Health Information and Quality Authority
Social Services Inspectorate

Inspection report
Designated Centres under Health Act 2007

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

Centre name:	Asgard Lodge Nursing Home
Centre ID:	0006
Centre address:	Monument Lane Kilbride, Arklow, Co Wicklow
Telephone number:	0402 32901
Email address:	asgardlodge@yahoo.ie
Type of centre:	☒ **Private** ☐ **Voluntary** ☐ **Public**
Registered provider:	James and Oonagh Tyrrell
Person authorised to act on behalf of the provider:	James and Oonagh Tyrrell
Person in charge:	Andrea Tyrrell
Date of inspection:	13 August 2012
Time inspection took place:	**Start:** 08:15 hrs **Completion:** 18:10 hrs
Lead inspector:	Linda Moore
Type of inspection	☐ **announced** ☒ **unannounced**
Date of last inspection:	26 and 27 July 2011

About inspection

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

In assessing the overall quality of the service provided, inspectors examine how well the provider has met the requirements of the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland* under 18 outcome statements. The outcomes set out what is expected in designated centres.

Outcome 1 *There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the statement of purpose, and the manner in which care is provided, reflect the diverse needs of residents.*
Outcome 2 *The quality of care and experience of the residents are monitored and developed on an ongoing basis.*
Outcome 3 *The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure*
Outcome 4 *Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse.*
Outcome 5 *The health and safety of residents, visitors and staff is promoted and protected.*
Outcome 6 *Each resident is protected by the designated centre's policies and procedures for medication management.*
Outcome 7 *Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied healthcare. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.*
Outcome 8 *Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.*
Outcome 9 *Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discreet and sensitive manner.*
Outcome 10 *Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.*

Outcome 11 *Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence.*
Outcome 12 *Adequate space is provided for residents' personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.*
Outcome 13 *The designated centre is managed by a suitably qualified and experienced nurse with authority, accountability and responsibility for the provision of the service.*
Outcome 14 *There are appropriate staff numbers and skill-mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.*
Outcome 15 *The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.*
Outcome 16 *The records listed in Part 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).*
Outcome 17 *A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.*
Outcome 18 *The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.*

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

The inspection report is available to residents, relatives, providers and members of the public, and is published on www.hiqa.ie in keeping with the Authority's values of openness and transparency.

About the centre

Location of centre and description of services and premises

Asgard Lodge Nursing Home is in a rural area a few miles from the centre of Arklow town in County Wicklow.

The centre provides 32 residential places to people over 65 years of age. Currently, one of their residents is under 65 and has been living in the centre for a number of years. There were two residents in hospital.

The building is single storey to the front and a new two storey extension was added to the back of the building in 2008.

A long avenue through landscaped gardens leads to the front of the centre. The entrance is wheelchair accessible through a large porch area onto a small corridor. The nurses' office is just inside the porch and beyond that is a large day room with a variety of seating, a large screen television and DVD player. There is a toilet and wash-hand basin beside the nurses' station. To the right of the nurses' office is a smaller day room with a conservatory which leads to a patio area overlooking the gardens. The dining room is through a door to the left and has a number of small tables with seating for four or five residents. Double doors on the other side of the dining room lead to the kitchen and the food storage areas.

A short corridor from the dining room contains a four-bedded room with full occupancy. There is a toilet with wash-hand basin on the corridor and a bathroom with a toilet, wash-hand basin and a shower. There is also a toilet, wash-hand basin and shower adjacent to the day room. A locked medication storage room is also located on this corridor and there is a "snug" or small sitting room for residents alongside it. The treatment/quiet room is at the end of the corridor. The furniture and equipment in the treatment room can be removed easily and the room is used as a single bedroom if required for critical or end-of-life care.

There is a longer corridor to the left at the end of the first corridor. The laundry room is at the start of this corridor and there is a sluice room next to this. The main bathroom has an assisted bath with hoist, a toilet and a wash-hand basin. There are five twin rooms, two of these rooms share two en suites with toilet, wash-hand basin and shower and the last twin room has a toilet and wash-hand basin. There are also six single bedrooms with en suite toilets and wash-hand basins on this corridor.

That corridor leads to a large open seating area and into the new two-storey part of the building. The upper floor can be accessed by stairs or a lift. There are six single bedrooms with en suite toilets, wash-hand basins and showers on each level. There is ample parking to the front of the building.

Date centre was first established:	1996
Date of registration:	16 February 2012
Number of registered places:	32
Number of residents on the date of inspection:	30

Dependency level of current residents as provided by the centre:	**Max**	**High**	**Medium**	**Low**
Number of residents	8	8	4	10

Gender of residents	**Male (✓)**	**Female (✓)**
	✓	✓

Management structure

This is a family run business. The Providers are James and Oonagh Tyrrell. The Person in Charge is Andrea Tyrrell who is the Providers' daughter. She is supported by her mother Oonagh who was the previous Person in Charge. All nursing staff, care assistants, housekeeping staff and kitchen staff report to the Person in Charge. James Tyrrell is responsible for the business management and the maintenance of the premises. A senior staff nurse or the Provider covers in the absence of the Person in Charge.

The person in charge was on leave on the day of the inspection and a nurse deputised in her absence.

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	1	7	2	2	0	3*

* Both providers were in the centre on the day of the inspection and one nurse was engaged in administration duties

Summary of compliance with 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*.

This report set out the findings of an unannounced inspection. This was the third inspection of the centre and it took place over one day. As part of the inspection, the inspector met with residents, relatives, and staff members. The inspector observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files.

The centre was well run and the healthcare needs of residents were met to a high standard. Residents had access to general practitioner (GP) services, to a range of other health services and evidence-based nursing care was provided.

Staffing levels adequately met the assessed needs of residents and there was a commitment to developing staff to ensure that they were competent to meet the changing needs of the residents. There was a culture of continuous quality improvement where audits were undertaken to monitor quality and identify areas for improvement.

The inspector found that improvements had continued to be made in all areas and most of the actions from the previous inspection were addressed by the provider and person in charge. Evidence of good practice was found in all areas. Improvements from the previous inspection included:

- the policy on the protection of vulnerable adults was revised
- appropriate sluicing arrangements were in place
- all staff attended training on fire prevention and management
- there was additional staff on duty
- medication management practices had improved
- the emergency plan and all policies and procedures were being revised to guide practice.

Improvements were still required in the development of the risk management policies and aspects of the premises. Other areas for improvement identified on this inspection included, screening in the shared bedrooms and the dining experience.

These areas for improvement are discussed further in the report and are included in the Action Plan at the end of the report.

Compliance 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*.

1. Statement of purpose and quality management

Outcome 1
There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the statement of purpose, and the manner in which care is provided, reflect the diverse needs of residents.

References:
Regulation 5: Statement of Purpose
Standard 28: Purpose and Function

Inspection findings
The inspector found that the statement of purpose accurately described the service that was provided in the centre and it was updated to describe the details of registration. The inspector was satisfied that the service met the diverse care needs of residents, as outlined in the statement of purpose which was kept under review by the provider.

Outcome 2
The quality of care and experience of the residents are monitored and developed on an ongoing basis.

References:
Regulation 35: Review of Quality and Safety of Care and Quality of Life
Standard 30: Quality Assurance and Continuous Improvement

Inspection findings
The inspector found that there was evidence that systems were in place to ensure that the quality of care given to residents was monitored, developed and improved on an ongoing basis. The inspector found that audits were completed on care planning, falls, restraint and medication management. The inspector found evidence that the provider was using this information to improve the quality of life and safety of residents. For example, there had been a reduction in the number of falls as a result of monitoring and this is further discussed under Outcome 5.

There was an active residents committee and the provider used feedback from the residents to improve the service.

Outcome 3
The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

References:
Regulation 39: Complaints Procedures
Standard 6: Complaints

Inspection findings
The inspector reviewed the complaints policy and its implementation and found that there was a good complaints process in place.

There was a complaints procedure and it was displayed in prominent locations in the centre. It explained the complaints process, how complaints would be addressed and included details of an independent appeals process. The management of complaints was carried out in line with the complaints procedure.

The inspector reviewed the complaints folder and found the small number of complaints were recorded in detail, identified the complainant, the issue, the action taken and the satisfaction of the complainant with the outcome of the action taken.

Residents told the inspector that they were given opportunities to provide feedback and found the person in charge and provider very approachable. As identified in the last inspection, the inspector found that a residents' advocate visited the centre regularly, she spoke to individual residents and would bring issues to the provider and person in charge on behalf of the resident if there were any issues raised.

2. Safeguarding and safety

Outcome 4
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse.

References:
Regulation 6: General Welfare and Protection
Standard 8: Protection
Standard 9: The Resident's Finances

Inspection findings
The provider and person in charge had taken measures to protect residents from abuse, although some further improvements were required in the area of managing residents' finances.

The providers had arranged training in detecting and reporting elder abuse. All of the staff who spoke with the inspector were clear on what constituted abuse and were aware of their responsibilities to report any suspicions of abuse to the person in charge. This had been an area for improvement at the previous inspection. Despite this good practice, the nurse in charge and the provider were not able to tell the inspector how they would manage any allegation of abuse in the absence of the person in charge.

Residents spoken to confirmed that they felt safe in the centre. The inspector reviewed the centre's policy on the prevention, detection and response to elder abuse and found that it gave guidance to staff on the types of abuse, the procedures for reporting alleged abuse and the procedures to follow when investigating an allegation of elder abuse. This had been revised since the last inspection.

The inspector noted that the residents' property lists were being completed for all residents on admission and were being updated and signed by residents, relatives and staff to reflect any changes in property maintained by residents.

There was a system to manage residents' finances and property and this had been carried out in line with the policy on the management of finances but there was some improvement required.

The inspector reviewed the financial records for a sample of residents and found that two of them were inaccurate. The amount identified in the record book did not match the amount contained in the envelope for the resident. The provider said this was an oversight on her behalf.

Outcome 5
The health and safety of residents, visitors and staff is promoted and protected.

References:
Regulation 30: Health and Safety
Regulation 31: Risk Management Procedures
Regulation 32: Fire Precautions and Records
Standard 26: Health and Safety
Standard 29: Management Systems

Inspection findings
The inspector found that practice generally in relation to the health and safety of residents, staff and visitors adequately promoted their safety. However, there were some areas for improvement.

There was an adequate system in place for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents. Detailed records were maintained of all accidents and incidents. Records viewed showed a low incidence of falls in 2012 and all had been responded to appropriately by staff. There was a reduction in the number of falls for the same period in 2011. Nurses attributed this to the use of low low beds, supervision and

bed alarms. Records of incidents included information on incidents and the actions taken in response to them. All of the records were dated and signed by a staff member and by the person in charge. Information relating to each incident was readily available and all follow up actions were recorded, dated and signed on the back of the accident form. The person in charge reviewed the reports for each resident to determine the root cause and preventative measures were being taken to prevent reoccurrence, such as medication review.

Staff were aware of residents' who were at high risk of falls and closely monitored them throughout the day. The person in charge had audited the reports to improve the general safety of residents.

Since the previous inspection, the person in charge had developed a risk register to identify and manage some of the risks identified at the previous inspection. This included the risks and control measures for the open stairwell on the first floor and the risk of residents absconding from the premises. However, the inspector found that staff were not aware of these risk assessments, the nurse in charge said there were plans to provide an information session to all staff in August 2012.

There was a health and safety statement in place which was updated in September 2011 and it related to the health and safety of residents, staff and visitors.

The inspector read policies on the risks specified in the Regulations such as violence and aggression, assault, residents going missing, self-harm and accidental injuries to residents and staff. While in practice the person in charge was identifying, recording, investigating and learning from serious or untoward incidents or adverse events involving residents there was no policy available to guide practice. This was identified as an area for improvement at the previous inspection.

The inspector found that the temperature of the water in two residents' bathrooms were very high (ranging from 61.1 degrees Celsius to 61.8 degrees Celsius). This was brought to the attention of the provider and an immediate response was required to ensure the safety of residents. The providers assured the inspector this would be addressed by 16 August 2012.

Overall fire safety was well managed. The inspector viewed the fire records which showed that fire equipment had been regularly serviced. The fire extinguishers were serviced annually and checked monthly by an external consultant. The emergency lighting and the fire alarm system had been serviced in July 2012. Monthly testing of the fire alarms was also carried out. Twice daily fire exits checks were carried out and recorded. The inspector found that all fire exits were clear and unobstructed during the inspection.

The inspector viewed the fire training records and found that staff had received up-to-date mandatory fire safety training and this was confirmed by staff. This was identified as an area for improvement at the previous inspection and had been fully addressed. A fire drill was carried out in April 2012. All staff spoken to knew what to do in the event of a fire.

The provider and person in charge had adequate control measures in place to monitor all visitors to the building. A visitors' book was maintained and completed daily.

The inspector reviewed the emergency plan and found that it had been updated since the last inspection. It was comprehensive and sufficient to guide staff on the procedures to follow in the event of an emergency. The inspector noted that the emergency plan had been updated to include a contingency plan for the total evacuation of residents in the event of an emergency.

Outcome 6
Each resident is protected by the designated centre's policies and procedures for medication management.

References:
Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines
Standard 14: Medication Management

Inspection findings
Overall, the inspector found evidence of good medication management practices but there was one area that required improvement. The policy on the management of controlled medications required improvement.

The inspector observed a nurse administering medications and found that medication was administered in accordance with the centre's policy and An Bord Altranais guidelines.

The inspector found that each resident's medication was reviewed regularly by the GP and pharmacist and there was documentary evidence to support this. The nurse in charge told the inspector that they had good involvement and support from their pharmacist who was also involved in the review and audit of medication.

There was a medication fridge and there were records of daily temperature checks being maintained.

There were improvements to the prescriptions since the previous inspection, for example, the maximum dose for as required medications (PRN) was prescribed by the GP. There were improvements to the recording of the administration of warfarin.

Medications that required special control measures were carefully managed and kept in a secure cabinet in keeping with the Misuse of Drugs (Safe Custody) Regulations, 1984. Nurses maintained a register of controlled drugs. Two nurses signed and dated the register and the stock balance was checked and signed by two nurses at the change of each shift. However, this good practice had not been included in the centre's medication policy.

Nurses had attended training in medication management.

3. Health and social care needs

Outcome 7
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied healthcare. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

References:
Regulation 6: General Welfare and Protection
Regulation 8: Assessment and Care Plan
Regulation 9: Health Care
Regulation 29: Temporary Absence and Discharge of Residents
Standard 3: Consent
Standard 10: Assessment
Standard 11: The Resident's Care Plan
Standard 12: Health Promotion
Standard 13: Healthcare
Standard 15: Medication Monitoring and Review
Standard 17: Autonomy and Independence
Standard 21: Responding to Behaviour that is Challenging

Inspection findings
Overall the healthcare needs of residents were met. Staff spoken to were very knowledgeable about the residents in their care. While there was evidence of good practice in the management of behaviours that challenge, falls management and the management of restraint, some improvements in these areas were required.

Residents had access to medical and allied health professionals. There was access to optician, dental, chiropody, dietician and occupational therapy. The nurse explained that the general practitioners (GPs) visited regularly and were available anytime if necessary. There was a system in place for each resident to be regularly reviewed by his or her GP and there was documentary evidence to support this.

The inspector reviewed a sample of residents' care plans and noted that nursing assessments and clinical risk assessments were carried out for all residents. The resident was assessed and the care plans were reviewed every three months. The inspector found that care plans were updated when there was a change in the resident's condition. There was a record of the resident's health condition and treatment given, completed on a daily basis. Residents and/or relatives were involved in the development of their care plans and the care plans were available to the residents.

The inspector reviewed the nursing notes of a resident with a wound and found that there were records to demonstrate assessment and the implementation of treatment plans. The inspector found that there was a wound management policy in place to guide staff response to wounds.

The inspector found that the nursing staff monitored the nutritional status of residents. Residents' weights were recorded each week and three residents were weighed monthly. Nutritional risk assessments were used to identify residents at risk and care plans were in place. All residents at risk were referred to the dietician and there were treatment plans in place. A review of two resident's records showed their weight had increased as a result of the care plan that had been implemented for them.

The inspector reviewed the centre's restraint policy and found that it had not been updated to reflect the recent national policy from the Department of Health on promoting a restraint free environment. A number of residents were using bedrails. A review of residents' records showed that consent forms were in place for the use of bedrails. Restraint assessments had been carried out for residents which identified the alternatives tried prior to restraint. However, the inspector reviewed a sample of care plans for residents who used restraint and found that they did not consistently provide guidance to staff. They did not include the care of the resident while in restraint. In addition, staff were not recording the duration of the use of restraint. The nurse in charge and staff said they had not received training on the use of restraint. The provider had stated in the previous action plan that training would be delivered to staff in September/October 2011. This had been identified as an area for improvement at the previous inspection.

While there was good practice in the management of residents with behaviours that challenge, this could be further enhanced. There was a comprehensive policy on the management of behaviours that challenge, but this had not been fully implemented. Residents' records included the identification of triggers that prompted behaviours and the behaviour itself was recorded using the ABC model. Residents were frequently reviewed by the GP and the psychiatric services. The inspector was informed that training in responding to behaviours that challenge had been provided to staff and staff could describe the interventions they used to manage the residents behaviour.

While the staff recorded all incidents that occurred, the resident's records did not include an assessment as per the policy. Staff could clearly describe the care that was delivered but the care plans did not adequately guide care.

As stated earlier in the report, the inspector found evidence of good practice in the management of falls. There was a policy on falls prevention and management. All residents at risk of falls had a falls risk assessment completed. However, while residents were comprehensively reviewed when they fell, not all residents who had fallen had their care plans updated to reflect their changing needs. In addition, nursing staff did not have access to the required resources to monitor residents with suspected head injuries i.e. a comprehensive neurological chart. This is an important aspect of the care of a resident following an unwitnessed falls or suspected head injury.

The inspector noted that most residents were provided with an extensive range of things to do during the day. A schedule of activities was available on a weekly basis. These included Sonas programme (a therapeutic communication activity which focuses on sensory stimulation), music and pet therapy. Pastoral care was provided each Saturday. Residents were also involved in art and crafts and reminiscence sessions.

While staff spent time engaging with residents with a dementia related condition, they were being included in activities and had some specific activities to meet their needs, there were no social or activity assessments to ensure that adequate social care plans could be developed to promote the quality of life of residents. The person in charge stated that she had identified this gap and was planning to introduce a social assessment process.

Outcome 8
Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.

References:
Regulation 14: End of Life Care
Standard 16: End of Life Care

Inspection findings
There were no residents receiving end of life care on the day of inspection. However, the inspector found that there were adequate procedures in place to ensure that appropriate end-of-life care could be provided when necessary. There was a policy on end of life care and the staff nurses explained that they accessed the services of the local palliative care team through the GP who provided support and advice when required. They also stated that residents at this stage of life had regular access to a minister of their chosen religion.

A single bedroom was available for residents for end-of-life care. This promoted the dignity and privacy of residents and their family.

Outcome 9
Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discreet and sensitive manner.

References:
Regulation 20: Food and Nutrition
Standard 19: Meals and Mealtimes

Inspection findings
The inspector found that residents received a nutritious and varied diet that offered choice. The dining experience in the main dining room was a pleasant sociable occasion but the inspector found that there was inadequate supervision of the care for residents who required assistance while eating and who dined in the large common room.

The inspector noted that overall meals were hot, well presented and tasty. Residents expressed satisfaction with their meals. The inspector saw residents being offered a variety of drinks throughout the day. There was a choice available to residents at each mealtime.

The inspector spoke with the chef and found that she had worked in the centre for several years and therefore had a very good knowledge of resident's dietary needs and preferences. The provider showed the inspector where the menus were changed to reflect the resident's feedback and preferences.

While the meal in the main dining room was a quiet, unhurried and relaxed experience, there were some areas for improvement identified at the meal time in the assisted dining room. A resident was observed to be in a reclined position while eating, which was a potential choking risk - when the inspector brought this to the attention of the nurse it was addressed and the resident was placed in an upright position to eat a meal.

Another resident's meal went cold while the staff were busy attending to other residents, the inspector brought this to the attention of the nurse in charge and this issue was addressed.

Two staff members were observed to be standing up while assisting residents which may have created a less relaxed environment, did not promote the dignity of the residents and did not promote the social aspect of the dining experience.

4. Respecting and involving residents

Outcome 10
Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

References:
Regulation 28: Contract for the Provision of Services
Standard 1: Information
Standard 7: Contract/Statement of Terms and Conditions

Inspection findings
The inspector reviewed a sample of contracts and found that they included details of the services to be provided for that resident and the fees to be charged.

Outcome 11
Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence.

References:
Regulation 10: Residents' Rights, Dignity and Consultation
Regulation 11: Communication
Regulation 12: Visits
Standard 2: Consultation and Participation
Standard 4: Privacy and Dignity
Standard 5: Civil, Political, Religious Rights
Standard 17: Autonomy and Independence
Standard 18: Routines and Expectations
Standard 20: Social Contacts

Inspection findings
The inspector found that residents' privacy and dignity was respected by staff in most regards but there was one area for improvement. The screening in the shared bedrooms was inappropriate and impacted on the privacy and dignity of residents.

The inspector observed staff knocking on the doors of occupied rooms and waiting for permission to enter. Staff interacted with residents in a courteous manner and addressing them by their preferred names. The inspector observed good interactions between staff and residents who chatted with each other in a comfortable way.

Residents' religious and civil rights were supported. Mass took place monthly in the centre and staff and residents told the inspector that the communion was available every Friday. Ministers of other religions visited every week.

The inspector reviewed the minutes of the residents' forum. These showed that all residents in attendance were very happy with the care delivered and offered no suggestions for improvement. The inspector noted that while this committee was in place and the provider and person in charge met with residents daily, two residents told the inspector, they were not aware of this committee. Also, there were no arrangements to ascertain the views of residents with a cognitive impairment who may not be able to attend the meetings.

The inspector observed and staff confirmed that mobile screening was inappropriate and did not provide adequate privacy for residents in shared rooms when personal care was being delivered. Also, if residents in shared rooms wished to have private time, they did not have access to screening in their bedroom which they could use themselves as required.

The centre was open to visitors throughout the day. The residents commended the staff on how welcoming they were to all visitors.

Daily and local newspapers were seen throughout the centre and residents confirmed their enjoyment of reading the paper and watching the news to keep up with current events.

Outcome 12
Adequate space is provided for residents' personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.

References:
Regulation 7: Residents' Personal Property and Possessions
Regulation 13: Clothing
Standard 4: Privacy and Dignity
Standard 17: Autonomy and Independence

Inspection findings
The inspector found there was adequate personal storage space in the bedrooms and locked personal storage was provided when residents requested this.

The inspector visited the laundry and noted that there was adequate space to segregate clean and soiled clothes. Clothing items were clearly marked with the name of the resident. The inspector spoke to the staff member in the laundry and found that she was knowledgeable about the systems in place to segregate laundry and prevent the spread of infection.

Residents expressed satisfaction to the inspector regarding the laundry and the general care of their clothes.

5. Suitable staffing

Outcome 13
The designated centre is managed by a suitably qualified and experienced nurse with authority, accountability and responsibility for the provision of the service.

References:
Regulation 15: Person in Charge
Standard 27: Operational Management

Inspection findings
The post of person in charge was full time and was filled by a registered nurse with the required experience in the area of nursing of older people. The person in charge had continued to keep herself up to date since the previous inspection. She had completed training in dementia, pain assessment, train the trainer in elder abuse and the inspection process. The inspector noted that a number of residents spoke very highly of her and stated that she was routinely available to them in the centre.

The person in charge was on leave on the day of the inspection and was replaced by a nurse who deputised in her absence with the support of the providers. She demonstrated a good knowledge of her responsibilities as outlined in the Regulations. She was observed to be available to staff and residents through out the inspection.

Outcome 14

There are appropriate staff numbers and skill-mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

References:

Regulation 16: Staffing
Regulation 17: Training and Staff Development
Regulation 18: Recruitment
Regulation 34: Volunteers
Standard 22: Recruitment
Standard 23: Staffing Levels and Qualifications
Standard 24: Training and Supervision

Inspection findings

The inspector found that there were sufficient levels of staff on the day of inspection to meet residents' needs and there was good supervision of communal areas where residents spend most of their time. All staff, residents and relatives agreed that there were adequate staff on duty. This was identified as an area for improvement at the previous inspection and had been addressed.

The inspector reviewed the policy on the recruitment, selection and vetting of staff and a number of staff files. The policy was in line with the Regulations. All staff files apart from one contained the requirements of the Regulations. There were two references instead of the required three references in that staff file.

The inspector carried out interviews with staff members and found that all were knowledgeable of residents' individual needs, the centre's policies, fire procedures and the guidelines for reporting suspected elder abuse. The inspector found that there were formal induction arrangements for newly employed staff members and an annual appraisal system was in place.

All nursing staff had the required up-to-date registration with An Bord Altranais for 2012.

6. Safe and suitable premises

Outcome 15
The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

References:
Regulation 19: Premises
Standard 25: Physical Environment

Inspection findings

For the most part the location, design and layout of the centre was suitable for its stated purpose and met residents individual and collective needs. However, there were some areas for improvement.

The centre was found to be well maintained, clean and homely throughout. The inspector found that the bedrooms were personalised with adequate space for belongings.

There was a secure garden which residents could access with the support of staff. In addition to this, the conservatory led onto a patio where some of the residents sat in the afternoon. Residents said they enjoyed the fresh air.

Cleaning staff were able to tell the inspector about the arrangements to manage the risk of infection, including the use of colour coded cleaning equipment. Alcohol hand gels were available throughout the centre and staff had ready access to latex gloves and disposable aprons. The inspector saw staff utilising these infection control measures regularly.

There were appropriate sluicing arrangements in place, this had been addressed since the previous inspection.

There was appropriate assistive equipment available such as hoists, pressure relieving mattresses and cushions, wheelchairs and walking frames. Handrails were available to promote independence. Hoists and other equipment had been maintained and service records were up to date. The provider had purchased specialised beds for all residents since the previous inspection.

The inspector observed the lack of appropriate signage throughout the centre which may have impinged on the independence and orientation of residents with dementia related conditions.

Storage for equipment was limited and the inspector observed equipment such as commodes and a weighing scales stored in the four-bedded room. The providers said this would be addressed with the new extension.

The providers were aware that the four-bedded room will not meet the requirements of the Standards and they were planning a refurbishment and extension programme to address this within the timeframe.

7. Records and documentation to kept at a designated centre

Outcome 16
The records listed in Part 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

References:
Part 6: The records to be kept in a designated centre
Regulation 26: Insurance Cover
Regulation 27: Operating Policies and Procedures
Standard 1: Information
Standard 29: Management Systems
Standard 32: Register and Residents' Records

Inspection findings
Records were maintained and stored in line with best practice and legislative requirements.

The Residents' Guide met the requirements of the Regulations and Standards, was informative and contained all the information required by the Regulations.

The inspector examined the directory of residents and found that it was maintained up to date and contained all of the information prescribed by the Regulations.

The person in charge had developed a comprehensive range of operational policies and procedures to include all those specified in Schedule 5 of the Regulations. The inspector reviewed a sample of the policies and found that they were informative and centre specific. The person in charge was in the process of reviewing all policies and planned to roll these out to staff in August 2012.

The providers had an insurance policy which provided insurance cover for the centre. However, it did not state that the liability to any resident shall not exceed €1000 for any one item.

Outcome 17
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

References:
Regulation 36: Notification of Incidents
Standard 29: Management Systems
Standard 30: Quality Assurance and Continuous Improvement
Standard 32: Register and Residents' Records

Inspection findings
Practice in relation to notifications of incidents was satisfactory. The person in charge was aware of the legal requirement to notify the Chief Inspector regarding incidents and accidents. To date all relevant incidents had been notified to the Chief Inspector by the person in charge.

Outcome 18
The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.

References:
Regulation 37: Notification of periods when the Person in Charge is absent from a Designated Centre
Regulation 38: Notification of the procedures and arrangements for periods when the person in charge is absent from a Designated Centre
Standard 27: Operational Management

Inspection findings
The providers were aware of the requirement to notify the Chief Inspector if the person in charge was to be absent for an extended period. The inspector was informed that there have been no absences of the person in charge for such a length that required notification to the Chief Inspector.

Closing the visit

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

Acknowledgements
The inspector wishes to acknowledge the cooperation and assistance of the residents, relatives, provider and staff during the inspection.

Report compiled by:

Linda Moore

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

14 August 2012

Health Information and Quality Authority
Social Services Inspectorate

Action Plan

Provider's response to inspection report*

Centre:	Asgard Lodge Nursing Home
Centre ID:	006
Date of inspection:	13 August 2012
Date of response:	11 September 2012

Requirements

These requirements set out the actions that must be taken to meet 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*.

Outcome 4: Safeguarding and safety

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

The nurse who deputised for the person in charge and the provider was not able to describe the how to manage an allegation of abuse in the absence of the person in charge.

Action required:

Make all necessary arrangements, by training staff or by other measures, aimed at preventing residents being harmed or suffering abuse or being placed at risk of harm or abuse.

Reference:

Health Act, 2007
Regulation 6: General Welfare and Protection
Standard 8: Protection

* 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: There is a clear procedure for responding to an allegation of abuse. The deputy person in charge and provider had received formal abuse training in July 2012 and are aware of Abuse Policy and Procedure. The person in charge is satisfied that they will follow procedure in future and will revise policy with deputies when she is on annual leave.	Complete

Outcome 4: Safeguarding and safety

2. The provider is failing to comply with a regulatory requirement in the following respect: Two residents personal money was not recorded correctly.
Action required: Ensure that a record is kept of each residents personal property signed by the resident and this record must be kept up to date.
Reference: Health Act, 2007 Regulation 7: Residents personal Property and Possessions Standard 9: Resident's Finances

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: All property records will be kept up to date as per policy.	19/08/2012 Complete

Outcome 5: Health and safety and risk management

3. The provider is failing to comply with a regulatory requirement in the following respect: The hot water temperature exceeded 60 degrees and was a risk of scalding residents. While in practice the person in charge was identifying, recording, investigating and learning from serious or untoward incidents or adverse events involving residents there was no policy available to guide practice.

Action required:

Provide sufficient numbers of toilets, and wash-basins, baths and showers fitted with a hot and cold water supply, which incorporates thermostatic control valves or other suitable anti-scalding protection, at appropriate places in the premises.

Action required:

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

Action required:

Ensure that the risk management policy covers, but is not limited to, the identification and assessment of risks throughout the designated centre and the precautions in place to control the risks identified.

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: Our plumbing contractor fitted thermostats to all hot taps. This work was completed on 27 August 2012. Risk management policy be reviewed and updated.	 27/08/2012 Complete 30/10/2012

Outcome 6: Medication management

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

The medication management policy did not include the procedure for the administration of controlled medications.

Action required:

Put in place appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents and ensure that staff are familiar with such policies and procedures.

Reference: Health Act, 2007 Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines Standard 14: Medication Management	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Policy on Supply, Possession and Administration of MDA's has been reviewed and now contains specific information re: administration of MDA's at night time.	16/08/2012 Complete

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

Residents' records of those with behaviours that challenge did not include an assessment as per the policy. Care plans for these residents did not adequately guide care.

Residents who had fallen did not have their care plans updated to reflect their changing needs.

Nursing staff did not have access to the required resources to monitor residents with suspected head injuries such as a comprehensive neurological chart.

Care plans for residents who used restraint did not consistently provide guidance to staff. Staff were not recording the duration of the use of restraint.

Action required:

Provide a high standard of evidence-based nursing practice.

Reference: Health Act, 2007 Regulation 6: General Welfare and Protection 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) Cohen Mansfield Agitation Inventory (CMAI) will be introduced to monitor manifestation of challenging behaviour. It will be integrated into care plans. 2) Care plan for one resident who had fallen had not been updated. This has now been updated. 3) Glasgow Coma Scale (GCS) form is now on file and available to nurses for monitoring neurological observations. 4) An addition to Care Plan has been added to our standard template to prompt nurses to document all considerations related to restraint. All care plans have been reviewed and updated for residents who use restraint.	 30/09/2012 17/08/2012 Complete 22/08/2012 Complete 24/08/2012 Complete

Outcome 9: Food and nutrition

6. The person in charge is failing to comply with a regulatory requirement in the following respect: There was inadequate supervision of the care for residents who required assistance while eating.	
Action required: Provide appropriate assistance to residents who, due to infirmity or other causes, require assistance with eating and drinking.	
Reference: Health Act, 2007 Regulation 20: Food and Nutrition Standard 19: Meals and Mealtimes	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: We endeavour to ensure that all residents have a pleasant dining experience. We will ensure that each resident is supervised according their needs. This particular issue was addressed with staff on the day of inspection.	 14/08/2010 Complete

Outcome 11: Residents rights, dignity and consultation

7. The provider has failed to comply with a regulatory requirement in the following respect: While a residents' committee was in place, some residents were not aware of it and there were no arrangements to ascertain the views of residents with a cognitive impairment who may not be able to attend the meetings.	
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: We are assured that all residents have been informed of the residents committee. Our independent advocate who chairs Residents Committee meetings is also an ambassador for residents who have a cognitive impairment. We have displayed posters and have personally invited family members of residents who have a cognitive impairment, to participate in this Committee, however, we have not had a commitment from any family member. We continue to encourage our residents continued participation in this committee.	14/08/2012 Complete

8. The provider is failing to comply with a regulatory requirement in the following respect: Mobile screening was inappropriate and did not provide adequate privacy for residents in shared rooms.
Action required: Provide residents with privacy to the extent that each resident is able to undertake personal activities in private.

Reference: Health Act, 2007 Regulation 10: Residents' Rights, Dignity and Consultation Standard 4: Privacy and Dignity	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: At present, curtains and mobile screens are facilitated in shared accommodation to ensure privacy. We are reviewing this with a view to implementing individual fixed curtains.	 31/01/2013

Outcome 15: Safe and suitable premises

9. The provider is failing to comply with a regulatory requirement in the following respect: There was a lack of storage space; therefore equipment was being stored in bedrooms.	
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	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: We have made provision for a storage area in our extension. Maintenance staff member has moved some items to the attic to allow for more space in storage areas.	 Date not known 17/08/2012 Complete

Outcome 16: Records and documentation to be kept at a designated centre

10. The provider is failing to comply with a regulatory requirement in the following respect: The insurance certificate did not state the cover against loss or damage to the property of residents including liability as specified in Regulation 26 (2). Revised policies had not yet been rolled out to staff to guide practice.	
Action required: Put insurance cover in place against loss or damage to the property of residents including liability as specified in Regulation 26 (2).	
Action required: Roll out all of the written and operational policies listed in Schedule 5 of the Regulations.	
Reference: Health Act, 2007 Regulation 27: Operating Policies and Procedures Regulation 26: Insurance Cover Regulation 21: Provision of Information to Residents Standard 29 Management Systems Standard 31: Financial Procedures Standard 1 Information	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: 1) Insurance certificate has been updated and a copy has been sent to the Authority. 2) Person in charge is ensuring staff awareness of Schedule 5 policies.	 17/08/2012 31/10/2012

Any comments the provider may wish to make:

Provider's response:

Following the visit we have amended most of the recommendations and will continue to monitor and improve all aspects of care provided to our residents.

Provider's name: James and Oonagh Tyrrell
Date: 11 September 2012