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:	Aclare House Nursing Home
Centre ID:	0001
Centre address:	4-5 Tivoli Terrace South Dun Laoghaire Co. Dublin
Telephone number:	01-2801345
Fax number:	01-2808650
Email address:	breegemuldowney@hotmail.com
Type of centre:	☒ **Private** ☐ **Voluntary** ☐ **Public**
Registered providers:	Aclare House Nursing Home Ltd
Person in charge:	Joseph Muldowney
Date of inspection:	5 September 2011
Time inspection took place:	**Start:** 11:00 hrs **Completion:** 15:30 hrs
Lead inspector:	Angela Ring
Support inspector:	None
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

Aclare House Nursing Home consists of two existing houses adapted to form one three storey centre. There are two staircases, one of which has a chair lift going up to the second floor. There are bedrooms on each floor and the ground floor has a kitchen, laundry and sluice room. The centre can accommodate up to 26 residents and cares for people with dementia, mental health problems and intellectual disability.

There are seven single rooms, three single en suite rooms with toilet, seven twin bedrooms and one twin bedroom en suite with toilet. In addition, there are three wheelchair accessible bathrooms and four accessible toilets. There is a day room and dining room on the first floor which are interconnected and a conservatory, with access to a secure courtyard and garden.

There is very limited parking at the centre but ample on street disk parking outside the centre. A new wheelchair ramp has been installed at the front of the centre.

Location

Aclare House Nursing Home is located in a quiet residential area close to Dun Laoghaire, Co. Dublin.

Date centre was first established:	1988
Number of residents on the date of inspection:	24 + 2 in hospital
Number of vacancies on the date of inspection:	None

Dependency level of current residents	**Max**	**High**	**Medium**	**Low**
Number of residents*	10	11	5	0

*includes residents currently in hospital

Management structure

Aclare House is a limited company and the company directors are husband and wife team, Joseph and Breege Muldowney. Breege Muldowney is the Provider and Joseph Muldowney is the Person in Charge and they both work full-time in the centre. There are two Clinical Nurse Managers (CNMs) and both work part-time and report to the Person in Charge. Nurses, care assistants, the activity coordinator, catering and cleaning 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	3	1	2	1	1 activities

Background

This inspection was carried out to follow up on the actions required from the previous inspection on 25 May 2010 which highlighted areas for improvement in the emergency plans, complaints management, risk management, policies and procedures, care planning, issues related to premises and medication management.

Summary of findings from this inspection

Overall, the inspector found that the provider and person in charge completed most of the actions required from the previous inspection. There was evidence that the provider enhanced the governance structure with the appointment of a new nurse manager and there were improvements made in care planning, providing opportunities for meaningful engagement, staff training and in complaints management.

However, improvements were still required in relation to care planning, falls prevention and management, developing a system of monitoring the safety and quality of care and the provision of adequate storage and staff changing facilities.

Issues covered on inspection

Directory of Residents
The inspector found that the register was not updated to include details of a resident who was recently transferred to hospital - this was rectified once it was notified to the provider.

Fire Precautions and Records
The inspector reviewed the fire records in place and found that there was a daily checklist carried out of fire exits and equipment. There was documentary evidence that the fire fighting equipment and the fire alarm was serviced and the staff had received training on fire prevention. There was also documentary evidence of fire drills taking place and the staff spoken to were aware of the fire procedures.

General Welfare and Protection
The inspector found that there was a policy on the prevention, detection and response to elder abuse. Staff had received training on elder abuse and the staff spoken to were aware of their responsibilities in reporting suspected abuse. The inspector reviewed records that demonstrated that the provider carried out an adequate investigation of an allegation of elder abuse in the centre.

Recruitment
The inspector reviewed the staff file of the new CNM and found that there was proof of identity, Garda Síochána vetting, three references, medical declaration, employment history and details of current registration status with An Bord Altranais.

Use of Restraint
The inspector found that there was a low use of restraint, there were no lap belts used and bedrails were only used for three residents. There were risk assessments carried out on the use of the bedrails and evidence of discussion with the general practitioner (GP). These assessments were repeated every three months to determine if they were still necessary. The CNM explained to the inspector that he and the person in charge had attended recent training on the new HSE policy on reducing the use of restraint.

System for Monitoring the Safety and Quality of Care to Residents
The inspectors found that the person in charge and CNMs were at the initial phase of implementing a system of auditing for quality monitoring purposes. Data was collected on the use of psychotropic drugs and sedation but this data had yet to be fully analysed for auditing purposes. There were also a small number of completed audits on nursing documentation with some areas for improvement identified. However, the inspector found that there was no robust system established for reviewing the quality and safety of care provided to residents and the quality of life of residents.

Opportunities for Meaningful Engagement
The inspector observed residents engaging in a variety of activities during the inspection such as playing cards, listening to music, sitting in the garden, playing skittles and reading the newspaper. Some residents told the inspector about a recent trip to the National Concert Hall which they enjoyed and there was evidence of coffee mornings being held.

Actions reviewed on inspection:

1. Action required from previous inspection:

Develop an emergency plan for responding to emergencies.

This action was completed.

The inspector reviewed the emergency plan and found that it contained phone numbers of relevant people and there was a designated place to evacuate residents if necessary. The senior nurse managers were aware of this emergency plan.

2. Action required from previous inspection:

Ensure that residents are aware of the procedures to be followed in the event of fire.

This action was completed.

The inspector found that some residents were involved in fire training where appropriate and there was documentary evidence to support this.

3. Action required from previous inspection:

Develop centre-specific operational policies and procedures which guide staff in their practice.

This action was completed.

The inspector found that the nurse manager had reviewed a number of policies and made them more specific and relevant to the centre. These policies included communication, end-of-life care, admissions, transfers and discharges, restraint and continence promotion. Staff told the inspector that the policies were discussed with them at staff meetings and this was verified by reviewing the minutes of these meetings.

4. Action required from previous inspection:

Provide adequate choice for residents at mealtimes.

This action was completed.

The inspector found that there was only one main course for lunch identified on the menu. However, when speaking to the chef, she explained the different meals she was preparing for the residents whom she knew did not wish to have the main course. The inspector found that the chef knew the individual residents dietary preferences as she had been working in the centre for a number of years. Residents told the inspector that they enjoyed their food and some of them spoke about how the chef knew their preferences.

5. Action required from previous inspection:

Put a system in place to ensure that there are arrangements for staff learning from incidents and adverse events.

This action was partially addressed.

The inspector found that incidents such as falls were discussed with staff at a handover report each day and this was verified by staff. There was also documentary evidence of incidents being discussed at staff meetings.

However, the inspector found that there was a lack of overall review and analysis of incidents such as falls to determine the pattern, root cause and the specific measures taken to prevent the reoccurrence of the incidents. In summary, there was no robust system in place for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents.

6. Action required from previous inspection:

Review all care plans to ensure they are personalised to the residents specific needs.

This action was partially completed.

The inspector reviewed a sample of care plans and found that residents were assessed on admission and reassessed every three months. Care plans were developed following the assessment, which were also reviewed every three months. Risk assessments were carried out on the risk of developing pressure ulcers, malnutrition, falls and cognitive impairment. The activity coordinator collected information on the residents' life histories in consultation with the resident and their family where possible.

There was a low turnover of staff and this resulted in the staff knowing the residents very well. Despite this, improvements were still required in making the residents care plan more person-centred and meaningful to the resident. The inspector found that the care plans were very clinical and did not give an adequate description of the residents preferred day and night routine and the information collected in life stories

was not used to inform the care planning process. There was also very little evidence of residents' involvement in their care plan. In summary, the care plans did not include all residents' needs such as their social and psychological needs.

7. Action required from previous inspection:

Maintain records of all details of residents with behaviours that challenge and carry out analysis on the information to inform future care of that resident.

This action was partially completed.

Due to the number of residents with dementia and mental health problems, there were a number of residents with behaviours that challenge. Although the inspector saw staff responding appropriately to these residents, the inspector found that residents' assessments and care plans were not person-centred enough to describe each resident's behaviour and the interventions required for each resident in order to provide a consistent approach to care.

8. Action required from previous inspection:

Provide adequate staff changing facilities.

This action was not completed.

The provider explained to the inspector that they had been researching various options to provide increased space but no changes had been made since the previous inspection. Therefore, there were no improvements made in providing changing facilities for staff and there was only one toilet available for all staff including catering staff which posed a risk for infection control.

9. Action required from previous inspection:

Provide suitable storage facilities.

This action was not completed.

As stated above, the provider explained to the inspector that they had been researching various options to provide increased space but no changes had been made. Therefore, there was no additional storage available and wheelchairs were seen stored in the hallway which posed a potential risk.

10. Action required from previous inspection:

Complete a risk assessment on the laundry facility.

This action was completed.

The inspector found that staff used an electric fan in the laundry for ventilation. The inspector spoke to the laundry assistant who explained that the door is kept locked when unoccupied by staff as a safety precaution.

11. Action required from previous inspection:

Maintain an accurate record of all complaints received and any action taken, the actions taken and the outcome for the complainant.

This action was completed.

The complaints procedure was displayed prominently at the entrance to the centre and the staff spoken to were aware of its content. The inspector met with one relative and spoke with a small number of residents and they said that their complaints were resolved quickly and to their satisfaction. The inspector reviewed the log of complaints and found that there was information on the actions taken in response to complaints and the outcome for the complainant. The person in charge explained that complaints and concerns expressed by residents and relatives were discussed at staff meetings and measures had been put in place to prevent their reoccurrence. Inspectors saw evidence of this in the minutes of staff meetings.

12. Action required from previous inspection:

Put in place a system to ensure that each medication prescribed has an individual signature of doctor.

This action was completed.

The inspector reviewed a large sample of prescriptions and found that each medication had an individual prescription.

13. Action required from previous inspection:

Record details of the management of residents with wounds.

This action was completed.

The CNM told the inspector that there were no residents with wounds on the day of inspection. However, the inspector saw that there was a centre-specific policy on wound management and specific documentation on the assessment and treatment of wounds available if required.

Report compiled by:

Angela Ring

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

6 September 2011

Chronology of previous HIQA inspections	
Date of previous inspection:	**Type of inspection:**
2 and 3 November 2009	☐ Registration ☒ Scheduled ☐ Follow-up inspection ☒ Announced ☐ Unannounced
25 May 2010	☒ Registration ☐ Scheduled ☐ Follow-up inspection ☒ Announced ☐ Unannounced

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Action Plan

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

Provider's response to inspection report *

Centre:	Aclare House Nursing Home
Centre ID:	0001
Date of inspection:	5 September 2011
Date of response:	23 September 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:

There was no robust system in place for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents.

Action required:

Ensure that the risk management policy covers the arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents.

Reference:

Health Act, 2007
Regulation 31: Risk Management Procedures
Standard 26: Health and Safety

* 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: At present all incidents are recorded, discussed with all staff and strategies are put in place to reduce further incidents. The condition of resident is monitored and any further treatment necessary is given. We will review our incident form and expand same to gather more information if necessary. We will monitor each resident post incident and document their condition. Each incident will be reviewed by a member of the management Team at the earliest possible opportunity. This review will look at the incident itself, the circumstances that led to incident if any, history of previous incidents etc., what immediate action was taken at the time of the incident to prevent reoccurrence, were correct procedures and policies followed, what steps were taken to prevent /reduce such incidents. Staff will be made aware of review outcomes and what needs to be learned from incident. Regular audits to be carried out to monitor incident and interventions with a view to the reduction of same.	6 months and ongoing

2. The provider has failed to comply with a regulatory requirement in the following respect: There was no robust system in place for reviewing the quality and safety of care provided to, and the quality of life of, residents in the designated centre at appropriate intervals.
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.
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: We endeavour to provide the highest quality care to each resident at all times. As acknowledged in your report We have carried out some audits. We will continue to carry out regular audits on the quality of care we provide. We will analyse the results and put in place any measures deemed necessary to improve care, and keep abreast of best practice. We will continue to liaise with other stakeholders in our residents care such as GPs Geriatricians, Palliative Care, Psychiatry of old age etc, in order to provide the best possible outcomes for them. Staff continues to be up-skilled by regular training.	Ongoing

3. The person in charge has failed to comply with a regulatory requirement in the following respect: Each residents needs were not set out in a care plan developed and agreed with the resident, including behaviours that challenge.	
Action required: Set out each resident's needs in an individual care plan developed and agreed with the resident.	
Reference: Health Act, 2007 Regulation 8: Assessment and Care Plan 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: We will review our present format of care planning with a view to making them more person-centred. We will incorporate our present life story books into the care plan. We will consult with the residents where possible and if not any other person who was significant in the resident's life to gather as many facts as possible about the resident in order to maximise the care we can give them. In particular we will look at areas such as hobbies/interests/likes/dislikes/routines etc. When a resident presents challenging behaviour we will monitor this closely and try to identify any precipitating factors with behaviour	Ongoing

that is challenging. External staff training has been arranged for all staff nurses and management team to explore a more person-centred approach to care plans.	

4. The provider has failed to comply with a regulatory requirement in the following respect: There were inadequate staff changing facilities. There were inadequate storage facilities.	
Action required: Provide suitable staff changing facilities.	
Action required: Provide suitable storage facilities.	
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: We are taking action to sort out storage. Regarding staff changing facilities, we do have a staff toilet and changing area but we are continuing to explore other possibilities to provide a bigger area for staff. Due to the economic climate of our country, the situation with banks, it is difficult to give a timeframe as to when we will be able to start this project, however we will do our best to put plans in place for this project.	3 months Ongoing

Any comments the provider may wish to make:

Provider's response:

We thank our highly motivated staff who continue to strive to provide high quality care for all our residents and we thank our inspector for the courtesy shown throughout the inspection and the valuable feedback given to the management team. We will endeavour to implement same.

Provider's name: Breege Muldowney
Date: 22 September 2011