Health Information and Quality Authority
Social Services Inspectorate

Inspection Report
Designated centres for older people

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

Centre name:	Riverview Nursing Home
Centre ID :	0163
Centre address:	Dublin Road Trim, Co Meath
Telephone number:	046-943 1857
Email address:	riverviewnh@hotmail.com
Type of centre:	☒ Private ☐ Voluntary ☐ Public
Registered providers:	Donna Quinn
Person in charge:	Rowena Tolentino Muldong Cueto
Date of inspection:	18 August 2009 19 December 2009 30 December 2009
Time inspection took place:	**18 August 2009 start:** 11:00hrs **18 August 2009 completion:** 17:10hrs
Lead inspector:	Leone Ewings
Support inspector:	Florence Farrelly
Type of inspection:	☐ Announced ☒ Unannounced
Purpose of this inspection visit	☐ Application to vary registration conditions ☐ Notification of a significant incident or event ☐ Notification of a change in circumstance ☒ Information received in relation to a complaint or concern

About the inspection

The purpose of inspection is to gather evidence on which to make judgments about the fitness of the registered provider and to report on the quality of the service. This is to ensure that providers are complying with the requirements and conditions of their registration and meet the Standards. That they have systems in place to both safeguard the welfare of service users and to provide information and evidence of good and poor practice.

In assessing the overall quality of the service provided, inspectors examine how well the provider has met the requirements of the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

Additional inspections take place under the following circumstances:

- to follow up on specific matters arising from a previous inspection to ensure that the action required of the provider has been taken
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Social Services Inspectorate (SSI) that a provider has appointed a new person in charge
- arising from a number of events including information received in relation to a concern/complaint or notification to the SSI of a significant event affecting the safety or well-being of residents
- to randomly "spot check" the service.

All inspections can be announced or unannounced, depending on the reason for the inspection and may take place at any time of day or night.

All inspection reports produced by the Health Information and Quality Authority will be published. However, in cases where legal or enforcement activity may arise from the findings of an inspection, the publication of a report will be delayed until that activity is resolved. The reason for this is that the publication of a report may prejudice any proceedings by putting evidence into the public domain.

About the centre

Description of services and premises

Riverview Nursing Home has accommodation for up to 14 residents. Services provided include long-term and respite care.

The centre has 14 beds with two single, one twin, two three-bedded and one four-bedded room. The accommodation is arranged on the upper and lower levels of the nursing home in a split level arrangement.

Communal sitting rooms are to the front of the centre. The kitchen and dining room is located on the upper level, with stair lifts linking each level. The front door reception area also has seating available.

The centre is set back from the road in well maintained gardens with a patio area located to the rear of the centre.

Location

Riverview is located on the Dublin road close to the nearby town of Trim.

Date centre was first established:	9 September 2004
Number of residents on the date of inspection	11

Dependency level of current residents	**Max**	**High**	**Medium**	**Low**
Number of residents	0	0	10	1

Management structure

The Provider is Donna Quinn who is involved with the day-to-day management of the centre. The Person in Charge is Rowena Cueto. The care assistants report to the Person in Charge or a staff nurse in the absence of the Person in Charge. A team of six care assistants work at the centre. Two catering staff are employed. There was no domestic staff in post at the time of the inspection to undertake cleaning and laundry.

Staff designation	Person in Charge	Nurses	Care staff	Catering staff	Cleaning and laundry staff	Admin staff	Other staff
Number of staff on duty on day of inspection	1	0	2	1	0	0	0

Background

The Inspection was unannounced, initiated in response to information received by the Authority. This information was in the form of a concern in relation to the care, welfare and safety of residents.

The information raised concerns in relation to care practices such as:

- food and choice at mealtimes
- staffing levels
- fire safety
- end-of-life care
- suitable and sufficient care
- complaints procedures.

The inspection focused on the issues raised in the concerns in order to ensure that all residents are receiving a good standard of care and that their safety is ensured.

Summary of findings from this inspection

During the inspection, inspectors spoke with residents and members of staff.

Inspectors found that the premises, fittings and equipment were clean and well maintained and there was a good standard of décor throughout the centre.

The centre has a complaints management policy in place and residents were aware of how to make a complaint.

The inspection identified areas where improvements were required including fire safety, documentation, recruitment practices, staffing, premises, meals and mealtimes, medication management and information for residents.

The required actions are outlined in the Action Plan at the end of the report.

Closure of centre 0163 Riverview

Following an unannounced inspection by the Authority on 18 August 2009, no written response was received by the Authority to the draft report issued to the provider. The lead inspector contacted the centre and ascertained that the person in charge had ceased employment on 16 November 2009. The provider was unable to appoint a person in charge who would meet the requirements of the Health Act 2007, and had failed to notify the Authority within the required timeframe.

The provider contacted the Authority on 2 December 2009 to verbally notify her intention to stop trading and close the nursing home on or around the 8 January 2010.

Residents and relatives were notified in writing on 1 December 2009 of the circumstances of the closure and the contact details of the provider, who offered her assistance in finding alternative homes for the remaining residents. Family and resident representatives undertook to visit a number of centres in the weeks preceding Christmas.

A letter issued to the provider by the Authority, on 18 December 2009, outlined the legislative requirement to notify the closure of the centre in writing to the Chief Inspector within the required timeframe.

Inspectors undertook an unannounced follow-up inspection on 19 December 2009 to ascertain the care and welfare status of the remaining nine residents at Riverview. Residents spoke to inspectors. A meeting was held with the staff nurse in charge who updated inspectors on which residents had alternative accommodation in place.

Staff rosters were reviewed, and it was ascertained that the provider was using a number of different nursing staff from a nursing agency. One nurse had agreed to act as a person in charge until closure. The food supplies and meals provided were inspected. Inspectors requested the provider to obtain further food supplies for the centre including fresh fruit.

Medication administration records and care plans were reviewed and found to be adequate. The centre's hygiene levels were also reviewed.

The provider informed the lead inspector on 21 December 2009 that it was not financially possible to make the necessary changes. The provider stated that this decision was not an easy one and stated that it had attempted for several months to come up with a plan that will allow it to overcome the changes that were necessary to comply with the regulations and legislation.

The lead inspector spoke to the provider on 21 December 2009. An agreement was made that a daily update of residents would be forwarded by e-mail or telephone to the inspectors for review. The provider was to notify the inspector of any issues or events which may have compromised the care and welfare of the residents at the centre. The provider was at the centre on a daily basis.

Inspectors undertook a second unannounced follow-up inspection on 30 December 2009 to review the nine residents living at the centre. One resident had yet to obtain alternative placement. A copy of a written staffing roster dated until 8 January 2010 was also obtained. A meal (lunch) was observed by inspectors, and food supplies were found to be adequate to meet the needs of the residents. The chef was working in the kitchen and a nurse and a carer were in attendance.

The provider at this time was actively working with the residents' relatives and other parties including the Health Services Executive and residents' representatives to manage the phased transfer of the residents to alternative accommodation.

All residents were re-located as of 7 January 2010 and the intention of the provider to close the centre was confirmed by telephone to the Authority on 8 January 2010. The provider was advised that the report was going to be published on the Authority's web-site, and a recommendation made for removal of Riverview (also known as St Anthony's) from the register of designated centres under the Health Act 2007 (Care and Welfare of Residents in Designated Centre for Older People) Regulations 2009.

The following issues relate to the initial inspection carried out by the Authority on 18 August 2009.

Issues covered on inspection

1. Food and choice at mealtimes

Inspectors interviewed the cook who confirmed breakfast is served to residents by carers and the nurse on duty each morning. The cook wrote up the daily menu on the board in the dining room prior to each meal. Inspectors confirmed with the cook that fresh vegetables were delivered weekly and stored in the fridge. The cook caters for residents with special dietary requirements.

Soup and other hot and cold drinks were available during the morning. Inspectors sat with and observed residents' eating lunch in the dining room. The lunch menu was displayed on a blackboard beside the door to the dining room. Some residents' were not aware of what was available and just asked for "something nice".

One resident ate lunch with the provider in the visitors' room, as this had been an earlier arrangement made with the provider. Not all residents eat in the dining room – the provider informed inspectors that one resident liked to eat in her room. Seating for meals was limited by the space available and six residents were seen to eat lunch around a single oval table accommodating 6 to 8 residents.

One resident using a walking aid had difficulty walking to her seat as a large chest freezer was placed in the dining room, and impeded her way. The cook told inspectors that frozen meat is stored in this freezer. Access to the dining room from the sitting room is on the electric stair-lift. A milk delivery took place at lunch time, via a rear fire exit door.

The cook served food and inspectors observed that residents were not offered any choice of food for lunch. Nursing or care staff did not supervise the meal in the dining room. One resident was seen to start eating a dessert put down in front of her in error, and it was then given to another resident to eat. Two residents' did not like the dessert available, but were not offered alternatives.

A number of residents spoken to by inspectors said they were happy with the food. However, there was no record of personal preferences of each resident. Staff did not encourage residents to eat. A number of residents' were observed by inspectors to eat a limited amount of food at lunchtime. On enquiry, one resident told the inspector that her gums were sore yet no soft alternative was offered to this resident.

After the meal, the person in charge showed the inspectors the care plans and nursing notes for some residents. The person in charge was unaware of the individual food intake of the residents. When questioned about the quantity of foot eaten by one

resident, the person in charge relied upon the report of the cook who after the meal recorded what each resident had eaten on a food-intake chart. Inspectors noted that this chart was not factually correct.

One resident, spoken to after lunch, was seen to have food on her clothes.

2. Staffing levels

The person in charge worked full-time and informed inspectors that when she was not on duty one of the other four staff nurses was rostered on duty.

On the day of inspection, there was one nurse (the person in charge) and two care assistants on duty providing direct care to 11 residents.

A copy of the staff roster was provided to the inspectors. This roster indicated that one staff nurse and one healthcare assistant was rostered for night duty. The provider stated she was in the process of recruiting another staff nurse.

The inspectors reviewed the working rota for the two weeks commencing 15 August 2009. The working hours of all staff were not included in the roster, and the roster was incomplete. There were no names on the roster for domestic staff or catering staff for the remainder of the weeks.

The provider told inspectors that the cleaner had recently left her post unexpectedly, and that both she and the person in charge had been cleaning the centre. The provider informed inspectors that she was working to review applicants' curriculum vitae in order to fill the post of cleaner.

A cook was on duty until 4.30pm and a new member of kitchen staff who was on orientation was assisting the cook. The previous cook had recently left his position.

Staffing records reviewed by inspectors were incomplete, and all staff had not been Garda Síochána vetted. Professional identification numbers for registered nurses were available for inspection by inspectors.

3. Fire safety

Staff who were spoken to had a clear understanding of the management structure and could describe their roles and responsibilities on a day-to-day basis and in the event of an emergency.

Care assistants reported to inspectors that they had received training in fire safety and evacuation. One care assistant was trained to be a fire warden, and described her role

in the event of a fire. The last fire drill that had been documented was held on 4 April 2008. One new member of staff on duty had not received centre-specific fire training.

The records reviewed by inspectors confirmed that the fire alarm had been tested on 21 January 2009, fire extinguishers serviced in September 2008. However, the last record of the emergency lighting check that was available for inspection was from 19 May 2006.

Inspectors were informed by the provider that the centre had a service agreement with a fire safety and service company and that the provider was awaiting a visit on the day of the inspection. When the inspectors left, this visit had not taken place.

Inspectors observed chemicals being stored in an under-sink cupboard which was not locked.

4. End-of-life care and communication

None of the residents at the centre required end-of-life care. Inspectors reviewed the files of past residents held at the centre and interviewed the staff nurse on duty about past experiences of how care was managed at the centre.

Nursing staff reported that on occasion a resident may be moved to Room 1, which was closer to the nurses' station, to be observed more closely. Inspectors confirmed this following a review of nursing notes. However, this room is also used by three other residents.

Frequent communication with relatives and friends was also documented by nursing staff. The nursing notes and care plans reviewed documented management of pain, fluid and nutritional needs, skin care and "turning", general practitioner (GP) visits, mouth care, and communication with the next of kin prior to and after death. Spiritual and psychological needs were also documented.

5. Suitable and sufficient care

Many residents commented favourably to inspectors about the centre.

The provider did not have a statement of purpose or a residents' guide, outlining the arrangements in place at the centre, for current or future residents.

Each resident had a nursing assessment and care plan in place. The person in charge had completed most of the documentation for the residents.

A resident reported that the person in charge had helped her get ready that morning and had done her hair earlier. This resident was interviewed by an inspector and was happy with the home, and felt she can go out if she chooses to do so.

Inspectors reviewed how medication was managed at the centre. There is a system in place for stock checking and disposal of medication on a weekly basis. However, no formal audit was being undertaken by the person in charge of how medication was administered and managed at the centre.

6. Complaints procedures

A complaints policy was displayed at the front door with details of what to do should a resident or relative wish to complain in writing.

The provider confirmed she maintained a record of complaints, which was located from her car which was parked outside the centre.

None of the residents reported having cause to make a complaint. One resident told inspectors that she “would complain to the senior nurse if she was worried” and that the staff were very kind.

The provider was aware of the regulatory reporting requirements relating to the details of any complaint to the Health Information and Quality Authority.

Report compiled by

Leone Ewings,
Inspector of Social Services,
Social Services Inspectorate,
Health Information and Quality Authority

8 January 2010

Health Information and Quality Authority
Social Services Inspectorate

Action Plan

Provider's response to inspection report

Centre:	Riverview Nursing Home
Centre ID:	0163
Date of inspection:	18 August 2009, 19 December 2009, and 30 December 2009
Date of response:	1 December 2009

Requirements

These requirements set out what the registered provider must do to meet the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

1. The provider is failing to comply with a regulatory requirement in the following respect: Medication management policy is not centre-specific. There was no evidence of audit of practice at the centre.
Action required: Develop a centre-specific medication management policy and ensure that the administration and recoding of all medication is in accordance with this policy and best practice.
Reference: Health Act 2007 Regulation 25: Medical Records Standard 15: Medication Monitor and Review Standard: 13 Healthcare

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: None received.	

2 The provider is failing to comply with a regulatory requirement in the following respect:	
Review current dining room and furniture provision and ensure it is accessible and adequate for all residents. Appropriate supervision and / or assistance to be given to any residents who require same with eating and drinking. The residents must be informed and offered choice at mealtimes.	
Action required: Review staff allocation and ensure a member of staff is available at mealtimes to supervise the dining room. Review area available for dining and furniture arrangements. Provision of adequate dining space for all residents.	
Reference: Health Act 2007 Regulation 20: Food and Nutrition Standard 19: Meals and Mealtimes Standard 25: Physical Environment	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: None received.	

3. The provider has failed to comply with a regulatory requirement in the following respect: A full and complete record of staff records was not available for inspection in compliance with Schedule 2.	
Action required: The registered provider to ensure a full and complete record of employment is kept in line with Schedule 2, for any persons managing or working at the designated centre.	
Reference: Health Act 2007 Regulation 18: Recruitment Regulation 24: Staffing Records Standard 22: Recruitment	
Please state the actions you have taken or are planning to take following the inspection with timescales:	**Timescale:**
Provider's response: None received.	

4. The provider has failed to comply with a regulatory requirement in the following respect: There was no statement of purpose or residents' guide available at the centre.	
Action required: The provider to create a written statement of purpose and a residents' guide. To meet the legislative requirements, this information must be provided in a form that is accessible to the residents.	
Reference: Health Act 2007 Regulation 5: Statement of Purpose Regulation 21: Provision of Information to Residents Standard 1: Information Standard 28: Purpose and Function	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**

Provider's response: None received.	

5. The provider has failed to comply with a regulatory requirement in the following respect: Cleaning materials are stored below the sink in the kitchen, and there is no lockable safe storage for cleaning materials and sluicing	
Action required: Provision of a separate cleaning room appropriate to the size of the centre, for the purposes of the catering staff. Hand-washing facilities are required and a lockable safe storage for cleaning materials and sluicing.	
Reference: Health Act 2007 Regulation 19: Premises Standard 25: Physical Environment	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: None received.	

6. The provider has failed to comply with a regulatory requirement in the following respect: Staff have not been trained in fire evacuation since 4 April 2008. New members of staff have not received centre specific training in fire safety. No evidence of emergency lighting check since 19 May 2006.	
Action required: Provision of fire safety training to all staff members. Emergency lighting checks to be undertaken by a suitably qualified person, and records of fire safety and evacuation maintained at the centre.	
Reference: Health Act 2007 Regulation 32: Fire Precautions and Records Standard 26: Health and Safety	

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: None received.	

7. The provider has failed to comply with a regulatory requirement in the following respect: The staff roster is incomplete, the planned roster has not been completed in full or for the forthcoming week.	
Action required: The person in charge shall ensure that there is a planned and actual staff roster showing staff on duty at any time during the day or night and that it is maintained.	
Reference: Health Act 2007 Regulation 16: Staffing Standard 23: Staffing Levels and Qualifications	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: None received.	

Recommendations

These recommendations are taken from the best practice described in *the National Quality Standards for Residential Care Settings for Older People in Ireland* and the registered provider should consider them as a way of improving the service.

Standard	Best practice recommendations
Standard 29: Management Systems	The person in charge ensures that staff receive training in and are familiar with and implement all policies and procedures within the residential care setting.

Any comments the provider may wish to make:

Provider's response:

Riverview Nursing Home
Dublin Road, Trim,
Co Meath

1st December 2009.

Ms Leona Ewings
HIQA Inspectorate Team
Dublin Regional Office
George's Court
George's Lane
Dublin 7

Dear Ms Ewings

It is with great sadness that I write to inform you that Riverview Nursing Home will be closing in the New Year. I have spoken with all of the Residents family members and a date for the 8th of January 2010 was agreed. Please know that this date is not final but one that has to be put in place in order to issue members of Staff with their correct notice. This decision is not an easy one and we have tried for several months to come up with a plan that will allow us overcome the changes that are necessary to comply with the HIQA standards. Financially it is not possible to make the necessary changes with the small number of residents that we can accommodate in Riverview.

I understand that the coming weeks will be difficult for both families and staff and I am working very closely with the families to ensure that our Residents are transferred to alternative accommodation with as little disruption as possible. All families have agreed not to move their family member until after Christmas. There will be no change to any of the day to day running of the Nursing Home. We have not informed Residents yet and families have asked that we do not until after Christmas.

This process is also very difficult on Staff. I am also working with them to try and find alternative employment for them. I have successfully placed three members of Staff to date.

I will forward you a detailed list of Residents and details of Nursing Homes they are transferring to when it is arranged.

I am available to meet to discuss this matter at your convenience.

Kind regards

Donna Quinn
Proprietor

Provider's name: Donna Quinn

Date: 1 December 2009