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:	Pilgrims Rest Nursing Home
Centre ID:	0376
Centre address:	Barley Hill Westport County Mayo
Telephone number:	098 27086/27152
Fax number:	098 27086/27152
Email address:	jnmarl@yahoo.ie
Type of centre:	☒ **Private** ☐ **Voluntary** ☐ **Public**
Registered providers:	Noel Marley
Person in charge:	Noel Marley
Date of inspection:	2 August 2011
Time inspection took place:	Start: 9:25 hrs Completion: 18:50 hrs
Lead inspector:	Mary McCann
Support inspector:	Brid McGoldrick
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

Pilgrims Rest Nursing Home is a private 34-bedded residential care centre providing long term, convalescent and respite care. It also provides care to residents with physical disabilities. It is a purpose-built bungalow style facility operational since 1998.

The entrance to the centre opens unto a reception area with a nurses' station, two sitting rooms, dining room and a kitchen located within close proximity. There is a third sitting room located to the back of the centre which is also used as a visitors' room. The bedrooms, store areas, staff rest room, changing facilities and laundry facilities all lie along corridors extending from the front of the building.

Accommodation includes eight twin bedrooms and 18 single bedrooms. All single bedrooms with the exception of one have en suite facilities which include a toilet and wash hand basin. The remaining single room has a dedicated wash hand basin and toilet facility directly across the corridor. Four of the twin bedrooms have en suite facilities which include a toilet and wash hand basin. Residents have access to three assisted bathroom/showers and five toilets, one of which is wheelchair accessible with assistive facilities.

An enclosed garden area is available for residents' use. There is ample car parking available for residents, staff and visitors.

Location

Pilgrims Rest Nursing Home is located in Barley Hill, on the Newport Rd, a rural location, approximately 2 kilometres north of Westport town, Co. Mayo. It is surrounded mainly by agricultural land.

Date centre was first established:	10 April 1998
Number of residents on the date of inspection:	33
Number of vacancies on the date of inspection:	1

Dependency level of current residents	Max	High	Medium	Low
Number of residents	11	10	9	3

Management structure

Pilgrims Rest Nursing Home is owned by a husband and wife partnership, Noel Marley and Pauline Mulroy. Noel Marley is the Provider and Person in Charge of Pilgrims Rest Nursing Home. His wife who is a registered nurse also works in the centre. She deputises in his absence and a team of nurses, carers, an activity coordinator, cleaning and catering staff, supports him in his role.

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	5	2	1	1	

These staffing levels relate to the morning on the day of inspection.

Background

This inspection report outlines the findings of an unannounced inspection which took place on the 2 August 2011. This was the third inspection of this centre by the Health Information and Quality Authority (the Authority). This inspection was carried out as part of the Authority's inspection programme to check progress on any outstanding actions from previous inspections and to monitor compliance with the Health Act 2007(Care and Welfare of residents in Designated Centres for Older People) regulations 2009 (as amended). This inspection focussed on the area of practice that required improvement as set out in the Action Plan of the inspection report dated 9 November 2010 and information received by the Authority since the last inspection with regard to night staffing levels at the centre.

The first inspection of this centre carried out by the Authority was a registration inspection carried out over a two day period on 24 and 25 May 2010. Inspectors found that while the centre met the needs of the residents, it failed to have adequate procedures in place to ensure the delivery of safe quality care. Some environmental factors also required action. An immediate action letter was issued on 26 May, 2010 requesting the provider to address fire safety management and procedures, risk management, staffing levels and skill mix, medication management, review of the hours allocated to the role of person in charge, privacy, dignity and confidentiality of residents' information. A satisfactory response was received on 09 June 2010. Inspectors also identified a number of other areas that required significant work by the provider/ person in charge to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended). These included protection and supervision of vulnerable residents, emergency procedures, staff training, quality and safety review, and access to peripatetic services to promote health and well-being.

The second inspection was a follow-up inspection carried out on 9 November 2010. The purpose of this announced follow-up inspection was to assess progress on matters to be actioned by the provider from the previous inspection of the centre. A person in charge fit person's interview was also carried out with the provider as he had applied to act as joint provider/person in charge. This inspection found that the provider in conjunction with the staff team has fully actioned 17 of the 36 requirements. Polices and procedures were available in draft format. There had been an increase in staffing levels which ensured greater supervision of residents thereby contributing to safer better care.

The statement of purpose required further review. A contract of care detailing the terms, conditions and provision of services had not yet been agreed with residents. Residents who spoke to the inspector expressed their satisfaction with the care provided.

The reports from these inspections can be found on www.hiqa.ie.

Summary of findings from this inspection

On review of the 19 outstanding actions from the previous inspection the inspectors found that 7 of the actions were completed, 11 were partially completed and one had had no input. Many of those which were partially completed required a lot of further work. The post of person in charge and provider is held by Noel Marley. He was familiar with the day-to-day running of the centre. Residents spoken with were complimentary of the service provision, however, a proportion of residents spoken with were unable to verbalise their views.

The inspection process included discussion with residents, the person in charge/provider and staff. Documentation examined included staff rosters, the complaints register, risk assessment documentation, care plans, medical records, policies and procedures, accident and incident records, audit documentation, residents register, and staff files.

As a result of findings on inspection together with analysis of notifications received by the Authority and review of information provided to the Authority, the inspectors were satisfied that adequate care was provided to residents to maintain their welfare and well-being. The inspectors were concerned that the documentation was inadequate and the provider/person in charge acknowledged that the documentation required improvement.

One staff nurse and one care assistant are rostered to work from 23:00 hrs to 08:00 hrs to meet the needs of up to 34 residents, 21 of whom were many maximum or highly dependent. This was discussed with the provider. The inspectors requested that the provider audit the night staffing allocation to ensure that staff can meet the adequate care needs of residents and for staff to be confident that they will be able to safely evacuate all residents swiftly should the need arise.

The action plan at the end of this report identifies areas where improvements are required to address deficits in the service and to comply with 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.* These improvements included for example, a review of night staffing levels, provision of mandatory training in fire safety, implementing controls identified to minimise risk, for example, erection of a fence to the external perimeter, greater linkage between assessment, implementation planning and evaluation of care and medication management. Other areas identified for improvement was the introduction of enhanced quality assurance systems and further development of policies and procedures, to ensure that policies provide guidance and support to staff.

Issues covered on inspection

1. Medication Management

The medication policy contained the procedures for prescribing, administering, recording and storing of medication.

The prescriptions were clear but did not include maximum doses for PRN (as required) medication. Recent photographic identification was not attached to each medication chart. Medication administration recording was blank for one period on one chart. Where medication was discontinued there was no signature by a medical officer. Medication charts were incomplete as there was no indication on charts reviewed of any allergic reaction. On one file reviewed there was a fax prescription received on the 9 June from the psychiatric medical staff detailing a prescription for a resident. This was administered from the fax prescription until 23 June when it was prescribed on the medication chart by the general practitioner (GP). This does not adhere to the centre's policy or best practice. Both regular medication and PRN (as required) prescription were on the same sheet. Inspectors were concerned that this could lead to errors in administration. The policy did not guide staff on the procedure for reporting and documentation of a medication error or if a resident had an adverse drug incident.

2. Assessment, Care Planning, Record keeping.

A computerised case file containing all care documents was available for each resident. These also included some recording of medical input from the GP. Some medical records were stored in a separate file also. Assessments were completed such as continence, moving and handling and falls risk assessments. There were social care assessments were not sufficiently detailed to ensure a comprehensive background was completed; no life histories or other documents were in place to support this.

All residents had an individual care plan, six of which were examined in detail. While assessments of the persons needs were completed there was poor linkage to the care plans. On files reviewed where there had been a change in the assessment of risk of falls. This did not trigger a review of the care and the implementation of an up-to-date person-centred care to ensure safe outcomes for residents. Although residents reported to inspectors that they were happy with the care they received, there was a lack of documentary evidence that the resident and their significant other were actively involved in the development and review of the care plan.

While the provider stated there was good access to GP and an out of hours service is also available to the centre, there was poor evidence that medical staff were reviewing residents medication as required and in any event at three monthly intervals.

There were good links described by the provider with psychiatric services. However when the Community Mental Health Nurse attended the centre and reviewed a resident he/she did not document this review in the residents' care file, consequently the centre did not have an accurate up-to-date clinical picture of the resident so as to inform the provision of safe quality care.

3. Review of Accident and Incident forms

The inspectors reviewed the process for recording incidents and accidents. Staff spoken with relayed a positive attitude towards reporting incidents. A high percentage of incidents related to falls which were un-witnessed. There was some evidence of risk minimisation in relation to falls which included review by the GP, use of protectors, and/or low beds, however on most occasions the records only detailed "GP informed". While vital signs such as temperature, pulse and blood pressure were recorded routinely, neurological observations were not recorded routinely where a resident hit their head or a fall was un-witnessed. In the documentation reviewed the next of kin was informed of the resident's accident by the nurse on duty.

One resident who had recurrent falls 02 June 2011, 24 June 2011 and 03 July 11 did not have an overall review of the incidents to minimise risk of further falls. The fall prevention policy required review to guide and inform staff in relation to ensuring safe quality care for residents.

4. Directory of residents

A register of residents who were currently accommodated in the centre was available. While information requested by the legislation was recorded, for example, personal details of residents, next of kin, and GP, the dates of admission and discharge, however, when a resident was temporarily transferred to outside the centre or cause of death this was not recorded.

5. Review of Quality and Safety of Care and Quality of Life

While the provider/ person in charge verbalised a commitment to provide a quality service and had commenced audits in relation to falls, and an analysis of the information had been completed to guide quality improvements, for example, increased staffing in the sitting room areas. There was poor evidence made available to inspectors that a system was in place for reviewing the quality and safety of care provided to, and the quality of life of, residents in the designated centre for example no audits had taken place in relation to care planning or medication management. The provider had recently completed a course on Quality and Audit in Clinical Practice (May 2011).

6. Staffing

Inspectors reviewed staff rotas for a 6 week period 23 May 2011 to 03 July 2011. There was no planned rota maintained. The changes such as replacement for sick leave were made on the actual roster and signed by the Person in Charge .There was

a registered nurse on duty at all times. The centre has recruited a secretary part-time to assist with clerical and administration duties. There is a low turnover of staff.

The breakdown of staff was as follows :

Staff Numbers	**Nurse**	**Care staff**
Day 08.00-14.00	* 2	 6
14.00-18.00	2	5
18.00-21.00	1	3
21.00-23.00	1	2
23.00-08.00	1	1

*Matron works 18 hours per week . The nursing cover for the weekend is reduced from two nurses to one nurse.

The staffing arrangements outlined above ,the dependencies of the residents, review of the statement of purpose, current profile (included 2 residents with behaviour that challenges on the day of inspection) that a review of staffing skill mix is required for evenings ,nights and weekend nursing cover. The provider / person in charge advised inspectors that he and his wife are available out of hours to give clinical advice if required, this was not documented on the rosters reviewed. The provider stated that he verbally informed staff of this and he would adapt a more formal approach and document it on the rota.

Actions reviewed on inspection:

1. Action required from previous inspection:
Review adequacy of current emergency lighting and fire exit signage

This action was completed. Emergency lighting and signage had been upgraded. There were emergency exit signs on all door leading out of communal areas, extra emergency lighting on corridors and further sensor lighting had been erected outside the building.

2. Action required from previous inspection:
Put procedures in place whereby all professional and legislative requirements and standards are met for all areas of medication prescribing, administration, storage and record keeping in the centre.

Put procedures in place whereby all professional and legislative requirements and standards are met for all areas of medication prescribing, administration, storage and record keeping in the centre.

Put a program of training in place on medication management within the centre for all staff involved in the administration of medicines

This action was partially completed. A medication management policy was in place. This detailed procedures in relation to ordering, prescribing, storing and administration of medication. A policy was also in place in relation to the creation of, access to, retention of and destruction of records.

All current employed staff nurses with the exception of one have attended a medication management course. The provider confirmed that it is planned that the nurse outstanding will complete a course in this area as soon as he can access a course in Castlebar. Areas of this action not completed are repeated at the end of this report.

3. Action required from previous inspection:
Put all procedures in place to notify residents and to ensure residents privacy while CCTV cameras are in use.

This action was completed. Closed circuit television (CCTV) is used external to the centre as a security measure. Signage was in place at the entrance informing all persons of the presence of CCTV.

4. Action required from previous inspection:
Develop and implement a communication policy providing instruction to staff on all aspects of communication within the centre.

Provide staff training on communication policy and the use of communication aids.

Provide residents who have difficulty in communicating verbally with appropriate aids and cues to assist them to move around the centre knowledgeably with ease and confidence.

This action was partially completed. A communication policy was made available to inspectors. This detailed various aspects of different communication strategies, however, it did not detail specifically communication strategies for effective communication with residents who are cognitively impaired and / or have dementia.

There were pictorial orientation cues around the centre detailing, for example, the location of toilets, bathrooms and residents individual bedroom areas. No non-verbal communication system had been developed by the centre to ensure all residents could communicate their views, needs and experiences thereby ensuring they had a voice in the running of the centre and their specific needs were met. Areas of this action not completed are repeated at the end of this report. The provider and three staff had attended a three day training course on dementia care. The provider confirmed that communication methods was incorporated into this course.

5. Action required from previous inspection:
Develop and implement a comprehensive policy detailing all aspects of restraint management for residents in the centre.

Put processes in place where residents have an in-depth assessment of the necessity of restraint and ensure where restraints are used it is as a last resort measure for the least amount of time.

This action was partially completed. Restraint measures in place included bedrails. A restraint policy was in place. The provider confirmed that his wife who works as a nurse at the centre had completed the Train the Trainer course on the new national HSE policy on restraint. It was planned that she would deliver training to all staff at the centre prior to the implementation of this. He stated that this policy together with the accompanying suite of forms would be enacted in the centre as soon as all staff was trained on the policy.

While the centre had completed a lot of work in this area since the last inspection and there was some documentation in relation to consent and review of restraint in the case notes these did not comply with best practices. Further work was required in order to ensure best practice and protect safety and human rights of residents, for example, risk assessments did not identify alternatives to the use of the restraint measure. There was no supporting evidence to suggest that the restraint measure was used as a last resort. There was no documentary evidence of on-going review of consent for the use of restraint measure. Documentation did not support that an explanation, which was likely to be understood by the resident and / or significant other was given to explain the potential risks and benefits of using the restraint measure, not using a restraint measure and any other suitable alternatives. The case

files reviewed did not clearly outline in cases where the resident was competent that the consent of the resident was obtained. It was not consistently documented on files reviewed that where a decision is made on behalf of a resident it must always be made with their best interests in mind and involve a multi-disciplinary approach.

An audit on the use of restraint was not undertaken at regular intervals to inform resident's care and training needs of staff.

6. Action required from previous inspection:
Complete a training needs analysis for all staff based on the needs of residents. Implement an appropriate monitoring system to provide for the ongoing assessment of staff suitability, skill and competence to deliver appropriate and sufficient care to meet the needs of residents.

Implement a programme of education and training to address any deficits in knowledge and on-going development in line with contemporary evidence-based knowledge.

This action was partially completed. The owners are both trainers, one in manual handling and the other in elder abuse. All staff working at the centre had received training in elder abuse recognition and reporting and manual handling. Of the 18 carers employed at the centre, six have completed further education and training award (FETAC) level 5 , six are currently completing and two plan to start in 2011. Three carers have degrees, one in social science the other two in nursing from abroad. Two part-time carers are student nurses.

The provider stated that he had completed a training audit on all staff at the centre. As a result of this a training programme was put in place. Areas identified to ensure safe quality care to residents included challenging behaviour, infection control and basic life support. Staff had attended training in Assessment of Care Needs in Older Persons (March 2011), Dementia Awareness Programme (May/June2011), Activities and Socialisation For Older People (April 2011), Challenging Behaviour in Older People (March 2011), Venepuncture Programme (February2011), Best Practice for Nurses and Midwives on Medication Management (April 2011), Policies Procedures and Guidelines (February 2011), Quality and Audit in Clinical Practice (May 2011).

In 2011 twelve staff had received training on infection control and eight staff had attended training on challenging behaviour.

Training on food safety and handling had not been completed for one staff who was working in the kitchen on the day of inspection. She was working in the kitchen covering maternity leave.

A significant area of training which was not up to date for staff was fire safety training. The centre employs 34 staff including the two owners who work at the centre. Twenty one staff required updating on fire safety training. The provider gave a firm commitment to arranging this. Areas of this action not completed are repeated at the end of this report.

7. Action required from previous inspection:
Conduct an evaluation of the adequacy of emergency equipment available to care for residents requiring urgent assistance to save their lives.

This action was partially completed .The wishes of residents and their significant others as to how they wanted care delivered at end of life was not documented in many instances. However, there were some files reviewed where this was documented. Records were available to support that all nursing staff had undertaken training in basic life support (August, September and November 2010).

Emergency equipment was available for life saving include the use of a defibrillator (AED) from the local football grounds.

Areas of this action not completed are repeated at the end of this report.

8. Action required from previous inspection:
Commence a process of bringing files of all staff currently employed in the centre in line with the requirements outlined in Schedule 2 of the Health Act 2007 (Care and Welfare of residents in Designated Centres for Older People) Regulations 2009 (as amended).

This action was partially completed. Six staff files were reviewed by the inspectors, two of which did not contain all documents requested in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended). This action is repeated at the end of this report.

9. Action required from previous inspection:
Revise admission policy to include procedures to be followed in the case of an emergency admission.

This action was complete. The admission policy was reviewed by the inspectors and it has been amended to reflect procedure for emergency admission.

10. Action required from previous inspection:
Remove inappropriate equipment from the sluice area.

This action was partially completed. While the sluice room has been cleared of most of the inappropriate materials, it still contained some inappropriate items for a sluice room for example two opened bags of grout for tiling. This action is repeated at the end of this report.

11. Action required from previous inspection:
Put in place a training schedule to inform all staff of the provisions of the Health Act 2007(care and welfare of residents in Designated centres for older people) Regulations (as amended) and resident rights.

This action was completed. Copies of the Health Act, regulations and standards were available to all staff and staff had signed that they had read these. The provider confirmed that these were also discussed at staff meetings.

12. Action required from previous inspection:
Put a programme in place where all staff are made aware of their responsibilities regarding managing risk in the centre.

This action was partially completed. A plan was in place to manage risks which included a centre-specific risk management policy and a health and safety statement. An emergency plan was available which detailed procedural guidelines in relation to flooding, fire and utility failure. Contingency arrangements were provided for should, it be deemed necessary to evacuate the building.

A risk register was available at the centre. This detailed the risk, controls necessary to minimise the risk and the person responsible for monitoring and ensuring controls were put in place to minimize the risk. A risk that was identified by the inspectors on first inspection in May 2010 was detailed on the risk register. This remained a risk. The control identified was to erect a fence around the perimeter of the property to ensure residents would not wander off the premises. This was due to have been completed from a previous action. This was discussed with the provider who acknowledged that this posed a risk to residents and he would action as a matter of priority. He stated that he had contacted a company to come and erect the fence but had not followed up on this. Current controls in place include accompanying residents while outside the building.

While a biannual inspection of servicing and testing of the fire detection and alarm system was in place not all staff had up to date mandatory training in fire safety and prevention.

Other risks included three of the emergency fire exit signs were not functioning properly as they were not lit up, there was dampness in one of the bedrooms and the carpet on the back corridor was poorly fitted in one area which could pose a tripping hazard. This action is repeated at the end of the report.

13. Action required from previous inspection:
Provide a sufficient number of toilets having regard for the number of dependent persons and wheelchair users in the centre and in line with the Health Act 2007 (Care and Welfare Of Residents in Designated Centre for Older People) Regulations 2009 (as amended).

This action has been completed. A new assistive toilet near the entrance in a front corridor has been of the building.

14. Action required from previous inspection:
Redraft the complaints policy to ensure all aspects of the complaints procedure are implemented and operational in the centre

The redrafted policy must be displayed in the centre.

Ensure residents are fully informed of the redrafted complaints procedure.

This action was partially completed. The complaints policy had been redrafted but does not comply with current legislation. There was no second person nominated in the centre to oversee all complaints are appropriately responded to and a record of the complaint detailing the investigation and outcome of the complaint and whether or not the resident was satisfied with the outcome. The provider stated that all residents had received a copy of the redrafted policy and it was on display in the centre.

The complaints log was made available to the inspectors. While it contained details of the complaint and the investigative process was detailed, there was no evidence of whether the resident or the complainant was satisfied with the outcome. While the date the complaint was made was recorded there was no further date entry with regard to the timelines of the investigative process or when the compliant had been deemed closed.

This action is repeated at the end of the report.

15. Action required from previous inspection:
Outline a statement of purpose that includes all the information required in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

This action was completed. The statement of purpose had been revised and submitted to the Authority.

16. Action required from previous inspection:
Revise the contract of care to include the total fees payable and by whom.

This action was partially completed. The contracts of care have been reviewed to show fees payable and by whom. Signed copies were available for all residents. However, the clause in the contract in relation to insurance cover does not comply with current legislation and the contract is unclear in clause two in relation to the provision of special nursing care. Areas of this action not completed are repeated at the end of this report.

17. Action required from previous inspection:
The provider shall put in place written policies and procedures on all the items listed in Schedule 5 of the Health Act 2007 (Care and Welfare Regulations in Designated Centres for Older People) Regulations 2009(as amended).

This action was partially completed. While all policies, procedures and guidelines to reflect the provisions of Schedule 5 of the Health Act 2007 were in place, some of these polices did not comply with current legislation and best practice, for example, the complaints policy (as discussed above at action 14) , the nutritional policy which did not include monitoring of nutritional intake. While the elder abuse policy did include a section on protected disclosure for staff. The provider was advised by the inspectors to ensure that all staff were made aware of this as he was a trainer in Elder Abuse and Protection. This action is repeated at the end of this report.

18. Action required from previous inspection:
Develop and implement a policy to safeguard against Legionella contamination

Review cleaning practices in accordance with best practices to minimize the risk of spread of infection.

This action was not completed. While the provider had stated in his reply to the action plan to the Authority that 'A policy to safeguard against Legionella contamination is in place', this was not available from the provider on the day of inspection. The provider confirmed that current cleaning practices do not include any procedure to minimise the risk of legionella infection, however he did confirm that he would enact this straight away. This action is repeated at the end of this report.

19. Action required from previous inspection:
Revise policy on the provision, management, maintenance, cleaning and repair of medical devices and equipment. Provide staffing training on the revised procedures.

This action was completed. A copy of the maintenance contract with an external company for the upkeep of all medical devices was provided to the inspectors. This contract provides for bi-annual servicing of all equipment.

Report compiled by:

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

4 August 2011

Chronology of previous HIQA inspections	
Date of previous inspection:	**Type of inspection:**
24/25 May 2010	☒ Registration ☐ Scheduled ☐ Follow-up inspection ☒ Announced ☐ Unannounced
9 November 2010	☐ Registration ☐ Scheduled ☒ Follow-up inspection ☒ Announced ☐ Unannounced

Health Information and Quality Authority
Social Services Inspectorate

Action Plan

Provider's response to inspection report *

Centre:	Pilgrims Rest
Centre ID:	0376
Date of inspection:	2 August 2011
Date of response:	31 August 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:

The number of staff on duty from 23:00 hrs until 08:00 hrs may not appropriate to the assessed needs and dependencies of the residents and the design and layout of the centre.

The number of nursing staff on duty at weekend may not be appropriate to the assessed needs and dependencies of the residents.

An actual and planned rota was not maintained.

Action required:

Provider to complete a comprehensive assessment of staffing levels required for these hours using recognised assessment tools and contemporary evidence based practice, to ensure the needs of the residents are met and the safety of the residents is not compromised.

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

Action required:

Provider to ensure that they are satisfied that procedures are in place to safely evacuate the residents at all times taking into consideration the residents specific needs and dependency levels.

Action required:
Maintain a planned and actual rota ,showing staff on duty at any time during the day and night.

Reference:

Health Act, 2007
Regulation 6: General Welfare and Protection
Regulation 9: Health Care
Regulation 16: Staffing
Regulation 31: Risk Management Procedures

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
1. Staffing 23:00 to 08:00 We have reviewed the staffing for this period and find that we need to formalise our on call arrangement where the on call staff is included in the roster. This will provide additional reassurance of help and support to the staff on duty whenever needed. We have no evidence of increased accidents or incidents during night time from an audit of accidents over the last 6 months.	1 September 2011
2. Staffing Weekends There is no evidence from audit that any increase incidents or accidence occurs at weekends. Staffing at weekends includes a nurse on duty at all times and the same level of care assistants, cleaning, kitchen, laundry as weekdays. The registered provider / person in charge is not rostered at weekends but is on call and does visit the centre over this period. This will be reflected in the roster from now on.	1 September 2011 1 September 2011
3. Evacuation of Residents in emergency Each resident is accessed as part of their moving and handling assessment to ascertain the most effective means of moving them in an emergency this is documented in their risk assessment and all staff are familiar with this. We have a comprehensive fire procedures policy with which all staff are familiar.	In place

Fire training has been updated for all staff due in August 2011. Emergency procedures are in place including an emergency on call rota. 4. Planned and actual rota will be in place from now on.	17 August 2011 and 24 August 2011 In place 1 September 2011

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

Not all aspects of medication management met the legislative or professional requirements.

Action required:

Put procedures in place whereby all professional and legislative requirements and standards are met for all areas of medication prescribing, administration, storage and record keeping in the centre.

Action required:

Put a program of training in place on medication management within the centre for all staff involved in the administration of medicines

Reference:

Health Act, 2007
Regulation 33: Ordering, Prescribing and Administration of Medicines
Regulation 27: Operating policies and procedures
Standard 14: Medication Management.

Please state the actions you have taken or are planning to take with timescales:	**Timescale**
1. Medication prescribing procedure has been reviewed with each nurse working in the centre so that on every occasion that a doctor prescribes he/she attends the centre to write up the medication in our Medication Administration Chart. Included in the prescription are maximum PRN Doses. We have, from last year a copy of each prescription held on record. 2. We have updated our prescriptions to include a photo where missing and drug allergy information where not in place.	In place from August 2011 2010 September 2011

3. The next medication management course takes place in the CNME Castlebar. Remaining staff have been booked into this course.	January 2012

3. The provider has failed to comply with a regulatory requirement in the following respect: There was poor evidence made available to inspectors that a system was in place for reviewing the quality and safety of care provided to, and the quality of life of, residents in the designated centre.
Action required: Establish and maintain a system for reviewing the quality and safety of care provided to, and the quality of life of, residents in the designated centre at appropriate intervals. Establish and maintain a system for improving the quality of care provided at, and the quality of life of residents in, the designated centre.
Reference: Health Act, 2007 Regulation 35: Review of Quality and Safety of Care and Quality of Life Standard 30: Quality Assurance and Continuous Improvement

Please state the actions you have taken or are planning to take with timescales:	**Timescale**
Provider's response: 1. We use a computerised care management system (CMS) which has facility to input all residents' assessments, risk assessments, care plans, accidents and incidents. There is a facility to review these at various intervals. Reviews prompts are built into the system making it very difficult not to review assessments and plans. We use the system to plan care according to assessment and review care at least 3 monthly but more often in case of necessity. We have ongoing staff training to ensure that this function is being properly utilised. We will formalise care auditing to specifically look at this.	In place September 2011

4. The person in charge is failing to comply with a regulatory requirement in the following respect:

When residents were seen by allied health professionals this review was not documented in the care file.

There was inconsistent evidence available that the resident or their significant other had been involved in completion or review of their care plan.

Care plans were not reviewed as required by the resident's changing needs and no less frequently than at three monthly intervals.

Residents had not had a comprehensive assessment of their social care needs, consequently the personal and social care needs of the residents' was not reflected or detailed in the care plans.

Assessments were not effectively utilised in the implementation and planning of care.

Residents who were subject to a restraint measure did not have a comprehensive person-centred care plan in place in all instances.

Action required:

Residents and/or their significant other should be involved in the completion and review of their care plan. Written evidence should be available of this.

Action required:

Ensure assessment findings are reflected in the implementation and planning of care and care plans are updated in light of revised assessments. This to include assessments and recommendations made by allied health care professionals.

Action required:

Ensure that a resident who is subject to a restraint measure has a comprehensive person-centred care plan in place which reflects good practice.

Action required:

Put in place process whereby personal and social care needs are assessed and reflected in the residents care plan.

Action required:

Keep each resident's care plan under formal view as required by the resident's changing needs or circumstances as and no less frequent than at 3-monthly intervals.

Reference:

Health Act, 2007
Regulation 8: Assessment and Care Plan
Regulation 9: Health Care
Standard 11:The Resident's Care Plan
Standard 3: Consent
Standard 13: Healthcare

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response:	
1. In the case of residents being unable to participate in assessment and planning, a relative is always consulted however this is not documented in every case but will be from now on.	September 2011
2. While assessment and care planning takes place with each resident, we will audit the effective linking of the two from now on.	September 2011
3. Restraint: Care plans for residents requiring or requesting restraint e.g. bedrails will be put in place.	30 September 2011
4. Restraint: we plan to educate staff and implement the national policy on restraint in the home.	January 2012
5. Social Care Needs: We access social care need in the assessment part of CMS using the 'Likes / Dislikes' format including headings: Activities, Emotions, Food. We are hoping to have a new life story format complete soon and plan to have an updated life story for each resident in December 2011.	30 November 2011
6. Care plan reviews: as mentioned in number 3 above.	

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

The communication policy in the centre did not address all communication strategies required to meet the needs of the current residents at the centre as required by the Health Act 2007 (Care and Welfare Of Residents in Designated Centre for Older People) Regulations 2009 (as amended).

Action required:

Develop and implement a communication policy providing instruction to staff on all aspects of communication within the centre.

Action required:

Provide staff training on communication policy and the use of communication aids.

Action required:

Provide residents who have difficulty in communicating verbally with appropriate aids and cues to assist them to move around the centre knowledgeably with ease and confidence.

Reference:

Health Act. 2007
Regulation 11: Communication
Regulation 6: General Welfare and Protection
Regulation 27: Operating policies and Procedures
Standard 2: Consultation and Participation
Standard 21: Responding to Behaviour that is Challenging

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Our communication policy is being updated to include communication with residents who have cognitive impairment Staff will be trained in this regard	1 October 2011

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

The provider has failed to put a comprehensive contemporary evidence based restraint policy in place which complies with best practice.

Action required:

Ensure informed consent is obtained from the resident where possible and where the resident is incapacitated the best interest of the resident is always protected.

Action required: Put processes in place where residents have an in-depth assessment of the necessity of restraint and ensure where restraints are used it is as a last resort measure for the least amount of time and are continually monitored.	
Reference: Health Act 2007 Regulation 31: Risk Management Procedures Regulation 6: General Welfare and Protection Regulation 27: Operating Policies and Procedures Standard 21: Responding to Behaviour that is Challenging	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: 1. We will review our restraint forms to include documentary evidence that we are in consultation with resident relatives and GP where appropriate. 2. See also response to item number 4 above.	

7. The person in charge has failed to comply with a regulatory requirement in the following respect: The provider had failed to ensure that at all times staff members have access to education and training to enable them to provide care in accordance with contemporary evidence-based practice.	
Action required: Provide staff with access to education and training to enable them to provide care in accordance with contemporary evidence-based practice.	
Reference: Health Act, 2007 Regulation 6: General Welfare and Protection. Regulation 17: Training and Staff Development Standard 24: Training and Supervision.	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**

Provider's response: We have an ongoing staff training programme in which we encourage and assist staff to avail of up to date training relevant to care of elderly. We use the CNME Castlebar to train staff in challenging behaviour, medication management, dementia care, among others. We have in-house training in moving and handling, elder abuse prevention, infection control, life saving, fire training. We will continue to review the level and standard of training achieved by each member of staff to comply with legislative requirements	30 October 2011

8. The provider has failed to comply with a regulatory requirement in the following respect: Residents were not afforded opportunity to record their end of life wishes.	
Action required: Identify and facilitate each resident's choice as to the place of death, including the option of a single room or returning home.	
Reference: Health Act 2007 Regulation 14: End of Life Care Standard 16: End of Life Care	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Each resident has an end of life care plan in place in which comments on their ability or willingness do discuss end of life care as well as recording any actual end of life wishes. We give an undertaking to residents to wherever possible comply with their wishes We will review for completeness each plan	October 2011

9. The provider has failed to comply with a regulatory requirement in the following respect: Personnel files did not contain documents detailed in Schedule 2, of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).	
Action required: Put in place 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.	
Reference: Health Act, 2007 Regulation 18: Recruitment Standard 22: Recruitment	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: We are reviewing and updating each file for compliance with legislative requirements.	30 October 2011

10. The provider has failed to comply with a regulatory requirement in the following respect: The sluice room was used to store some inappropriate items.	
Action required: Remove inappropriate equipment from the sluice area.	
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 painter left a bag of filler in this room. It is removed.	Done

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

A comprehensive identification and assessment of risks and hazards throughout the exterior of the centre that is reflective of the regulations had not been undertaken and suitable precautions were not in place to control those risks identified.

When residents sustained falls there was evidence of poor medical review and no evidence was available of the recording of neurological observations.

There was no overall review of accidents and incidents to inform learning from serious or untoward incidents involving 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.

Ensure when accidents occur that appropriate health care is provided.

Where a resident falls un-witnessed or is at risk of a head injury due to an accident neurological observations to be recorded.

Action required:
Ensure that the risk management policy includes the arrangement for identification, recording, investigating and learning from serious or untoward incidents involving residents.

Reference:

Health Act, 2007
Regulation 30: Health and Safety
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: **Grounds risk assessment** A risk assessment of the grounds last year identified the need for a perimeter fence which has not yet been erected. This will be completed by 30 September 2011. There have been no accidents to residents outside while walking as they are always accompanied except in the enclosed garden where assessed residents may walk alone.	30 September 2011

Accidents medical aid We summon medical aid at the time of an accident this will be documented in the accident record.	1 September 2011
Head injury neuro obs Head injury Neuro obs will be recorded on all suspect head injuries.	1 September 2011
Accident audit We have a practise of auditing accidents but need to improve on blending this with care planning	30 September 2011

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

The complaint policy does not contain all the procedures outlined in the Health Act 2007 (Care and Welfare Of Residents in Designated Centre for Older People) Regulations 2009 (as amended).

Action required:

Provide written operational policies and procedures relating to the making, handling and investigation of complaints from any person about any aspects of service, care and treatment provided in, or on behalf of a designated centre.

Action required:

Ensure the complaints procedure contains an independent appeals process, the operation of which is included in the designated centre's policies and procedures.

Maintain a record of all complaints detailing the investigation and outcome of the complaint and whether or not the resident was satisfied.

Action required:

Inform complainants promptly of the outcome of their complaints and details of the appeals process.

Make a person available, independent to the person nominated in Regulation 39(5), to ensure that all complaints are appropriately responded to and that the person nominated under Regulation 39(5) maintains the records specified under Regulation 39(7).

Reference:

Health Act, 2007
Regulation 39: Complaints Procedures
Standard 6: Complaints

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: Complaints policy to be reviewed and updated to comply fully with the Health Act including; independent appeals, named person in-house as second avenue apart from provider. Improved recording of outcomes.	30 October 2011

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

The contract of care did not meet the regulations.

Action required:

Ensure each resident's contract deals with the care and welfare of the resident in the designated centre and includes details of the services to be provided for that resident and the fees to be charged.

Reference:

Health Act, 2007
Regulation 28:Contract for the Provision of Services
Standard 1 : Information
Standard 7: Contract/Statement of Terms and Conditions

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: Addendums to the contract of care have been circulated for signing awaiting response on a number of these.	30 October 2011

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

The directory of residents did not comply with current legislation.

Action required:

Ensure that the directory of residents includes the information specified in Schedule 3 paragraph (3) of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 as amended.

Reference: Health Act, 2007 Regulation 23: Directory of Residents Standard 32: Register and Residents' Records	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The directory has been updated.	 Done

Any comments the provider may wish to make:

Provider's response:

(No response).

Provider's name: Noel Marley
Date: 31 August 2011