. This was discussed with the provider and was also an action following the centre's previous inspection. Separate to external training, the provider also provided training on fire building safety training, which involved a detailed walk through the premises and familiarising with safety features, exits et cetera. Some staff had received this training in 2016, however, some staff had not received this training since 2013.

Although fire drills were taking place, these required development to fully demonstrate that the arrangements in place were sufficient to maintain the safety of residents at all times in the event of a fire. For example, drills did not include simulating evacuations in day or night time conditions, to develop practices and enhance learnings. It was not evident as to how long it would take to evacuate specific compartments. This was discussed in detail with the provider, prior to the close of the inspection. The provider demonstrated a commitment to developing this area of fire safety.

Judgment:
Non Compliant - Moderate

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

Theme:
Safe care and support

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

Findings:
There were written policies in place for the management of medications. Areas of non-compliance were identified in this outcome.

Medications were stored securely in a locked trolley at all times over the course of the inspection. A medication round was observed and it was noted that not all medications were administered at their prescribed time, with some being administered more than two hours after the time on the resident's prescription. Staff and management explained that this was to allow a person centred approach to care, however, inspectors found that there was risk associated with this practice as nurses were not administering medications in line with current guidelines and legislation. Also, it was found to be unsafe practice as a number of omissions on the residents' medication administration records were identified, therefore, it was not possible to verify if a resident had received their medication nor verify the time at which a resident had received same.

Specific nursing interventions that were required before the administration of specific medication were not always implemented as seen in the records reviewed.

Nurses in the centre transcribed prescriptions, the assistant director of nursing and the person in charge confirmed that it could take up to three months before this was counter signed by the registered prescriber. This timeframe is not in line with current guidance for nurses, the centre's medication policy did not set a timeframe, as confirmed by the person in charge. She stated that until the transcribed prescription was signed by the registered prescriber, the original prescription was kept with the transcription to allow nursing staff to verify the prescription before administering same.

The management of controlled medicines was found to be safe and in line with current guidelines and legislation and there were appropriate procedures in place for the handling and disposal of unused and out date medicines.

Medication practices were subject to audit, however, inspectors found that these required development to ensure they identified the issues raised over the course of the

inspection. Medication errors were documented and learnings resulted from same.

The assistant director of nursing confirmed that a pharmacist visited the centre on a three monthly basis and a notice was displayed in the centre to inform residents of this visit in case they wished to meet with the pharmacist.

Judgment:
Non Compliant - Moderate

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

Theme:
Safe care and support

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

Findings:
A record of incidents occurring in the centre was maintained. Notifications within three days of any incident set out in paragraphs 7(1) (a) to (j) of schedule four of the regulations were submitted. A quarterly report was provided to HIQA as required, however, information regarding the use of restraint was inaccurate and required review.

Judgment:
Substantially Compliant

Outcome 11: Health and Social Care Needs
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

Theme:
Effective care and support

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

Findings:
Overall, inspectors were satisfied that residents' health and social care needs were met by the staff and resources in the centre.

Thirteen General Practitioners (GPs) visited the centre. Residents could choose to retain the services of their own GP or change to a more local practitioner if they so wished. Staff discussed the ways they could access the services of allied health professionals, such as speech and language therapists, occupational therapists and dietitians, and documentary evidence in residents' files demonstrated referrals and reviews occurred as required.

Monthly weights (at a minimum) and vital sign observations were recorded monthly as evidenced in the sample of residents' files reviewed. Routine blood profiling was also carried out as observed in resident files. Residents were enable to make healthy choices. For example, numerous exercise stations were situated throughout the centre with notices encouraging and reminding residents to carry out physical activity. The on-site physiotherapists provided group exercise activities as well as one to one sessions.

Residents were assessed before or on admission and care plans detailing needs and choices were developed. Assessments were completed four monthly to identify any changing needs of residents and these included matters such as skin integrity, independence levels, falls risk and activities of daily living. These were seen to be up to date.

Care plans were in place and overall these were found to be person-centred in their approach and on the whole, reflected the good knowledge of the staff. However, inspectors found that at times, information required streamlining to ensure that problems and their associated interventions were clearly identifiable. For example, it wasn't always clear which care plan referred to which need or that relevant care plans had been updated with allied health professional recommendations post review. All grades of staff who spoke with inspectors were able to clearly articulate their knowledge of the residents and their needs, therefore, inspectors were satisfied that the issues relating to care planning pertained to documentation. Hence, this is discussed further and actioned under outcome 5, documentation.

Residents and relatives who spoke with inspectors said that they were familiar with their care plans and a sample of files reviewed recorded resident and or relative discussions. The assistant director of nursing discussed the results of care planning audits that showed that improvements were required in the centre's systems for ensuring resident and family input was always sought and obtained in the development of care plans and this was subject to monthly audits since October 2016 to improve compliance. Care plan evaluations were carried out four monthly as per documentary evidence.

Staff were observed to seek consent before giving care and residents' preferences for treatment were documented. Systems were in place to ensure that relevant information about residents was provided when they were absent or returned from another care setting. Records seen by inspectors demonstrated this.

Judgment:
Compliant

Outcome 12: Safe and Suitable Premises
The location, design and layout of the centre is suitable for its stated purpose

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

Theme:
Effective care and support

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

Findings:
The design and layout of the centre were found to be in line with the statement of purpose. The centre was purpose built in 2006 and comprised two floors, with two elevators servicing each floor. The layout promoted residents' dignity, independence and wellbeing. There was an internal courtyard with raised flowerbeds and seating areas. The activities coordinator said that the outside space was used more in the summer months.

The centre was homely and tastefully decorated with ample furnishings, fixtures and fitting. Overall, the centre was well maintained, there was some minor decorative upgrade required in the large day sitting room on the ground floor and the provider was aware of same. There was adequate heating, lighting and ventilation. The entrance foyer was decorated as a 'street scene' and with shop fronts such as a post office and the frontage of a public house that was a landmark in the area.

There were plentiful seating areas throughout and residents were seen to sit in the main lobby by the nurses' station and observe the goings on throughout the day. There was a large sitting room that was utilised for the scheduled activities and another well appointed sitting area that offered a quieter atmosphere; a number of residents were seen to use the space with their friends and family over the inspection.

The first floor gave residents access to a gym with exercise equipment, this room was utilised in conjunction with the physiotherapy staff.

The layout of the centre supported freedom of movement and circulation areas were equipped with aids such as grab rails. There was signage and cues to assist with orientation. Toilet areas were accessible from communal areas. There was a separate cooking facility in the dining room area for residents who partook in baking activities.

All bedrooms had full ensuite facilities. There were 38 single occupancy rooms on the ground floor with one multiple occupancy room. On the second floor there was 19 single occupancy rooms and three twin bedrooms. The single rooms on the second floor were arranged in suites and offered larger floor space. Bedrooms were seen to be furnished with residents' personal items including furniture they had brought from home. Residents and relatives confirmed that they had sufficient space for their belongings.

There was a functioning call bell that showed how long the bell had been ringing for. Call bells were observed to generally be answered in under one minute over the course of the inspection.

Judgment:
Compliant

Outcome 13: Complaints procedures
The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Person-centred care and support

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

Findings:
There were policies and procedures for the management of complaints. The complaints process was displayed in the reception area and outlined in the residents' guide. The person in charge was the person nominated to deal with complaints. Records indicated that complaints were minimal, the last being mid 2016.

Residents said that they would not hesitate to make a complaint if they had one. Relatives said that they were very happy with the care and were aware of who they could complaint to if they needed to.

Judgment:
Compliant

Outcome 14: End of Life Care
Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.

Theme:
Person-centred care and support

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

Findings:
There were written operational policies in place for end-of-life care which staff were familiar with. The file of a recently deceased resident was reviewed and documentary

evidence demonstrated that the care delivered to this resident had been done so with input from the resident's General Practitioner (GP) and local palliative care services. A care plan set out the resident's wishes regarding the care they wished to received at the end of their life. Nursing narrative notes demonstrated that family were aware of the resident's deteriorating condition.

Staff confirmed that they had access to community palliative care services and records indicated that appropriate medications to manage pain or associated symptoms were prescribed when required.

An oratory was available in the centre and the assistant director of nursing explained that residents were often waked there after their passing. Staff explained that residents were informed when another resident was deceased and were supported to pay their respects if they so wanted to.

End of life wishes were recorded in the sample of files reviewed.

End of life care practices were not subject to audit to ensure that any areas, if any, that required development were identified. This was discussed with the person in charge and the provider.

Judgment:
Compliant

Outcome 15: Food and Nutrition
Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.

Theme:
Person-centred care and support

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

Findings:
There was a comprehensive policy for the monitoring and recording nutritional intake which was put into practice. A specific care assistant was allocated to the dining room on a daily basis and they supervised nutritional intake. This was recorded on the centre's electronic care records to which care assistants had access.

There was access to fluids throughout the day and overall residents were offered assistance in discreet and sensitive manner.
Special dietary requirements were addressed. An information sheet was kept in the kitchen outlining residents' nutritional needs and including the outcome of speech and language therapist's reports. The chef spoke with the inspector and demonstrated in-

depth knowledge of the residents' needs and preferences and were aware of recent changes in residents' care.

Food was properly cooked and prepared and was wholesome and nutritious. The chef confirmed that it had been reviewed by a dietician in 2016 to confirm it was nutritionally balanced. Menus were displayed on the walls and these were complemented by pictorial menus.

Residents said they had sufficient choice and it was observed over the course of the inspection that residents felt free to express their personal choice at meal times. Three options were on the menu daily. The chef prepared home baking for residents.

Light snack options such as sandwiches were available after the supper meal if residents wished to have extra. Residents and relatives confirmed this. Some improvements were required to ensure a person centred approach was maintained at all times.
At lunchtime, it was observed that some staff assisted two residents simultaneously to eat their meals. This approach was found to be task based and not individualised or person centred and was discussed in detail with the person in charge.

Judgment:
Substantially Compliant

Outcome 16: Residents' Rights, Dignity and Consultation
Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

Theme:
Person-centred care and support

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

Findings:
Overall, residents rights and dignity were maintained and the centre's ethos of person centred care was implemented. Some evidence of task based care was observed as discussed below.

It was evident that the management and staff of the centre were committed to residents leading the decisions relating to their care and that care be delivered in a manner that was dignified and respectful. Residents were consulted about how the centre was planned and run and feedback was put into practice such as requests for additional music in the activities calendar and preferences at meal times. Information regarding independent advocacy services were displayed on the 'community notice

board'.

Staff demonstrated a knowledge of residents' backgrounds and histories and tools such as photograph memory boards were displayed outside resident's bedrooms which facilitated staff in finding out more about the residents that they cared for. Residents could get exercise personal autonomy and were free to decide how they spend their day such as when they got up for the day, what time they dined or whether they chose to participate in activities.

Residents were facilitated to exercise their civil, political and religious rights. Residents' meeting minutes demonstrated that residents were reminded of upcoming elections. Mass was celebrated in the centre on a monthly basis and the person in charge said that some residents availed of the centre's transport bus to go to mass on a Sunday in the local church.

The assistant director of nursing spoke about the centre's cultural policy which was in place to assist staff in caring for resident who various faiths and beliefs. She stated that links with other faiths in the local community were established.

There were adequate facilities in place for occupation and recreation, including the opportunity to undertake personal activities in private. There was ample space to receive visitors in private such as the sun room, the oratory, the library and other secluded spaces. The library room held a personal computer which had allowed access to internet services and video calls with family. A resident spoke of how they loved to spend time in the library room, reading their book in relaxed surroundings. There were no restrictions on visits and residents had access to a private telephone in their own bedrooms.

Staff were observed to knock and announce themselves before entering residents' bedrooms. Staff demonstrated an awareness of residents' communication needs and care plans were in place for residents who required specific support in this regard in the sample of files reviewed.

Each resident had the opportunity to participate in activities that were meaningful and purposeful. For example, residents were seen to be involved in typical household tasks such as sweeping the floor or were observed to be invited by staff to assist in setting the tables. A more structured comprehensive activities plan was also in place. Residents were seen to engage in home baking that was baked in a small kitchenette adjacent to the day sitting room. Activities specifically developed for residents with a dementia were also in place. An activities coordinator was in the centre Monday to Sunday and they were supported by another colleague who visited the centre twice per week for two hours who focused on spending time with residents who preferred to stay in their rooms or engaging in one to one activities.

Judgment:
Compliant

Outcome 17: Residents' clothing and personal property and possessions
Adequate space is provided for residents' personal possessions. Residents can

appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.

Theme:
Person-centred care and support

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

Findings:
There was a policy on residents' personal property and possessions and property lists were seen in the sample of residents' files reviewed. Residents and relatives said they had ample space for belongings. The laundry area was very well maintained on the days of inspection and a labelling system was in place. The laundry practices described to inspectors gave assurances that best practice guidelines were implemented.

Judgment:
Compliant

Outcome 18: Suitable Staffing
There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

Theme:
Workforce

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

Findings:
Overall, over the course of the inspection, inspectors found that staffing arrangements in the centre were appropriate to meet the needs of the residents. The person in charge stated that an additional care assistant had been rostered on duty to assist with the inspection process.

There was sufficient staff with the right skills, qualifications and experience to meet the needs of the residents. The person in charge and the assistant director of nursing were supported by two recently appointed clinical nurse managers. Senior care assistants held supervisory duties and supported care assistants. An actual and planned rota was

available for inspection. This confirmed that a nurse was on duty at all times.

The person in charge stated that there had been a higher than usual turnover of nursing staff due to circumstances outside the control of the centre, but that they had recently recruited four nurses who were due to commence in February 2017. In the meantime, the person in charge or the assistant director of nursing provided cover on an intermittent basis if required. Residents and relatives confirmed their satisfaction with staffing levels.

Some staff members said that morning times in particular could be very busy and time to sit and chat with residents was limited as there were many tasks to attend to. This information was relayed to the provider at the close of the inspection. The provider had recently sent out a staff survey, in which some staff said they had documented this issue, and he was in the process of collating and analysing results to inform the continued development of the service.

Staff had access to training, including mandatory training and additional training in relevant topics such as dementia care and training in restraint. As stated and actioned in outcome eight, Health and Safety, mandatory fire safety training was not up to date.

Staff demonstrated an awareness of policies and staff signature sheets confirming same had been read were attached. Care assistants reported to senior care assistants, staff nurses and clinical nurse managers. The assistant director of nursing and person in charge stated that they engaged in nursing duties on a regular basis such as medication management rounds and ensured they were a visible presence in the centre to ensure high standards of care.

A morning shift handover was observed and detailed information regarding residents' needs was imparted to staff. On Mondays and Wednesdays these handovers were attended by all grades of staff including kitchen and household staff. This was seen to occur on the handover observed and staff confirmed that it was an ongoing weekly arrangement.

Staff were subject to annual appraisals as confirmed by staff and documentary evidence. New staff were subject to a six month probationary period that included three reviews by a senior staff to determine suitability to the role and identify areas that required additional support. An induction programme was also in place as evidenced in a selection of staff files.

There were effective recruitment procedures in place. The sample of staff files reviewed held the requirements of schedule two of the regulations. Up to date registration with the relevant professional body was maintained for relevant staff. The person in charge gave a verbal assurance that a vetting disclosure was in place for all staff and this was seen to be so in the random sample of files reviewed.

Judgment:
Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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Regulation Directorate

Action Plan

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

Provider's response to inspection report[1]

Centre name:	Haven Wood Retirement Home
Centre ID:	OSV-0000236
Date of inspection:	31/01/2017
Date of response:	17/02/2017

Requirements

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

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

Outcome 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:
Documentation was not always up-to-date, for example:
An incident involving a resident had not been documented in the nurses' daily narrative note.
Wound care documentation was, at times, inconsistent.
Where a specific problem or need had been identified, a specific care plan was not in place. Instead, the interventions were recorded under a non-specific care plan which

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

meant the problem or need wasn't always clearly identifiable.

1. 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:
a) Standard Operating Procedure Document to be reviewed and updated.
17th February, 2017
b) As part of the 2017 Staff Appraisals, all relevant staff to be met and given refreshment guidance / training on interventions and requirements relating to documents.
16th of March, 2017.
c) Nurse Induction Record to be updated to ensure training given is consistent across new recruits.
16th of March, 2017.
d) All relevant staff to complete "Health Care Records Management" on HSEland.
24th of March, 2017.
e) Records Audits to be further developed to cover identified areas for improvement.
31st March 2017

Proposed Timescale: 31/03/2017

Outcome 07: Safeguarding and Safety

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was a policy in place for the use of restraint, however, this required review to ensure it was in line with national policy 'Towards a Restraint Free Environment'. For example, the definition of restraint in the centre's policy was not in line with the definition set out in the national policy.

Formal comprehensive assessments were not completed prior to the use of bed side rails to determine their suitability for each resident.

The centre's own policy was not fully implemented at all times, for example, when the use of equipment such as lap belts was in use.

Care plans required review to ensure that they fully directed use, for example: the frequency of safety checks and restraint release protocols.

2. Action Required:
Under Regulation 07(3) you are required to: Ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the

website of the Department of Health from time to time.

Please state the actions you have taken or are planning to take:
a) Full review of current practice including the risk management tool and the policy to be completed.
31st March 2017.
b) Policy & Records to be developed to ensure National Standard are adhered to while taking into account the residents with capacity personal preference to have bedrails in place. (All bed rails in use during the inspection where per consenting resident's requests and understanding of consequences of use).
31st March 2017.
c) HIQA Quarterly Return to detail use of restraint where consent has been obtained from resident.
31st March 2017
d) Audit Schedule to include restraint audits.
31st March 2017
e) Completion of Care Plan review in line with previous action on documentation.
31st March 2017

Proposed Timescale: 31/03/2017

Outcome 08: Health and Safety and Risk Management

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Infection prevention and control procedures required review to ensure that they were consistent with the standards for the prevention and control of healthcare associated infections published by HIQA.

For example:

The cleaning trolley was found to be visibly dirty and stored in the centre's laundry area.
Household staff had an inadequate supply of cleaning cloths to ensure effective prevention of infection and the storage of such cloths promoted cross contamination.
Training records for staff carrying out housekeeping duties did not demonstrate that relevant training had been delivered.

3. 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:
a) Cleaning trolleys are being cleaned as required during use, and at a minimum at the

end of a day.
1st Feburary 2017
b) Training Course for Infection Control for Housekeeping to be developed and sourced from external accredited provider.
- Course development – 14th of February, 2017.
- Source of training – 16th of February, 2017
- Course to be held – all staff trained by 28th of April, 2017.
c) Update System for cleaning materials and colour code listing of appropriate materials and locations of use.
28th February, 2017.

Proposed Timescale: 28/04/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Fire drills required further development to ensure that they adequately tested the fire safety arrangements in place to ensure resident safety at all times.

4. Action Required:
Under Regulation 28(1)(e) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and residents are aware of the procedure to be followed in the case of fire.

Please state the actions you have taken or are planning to take:
a) New Training Module to be developed in the practise of Fire evacuation.
31st of March, 2017.
b) All Staff to have completed the Fire Evacuation Training
30th of June, 2017.

Proposed Timescale: 30/06/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all staff had up to date fire safety training.

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

and the procedures to be followed should the clothes of a resident catch fire.

Please state the actions you have taken or are planning to take:
a) Staff Fire Training to be brought up to date.
31st March, 2017.
b) New Training Module to be developed in the practise of Fire evacuation.
31st of March, 2017.
c) All Staff to have completed the Fire Evacuation Training
30th of June, 2017.

Proposed Timescale: 30/06/2017

Outcome 09: Medication Management

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all medications were not administered at their prescribed time, with some being administered more than two hours after the time on the resident's prescription.

A number of omissions on the residents' medication administration records were identified, therefore, it was not possible to verify if a resident had received their medication nor verify the time at which a resident had received same.

The centre's medication policy required review to ensure it fully guided the practice of transcription.

6. 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:
a) Medications are currently administered to accommodate sleeping & resting periods for our residents. This is part of our ethos of being Person Centred. We recognise that this practise is not fully compliant to prescribed times of the day.

We are undertaking a review of all medications prescribed times with GPs to adjust timings in accordance with residents normal sleeping patterns.
31st of March, 2017.

b) We are undertaking a review of our medication records to reflect the actual time medication is given to a resident.
31st of March, 2017

c) This review will include an examination of switching to an electronic system of recording medication administration.
7th of March – site visit to existing user.
31st of March – decision taken on switch to electronic or new paper system.
30th of April - Implementation

d) Omissions in relation to recording of administration of medication highlighted to all staff involved immediately following inspection and this information utilised to guide the training programme for Nurses in 2017. This practice will be subject to ongoing audit.
15th February 2017

e) Comprehensive review of the medication policy will include the review of the process of transcription, by the PIC, ADON, Company Doctor and Pharmacist, as the current arrangement for Doctors visits as per the DOHC agreement.
30th April 2017

Proposed Timescale: 30/04/2017

Outcome 10: Notification of Incidents

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A quarterly report was provided to HIQA as required, however, information regarding the use of restraint was inaccurate and required review.

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

Please state the actions you have taken or are planning to take:
a) In line with the DOHC Guidelines on restraint and their classification we will report all episodes of restraint on HIQA quarterly notifications.
31st January, 30th April, 31st July and October every year.

Proposed Timescale: Completed.

Proposed Timescale: 17/02/2017

Outcome 15: Food and Nutrition

Theme:
Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
At lunchtime, it was observed that some staff assisted two residents simultaneously to eat their meals. This approach was found to be task based and not individualised or person centred.

8. Action Required:
Under Regulation 18(3) you are required to: Ensure that an adequate number of staff are available to assist residents at meals and when other refreshments are served.

Please state the actions you have taken or are planning to take:
a) The practise of residents taking their meals at an appropriate communal time is to be reviewed to ensure the ethos of person centred and adherence to regulations.
28th February 2017

Proposed Timescale: 28/02/2017