Health Information and Quality Authority
Social Services Inspectorate

Inspection report
Designated centres for older people

Centre name:	Ashlawn House Nursing Home
Centre ID:	0407
Centre address:	Limerick Road Nenagh Co Tipperary
Telephone number:	(067) 31433
Fax number:	(067) 34163
Email address:	info@ashlawnnursinghome.com
Type of centre:	☒ **Private** ☐ **Voluntary** ☐ **Public**
Registered provider:	Ashlawn House Nursing Home Ltd.
Person in charge:	Alene Curtin
Date of inspection:	7 June 2011
Time inspection took place:	**Start:** 09:30 hrs **Completion:** 15:00 hrs
Lead inspector:	Mary Costelloe
Support inspector:	N/A
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 ☒ Follow-up inspection

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 (as amended) 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 matters arising from a previous inspection to ensure that actions required of the provider have been taken
- following a notification to the Health Information and Quality Authority's Social Services Inspectorate of a change in circumstance for example, 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 wellbeing 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

Ashlawn House is a family owned and operated centre. It was first established as a designated centre in 1979. It is a single-storey building set on six acres of grounds. A twelve-bedded dementia care unit was added and completed in 2009. The centre provides long-term and short-term care and dementia care to residents' over 18 years. There are 41 places and on the day of inspection there were 40 residents.

The main entrance is to the front of the building, the dining room, conservatory, and nurses' office are located in this area.

Bedroom accommodation consists of 27 single bedrooms and 7 double rooms. All bedrooms have en suite facilities. Fifteen of the bedrooms have en suite shower, toilet and wash-hand basins and 12 bedrooms have en suite toilet and wash-hand basin. Twelve single bedrooms are located in the dementia care unit, all are en suite with assisted shower and toilet. There are three additional assisted bathrooms and toilets for residents, two separate toilets for visitors and two staff toilets.

The kitchen, laundry, sluice room and cleaners' room are located centrally in the building.

The centre has a variety of communal day spaces including two sitting rooms, dining room, conservatory and smoking room. The dementia care unit has a separate dining room and two day rooms. An oratory is available for use by residents and relatives for prayer and reflection.

All rooms have views of the extensive landscaped gardens. Residents can use the garden and there is also a secure enclosed courtyard garden, with seating available for residents' use. The building is wheelchair accessible and there is ample car parking for staff and visitors to the front of the building.

Location

Ashlawn House is situated three and a half miles south west of Nenagh town on the main Dublin/Limerick road in County Tipperary. It is set in a scenic rural area.

Date centre was first established:	1979
Number of residents on the date of inspection:	40
Number of vacancies on the date of inspection:	1

Dependency level of current residents	Max	High	Medium	Low
Number of residents	0	9	21	10

Management structure

Ashlawn House is a family run business trading as Ashlawn House Nursing Home Ltd. Peter Curtin is the Provider and his wife Alene Curtin is the Person in Charge. The Provider manages the accounts and maintains the premises. The Person in Charge has responsibility for provision of care and reports to the Provider. Marie Carey is the Deputy Person in Charge, a Clinical Nurse Manger (CNM) has recently been appointed, they both report to the Person in Charge. Nursing staff report to the CNM while care assistants report to the nurse on duty. Household and kitchen 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 including CNM	4 + 2*	2	3	1	1**

* 2 State Enrolled Nurses
**1 Maintenance Operator

Background

Ashlawn House Nursing Home was first inspected by the Health Information and Quality Authority (the Authority) on 13 and 14 April 2010. Inspectors found that the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 were met. Inspectors were satisfied that residents' nursing, medical and healthcare needs were adequately met.

The action plan identified areas where improvements were required to comply with the requirements of the Regulations and the *National Quality Standards for Residential Care Settings for Older People in Ireland.*

These improvements included:
- training and management of behaviours that challenge
- opportunities to participate in the development of activities appropriate to residents' interests
- development of the care planning processes
- implementation of auditing
- development of a residents' committee and advocacy service
- formal system for monitoring staff performance and development.

The inspection report can be found at www.hiqa.ie under centre number 0407

This additional inspection report outlines the findings of a follow up inspection that took place on 7 June 2011. The inspection was unannounced and focused on the actions of the inspection of 13 and 14 April 2010.

Summary of findings from this inspection

Overall, the inspector was satisfied that the provider had implemented many of the actions required from the previous inspection within the agreed timeframes. Some actions had been partially addressed but the provider, person in charge and CNM were positive in their attitude and were committed to ensuring completion of all actions in a timely manner.

The key measures taken by the provider since the previous inspection were as follows:

- all staff had been provided with training in behaviour that challenged
- systems to review the quality and safety of care and quality of life of residents in the centre such as audits of falls, accidents/incidents, complaints and medications were implemented
- the medication policy had been updated to include guidance on PRN (as required) medications and discontinued medications had been signed by the GP
- a formal staff appraisal system had been introduced
- residents were being offered choice of location at which to have their meals
- a computerised nurse documentation system had been put in place.

Actions requiring further work included documentation of the care planning process and provision of appropriate and suitable activities for residents based on their assessed interests and capabilities.

Following this inspection the inspector noted additional actions required including the review of staffing levels and improvements to the décor, fixtures and fittings in the dementia care unit.

Actions reviewed on inspection:

1. Action required from previous inspection:

Provide suitable and sufficient care to maintain the resident's welfare and wellbeing, having regard to the nature and extent of the resident's dependency and needs as set out in their care plan.

Provide staff with training in behaviour that challenges pertinent to their role.

This action was completed.

The person in charge told the inspector that all staff had received training on behaviours that challenge. Training records reviewed confirmed that the training took place in August 2010 and in March 2011. Staff spoken to told the inspector that they found the training interesting and beneficial and were knowledgeable on how to respond to residents with behaviours that challenge.

2. Action required from previous inspection:

Assess and record the preferred routines, expectations, likes and dislikes of residents in their care plan.

Provide opportunities for residents to participate in development of activities appropriate to his or her interests and capacities.

Consult with residents and provide them with information about the activities available to them.

This action was partially completed.

The person in charge and the CNM showed the inspector the computerised nurse documentation system which had been put in place in February 2011. The inspector reviewed a sample of residents' files. The recreation and social interaction section had not been completed therefore activities provided were not based on the residents assessed preferences and capabilities. The person in charge told the inspector that nursing staff were still in the process of transferring and completing the required information. She told the inspector that two activity coordinators had been employed since the previous inspection, but both had since left the service. She said that she was actively trying to recruit another suitable person. She said that the last activities coordinator had documented residents preferred routines, likes and dislikes as well as their past interests and hobbies. However, this documentation was not available during the inspection. The person in charge told the inspector that a staff member who facilitated the Sonas programme and who was not currently on duty had the records.

There were limited activities taking place. A notice of daily activities/events were displayed on the notice board and on the board at the nurses' station. Mass took place weekly, the rosary was facilitated daily, physiotherapy (gentle exercise programme) took place weekly, a live music session was held every two weeks. One member of staff was trained in Sonas (programme specifically for persons with dementia or Alzheimer's), and a two hour Sonas programme was scheduled on three afternoons a week.

The inspector noted that during the inspection there were no meaningful activities taking place in the dementia care unit, the television was on in the day room but at times the content was inappropriate for residents with dementia. Staff in the unit had received limited training in appropriate therapies for residents with dementia such as reminiscence therapy and reality orientation.

3. Action required from previous inspection:

Put systems in place to ensure that residents' needs are set out in an individual care plan developed and agreed with each resident. Keep the residents' care plan under formal review as required by the resident's changing needs. Ensure that issues such as catheter care are addressed in the care plan.

Ensure that each resident has an individual care plan which identifies and social care needs and is agreed with each resident. The care plan should be made available to residents and should be formally reviewed every three months or as dictated by residents changing needs and/or circumstances.

This action was not completed.

The inspector reviewed a sample of residents' files on the computerised nursing documentation system including residents with a catheter, gastronomy tube feed and pressure ulcer. A comprehensive nursing assessment had not been completed for all residents. Risk assessments had been completed for each resident but some were not up-to-date. While there was a care plan in place for the resident with an indwelling catheter, there was no specific care plan in place for the resident on tube feeding. The inspector reviewed the file of a resident with a grade three pressure ulcer. A wound care plan was in place as well as a wound care chart. The wound assessment was not up-to-date, it was last updated on 24 May 2011 and therefore it was difficult to assess the progress and current status of the wound. The Chief Inspector had not been notified of the pressure ulcer in accordance with the requirements of the Regulations.

The person in charge showed the inspector the facility available on the computerised documentation system to record residents/relatives' involvement in the review of care plans. She confirmed that this had not yet commenced. The person in charge told the inspector that it was her intention to update residents and relatives at the next residents' council meeting scheduled for 14 June regarding the new computerised documentation system including access to and consultation about care plans.

4. Action required from previous inspection:

Carry out audits on issues to gather data on issues related to the safety of care and quality of life of residents, such as accidents and incidents, falls records.

Establish and maintain a system to review the quality and safety of care and quality of life of residents in the centre.

This action was completed.

The CNM showed the inspector a number of audits which she had recently completed including audits of falls, incidents and accidents, complaints and medication. The inspector reviewed the last falls audit which was completed on 3 May 2011. The CNM had identified residents at high risk of falls, times of falls and location of falls. She had also reviewed accident/incident reports as well as the action taken to prevent further falls. There were five falls recorded in April 2011 and one fall recorded in May 2011. The CNM told the inspector that she had discussed the results of the audit with staff and falls management training for staff had been arranged and completed the week prior to the inspection. Staff confirmed they had received this training. Incidents and accidents had last been audited on 10 May 201 and complaints on 24 March 2011.

5. Action required from previous inspection:

Take reasonable measures to prevent accidents to residents in their bedrooms and throughout the centre

This action was completed.

This action had referred to bed rails in place for two residents which had a wide gap between the bed and the rail. These beds had been replaced and specialised beds were now in use.

6. Action required from previous inspection:

Put formal arrangements in place to facilitate consultation and participation of residents in the organisation.

This action was partially addressed.

The residents committee had not yet held a meeting. The CNM showed the inspector copies of written letters which had been sent to all relatives and residents informing them of the up coming inaugural residents committee meeting scheduled for 14 June 2011. She told the inspector that she had received a positive response to date and many relatives had indicated that they would attend. She said that the first meeting

would be chaired by the person in charge and that the intention was that following meetings would be chaired by a resident or relative. The person in charge told the inspector that a resident's advocate had been appointed. She stated that Garda Síochána vetting was now in place for this person and that she would be attending the residents meeting.

7. Action required from previous inspection:

Further, develop and implement the current policy on medications to include a policy on PRN medications.

Implement a system of medication audit.

Ensure that discontinued medications are consistently signed as discontinued.

This action was completed.

The inspector reviewed the updated medication policy which included guidance for staff on PRN medications.

The CNM had commenced auditing of medications. The inspector reviewed the last audit which took place on 12 April 2011, the audit findings and action plan were clearly documented. The CMN had written to all nursing staff advising them of the outcome of the medication audit.

The inspector reviewed a sample of residents medication prescribing and administration charts and noted that all discontinued medications had been signed by the GP.

8. Action required from previous inspection:

There was no formal system for monitoring staff performance and development.

Introduce a process to ensure that all staff members are supervised on an appropriate basis pertinent to their role.

This action was completed.

The person in charge told the inspector that she had completed appraisals for all staff. The inspector reviewed a sample of staff files and staff spoken to confirmed that appraisals had taken place.

9. Action required from previous inspection:

Devise and implement a system that provides and promotes a choice of location for residents' dining that promotes opportunities for social interaction.

This action was being addressed.

Staff told the inspector that all residents had choice in regard to dining location. Staff said that some of the longer term residents historically dined in their bedrooms and now found it difficult to change but all were encouraged to dine in the dining room. The inspector spoke with a number of residents who dined in their bedrooms and all stated that they could choose to dine in the location that suited them. Some residents said that sometimes they had lunch in the dining room and on other occasions they preferred to dine in their bedroom. Staff stated that many of the more recently admitted residents had their meals in the dining room.

The inspector observed the dining experience at lunch time in the main dining room and spoke with residents there. Residents confirmed that they enjoyed their lunch and that choice of menu was offered daily. Residents and staff communicated during lunch and it was an unhurried and social occasion.

Other issues identified on inspection

Staffing Levels and Skill-mix
The inspector had concerns regarding the staffing levels based on the number and dependency levels of residents and the size and layout of the building. The inspector noted that the number of residents had increased from 26 at the time of the previous inspection to 40 on the date of this inspection. However, the staffing levels and skill mix over a 24 hour period had not been reviewed in line with the increase in resident numbers. The inspector was particularly concerned that there was only one nurse on duty from 4.00 pm to 8.00 am to supervise the delivery of care to 40 residents including the 12 residents in the dementia care unit.

Staff spoken to and staffing rotas reviewed by the inspector confirmed the following staffing levels.

Nursing staff for the centre including the dementia specific unit
8.00 am to 4.00 pm – 2 nurses
4.00 pm to 8.00 am – 1 nurse

Care Staff
Dementia unit
8.00 am to 10.00 pm – 2 care assistants (state enrolled nurses)
10.00 pm to 8.00 am – 1 care assistant

Main centre
8.00 am to 2.00 pm – 4 care assistants
2.00 pm to 4.00 pm – 3 care assistants
4.00 pm to 8.00 pm – 2 care assistants
8.00 pm to 8.00 am – 2 care assistants

Dementia specific unit
The dementia care unit was purpose-built, clean and bright. However, the design and décor resembled that of a generic residential unit as opposed to a dementia specific unit. There was limited signage provided throughout the unit, no landmarks, cueing or highly distinctive visually unique elements to help orient residents with dementia. All doors throughout the unit were the same colour, there was no distinction between bedroom doors and other doors in the building to allow residents to find and know their own room. Many of the bedrooms were minimally decorated with very few personal possessions. There was a lack of fixtures and fittings to aid and promote reminiscence practice. There was limited use of appropriate colours in line with best practice. The door thresholds leading to the enclosed garden areas were raised; this posed a potential falls risk to residents.

Report compiled by:

Mary Costelloe

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

14 June 2011

Chronology of previous HIQA inspections	
Date of previous inspection:	**Type of inspection:**
13 and 14 April 2010	☒ Registration ☐ Scheduled ☐ Follow-up inspection ☒ Announced ☐ Unannounced

Health Information and Quality Authority
Social Services Inspectorate

Action Plan

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

Provider's response to inspection report *

Centre:	Ashlawn House
Centre ID:	0407
Date of inspection:	7 June 2011
Date of response:	6 July 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:

All residents preferred routines, expectations, likes and dislikes had not been documented on the computerised nurse documentation system and the recreation and social interaction section had not been completed. Therefore, activities provided were not based on the residents assessed preferences and capabilities.

There was no dedicated activities coordinator employed and the inspector noted that during the inspection there were no meaningful activities taking place particularly in the dementia care unit.

Action required:

Assess and record the preferred routines, expectations, likes and dislikes of residents in their care plan.

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

Provide opportunities for residents to participate in development of activities appropriate to his or her interests and capacities.

Consult with residents and provide them with information about the activities available to them.

Reference:

Health Act, 2007
Regulation 6: General Welfare and Protection
Regulation 8: Assessment and Care Plan
Standard 20: Social Contacts
Standard 18: Routines and Expectations
Standard 2: Consultation and Participation

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response:	
Comprehensive assessments completed to include the preferred routines, expectations, likes and dislikes of residents in their care plans.	Complete
Residents are provided with opportunities to participate in the development of activities via input at residents council meetings and consultation with the newly employed activities coordinator, who is working three days a week currently, this will be reviewed regularly. In addition to this, extra activities are being provided in the dementia unit to support the activities coordinator e.g. day trips, individual beauty treatments, reminiscence therapy.	Ongoing
Information is provided to residents regarding activities via the notice board, the activities coordinator and via resident council meetings.	Ongoing

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

A comprehensive nursing assessment had not been completed for all residents. Risk assessments had been completed for each resident but some were not up-to-date. There was no specific care plan in place for the resident on peg feeding. The inspector reviewed the file of a resident with a grade three pressure ulcer. The wound assessment was not up-to-date, it was last updated on 24 May 2011 and therefore it was difficult to assess the progress and current status of the wound. The Chief Inspector had not been notified of the pressure ulcer in accordance with the requirements of the Regulations.

The person in charge showed the inspector the facility available on the computerised documentation system to record residents/ relatives' involvement in the review of care plans. She confirmed that this had not yet commenced. The person in charge told the inspector that it was her intention to update residents and relatives at the upcoming residents council meeting scheduled for 14 June regarding the new computerised documentation system including access to and consultation about care plans.

Action required:

Set out each resident's needs in an individual care plan developed and agreed with the resident.

Action required:

Keep each resident's care plan under formal view as required by the resident's changing needs or circumstances and no less frequent than at three-monthly intervals.

Action required:

Make each resident's care plan available to each resident.

Action required:

Give notice to the Chief Inspector without delay of the occurrence in the designated centre of any serious injury to a resident.

Reference:

Health Act, 2007
Regulation: Assessment and Care Plan
Regulation 36: Notification of incidents
Standard 10: Assessment
Standard 11: The Resident's Care Plan
Standard 29: Management Systems
Standard 30: Quality Assurance and Continuous Improvement
Standard 32: Register and Residents' Records

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Residents needs are set out in an individual care plan and discussed with the resident.	Ongoing

Residents care plans are under review on a three-monthly basis, or as required by their changing needs. Care plans are available to residents and their families, and a notice has been put on the notice board to inform residents and relatives. It has also been discussed at the residents council meeting which took place on 14 June 2011 and will be on monthly basis going forward. Next meeting due 14 July 2011. Chief inspector will be notified without delay of the occurrence of a serious injury, to include pressure sores, going forward. On this occasion the resident was transferred to Ashlawn with an existing pressure sore, and as such it was felt that as the serious injury did not occur here, it was not necessary to inform chief inspector. The updating of wound assessments has been discussed individually with the nursing staff. However, a meeting is scheduled for Wednesday 20 July 2011to provide further information on the Epic Care system.	Ongoing Complete Ongoing

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

The residents committee had not yet held a meeting. The CNM showed the inspector copies of written letters which had been sent to all relatives and residents informing them of the up coming residents committee meeting scheduled for 14 June 2011.

Action required:

Put in place arrangements to facilitate residents' consultation and participation in the organisation of the designated centre.

Reference:

Health Act 2007
Regulation 10: Residents' Rights, Dignity and Consultation
Standard 2: Consultation and Participation

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: There had previously been an informal Residents' Council. However, management felt that this was insufficient and a formal Residents' Council is now up and running, next scheduled date 14 July 2011	 Complete

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

The inspector had concerns regarding the staffing levels and skill-mix based on the number and dependency levels of residents and the size and layout of the building. There was only one nurse on duty from 4.00 pm to 8.00 am to supervise the delivery of care to 40 residents including the 12 residents in the dementia care unit.

Action required:

Review the staffing levels and skill-mix to ensure that the numbers and skill-mix of staff are appropriate to the assessed needs of residents, and the size and layout of the designated centre.

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:	
Staffing levels are under constant review at Ashlawn House. The dependency level has decreased significantly and occupancy is lower since inspection date.	Ongoing
As a result, it has been decided to increase nursing hours by 10 per week to have two nurses on duty until 6.00 pm. In addition to this, either the DON or ADON or CNM are on call outside of these hours to provide support. Both the DON and ADON live in very close proximity to the nursing home and would be able to come to assist the nurse on duty should the need arise.	Complete
Should dependency levels increase, this will again be reviewed.	Ongoing

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

The design and décor of the dementia unit resembled that of a generic residential unit as opposed to a dementia specific unit. There was limited signage provided throughout the unit, no landmarks, cueing or highly distinctive visually unique elements to help orient residents with dementia. All doors throughout the unit were the same colour, there was no distinction between bedroom doors and other doors in the building to allow residents to find and know their own room. Many of the bedrooms were minimally decorated with very few personal possessions.

There was a lack of fixtures and fittings to aid and promote reminiscence practice. There was limited use of appropriate colours in line with best practice.

Action required:

Ensure the physical design and layout of the premises meets the needs of each resident, having regard to the number and needs of the residents.

Reference:

Health Act 2007
Regulation 19: Premises
Standard 25: Physical Environment
Standard 28: Purpose and Function

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response:	
The physical design and layout of the unit does meet the needs of the residents. However, the activities coordinator is now involved in personalising this area for the residents.	Ongoing
Families have been encouraged to bring in personal items from home to create an air of familiarity for the residents.	Ongoing
Photographs from day trips will be on display for residents and families to view.	Ongoing
Appropriate signage for bathrooms, toilets, garden etc. are on display to provide visual cues for residents in the dementia unit.	Completed

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

The door thresholds leading to the enclosed garden area from the dementia care unit were raised; this posed a potential falls risk to residents.

Action required:

Take all reasonable measures to prevent accidents to any person in the designated centre and in the grounds of the designated centre.

Reference: Health Act 2007 Regulation 31: Risk Management Procedures Standard 26: Health and Safety Standard 29: Management Systems	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Measures have been taken with the door thresholds leading to the enclosed garden that posed a potential falls risk to residents.	Complete

Any comments the provider may wish to make:

Provider's response:

We would like to thank the inspector for the courteous manner in which the inspection was conducted, and her general advice. We were very grateful that she acknowledged all the work that has taken place since the last visit. We look forward to her next visit to review our recent progress.

Provider's name: Ms. Alene Curtin RGN - Director of Nursing
Date: 4 July 2011