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:	Gowran Abbey Nursing Home
Centre ID:	0232
Centre Address:	Gowran Co Kilkenny
Telephone number:	056-7726500
Email address:	info@gowranabbeynursinghome.ie
Type of centre:	☒ **Private** ☐ **Voluntary** ☐ **Public**
Registered provider:	Dr Finian Gallagher on behalf of Gowran Partners
Person in charge:	Bridget Kirwan
Date of inspection:	4 May 2011 and 5 May 2011
Time inspection took place:	**Day- 1 Start:** 10:30hrs **Completion:** 20:30hrs **Day- 2 Start:** 09:30hrs **Completion:** 16:00hrs
Lead inspector:	Noelene Dowling
Support inspector(s):	Mary Moore
Type of inspection:	☒ **Registration** ☐ **Scheduled** ☒ **Announced** ☐ **Unannounced**

About 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 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland* under the following topics:

1. Governance and leadership: how well the centre is organised.
2. The quality of the service.
3. How well the healthcare needs of residents are met.
4. Premises and equipment: appropriateness and adequacy.
5. Communication: information provided to residents, relatives and staff.
6. Staffing: the recruitment, supervision and competence of staff.

This report summarises the findings of the inspection under some or all of these topics, highlighting areas of good practice as well as areas where improvements were required as follows:

Evidence of good practice – this means that an acceptable standard was reached and the provider demonstrated a culture of review and improvement and aimed to drive forward best practice.

Some improvements required – this means that practice was generally satisfactory but there were areas that need attention.

Significant improvements required – this means that unacceptable practice was found.

The report also identifies minor issues, where applicable, to which the provider should give consideration to enhance the quality of the service.

Registration inspections are one element of a process to assess whether providers are fit and legally permitted to provide a service. The registration of a designated centre is for three years. After that the provider must make an application for registration renewal at least six months before the expiration date of the current registration. New providers must make an application for first time registration 6 months prior to the time the provider wishes to commence.

In controlling entry to service provision, the Chief Inspector of Social Services is fulfilling an important regulatory duty under section 40 of the Health Act 2007. Part of this duty is a statutory discretion to refuse registration if the Chief Inspector is not satisfied about a provider's fitness to provide services, or the fitness of any other person involved in the management of a centre.

The registration inspection is one element for the Chief Inspector to consider in making a proposal to the provider in respect of registration. Other elements of the process designed to assess the provider's fitness include the information provided in the application to register, the Fit Person self-assessment and the Fit Person interviews. Together these elements are used to assess the provider's understanding of, and capacity to, comply with the requirements of the regulations and the Standards. Following assessment of these elements, a recommendation will be made to the Chief Inspector and the formal legal process for registration will proceed. As a result, this report does not outline a final decision in respect of registration.

The report is available to residents, relatives, providers of services and members of the public, and is published on our website www.higa.ie.

About the centre

Description of services and premises

Gowran Abbey Nursing Home is a purpose-built facility which commenced operations in 2007. It accommodates 48 older persons on a long-term, convalescence and respite basis. Persons under 65 years old will be considered for admission on an individual basis according to their assessed needs. The accommodation consists of 48 single bedrooms with en suites which contain an assisted shower, toilet and wash-hand basin. Although there are 49 bedrooms only 48 are utilised for residents' use. Gowran Partners also operate 10 independent semi-supported houses on the grounds of the designated centre.

The accommodation consists of a large entrance foyer, with a reception area and comfortable seating areas and coffee tables. There is a large dining room, day room, oratory and a large multi-purpose room which is used for activities, visits, and celebratory occasions for residents and their families. A smoking room, combined treatment room and appropriately equipped hairdressing room is provided. Two nurses' stations, administrative offices, kitchen and laundry complete the accommodation.

There are four assisted toilets and one assisted bathroom for residents' use. There are two enclosed courtyard gardens with seating which residents can access easily, and the grounds and car parking spaces are well maintained.

A retirement village, consisting of 10 independent houses is located adjacent to the centre and is also under the management of Gowran Partners.

Location

Gowran Abbey Nursing Home is located in the village of Gowran, 10 miles from Kilkenny City and close to all amenities.

Date centre was first established:	2007
Number of residents on the date of inspection	47*
Number of vacancies on the date of inspection	0

*One resident in hospital

Dependency level of current residents	**Max**	**High**	**Medium**	**Low**
Number of residents	20	17	10	0

Management structure

Dr Finian Gallagher is the Registered Provider on behalf of Gowran Partners. Bridget Kirwan is the Person in Charge. Anne Phelan is the Key Senior Manager and supports the Person in Charge. All staff report to the Person in Charge.

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	2	9*	4	3	1	2**

* Nine care assistants until 14:30hrs, four care assistants until 20:00hrs
** Activities coordinator, maintenance person

Summary of findings from this inspection

This was the second inspection undertaken by the Health Information and Quality Authority in Gowran Abbey Nursing Home. A regularity monitoring inspection was undertaken on 15 September 2010 which focused on key regulatory requirements. Four specific actions were identified following that inspection and this inspection found that all of those actions had been satisfactorily addressed by the provider. This inspection took place following application by the provider for registration.

As part of the registration process the provider has to satisfy the Chief Inspector that he is fit to provide the service and that the service will comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009. As part of the application for registration the provider was requested to submit relevant documentation to the Health Information and Quality Authority (the Authority) including completion of the Fit Person self assessment. This documentation was reviewed by the inspector to inform the inspection process.

This document was comprehensively completed and outlined current practices as well as changes the provider wished to make having reflected on the process. These changes combine person-centred issues, clinical care matters and practical matters such as:

- increased representation for residents
- introduction of comment cards
- support for residents with dementia
- improvements to the end-of-life care model
- increase in the availably of specialist equipment to support independence such as utensils for eating
- training for staff in challenging behaviours
- review of usage of bedrails and assessment tools
- audits of falls
- medication management
- a detailed induction checklist
- plans to extend to provide additional storage and a family room in the event of a resident been unwell.

Inspectors found that a significant number of these issues had been put in place including training for staff, availability of assistive utensils, reviews of bedrails and falls, training in end-of-life care, medication management, use of comment cards, and a detailed induction checklist for staff. Planning permission has been secured for the extension although no dates for commencement have been decided.

In order to assess the fitness of the provider and the key senior manager Fit Person interviews were held. The provider and person in charge demonstrated a good knowledge of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

Other documentation reviewed by inspectors included operational policies, residents' records, staff rosters and training records, meeting records and maintenance logs. Inspectors met with residents, relatives and staff.

The findings of this inspection indicate that the provider and person in charge have made considerable efforts to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland* and are substantially compliant.

There was evidence of good governance with effective management systems in place. Risk management procedures, health, and safety procedures were evident and legal requirements such as the statement of purpose and insurance were available and adequate. Complaints were found to be managed transparently and effectively and the person in charge acted promptly when any issues of concern arose.

Good practice was found in healthcare and access to allied health services. There was attention paid to the quality of residents' lives with person-centred practices and choice in their daily lives and an opportunity to influence practice. Attention was also paid to the needs of residents with communication difficulties. Staffing was adequate and resident focused and detailed training schedules had been implemented.

A number of improvements were necessary in order to meet the requirements: These included:

- adequate systems of ventilation on the premises
- recruitment and vetting of staff
- recording of allied health specialist interventions in resident records.

The action plan at the end of this report outlines these improvements necessary to meet the requirements the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland.*

Comments by residents and relatives

Inspectors met with and spoke to residents and relatives and received five completed questionnaires from residents prior to the inspection and eight from relatives. Residents' comments included that they felt that staff were very attentive and kind to them. They stated that they were confident that the person in charge was amenable to hearing any concerns they raised and would act accordingly. One relative complimented the pre-admission procedure and how the visits to the centre and the detailed information provided had helped in the decision making and admission process. They confirmed that they were kept informed of any changes in healthcare needs and always consulted regarding the care provided.

Overall findings

1. Governance: how well the centre is organised

Outcome: The centre is well organised and managed and complies with the requirements of the Health Act 2007, the regulations and standards.

Good governance involves the effective and efficient deployment of resources in accordance with the stated purpose and function of the centre. Governance includes setting clear direction for the service, a commitment to continual improvement and having a system in place to effectively assess and manage risk.

Evidence of good practice

Inspectors found good governance systems in place. The person in charge is suitably qualified and experienced, is present in the centre Monday to Friday and is also on call. There is a suitably qualified nurse who undertakes the duties of management in the absence of the person charge. Staff were clear on the reporting structure. There was evidence of effective management overview and monitoring of practice.

Legal requirements such as the written documentation of compliance with the requirements of the statutory fire authority statement of purpose, contracts of care, adequate insurance and compliance with environmental health regulations were found to be met. The directory of residents was viewed by the inspector and found to contain all of the details required by Schedule 3 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

Inspectors found that admissions were congruent with the statement of purpose. The individual needs of a resident under the age of 65 were managed appropriately with access to supports from allied external services.

The provider and the person in charge had complied with their responsibility to notify the Chief Inspector of significant occurrences within the centre.

A detailed and centre-specific emergency plan had been developed, which included a generator in the event of loss of power and a detailed plan in the event of a resident going missing from the centre. A centre-specific health and safety statement which includes identification of risk and appropriate measures to manage the risks was available.

Detailed risk management policy and practices were in place and procedures were evident. These included medication and falls audits with remedial actions evident as a result to safeguard residents. There were systems in place to monitor the quality of

life and safety of care for residents included ongoing feedback from the residents' forum, one-to-one feedback from residents and relatives, information gleaned from the staff meetings, and audits of practice.

Some improvements required

Inspector examined a sample of records pertaining to monies kept for safe-keeping by the provider. These records were very detailed with expenditures clearly documented and the records correlated with the monies held. However, there was no system by which residents or relatives were routinely provided with accounts and signed for the monies.

2. Quality of the service

Outcome: Residents receive a good standard of service, appropriate treatment and are treated with courtesy and respect.

A quality service is one where residents are protected from harm or abuse, where practice is person-centred, where rights are protected, where residents are enabled to play an active part in the centre and where management, staff and residents work together towards continuous improvement.

Evidence of good practice

Inspectors found that residents had choice in their daily routines, such as when they got up or retired and how they spent their time. Residents and relatives confirmed this. The layout of the premises allows for residents to have quiet time alone to read or visit with relatives.

Inspectors joined residents for lunch and those residents who needed assistance were supported in an unhurried and dignified manner. Independence was promoted by staff offering minimal assistance to residents when required and the availability of assistive eating utensils. A menu is available and residents confirmed that choices in regard to food were respected and it was evident to inspectors that staff were very familiar with residents' preferences. The food was freshly cooked and nutritious and the meal was a social and unhurried occasion.

Social relations were supported by an open visiting policy and relatives were observed visiting at all times of the day. Inspectors observed that staff, the person in charge and the provider were well known and communicated easily with relatives and visitors.

The complaint policy was detailed and included an appeals process. Inspectors examined the complaints log and found there was a transparent attitude to the management of complaints or concerns raised. All issues were satisfactorily dealt with by the person in charge and the outcome and level of satisfaction of the complainant was detailed. Residents and relatives confirmed that they can approach the person in charge or any staff, that they were satisfied their concerns were addressed and that the person in charge demonstrated that she was motivated to ensure they were happy with the outcome.

The residents' forum is another avenue whereby residents can make suggestions and raise issues. Records of the residents' forum which is used to include residents in the running of the designated centred showed that these were utilised to inform residents of any forthcoming changes and primarily to take feedback from residents. For example, changes to activities and the inclusion of more music was requested

and acted upon. Access to more regular physiotherapy was also requested and this was provided. These meetings are chaired by the activities coordinator. Records demonstrated a good attendance by residents and some relatives, with 19 attending in January 2011 and 31 attendees in April 2011. Meetings are held quarterly.

A suggestion box is strategically placed and comment cards have randomly been given to residents, relatives and staff. Inspectors found that these contained positive feedback.

There was variety to the residents' day, with activities aimed at all residents, and inspectors observed constant and friendly interaction between staff and residents regardless of the time of day. Residents were observed reading the paper in quiet corners or having their tea in the day room in order to watch the racing, or walking to the local village. The secure courtyards are accessible to residents and they confirmed that they enjoyed access to them in fine weather.

The activities coordinator has trained in Sonas and also in Activities in Care. She is available four days per week (for a total of 26 hours) and residents confirmed that these are important factors to the quality of their lives. Sonas takes place four times per week and the group is rotated to ensure that all residents who wish to or who would benefit from this are able to participate. Question and answer sessions, relevant to the resident population are also held along with music, karaoke and crafts.

The activities coordinator also attends residents on an individual basis for hand message or reading, depending on the resident's capacity and preference. Life story books have been commenced with some residents. Inspectors observed the Sonas session and found that the activities coordinator tries to include all residents in the activity or make them aware of aspects of it and the question and answer session observed was lively. Residents stated that they appreciated the gentle exercise sessions as they felt it benefited their mobility.

Resident's spiritual needs and choices are supported by the presence of the oratory for quiet reflection. A number of staff are ministers of the Eucharist; mass takes place weekly and non-catholic denominations are supported by visits from relevant ministers. While there is no specific model for end-of-life care, inspectors found that referrals were made to palliative care specialists in accordance with residents' care needs. The key senior manager has undertaken training in the support of residents at this time which is implemented in practice. One relative informed inspectors that their relative (a resident) and family members had been consulted and supported in a respectful manner at such a time, and following the death of the resident.

Inspectors found that residents' independence was promoted by encouraging them to remain mobile with staff support or the use of walking aids and continence promotion strategies.

The centre policy on the use of restraint includes a direction to utilise all other options in the first instance and this was implemented. Inspectors found that

methods of restraint were not overused. Where bedrails were used their usage was risk assessed and when they were deemed a risk to residents they were removed. Alternative strategies such as low beds or mattresses on the floor were utilised. The rationale for the use of bedrails and wandering tags, which were used for two residents, was clearly outlined and informed consent was evident.

Inspectors observed that the care plans for residents contained very detailed and person-centred biographical information which was used to support residents. Care plans of residents who were distressed showed a very clear understanding of the residents' social and psychological needs and attempts to support them. For example, a resident was permitted to walk for long periods during the night or evening and at times sleep in the day room as this relieved the distress.

Staff have undergone training in elder abuse and the protection of vulnerable adults with the remaining ten staff scheduled for training in May 2011. Staff were able to articulate an informed understanding of what would constitute abuse and what actions they should take in the event of such an issue occurring. Records and interviews confirmed that the staff, person in charge and the provider had acted in a timely and responsible manner when an issue of misconduct was observed and subsequently swiftly reported. Other systems for protection of residents include the open visiting policy, residents' forum, and access to the person in charge.

Some improvements required

The policy on abuse requires amending to include the actions to be taken in the event of an incident of abuse occurring between residents or by the centre managers and the role of statuary agencies in investigating or assessing such incidents.

3. Healthcare needs

Outcome: Residents' healthcare needs are met.

Healthcare is integral to meeting individual's needs. It requires that residents' health, personal and social care needs are assessed and reviewed on an ongoing basis, within a care planning process, that is person centred. Emphasis is firmly placed on health promotion, independence and meaningful activity.

Evidence of good practice

Resident's may retain their own general practitioner (GP) or agree to transfer to the care of the medical director of the company. Records showed that two thirds of residents were attended to by the medical director who undertakes a formal medical round of the centre once weekly but is also readily available outside of this time. Out-of-hours service is provided. Records confirmed that residents are seen by GPs very frequently. Inspectors found that the nursing staff and the person in charge had detailed and up-to-date knowledge of the resident's health and this was monitored closely.

Inspectors reviewed five residents' records and found that residents' healthcare needs and capacities are assessed on admission and regularly reassessed using appropriate assessment tools for risk of falls, nutrition, pressure areas and dependency levels. Vital signs were monitored regularly. Nursing records examined were very detailed; they corresponded to the instructions in the care plans and were completed by staff morning and evening.

Inspectors saw evidence of referrals to wound management specialists and staff were knowledgeable on the required treatment plans. Grading and assessments of pressure areas are undertaken using recognised tools and documentation. Residents at risk of developing pressure wounds are monitored by the use of pressure relieving mattresses and cushions. Preventative diet and skin care regimes were found to be implemented. Fluids were encouraged and where deemed necessary intake recorded. Inspectors observed residents been offered and assisted to take fluids during the day and evening.

Access to allied health specialists was evident, with evidence of referral to speech and language, and occupational therapy. Chiropody is available weekly or as required and additional physiotherapy is provided weekly by the provider outside of that sourced through the Health Service Executive (HSE).

Other disciplines such as mental health or disability specialists were accessed and available for residents when required. Inspectors noted good communication and

liaison in records and from interview with the person in charge and staff between these services to support continuity of care for residents.

The inspector found that all medications, including controlled drugs and crushed medications are prescribed, administered, stored, disposed of and accounted for in accordance with An Bord Altranais Guidelines (2007). The medication policy is up to date and adequate. Inspectors found that the use of pro-re-nata medication is monitored. A record of one drug error was reviewed and the actions taken to address this were timely and appropriate with medical advice sought promptly and family informed. This incident was addressed satisfactorily by the person in charge.

Some improvements required

A detailed audit of medication management practices was undertaken. This provided information on practices in relation to the prescribing, administration, returns and the signage of all documentation in relation to medication. This audit found that although the GPs were reviewing medication this was not consistently entered in the residents' notes or on the prescription records. The person in charge was considering the best method to ensure this review was recorded and evidenced. The pharmacist had undertaken an information session in regard to medication usage.

Records demonstrated that resident's weights were checked on a monthly basis. Nutritional assessment and preferences were undertaken on admission. Dietary advice was sought from specialists as residents' needs changed, and the outcome recorded by the specialist and communicated to the catering staff. Specialist nutritional supplements were used. The catering staff demonstrated a detailed knowledge of the residential nutritional needs, and food was prepared in accordance with the revised care plans. However, inspectors found that the previous plans had not been removed thereby creating a risk of error.

While the care plans were very detailed and recorded all health practitioner visits, it was difficult to ascertain the details of the interventions of some allied health specialist such as the occupational therapists. Staff explained that they have been informed that these practitioners maintain their own records for the HSE and do not record in the resident's record.

4. Premises and equipment: appropriateness and adequacy

Outcome: The residential care setting provides premises and equipment that are safe, secure and suitable.

A good physical environment is one that enhances the quality of life for residents and is a pleasant place to live. It meets residents' individual and collective needs in a comfortable and homely way, and is accessible, safe, clean and well-maintained. Equipment is provided in response to the assessed needs of each of the residents and maintained appropriately.

Evidence of good practice

The premises were clean, bright, well decorated and well maintained. Furnishings and fittings were of a good standard. The design, layout and accommodation provided were fit for purpose. There was adequate communal space, including the large dining room and day room, activities room, oratory and smoking room. The design of the building and strategically placed seating allows residents or visitors to sit quietly and in privacy. Residents' bedrooms were spacious and personalised with photos, soft chairs, mementos, plants and some personal furnishings. All bedrooms had televisions and telephone points and ample storage space for residents' personal belongings with lockable storage space for valuables. All en suites contained assisted showers, wash-hand basins, toilets, grab-rails and call-bells. There is a separate assisted bathroom and three assisted toilets available and accessible to the communal areas of the premises. The secure entrance door and the design of the premises mean that residents are free to walk and wander in safety. Two enclosed courtyard gardens with seating were easily accessible to residents.

There were adequately equipped sluice rooms, and a combined treatment and hairdressing room and adequate and separate changing facilities for kitchen and other staff.

All of the beds used were profiling, and pressure-relieving mattresses are used as necessary. Records of the servicing of all equipment used for residents' safety and comfort including hoists, wheelchairs and profiling beds were examined and were up to date with the last service undertaken in February 2011. The wandering alarm system used for residents was last serviced in May 2011. Inspectors observed staff responding to this alert in a timely and calm manner.

Inspectors found good practice in relation to infection control, and observed staff taking the necessary precautions and knowledgeable on best practice in this area with well equipped cleaning trolleys ,hand sanitizers and personal protective equipment available and utilised. The laundry room was well equipped and linen is appropriately segregated. The catering staff have completed the required Hazard Analysis Critical Control Points (HACCP) training and good food management systems

were observed and articulated. Maintenance tasks were found to be attended to speedily with actions required and timescales clearly entered in the maintenance log.

Although storage for equipment is not extensive, the design of the premises allows for equipment such as hoists, and wheelchairs, to be stored without causing a risk of impediment of access or accident. The provider has received planning permission for an extension, which includes storage space for equipment.

Some improvements required

The inspector examined records in relation to the servicing of all fire safety equipment and found good practice was adhered to. There was evidence that fire training was provided to staff yearly and staff were able to articulate the actions taken to protect the residents in such an event with good knowledge of the fire compartments and how to utilise them. Fire fighting equipment is serviced annually. The fire alarm system was tested quarterly and the emergency lighting was serviced annually. Ski pads are fitted on all beds. A daily inspection of fire exits takes place and the fire alarm is tested weekly.

However, inspectors noted that while there are detailed instructions and diagrams on means of escape specific to the location in residents' bedrooms and staff offices these are not available in the communal or hallway areas. This could prevent visitors in these locations from responding effectively.

Due to the layout of the premises the internal hallways do not have access to natural ventilation. Both sluice rooms and residents' en suites are ventilated mechanically. Inspectors noted a distinct malodour about the premises, which is not conducive to good infection control and points to a lack of adequate ventilation.

5. Communication: information provided to residents, relatives and staff

Outcome: Information is relevant, clear and up to date for residents.

Information is accessible, accurate, and appropriate to residents' and staff needs. Feedback is actively sought from residents and relatives and this informs future planning and service provision. Information is recorded and maintained in accordance with legal requirements and best practice and is communicated to staff on a need to know basis to ensure residents' privacy is respected.

Evidence of good practice

Inspectors found that there were effective communication systems in place. Residents are given a comprehensive guide and interviews confirmed this. There was evidence of constant communication between staff and residents with evidence of consultation on care plans. Relatives informed inspectors that they are informed of any changes in residents' health and consulted regarding the interventions taken.

There is some pictorial signage used for residents to identify the purpose of different rooms and direct them through the premises. Staff had introduced writing boards to support residents who could not communicate verbally and had adapted the call-bells to enable residents with a physical disability to access them.

The provider has developed all policies required by Schedule 5 of the Health Act (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended). Although some of these are generic they have been adapted to suit the centre.

Mechanisms to ensure good communication between staff and continuity of care for residents are the staff team meetings, nursing reports and management forum meetings. Records indicate that care assistant and nursing staff meetings take place quarterly or as required. The records of these meetings examined by inspectors demonstrate that they contain direction and discussion on both quality of life issues for residents, policy implementation and practice development. The person in charge attends the morning handover and uses this forum to educate staff and ensure residents' care plans are adhered to. Inspectors attended the evening handover report and found that this was comprehensive and detailed with all staff knowledgeable on the residents' care needs and daily life.

Staff: the recruitment, supervision and competence of staff

Outcome: Staff are competent and recruited in sufficient numbers to meet residents' needs.

Staff numbers and skill-mix are determined by the size and complexity of the service and there should be sufficient competent staff on duty, both day and night, to meet the needs of residents. Robust recruitment and selection procedures ensure the appointment of suitably qualified and experienced staff. Staff are supported in their work by ongoing training and supervision.

Evidence of good practice

Staff were observed continually communicating and engaging with residents regardless of the residents' capacity to communicate directly. Inspectors observed good staff supervision in the communal room at all times during the inspection which had been an action identified in the regulatory monitoring inspection.

Inspectors found that the provider had increased the number of nursing staff on night duty as required by the monitoring inspection in 2010. For nursing purposes the centre is divided into two sections with a staff nurse assigned to each section and care assistants assigned in groups of one or two, taking residents' dependency levels into account. This arrangement was well planned and supported good care for residents.

Inspectors found that the numbers and skill mix of staff was appropriate to the assessed needs of the residents. There are two nurses on duty at all times including weekends and between nine and four care assistants on duty until 20:30hrs. Overnight this is reduced to two nurses and one care assistant.

Training of staff, division of roles and robust management system contributed to the wellbeing and overall quality of life of the residents. A comprehensive training schedule had been implemented for all grades of staff. Inspectors found that this included mandatory training in manual handling, fire safety and elder abuse. Six of the care assistant staff have completed Further Education and Training Awards Council (FETAC) level Five training, with 6 more undergoing this training currently supported by the provider.

Other training pertinent to the needs of the resident population including both clinical practice and resident care has been undertaken and planned. For example, four nursing staff have undertaken training in administration of subcutaneous fluids; four staff received revised training in medication management in February 2011, 24 staff received training in managing challenging behaviours in January 2011, three staff have undergone training in gerontology since 2010, 45 staff attended training on the prevention of infection. Prospective training dates have been arranged for person-centred dementia care and stroke care.

A detailed induction programme is in place, pertinent to the specific role of the staff which includes health and safety, fire safety, customer care, elder abuse, clinical risk and infection control which staff confirmed they participated in.

The person in charge had recently implemented a yearly staff appraisal system in 2009 and the records available demonstrated that this is used as a staff development tool and to address practice issues as pertinent to staff roles.

Significant improvements required

There was a detailed and centre specific policy on the recruitment, selection and vetting of staff. However, this was not reflected in practice. A review of four personnel files found that the required three references, evidence of mental and physical fitness were not present. Volunteers were not vetted.

Inspectors found an arrangement whereby care assistant staff are recruited independently of the provider to provide individual one-to-one care for a resident. The provider had no evidence of the adequacy of the recruitment process or the training and experience of these staff. The staff, by virtue of their presence in the centre had access to all residents. No adequate record of which of these externally recruited staff attended to this individual resident on any one day is maintained. There is no formal reporting procedure in relation to the resident's care although the nursing staff remain responsible for the resident's medical care needs. This arrangement is unsuitable in its current configuration.

While the staff ratios are assessed based on the numbers of residents residing in the nursing home inspectors were concerned that the independent houses are connected to the nursing home by call-bell and fire alarm system. They may attend the centre for meals or prayers as they wish and inspectors observed that this did not impact negatively on the residents. However, there are no records maintained of occasions when the nursing staff were required to attend to a resident in the independent houses. The person in charge and nursing staff informed inspectors that this has only occurred very infrequently and in the case of absolute emergency. The provider stated that this was a good-will gesture should a resident in the houses require immediate assistance.

However, the availability of the nurse call-bell and fire alarm connection is outlined in the centre brochure as part of the service provided to residents in the independent accommodation. This indicates it is a more formal arrangement and a right of residents who decide to reside in the independent accommodation. In such an event the absence of the nurse from the nursing home could diminish the capacity of the remaining staff to provide adequate care .This occurrence has not been adequately accounted for.

Closing the visit

At the close of the inspection visit a feedback meeting was held with the nominated provider and the person in charge to report on the inspectors' findings, which highlighted both good practice and where improvements were needed.

Acknowledgements

The inspectors wish to acknowledge the cooperation and assistance of the residents, relatives, provider and staff during the inspection.

Report compiled by:

Noelene Dowling
Inspector of Social Services
Social Services Inspectorate
Health Information and Quality Authority

13 May 2011

Chronology of previous HIQA inspections	
Date of previous inspection:	**Type of inspection:**
15 September 2010	☐ Registration ☐ Scheduled ☐ Follow up inspection ☒ Monitoring inspection ☐ Announced ☐ Unannounced

Health Information and Quality Authority
Social Services Inspectorate

Action Plan

Provider's response to inspection report*

Centre:	Gowran Abbey Nursing Home
Centre ID:	N0232
Date of inspection:	6 May 2011 and 7 May 2011
Date of response:	3 June 2011

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 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

1. The provider has failed to comply with a regulatory requirement in the following respect:

Full and satisfactory information in relation to staff employed by the provider or others to work at the designated centre was not available.

Action required:

Implement recruitment procedures to ensure no staff member is employed unless the person is fit to work at the designated centre and full and satisfactory information and documents specified in Schedule 2 have been obtained in respect of each person, including staff employed by external agencies to work at the centre.

Reference:

Health Act 2007
Regulation 18: Recruitment
Standards 22: Recruitment

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

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: The recruitment practice has been reviewed to comply with our Nursing Home specific policy for all staff including external agencies thus ensuring the documentation specified in Schedule 2 is obtained in the required timeframe and detailing the prospective employees fitness and suitability to work in the Centre.	Ongoing

2. The provider has failed to comply with a regulatory requirement in the following respect:

Volunteers were not vetted appropriate to their role in the designated centre.

Action required:

Ensure volunteers working in the designated centre are vetted appropriate to their role and level of involvement in the designated centre.

Reference:

Health Act 2007
Regulation 34: Volunteers
Standard 20: Social Contacts
Standard 22: Recruitment

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: The protection, safety, and comfort of our residents is paramount and the role of the volunteer has beneficial effects for the residents in maintaining social contacts. The role of the volunteer has been reviewed and on the limited occasions when volunteers are present in the centre to provide entertainment through music or dance it is in the presence of staff with volunteers having minimum level of involvement with the residents. Prospective volunteers will be vetted appropriately to their level of involvement and in compliance with Regulation 34 of the Health Act 2007	Ongoing

3. The provider has failed to comply with a regulatory requirement in the following respect:

Residents' records did not contain information on treatment provided by allied health practitioners who undertake treatment or assessment of residents.
Action required: Maintain, in a safe and accessible place, a record in respect of each resident with details of investigations made, diagnoses and treatment given, signed and dated by the practitioner involved to ensure completeness.
Reference: Health Act 2007 Regulation 25: Medical Records Standard 13: Healthcare

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Prior to the day of inspection referrals had been submitted to, and telephone contact made with the community occupational therapy department for advice regarding assistance with aids for two residents but had not been reviewed by the health professional. Details of telephone contact are documented in the residents file by the nurse dealing with the issues. The files of these two residents were viewed by the inspectors and their cases discussed but it was not clearly documented that assessment had not taken place which may have led to confusion with regard to documentation by that health professional. For many other allied health disciplines HSE policy restricts the health professional from documenting the visit in the nursing home notes.	Ongoing

4. The provider has failed to comply with a regulatory requirement in the following respect: There was insufficient evidence that residents' medication was reviewed in conjunction with the care plan review no less frequently than at three-monthly intervals.
Action required: Ensure that the review of residents' medication takes place no less frequently than at three-monthly intervals and this is clearly documented in resident's medical records.

Reference: Health Act 2007 Regulation 8: Assessment and Care Plan Regulation 25: Medical Records Standard 15: Medication Monitoring and Review Standard 11: The Resident's Care Plan	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The documentation procedure for the three monthly medication reviews by GP's has been reviewed and a process implemented to ensure the reviews are clearly evident in the residents notes.	Complete

5. The provider has failed to comply with a regulatory requirement in the following respect: The policy on the prevention, detection and response to abuse was not sufficiently detailed to reflect the requirements should an incident occur.
Action required: Ensure that all policies are centre specific and reflective of the practices as implemented and in line with legislation with particular reference to the policy on the prevention, detection and response to abuse.

Reference: Health Act 2007 Regulation 27: Operating Policies and Procedures Standard 29: Management Systems	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Policies are reviewed on an on-going basis to ensure they are up to date and reflect changes in practice and are centre specific. The policy on abuse has been reviewed and now details actions to be followed in the event of specific incidents of abuse or misconduct by residents, staff, managers, allied	Complete

health professionals or visitors. Contact details of local area elder abuse office and statutory agency included.	

6. The provider has failed to comply with a regulatory requirement in the following respect: The provision of nursing staff support to the independent accommodation has not been adequately planned to account for any possible impact on staffing levels in the designated centre should this be a regular occurrence.	
Action required: Review the arrangements for nursing staff support to the independent houses to ensure that should staff be detained for periods offering such support the designated centre remains adequately staffed.	
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: As there are two nurses on duty in the nursing home at all times the needs of the nursing home residents will not be compromised by attending to the occupant of the independent living houses in the event of an emergency. However if such an event occurs where a nurse or other staff member, is detained arrangements for replacement staff for the nursing home are in place.	Complete

7. The provider has failed to comply with a regulatory requirement in the following respect: Ventilation systems on the premises were inadequate.
Action required: Ensure that adequate ventilation is provided in all parts of the premises.
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: The mechanical ventilation system installed in the centre was installed to specification contained in building regulations. However, following the concerns of the inspectors the system is under review and will be improved to ensure comfort for residents and all who visit and to comply with best practice infection prevention and control measures	1 November 2011

8. The provider has failed to comply with a regulatory requirement in the following respect: Systems for evidencing the transparent management of residents' monies were not adequate.
Action required: Put in place a procedure where at regular intervals residents or relatives are provided with accounts of monies held by the provider and are enabled to demonstrate agreement with the statements provided.
Reference: Health Act 2007 Regulation 7: Residents' Personal Property and Possessions Standard 9: The Resident's Finances.

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Arrangements and agreement now in place for residents and for relatives to attend during office hours to review and agree account statements of monies held for residents.	Completed

Any comments the provider may wish to make:

Provider's response:

Gowran Abbey Nursing Home are committed to providing the highest standard of care and best quality of life possible for the residents entrusted to our care and this is done by an educated, caring and committed staff working together with the standards to achieve the best possible outcome for our residents.

We appreciate the need for comprehensive documentation however maintaining detailed documentation is time consuming on nursing staff and takes from time to interaction with the resident in a relaxed way.

At Gowran Abbey Nursing Home we strive to create a homely and independent quality of life for our residents but we feel the regulations in the present form is restrictive.

We would like to like to thank the inspectors Ms Noelene Dowling and Ms Mary Moore for their professionalism, and consideration to all during the inspection process.

Provider's name: Dr Finian Gallagher

Date: 3 June 2011