Health Information and Quality Authority
Social Services Inspectorate

Inspection report
Designated centres for older people

Centre name:	Melview House Nursing Home
Centre ID:	0250
Centre address:	Prior Park Clonmel Co Tipperary
Telephone number:	052-6121716
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Email address:	melviewcareltd@eircom.net
Type of centre:	☒ **Private** ☐ **Voluntary** ☐ **Public**
Registered providers:	Melview Care Ltd
Person in charge:	Davina Hanly
Date of inspection:	24 September 2012
Time inspection took place:	**Start:** 09:15hrs **Completion:** 21:30hrs
Lead inspector:	Mary Moore
Support inspector:	Noelene Dowling
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

Melview House Nursing Home was originally a 57-bed facility established in 1970 and is now owned by Melview Care Ltd. Long-term, convalescence and respite care are provided. Although originally registered for 57 beds, the centre is now operating as, and has applied to be registered as, a 50-bedded facility, due to some operational reorganisation of accommodation.

On the day of inspection, there were 40 residents living in the centre, all of whom were in receipt of long-term care.

Melview House is almost 200 years old; it was originally built as a private dwelling and in later years was used as a convent and medical facility by a religious order, the Medical Missionaries of Mary. It has operated as a nursing home in private ownership since about 1985. Melview House is an architecturally significant listed building. It is a three-storey over-basement structure; resident accommodation is provided on the ground, first and second floors. The basement area primarily accommodates service areas, staff facilities and administration offices. The following description of the premises reflects the alterations that have been made by the provider in response to previous inspection findings and fire safety requirements.

The main entrance provides access to the ground floor of the main building; the entrance retains the original three limestone steps. A ramp is provided, leading to a small lobby area or porch and the main reception area.

The ground floor accommodation consists of a sitting room and dining room for residents, and four bedrooms providing accommodation in total for eight residents in four two-bedded rooms. Two of these bedrooms are en suite with toilet, wash-hand basin and assisted shower. There is a bathroom with toilet, wash-hand basin and low level bath with electric seated insert, and a further single toilet provided for residents' use. A sluice room, staff toilet and changing facilities and the laundry are also accommodated on the ground floor. The oratory has been relocated from its original location on the first floor to the ground floor but three steps down are required to be negotiated in order to access it. From the ground floor, there is access to adjoining buildings originally used as stables that now accommodate administration offices, a meeting room, mortuary, a smoking area for staff and boiler rooms.

The basement is accessed from the ground floor by means of a restricted stairwell and accommodates the main kitchen and ancillary stores, offices for the person in charge, and changing and toilet facilities for catering staff.

The first floor is accessed by means of a stairwell from the ground floor that leads directly to the nurses' station; a further stairwell leads to a large central landing area, residents' bedrooms, and the lift and lobby area. There are four bedrooms providing accommodation for twelve residents, two two-bedded rooms and two four-bedded rooms, none of which are en suite. One of the two-bedded rooms replaces

the original residents' communal/dining area. There is a bathroom with toilet, wash-hand basin and assisted shower and a second separate toilet and wash-hand basin provided for residents. A further stairwell leads up to the second (top) floor; again there is a main central landing with a residents' sitting/dining room and three bedrooms providing accommodation for ten residents, one twin bedroom and two four-bedded rooms. These bedrooms are not en suite; a bathroom with a toilet, wash-hand basin and assisted shower and a separate toilet and wash-hand basin are again provided.

Further resident accommodation is provided in what has been to date referred to in the centre as the "back block" or the "back wing" but has recently been renamed the Orchard wing. This is a later construction circa 1950's accessed from the first floor nurses' station and currently provides accommodation for twenty residents. There are 13 single rooms, two twin-bedded rooms, and one three-bedded room; one of the twin-bedded rooms is en suite with toilet, wash-hand basin and non-assisted shower. There are two bathrooms with toilet, wash-hand basin and assisted showers, a bathroom with toilet, wash-hand basin and floor level bath, and one further single toilet available for residents' use. This 'back wing" originally provided for only one sitting room/dining room and a separate dining room has been provided in the area that originally served as the chapel; access to it, however, is again dependent on the negotiation of steps. Some rooms have been reconfigured to provide a temporary nurses' station and other service areas such as a cleaners' room and storage.

A passenger lift is in place but only serves the central block of the premises from basement to top floor level; it does not facilitate access to the back wing or the nurses' station which are accessed only by means of stairwells.

Outside there is some seating to the front of the building, an area of decking to the rear of the building and a large green area to the rear of the premises, which were originally tennis courts. There is ample car parking to the front of the building.

Location

Melview House is situated in a cul-de-sac on a spacious mature site, in a residential area slightly removed from the town centre of Clonmel.

Date centre was first established:	1970
Number of residents on the date of inspection:	40
Number of vacancies on the date of inspection:	10

Dependency level of current residents	Max	High	Medium	Low
Number of residents	8	14	4	14

Management structure

Melview House Nursing Home has been owned by Melview Care Ltd since 2005. Mr Dermot Dougan, a director of Melview Care Ltd, is the nominated Registered Provider. The nominated Registered Provider had on 1 June 2012 entered into a business agreement with a company, referred to in this report as the contracted managers, to provide "nursing home management services" in the centre.

Mr Dermot Dougan remains the legally responsible registered provider. The new Person in Charge (PIC), Davina Hanly, took up her post on 7 August 2012 and reports to the contracted managers. A new Key Senior Manager (KSM), Sisilyamma Emmanuel, has been recruited and commenced employment on the day of inspection, 24 September 2012. There are approximately 50 staff employed comprising nursing staff, care assistants, household staff, catering staff, administration and maintenance staff. All staff report to the Person in Charge.

Staff designation	Person in Charge	Nurses	Care staff	Catering staff	Cleaning and laundry staff	Admin staff	Other staff
Number of staff on duty on day of inspection	1	1*	7	4	3	1	4**

* One nurse was on duty at 08:00hrs. A second nurse came on duty at 12:00hrs
** The activities coordinator and one of the contracted managers. Also in the centre were a physiotherapist and an assistant Director of Nursing from the company of the contracted managers in a support/advisory capacity.

Background

This inspection was the eighth inspection of the centre by the Authority since 21 September 2010 and was a one-day unannounced inspection; a site visit had also been undertaken by the Authority on 22 July 2011.

Based on the failures to meet regulatory requirements as identified during all of these inspections, on 22 June 2012 written notice was issued to the provider of the Chief Inspector's decision to refuse and cancel the registration of Melview House Nursing Home. On that date the Chief Inspector also requested in the interests of the health and welfare of residents that no new residents be admitted to the centre during the process set out in the notices to cancel and refuse the registration of the centre. On 20 July 2012 written notice was issued to the Chief Inspector advising that pursuant to Section 57 (1) of The Health Act 2007 the provider was to exercise his right of appeal to the District Court concerning the decision of the Chief Inspector.

The purpose of this inspection was to establish what progress was made by the provider in implementing the required improvements as set out for him in the 19 actions that had emanated from the last inspection of 15 August 2012 and 16 August 2012. Overall, those inspection findings were poor. While there was evidence of actions taken to address the improvements required the inspection findings did not demonstrate evidence of substantive improvements or enhanced clinical, safety and quality of life outcomes for the residents. It was of serious concern to inspectors that there was no evidence of a system for reviewing the impact of newly implemented systems. That report sets out the inspection findings in detail but they included poor findings on nursing assessment and care planning, risk management, the management of residents' complaints, fire precautions, timely and equitable medical review and treatment, protection issues, the management of falls, the management of residents with compromised nutrition, resident choice, consultation and participation, recruitment practices and the supervision of staff and care delivery. Inspectors found practice in relation to residents with particular nutritional requirements to be chaotic, inconsistent and unsafe. There was no evidence to support learning from previous accidents and incidents. Residents reported a lack of choice and control over basic routines such as the provision of refreshments. Inspectors noted no interaction by some staff with residents, no strategies to support residents when they became agitated or distressed and in one instance staff ignored the requests of one of these residents.

Given the significance and repeat nature of the inspection findings, immediate implementation and/or completion timescales were set by the Authority.

Summary of findings from this inspection

This inspection was an unannounced one-day inspection.

On arrival the person in charge was on duty and one of the contracted managers was expected, and the newly recruited key senior manager commenced her first day of employment on the day of inspection; the centre was not, however, adequately staffed.

Improvement was evidenced primarily in relation to the provision of meaningful and therapeutic activities, access to timely and equitable medical review for residents, and the management of residents with specific nutritional requirements. However, despite this improvement only two actions were satisfactorily resolved and 17 actions were reissued to the provider. The improvements achieved were further counter-balanced by concerning and poor findings in relation to recruitment procedures, the maintenance of adequate staffing and skill-mix, deficits in fire safety procedures, the management of falls, accidents and incidents, and medication management practices.

Inspectors found that there was an over-reliance on documentation and checklists as evidence of the delivery and supervision of care, whereas again the inspection

findings indicated that the completion of the documentation did not equate with the delivery of care, the accuracy and appropriateness of that care or the standard to which the care was delivered. Where new systems had been introduced these were poorly implemented and monitored and resulted in deteriorating findings such as in medication management. Staff shortages and ongoing issues with the design and layout of the premises continued to impact on the quality and safety of care and services delivered to residents.

Actions reviewed on inspection:

1. Action required from previous inspection:

The provider shall ensure that all reasonable measures are taken to protect each resident from all forms of harm and/or abuse regardless of the residents' capacity or manifested behaviours. Such protective measures are explicitly outlined, implemented and evaluated.

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.

Review, amend, agree and implement a policy and procedures for the prevention, detection and response to abuse based on the recommendations of inspection findings.

This action was not satisfactorily resolved. Inspectors examined the policy on the prevention, detection and response to abuse and found that while appendices had been added, it had not been revised as required and requested by the Authority to outline the procedure for reporting, investigating and responding in the event of an allegation being made against the person in charge or any other member of the governance team.

Practice in relation to protection was again found not to be robust. Poor and unsafe recruitment procedures were evident and there was an absence of constructive action by management when staff management systems were not in line with safe practice, such as the provision of sufficient staffing and the appropriate supervision of staff. Staff spoken with had no knowledge of recent protection issues in the centre or any supervisory arrangements/protective measures in place.

The provider had undertaken a brief update on training for staff in recognising and responding to abuse. Inspectors were informed that some brief training on challenging behaviour had also been undertaken in this training session.

2. Action required from previous inspection:

Each resident, regardless of location, diagnosis and physical and/or cognitive ability is given opportunities for participation in meaningful and purposeful activity and occupation that suits his/her needs, preferences and capacities, previous routines,

social and recreational interests. Staff are encouraged to view activities as an opportunity to enhance physical, cognitive and social wellbeing and an opportunity to interact and engage with residents.

Facilitate, by means of education and supervision, all staff to have up-to-date knowledge and skills to allow them to respond to and manage behaviour that is challenging in a manner that promotes positive person-centred outcomes for residents. Management strategies are based on staff knowing and understanding each resident, their biography and behaviours and the benefit of positive communication and person-centred interventions.

Though not fully resolved some improvements were observed. However, based on their observations, interviews and reviewing of records inspectors were not satisfied that all staff were aware of and implemented agreed strategies and plans for the provision of therapeutic person-centred care including the management of behaviours that challenged.

The contracted manager had engaged the services of a physiotherapist from another of their centres who had spent considerable time in the centre primarily training the activities coordinator and existing physiotherapist on how to undertake specific individualised exercises and activities with residents. Inspectors observed, and records and interview confirmed, that the group and individual activities were taking place.

Some, but not all care plans had been amended to include personal biographies, preferences and abilities in terms of devising and implementing day-to-day activities. There were references to individual hand massages for residents unable to participate in any other activities and these were seen to be undertaken.

The activities coordinator maintained detailed records of what each resident participated in on a daily basis and there was evidence that some residents were being supported to take walks outside.

There was evidence that efforts had continued to mitigate the impact of the division of the premises on residents and that activities, including mass, were divided between the floors to ensure residents had an opportunity to participate.

The activities coordinator was scheduled to undertake Sonas therapeutic training in November 2012.

There was, however, evidence of further required learning and improvements in relation to the continuum of care provided to residents as opposed to structured activities sessions. Some staff had a brief introduction to the management of challenging behaviours. Care plans did reference challenging behaviour interventions for staff to use. However, on interview staff cited their own strategies and were not aware of the guidelines that were contained in the care plans. Staff labelled residents requiring assistance with fluids and at mealtimes as "feeders" and informed inspectors that these residents were woken up, given their breakfast and medication

between 07:00hrs and 07:30hrs. Residents' records confirmed this. Staff approached a resident with dementia who was seated in a wheeled chair and without warning or explanation to the resident moved the resident to the other side of the dayroom leaving the resident's personal bag that contained family photographs used as part of her therapeutic care plan behind. The bag and its therapeutic personal contents could not be located later in the day when the resident's demeanour indicated that it was required for her care. Another resident was noted by the inspector to have an unused body-fluid drainage bag with the tubing cut and angled to a shorter length. When asked as to its purpose the resident told the inspector that he had been given it by staff to practice his breathing exercises; the person in charge or the contracted manager were unaware and unable to confirm this practice.

3. Action required from previous inspection:

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.

Provide adequate private and communal accommodation for residents.

Ensure the size and layout of rooms occupied or used by residents are suitable for their needs.

Maintain the equipment, including passenger lifts for use by residents, people who work at the designated centre and all other persons in good, safe working order. There is written confirmation of this from a competent person.

Provide sluicing facilities, including bedpan washers, that are appropriate to the size of the building and easily accessible from all areas of the building. All replacement sinks are stainless steel.

Provide a suitable private area that is easily and universally accessible where residents can meet visitors in private.

Ensure that residents have access to a safe, secure outdoor space with seating, accessible to all residents, including residents with mobility impairments and those using wheelchairs. The grounds are kept safe, tidy and attractive.

This action was not met. There was evidence of some remedial actions but the challenges posed to residents and staff by the design and layout of the building remain unresolved.

The person in charge confirmed that one resident had transferred to another designated centre since the last inspection as management and responsible family members had agreed that the premises did not adequately meet his needs and provide him with a safe therapeutic environment. This resident was fully mobile with advanced dementia and was observed on previous inspections by inspectors to require almost constant staff supervision due to the absence of safe circulation areas internally and externally and the prevalence of stairwells.

The person in charge reported that the passenger lift had not malfunctioned since the last inspection and none were seen to be recorded. However, while the inspector saw an e-mail confirming that a quotation had been sought on a maintenance contract for the lift, the contracted manager told the inspector that the lift had not yet been subjected to a thorough six-monthly examination by a competent person in line with the relevant legislation and as outlined in the provider's response to the action plan, to ensure that the lift was safe and did not pose a risk to the health and safety of residents, staff and other persons.

A bedpan washer was installed on the top floor sluice room.

The contracted manager informed the inspector that plans continued for the demolition and replacement of the back wing with a 60-bedded purpose-built unit and that negotiations were ongoing in relation to securing the required finances. They were progressing the procurement of a 25-bed temporary structure, and drawings were made available to the Authority; planning permission for the temporary structure had not yet been granted. The proposed implementation date for the temporary structure was mid November 2012 and early 2014 for the completion of the replacement purpose build. The contracted manager clarified that they were aware that the temporary structure could not be used for resident accommodation until inspected by the Authority.

4. Action required from previous inspection:

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. The assessment of risks includes all areas of work and work practices. Ensure that all staff adhere to the implementation of the identified controls.

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.

Review the findings of the risk assessments and the controls identified to reduce, control or eliminate the risks to residents, staff and visitors. Identify and implement the remaining controls and review and amend as required the adequacy of all controls.

The risk assessments are reviewed on an ongoing basis and updated as required.

Ensure that residents have access at all times to a readily accessible and properly functioning call-bell system.

Complete risk assessments and take appropriate remedial action in response to the specific risks as identified in this report; the management of restricted stairwells and exits, maintenance of the external fire escape ramp, appropriate window restrictions.

Ensure that staff have available to them contemporary evidence-based manual handling devices and receive the appropriate training from a competent person in their use.

This action was not met. Some progress had been made in relation to specific findings and requirements from the August 2012 inspection. Restricting gates on stairwells were seen to be appropriately managed, identified windows had restrictors in place, the external fire escape ramp was clean and moss free. Additional physiotherapy resources and input had been sourced and staff were seen to have been supplied with and used additional sit-to-stand hoists, handling belts and sliding sheets to assist them in moving and handling tasks; staff spoken with confirmed that they had attended training on the use of such equipment. An existing staff member had recently been appointed health and safety officer and was the responsible person for hazard identification. While having good solid experience in the centre she confirmed that she did not have prior experience, education or training in risk identification, assessment and management. A basic monthly identification of existing risks had been introduced and was seen to predominantly consist of the identification and repair of environmental hazards such as trailing cables, unlocked clinical waste storage and doors that did not close properly.

All of the above were reactive in response to inspection findings and there was little evidence to support an understanding and implementation of a robust pro-active culture of risk management both in relation to existing risks or the identification of potential risks. The centre-specific risk register compiled by an external consultant in March 2011 had not been reviewed as requested on repeated inspections as findings supported that all identified controls were not implemented in practice. Taking this overarching finding in conjunction with the findings on falls prevention, the review of accidents and accidents including injuries with unknown aetiology, fire safety procedures and medication management systems, inspectors were not satisfied that proactive risk management was a key component of the governance of the centre.

The inspector noted a chair on the first floor landing of the external fire escape yet staff spoken with, including the person in charge, did not know it was there or that, as confirmed by other staff spoken with, it was there to facilitate resident smoking. In addition, there was no evidence of an assessment of the potential risks including deactivation and reactivation of the alarmed fire door to access the area, or the risk that a more vulnerable resident may access the area and the external fire ramp or attempt to use the chair to scale the protective railing. Dependent and vulnerable residents were seen not to have access to call bells; a call bell check had been integrated into the care delivery record but these were seen to be not consistently completed by staff.

The policy outlining the arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents was complex and not centre-specific.

5. Action required from previous inspection:

Put in place and implement a comprehensive emergency plan and adequate arrangements that clearly outline for staff the contingencies in place for responding to a loss of power and the actions to be taken while awaiting the restoration of services so as to protect resident safety, comfort and wellbeing and any prescribed treatments.

This action was met. Inspectors examined the emergency plan and found that it was satisfactory with arrangement made for evacuation, loss of power and emergency accommodation if required. A flow chart outlining the procedure to be followed had been posted in prominent locations and nursing staff were aware of the content of the plan, where to access it and where to access the emergency phone numbers if required.

6. Action required from previous inspection:

The provider shall ensure that, in consultation with the relevant fire authority, there is safe egress (adequate means of escape) from all areas of the premises in the event of fire or other such emergency. The provider shall ensure that all means of egress are appropriately maintained and fit for purpose.

The provider shall ensure by means of fire drills and fire practices at suitable intervals, that staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire, including the procedure for evacuation and saving life.

The provider shall ensure that there are appropriate systems in place for the review and management of each resident's personal emergency evacuation plan (PEEP).

The PEEP is integral to fire training and readily available to staff and emergency services.

The provider shall ensure that there is maintained, in a safe and accessible place, one record (the fire register) of all fire practices which take place at the designated centre.

This action was not satisfactorily resolved. There was evidence of action taken but risks were also identified.

Suitable fire safety devices/closures had been installed on doors where this was observed to be absent on the previous inspection of 15 August 2012; staff were seen to adhere to their use. Inspectors observed that the fire door from the basement and kitchen area seen to be left open during the previous inspection was safely closed on this occasion. Daily checks on the fire alarm panel and the accessibility of the fire

exits were also recorded and a weekly fire drill took place; the fire detection system was routinely tested on the day of inspection

The provider had been requested to have the emergency egress route from the kitchen reviewed by the local fire safety officer. The contracted manager stated that he had made a verbal request for this but the review had not yet occurred. No changes were observed in this exit and the handle on the window (which is the designated fire exit) was seen to be still broken.

Records demonstrated that fire safety training had taken place on three occasions during August 2012. Staff spoken with identified that this consisted primarily of instructions as to how to use the fire fighting equipment. Some staff were able to articulate how they would evacuate residents if necessary although they also said that their intended actions was based on their own common sense as opposed to their knowledge of specific instructions or training.

The personal evacuation plan for each resident which the provider had agreed to alter following the previous inspection had been reviewed for each resident and was found to correspond with the resident's current mobility status; the details were entered on a single document and maintained in the nurse's station. It detailed the resident's need for support during evacuation such as wheelchair, ski sheet or evacuation chair. Of concern to inspectors was that the evacuation chair was identified for use by eight residents on the same floor with only one such chair available in the premises. One night duty staff nurse could not demonstrate any knowledge of what to do in the event of fire. When inspectors enquired as to the availability and location of the ski sheets identified for use with residents this member of staff indicated that they might be kept on the top floor and that staff would have to go to that floor to access them in the event of an evacuation. The staff member was not aware that these were already in place as required on some residents' beds. Another staff member declined to share their knowledge of fire safety procedures and told the inspector that they were too tired.

As nursing staff play a key role in the management of emergencies such as fire, this finding, combined with the additional vulnerabilities of night time such as residents in bed and sleeping, perhaps with the assistance of medication and diminished staff numbers, was of serious concern to the inspectors.

7. Action required from previous inspection:

Establish and maintain an effective system of quality assurance for improving the quality of care provided at, and the quality of life of residents in, the designated centre.

Consult with residents and their representatives in relation to the system for reviewing and improving the quality and safety of care, and the quality of life of residents.

The provider shall ensure that issues raised individually by residents or by the residents' representative group are acknowledged, responded to and recorded, including the actions taken in response to issues raised. Action taken in response to the issues raised clearly demonstrates change and improvement on all matters significant to and affecting the quality of life of the resident.

The person in charge shall collect and audit clinical and non-clinical data for the purposes of ongoing quality monitoring and continuous improvement and take appropriate action in response to any findings of concern.

This action was not met; there was evidence of some action taken. Residents had been consulted with and there was some evidence to support that resident' concerns and requests were of significance to management and had been discussed with staff in an attempt to address the issues raised. Staff had been provided with catering facilities such as a toaster, microwave, and water boiler in the first floor dining room so as to facilitate them in responding to residents' requests and requirements. However, it was not clear that these actions equated with actual improvements for residents in relation to issues of concern raised by them or that the quality and safety of care and services provided to them, outside of formal systems for doing so, was reviewed and monitored on an ongoing basis.

Twenty-one customer satisfaction surveys were completed with residents on 21 August 2012. These were transparent, the majority were completed by the residents themselves and indicated that they were willing and prepared to complain. While expressing satisfaction with aspects of the centre they also identified the quality and quantity of food, the privacy afforded to them and the manner in which their personal needs were attended to by staff as areas requiring improvement. There was evidence that the findings had been reviewed individually by the person in charge, that the improvements required related primarily to catering and care staff and were discussed at staff meetings. However, one resident again told the inspector that he had recently been refused a cup of tea by a carer on night duty; another resident said that he "might or might not get one" and asked the inspector "should I get one?" Similar findings were evident in the management of complaints and these are discussed in the next section of the report.

Two residents were noted to have no footrests in place on their chairs. The physiotherapist stated that one resident did not have a footrest as it was broken and the other resident was to have a footstool in position; this was not seen to be in

place throughout the inspection and staff spoken with did not demonstrate a sense of accountability for non-compliance with care required for the resident's comfort.

Clinical data had been collated from 20 August 2012. These indicated that at the time of inspection four residents were on antibiotic therapy for chest and urinary tract infections. The person in charge confirmed that while data was collected it had not been reviewed for the purposes of quality assurance. The falls as seen listed in the accident and incident log were not included in the data collated.

Falls prevention and management systems were not adequate and did not support the provision of safe suitable care to residents assessed as at risk of falls; again this is discussed in the relevant section; ongoing deficits were identified in risk management, recruitment and staffing. Collectively these are all strong indicators of the absence of a robust and meaningful system of quality assurance.

8. Action required from previous inspection:

Ensure that there is one clear legislatively compliant written policy and procedure in place for staff in relation to the logging and management of complaints and all staff are familiar with it.

The person in charge will ensure that all complaints and comments are fully recorded, investigated and explored with staff for feedback and future learning. Measures required for improvement that are in line with best practice and are evidence based are identified, implemented and evaluated and there is clear evidence of this.

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

Inform complainants promptly of the outcome of their complaints and details of the appeals process. Maintain a record detailing the investigation and outcome of the complaint and whether or not the complainant was satisfied.

Ensure that the centre provides an environment that is conducive to residents, staff, family members, advocates and visitors being able to raise issues and complaints verbally and in writing in a spirit of openness and partnership and without fear of adverse consequences.

This action was not met. Some improvement was evident but further work was required to ensure that there was a transparent, adequately managed, objective and effective complaints management system. There was still evidence to support that complaints were not seen and welcomed as opportunities for learning and improvement.

Policy in relation to the management of complaints had been reviewed as required and a synopsis of this was posted in the hallway of the centre. The policy was

satisfactory and the person in charge was clear as to her role and that one of the contracted managers would oversee her management of complaints. Inspectors were informed that there were no formal complaints made in the period since the inspection of 15 August 2012.

Practice however remained problematic. The informal complaint log contained a number of issues that had been raised by residents and were managed in the first instance through an informal process in accordance with the policy. A resident had stated that she had been given the wrong meat for her meal and that the soup was cold. The staff who took the complaint recorded that she had spoken with catering staff who had stated that the resident had received the correct meat and that he had tested the soup with a probe before it was served. The nurse indicated in the record that the resident was satisfied with this response. However, there was no evidence in this response to suggest that the resident's experience and complaint was seen as valid or that any attempt to reassure the resident in an objective manner was made. Another complaint related to a resident finding two medicine pots in his pot of tea. The action of the person in charge was to request staff to be vigilant but it did not demonstrate that any enquiry or investigation was undertaken either in the catering or housekeeping area as to how this incident had occurred.

Some of the complaints recorded were not signed by the staff member who accepted and recorded them and the monthly review of complaints agreed by the provider had not taken place for the purposes of quality improvement.

9. Action required from the previous inspection:

The person in charge will ensure that the care plan is based on a current comprehensive evidence-based nursing assessment, reflects the assessment findings, the residents' actual needs and sets out in detail the action to be taken by staff for each individual resident thereby ensuring the provision of suitable and sufficient care.

The care plan is re-evaluated and updated in a timely and safe manner as indicated by the residents' changing needs and significant events. All elements of the care plan, assessment, planned care, and carers care delivery record are clearly understood and communicated to staff and demonstrate an integrated, consistent and safe plan of care.

The person in charge shall ensure that the standard of care planning is the subject of regular audit.

Provide each resident with a high standard of evidence-based nursing practice.

Put in place suitable and sufficient care to maintain each resident's holistic welfare and wellbeing, having regard to the nature and extent of each resident's dependency and needs.

This action was partially resolved. Improvements were noted and the concerning deficits identified in August 2012 had largely been rectified. The contracted

managers had sourced additional senior nursing resources from their existing centres to review and work with nursing staff on the care planning process. The review process described to the inspector was informal, and while improvement was acknowledged it was also agreed that further work and improvement was required.

Inspectors did identify ongoing deficits and were not satisfied that care plans and care delivery records presented as one integrated and consistent plan and record of care that actually ensured that each resident received the care that was required by them and planned for. This was specifically evidenced in relation to falls and falls prevention, wound care, physiotherapy, and pain assessment and treatment. Again there were concerning deficits in the carers' care delivery records in relation to the accuracy and appropriateness of the information given to them and the accuracy and relevance of their completion.

Specific examples to support this finding were:

- while the basic resident comprehensive assessments and risk assessment tools were current they were not an accurate assessment of the resident and their needs
- pain assessments and care plans for residents with current pain were in place but had not been completed in a manner that was relevant to the residents' requirements
- some identified preventative and health promoting interventions were not integrated into the care plan
- some preventive and health promoting interventions while planned for were not implemented in practice
- some nursing documentation reviewed was completed in a subjective manner and not in line with professional body guidelines on clinical documentation
- staff spoken with were not familiar with care plans and therapeutic interventions for the management of behaviours that challenge
- while wound prevention and management care plans were in place they did not demonstrate strong evidence of evidence-based practice such as supporting wound tracing or photographic evidence.

10. Action required from previous inspection:

The person in charge will ensure that all staff are familiar with, adhere to and implement the centre-specific, evidence-based falls prevention and management programme.

Put in place appropriate systems/interventions and plans of care aimed at preventing residents being harmed or sustaining injury or being placed at unnecessary risk of accident and injury.

Put in place appropriate and effective arrangements for reviewing serious or untoward accidents, incidents or adverse events involving residents including falls. The review identifies patterns and trends, required improvements and informs care and practice to avoid repeat occurrences.

This action was not met. The inspector again found that the approach to falls prevention and management was inconsistent. A combination of factors such as non-adherence to policy, deficits between planned and implemented care, and the absence of a robust system of review resulted in an ongoing risk of falls and injury for residents.

Five falls were recorded since the last inspection. The inspector reviewed accident and incident records, care plans, nursing progress notes, medical notes and nursing transfer letters and found that:

- a resident who had a recent fall and consequent fracture was assessed for falls risk by nursing staff as being "immobile/bedfast/bed-bound". Staff spoken with confirmed that the resident was mobile with assistance
- while falls-prevention care plans were in place and were reviewed post falls, preventative interventions as identified in the review of falls by the person in charge such as "supervise at all times" and the provision of hip protectors were not integrated into the care plans. Interventions that were identified in the preventative care plan were not evidenced in practice. The inspector saw that the resident with the recent fall and fracture did not have access to a call bell, was not supervised at all times and did not have a movement alarm chair-pad. The person in charge told the inspector that a floor-based movement alarm was in place but was not effective and had been removed in the morning; this was not referenced in the nursing progress notes or the care plan reviewed by the inspector
- there was no reference in the carers' delivery care record to falls risk, supervision, movement alarm mats or the use of hip protectors. One carer spoken with was aware that two residents in her care were to wear impact reducing hip protectors and these were in place. Another resident, however, did not have her preventative hip protectors in place; they were subsequently applied by staff following a query from the inspector.

There were concerning inconsistencies noted between accident and incident records, nursing records, nursing transfer letters and medical records reviewed. One accident and incident record and nursing progress notes stated that a resident stood up in the day room, walked a few steps and fell, facial abrasions were noted. However, on medical review the GP noted that the resident had fallen and "hit head off bedside locker". The accident was stated to have been witnessed by a staff member. Neurological observations were ordered, recorded and stated by nursing staff to be stable. The inspector noted however that the resident's blood pressure was elevated at 22:00hrs but was not rechecked by nursing staff until 06:00hrs.

A further accident and incident record stated that a resident slipped from her chair on to the floor yet the nursing transfer letter said that she hit her head on the floor and that it was normal for the resident to be confused; she was consequently assessed in the acute sector as someone who was confused at all times. Nursing staff confirmed that she was intermittently confused and her Mental Test Score on 18 August 2012 was 30/30.

A further incident record reviewed was completed in a highly subjective manner by nursing staff and somehow portrayed the resident's self report of a fall as invalid.

A 90 year-old resident with a history of intermittent confusion was cited as the witness to one fall, clearly establishing that the location, a high-dependency day room was unsupervised by staff at the time of the fall. Vulnerable residents were seen to be unsupervised by staff at peak activity times, these times equated to the times of previous falls as identified on the accident and incident records.

A further dependent resident on 3 September 2012 was noted to have a swollen, bruised and painful right arm. Medical care was sought but the person in charge confirmed that while she was aware of the injury this was not viewed as an adverse incident and there was no evidence to support that the cause of the injury was investigated. The discharge summary from the acute sector noted that no information was available as to the genesis of the injury.

These findings are not conducive to the robust management and review of accidents and incidents and do not ensure that residents are protected, appropriately reviewed, assessed and treated post injury. The findings were discussed with the person in charge who was aware of some but not all of the findings; she said that she had spoken with staff in relation to their standard of documentation.

The centre-specific falls management policy was not implemented in practice and was signed as read and understood by twenty staff; no staff member had signed post March 2012.

11. Action required from previous inspection:

The provider shall ensure that equitable access to timely and appropriate medical care by a medical practitioner is facilitated for each resident so that each resident is supported on an individual basis to achieve and enjoy the best possible health.

Progress had been made to resolve this matter. However, the findings in relation to medication management practices, specifically the errors noted between the medication prescription records and the administration records, indicate that this progress did not translate into safe medication management practices, primarily due to the fact that nursing staff and not the general practitioner (GP) were generating the prescriptions.

The person in charge told the inspector that the centre had contacted and liaised with each GP since the last inspection and she provided for inspection a record of each resident's medical review history. This record indicated that, with the exception of four residents, medical reviews were current; negotiation of these reviews was ongoing. The inspector cross referenced this record with a sample of residents' records and the records supported current medical review; deficits identified on the last inspection had been addressed.

12. Action required from previous inspection:

The person in charge will ensure that management systems are in place that ensure that all staff are appropriately supervised on a regular basis.

The person in charge will ensure that at all times there are formal systems in place to ensure that care is supervised and monitored by a competent registered nurse so that care and services are delivered in accordance with best practice and the needs of the resident as set out in their plan of care.

Develop and implement a robust staff appraisal system that is appropriate to the specific needs of the centre and addresses issues raised in care and practice. Each staff member is informed of their progress and has an opportunity to rectify limitations and develop capabilities and strengths.

Provide staff members with access to education and training to enable them to meet the needs of the residents and provide care in accordance with contemporary evidence-based practice.

The action was not resolved and there was evidence of deterioration. Rosters demonstrated that recently on the night of 5 September 2012 only one staff nurse had been available to provide care, supervision and clinical leadership and on another occasion only one staff nurse was available from 15:00hrs until 20:00hrs. On the day of the inspection there was again only one nurse available from 08:00 hrs necessitating the person in charge to undertake nursing duties until after 12:00hrs when a second nurse was sought and available for duty. Given the size and layout of this premises and the number and dependency levels of the residents this is not acceptable.

One new nurse commenced work on the day of the inspection. The contracted manager has indicated that this person will also take up the role of key senior manager in the absence of the person in charge. The contracted manager also informed inspectors that a new clinical nurse manager had been recruited and is due to commence employment in the weeks following the inspection. The inspectors therefore cannot make any finding in relation to the benefit or outcome of this plan at this time and the findings in relation to staffing and skill-mix are based solely on the findings at the time of inspection which were not acceptable.

There was no evidence of supervision or governance of staff. The contracted manager stated that an appraisal system had been implemented insofar as staff had been issued with appraisal forms to complete and return. However, while acknowledging some difficulties with staff performance as outlined in a number of inspections there was no procedure implemented to address these and take appropriate safeguarding action in a timely manner.

There was no evidence that staff were being adequately monitored on a daily basis or that care delivery on a day-to-day basis was being supervised. Based on the inspection findings inspectors were satisfied that there was an over-dependence on

documentation such as the care delivery records as evidence of care delivered but not of the accuracy of the content or completion of the records by staff or any clarification that the care was actually implemented. This was further impacted upon by the nursing staff shortages, the design and layout of the premises and opportunity for the person in charge to supervise care delivery; these longstanding issues have not been satisfactorily resolved.

This conclusion is supported by the findings in relation to falls, medication management, the non-use of supportive equipment such as call bells, hip protectors, pressure-relieving cushions, footstools and diversional interventions for residents who required them due to their risk of falls and frailty but were seen not to have them in place, and the lingering confusion as to responsibility for ensuring that residents' dietary requirements were in fact and in practice fully adhered to.

A training matrix was provided for inspection and some staff training had been undertaken. Staff had attended fire safety training, elder abuse refresher training and an update of manual handling training. However, the training matrix provided did not correlate with dates seen by inspectors on staff training records. Of concern to inspectors was the impact of training and the learning gained, specifically in relation to fire safety, given the deficits identified. The provider stated that further training in behaviours that challenge and dementia was scheduled for November 2012.

13. Action required from previous inspection:

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.

The person in charge will ensure that all staff receive induction training specific to the needs of the centre, and there is clear evidence of the satisfactory completion of induction.

The provider will ensure that each staff member's file shall include and confirm the terms and conditions of their employment including:

- the date on which they commence and shall cease employment
- the position they hold, the work that they perform, the number of hours for which they are employed each week and any other records in relation to their employment.

Maintain a planned and actual staff rota, showing staff on duty at any time during the day and night. Ensure that rostering arrangements are compliant with all relevant health and safety and employment legislation.

This action was not met and there was evidence of poor and unsafe recruitment procedures. The personnel files of the most recently recruited staff were reviewed

and the inspector found that one staff file held no references whatsoever; one staff file held one reference prior to commencing post and another staff file did not contain any reference from the person's most recent employer. Evidence of Garda Síochána vetting was not available and there was no evidence (other than self declaration) of physical and medical fitness to carry out the work for which they were employed, all as required by the regulations. There was no evidence of verification of the information provided in the available references although the person in charge stated that she had undertaken this.

There was an induction plan in place but its constructive implementation could be seen to have been impacted upon by the overall shortage of staff.

A new staff member was on induction on the day of inspection with a depleted nursing complement and this had also occurred on another day scheduled for the induction of another newly recruited staff member. This is not satisfactory and would significantly impact on the permanent/experienced nurse's ability to provide adequate and effective induction while also responsible for the provision and supervision of care to forty residents.

14. Action required from the previous inspection:

The provider shall ensure that all the written operational policies and procedures of the designated centre are reviewed in line with best practice, regulatory and legislative changes and any recommendation made by the Chief Inspector. Ensure that all policies have a current evidence base, are centre-specific, have a clear implementation date and clearly set out for staff centre-specific roles, responsibilities, procedures and reporting mechanisms.

The person in charge will ensure that staff have available to them, are familiar with and implement all policies and procedures in practice to guide and inform a high standard of evidence-based nursing practice. There is clear evidence of this.

This action was not met. The provider had been given a completion timeframe by the Authority of 16 November 2012. Of concern to inspectors was that while there was evidence of policy review this did not translate into improvements in care and practice as policies were not implemented. A significant example of this was the area of medication management where the implementation of a new policy and practice resulted in poorer findings and practice in relation to the transcribing of medications. Further examples were ongoing deficits in falls prevention and management, recruitment procedures, the management of accidents and incidents and end-of-life care. The policy on the prevention, detection and management of abuse had not been reviewed as requested.

15. Action required from previous inspection:

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

The provider shall ensure that an accurate record is maintained in a safe and accessible place, of each drug and medicine administered in respect of each resident, giving the date of the prescription, dosage, name of the drug or medicine, method of administration, signed and dated by a medical practitioner and the nurse administering the drugs and medicines in accordance with any relevant professional guidelines.

The provider shall ensure that each resident benefits from his/her medication to maintain their health and quality of life. The provider shall ensure that the resident by virtue of adequate review or assessment does not suffer unnecessarily from excessive, unrequired, inappropriate or inadequate medication treatment regimes.

This action was not met and the inspection findings supported deterioration with evidence of poor and unsafe medication management practices. A new medication management policy was in place dated 5 September 2012 as was a new system for recording the administration of medications; this was supplied to the centre by the pharmacy. However, the inspector found that practice was not in line with nursing regulatory body guidelines or local policy. The newly implemented policy stated that transcribing was not allowed under any circumstances and it was the responsibility of the GP to write or computer generate the medication prescription sheet; however, nursing staff spoken with confirmed that they generated (transcribed) the prescription sheets on the computer. This was not evident from the prescription record nor was there any evidence of a risk-reducing double-checking system. Numerous errors were noted on a random sample of three residents' medication prescription and administration records reviewed. These included:

- one resident had two prescription sheets in place, one being an original and the other a photocopy of the original, yet both had different medications added to them on the same day; nursing staff spoken with had no rationale for this
- a transcribed prescription record stated that the medication prescribed was Tegretol but the administration sheet stated that Tegretol Retard, the controlled release form of the drug was administered to the resident
- discontinued medications were not signed and dated as such and one resident received a discontinued medication for a further forty-eight hours following its discontinuation
- one medication prescribed to be administered in the morning was dispensed to be administered and was administered at night-time
- the route of administration, the dosage and the maximum dosage were not at all times stated. One generated prescription stated that the resident was

prescribed Largactil 25mg/ml PRN; the medication administration sheet stated that the resident was to receive Largactil 2.5% 2ml injection PRN

- a combination of both trade and generic names were interchangeably used
- the inspector saw a mortar and pestle and a medication crushing device both of which were confirmed to be in use by nursing staff. The former was made of wood, worn and porous; the latter contained a significant amount of medication residue and indicated a risk of medication interaction/ contamination.

It was of serious concern to inspectors that one resident following medical review was prescribed an antibiotic for an acute infective process but was not supplied with and administered that medication for a further 19 hours. This was confirmed by the person in charge.

16. Action required from previous inspection:

Ensure that there are adequate and appropriate agreed policies, protocols and procedures in place for the admission and discharge of residents to and from the designated centre to ensure appropriate continuity of care and that residents are admitted and discharged in a planned and safe manner.

There is clear policy and procedure to ensure that all relevant information about each resident who is temporarily absent from the designated centre for treatment at another designated centre, hospital or other place, is provided to the receiving designated centre, hospital or other place.

Inspectors reviewed one element of this action; the information provided to admitting/treating facilities when residents were temporarily absent from the centre. Improvement was noted in that a centre-specific nursing transfer letter was in place and a copy was retained in the resident's record. However, inspectors were not satisfied that all relevant information and accurate information about the resident was exchanged. The potential risk in relation to adequate and appropriate assessment and treatment of the resident had been discussed in the report in relation to falls.

17. Action required from previous inspection:

Put in place written operational policies and protocols for end-of-life care that are centre specific and clearly outline adequate arrangements for the provision of end-of-life care so that it does not unreasonably infringe upon the wishes, rights, privacy and dignity of other residents.

The person in charge shall ensure, where there is no option but to provide end-of-life care in shared accommodation that the physical, emotional and psychological needs of all residents, and where appropriate their representatives, are respected and adequately responded to. Policy clearly addresses this.

This action was partially addressed.

The end-of-life policy was reviewed and found to be comprehensive, encouraged consultation, decision making, symptom management and palliative care if appropriate. It also cited the importance of offering choice of accommodation for residents at this time and that where possible single rooms would be made available. Policy also stated that the mortuary was available for use if necessary and outlined a reasonable timeframe for the removal of residents' remains.

Works have not been completed to make the mortuary completely suitable and the contracted manager was forthright about this, but basic facilities were available and works were ongoing.

Inspectors examined a number of care plans and found that despite the policy endorsement of discussion and consultation the end-of-life wishes and preferences of residents were not addressed in any meaningful way regarding this. For example, the only reference to this aspect of care in three care plans reviewed was a statement that family members would make "the funeral arrangements". Planning for appropriate response and intervention in the event of death was also of concern. Inspectors saw that a resident's medical record stated that following consultation with family members a decision had been taken by clinicians that resuscitation would be futile and was not to be used in the event of a sudden deterioration. The person in charge was not aware of this and it was not addressed in the nursing care plan and therefore no explicit instructions had been given to staff as to how to manage the sudden or unexpected death of the resident.

The substantive issue of the needs and wishes of the other residents in shared accommodation had not been adequately addressed. A resident had passed away in one of the shared bedrooms. While the remains had been removed in a timely manner inspectors found no reference whatsoever in the other resident's daily or nursing record to the fact that a death had occurred in the resident's private accommodation or what discussion or reassurance had been provided to the resident in what was both a disruptive and possibly emotionally and psychologically upsetting event for the other resident.

18. Action required from previous inspection:

Put in place and ensure that staff implement at all times written operational policies and procedures relating to the health and safety, including food safety, of residents, staff and visitors. Staff receive relevant training in it.

Ensure that all inspection reports are maintained and made available at all times for inspection and monitoring purposes.

This action was partially met. As outlined in the provider's response to the action plan a new catering supervisor had been recruited and was employed to work four days per week.

The most recent environmental health officer's (EHO) report dated 28 August 2012 was made available for inspection and was seen to make a number of recommendations. The contracted manager had responded to this and informed the inspectors that they intended and had made plans to comply with the requirements as outlined including the provision of new equipment.

Although staff were implementing the food safety management systems they still did not demonstrate a sound knowledge of the required outcomes and risk factors.

19. Action required from previous inspection:

The person in charge shall ensure that each resident is provided with food and drink in quantities adequate for their needs, which is properly prepared, cooked and served; is wholesome and nutritious; offers choice at each mealtime; is varied and takes account of any special dietary requirements; and is consistent with each resident's individual needs.

Provide appropriate assistance to residents who, due to infirmity or other causes, require assistance with eating and drinking. Assistance is offered discreetly, sensitively and individually.

The person in charge shall ensure that meals are unhurried social occasions and staff participate in and view mealtimes as an opportunity to communicate, engage and interact with residents.

Provide meals, collations and refreshments at times as may reasonably be required by residents.

Implement comprehensive and effective policy and practice for the monitoring and documentation of residents' nutritional and fluid intake.

This action was partially resolved. Practice in relation to residents with particular dietary requirements, swallow care plans, those requiring nutritional support and therapeutic diets had improved since the concerning findings of the last inspection. Inconsistencies continued, however, and practice required ongoing monitoring to ensure that improvement was sustained and residents received the required care and nutritional support. As previously discussed in the report there was also evidence to support that there were lingering problems with the quality of meals in general and residents' access to snacks and refreshments at times of their choosing and preference.

A dietician had been sourced and assessed the residents using a recognised nutritional screening tool. The person in charge informed inspectors that this process had identified seven further residents as requiring additional nutritional support. On the day of inspection 17 of the 40 residents, approximately 42%, were in receipt of prescribed nutritional supplements. Revised dietary plans were being implemented on the day of the inspection. These were comprehensive and in the main the information between nursing and catering staff correlated but catering staff spoken

with were still confused as to their role and responsibilities in implementing the nutritional regime. For example, there was an instruction in the revised documentation for the catering staff to fortify certain foods by the addition of specific supplements. The catering staff did not know this, however, and were very clear that following the findings of the previous inspection of 15 August 2012, all nutritional additives with the exception of fresh cream were the responsibility of the nursing staff to administer and add to residents' meals.

The person in charge stated that she had informed the kitchen staff of the arrangements in place and that the new catering supervisor was aware of them. However, the catering supervisor worked four days per week, the information did not appear to have been communicated in his absence, and therefore the governance arrangements in his absence were vital to ensuring consistency of care and practice. Clarity and consistency regarding the responsibility for tasks must be assured if residents' dietary needs and requirements are to be met in a sustained manner.

Inspectors observed an improvement in the availability of fresh fruit and vegetables for residents.

Improvements were also noted in the layout of the dining rooms and the dayroom in the Orchard wing to make them more comfortable and inviting. Seven residents were still required to have their meals in the dayroom by virtue of the fact that the steps to the dining room made it inaccessible to them. With the exception of the labelling of dependent residents as "feeders" the inspectors did not on this occasion observe poor staff practices while staff were providing assistance to residents at mealtimes.

Report compiled by:

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

4 October 2012

Chronology of previous HIQA inspections	
Date of previous inspection:	**Type of inspection:**
21 September 2010	☐ Registration ☐ Scheduled ☐ Follow-up inspection ☒ Regulatory Monitoring ☐ Announced ☒ Unannounced
2 February 2011 and 3 February 2011	☒ Registration ☐ Scheduled ☐ Follow-up inspection ☒ Announced ☐ Unannounced
24 May 2011	☐ Registration ☐ Scheduled ☒ Follow-up inspection ☐ Announced ☒ Unannounced
22 July 2011	☐ Registration ☐ Scheduled ☒ Follow-up inspection ☐ Announced ☒ Unannounced
7 February 2012 and 8 February 2012	☐ Registration ☐ Scheduled ☒ Follow-up inspection ☒ Announced ☐ Unannounced
29 May 2012, 30 May 2012, 1 June 2012 and 5 June 2012	☐ Registration ☐ Scheduled ☒ Follow-up inspection ☐ Announced ☒ Unannounced
15 August 2012 and 16 August 2012	☐ Registration

	☐ Scheduled ☒ Follow-up inspection ☐ Announced ☒ Unannounced

Health Information and Quality Authority
Social Services Inspectorate

Action Plan

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

Provider's response to inspection report *

Centre:	Melview House Nursing Home
Centre ID:	0250
Date of inspection:	24 September 2012
Date of response:	19 October 2012

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: Practices in relation to protection were again found not to be robust.
Action required: Review, amend, agree and implement a policy and procedures for the prevention, detection and response to abuse based on the recommendations of inspection findings.
Action required: The provider shall ensure that all reasonable measures are in place to ensure that each resident is safe in the centre from all forms of harm or abuse, neglect or acts of omission, through deliberate intent, negligence or ignorance by others. All staff including management are aware of and implement these measures at all times.

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

Protective measures are explicitly outlined, communicated, implemented and evaluated.	
Reference: Health Act, 2007 Regulation 6: General Welfare and Protection Regulation 17: Training and Staff Development Standard 8: Protection Standard 24: Training and Supervision	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response:	
Staff recruitment policies and practices will adhere to current legislation and best practice.	Immediate
Updated policy on abuse implemented and will be evaluated at management meetings.	Ongoing
Training plan to include abuse and protective measures instigated.	31 October 2012

2. The provider has failed to comply with a regulatory requirement in the following respect: Regardless of intent there was evidence of lingering de-personalised staff attitudes and behaviours in their interactions with residents.	
Action required: Facilitate, by means of education and supervision, all staff to have up-to-date knowledge and skills to allow them to respond to and manage all residents and specifically those residents who exhibit behaviour that is challenging in a manner that promotes positive person-centred outcomes for residents. Management strategies are based on staff knowing and understanding each resident, their biography and behaviours and the benefit of positive communication and person-centred interventions.	
Reference: Health Act, 2007 Regulation 6: General Welfare and Protection Regulation 10: Residents' Rights, Dignity and Consultation Standard 18: Routines and Expectations Standard 20: Social Contacts Standard 21: Responding to Behaviour that is Challenging	
Please state the actions you have taken or are planning	**Timescale:**

to take with timescales:	
Provider's response: All staff are trained to treat residents with dignity and respect, and all interaction is person-centred.	Ongoing
Further training in communicating and dignity and respect of residents will be undertaken.	16 November 2012
Recent protection issues will be alluded to in further abuse training.	1 November 2012
The practice of using body fluid bags to improve elderly clients CO2 levels and for spirometery measurement is practised by physiotherapists in the acute setting.	Completed
Two training sessions of responding to challenging behaviour have been completed.	20 October 2012

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

The physical design and layout of the building is not suitable for its stated purpose. It does not meet the residents' individual and collective needs.

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.

Action required:

Maintain the equipment, including passenger lifts for use by residents, people who work at the designated centre and all other persons in good, safe working order. There is written confirmation of this from a competent person.

Reference:

Health Act, 2007
Regulation 19: Premises
Regulation 31: Risk Management Procedures
Standard 25: Physical Environment
Standard 26: Health and Safety
Standard 28: Purpose and Function

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: Deficits in the design and layout of the centre will be addressed with the provision of the planned temporary unit. There is written confirmation from a competent person that the lift is in good and safe working order.	 November 2012 Completed

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

The inspectors were not satisfied that proactive risk management was a key component of the governance of the centre.

Action required:

Ensure that the risk management policy and register 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. The assessment of risks includes all areas of work and work practices. Ensure that all staff adhere to the implementation of the identified controls.

Action required:

Review the findings of the risk assessments and the controls identified to reduce, control or eliminate the risks to residents, staff and visitors. Identify and implement the remaining controls and review and amend as required the adequacy of all controls.

The risk assessments are dynamic and are reviewed, amended and updated on an ongoing basis as required.

Action required:

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

Action required:

Ensure that all residents have access at all times to a readily accessible and properly functioning call-bell system.

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: Appointed health and safety representative will receive training in Health and Safety and Risk Management. Risk assesments will be updated to include risks identified and risks in all areas of work and work practices. Risk assessment findings will be reviewed and amended as required and centre-specific learning outcomes will be identified and corrective actions implemented.	 7 November 2012 10 November 2012 10 November 2012

5. The provider has failed to comply with a regulatory requirement in the following respect: Deficits and risks were identified in fire safety and fire evacuation procedures.
Action required: The provider shall ensure that, in consultation with the relevant fire authority, there is safe egress (adequate means of escape) from all areas of the premises in the event of fire or other such emergency. The provider shall ensure that all means of egress are appropriately maintained and fit for purpose.
Action required: The provider shall ensure by means of fire drills and fire practices at suitable intervals, that the staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire, including the procedure for evacuation and saving life.
Action required: The provider shall ensure that where risks are identified and brought to the attention of the provider, including deficits in staff fire safety knowledge, all reasonable measures are taken to ensure the safety of residents and other persons in the centre in the event of fire.

Reference: Health Act, 2007 Regulation 32: Fire Precautions and Records Standard 26: Health and Safety	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response:	
Request sent to the fire authority to inspect the centre.	Completed
Identified means of egress has been repaired.	Completed
Fire drills are practised at suitable intervals.	Ongoing
A competent person in fire safety has inspected the centre and a training plan in fire safety based on his findings is arranged for staff.	1 November 2012

6. The provider has failed to comply with a regulatory requirement in the following respect: There were strong indicators of the absence of a robust and meaningful system of quality assurance.
Action required: Establish and maintain an effective system of quality assurance for improving the quality and safety of care provided at, and the quality of life of residents in, the designated centre.
Action required: The provider shall ensure that issues raised individually by residents or by the residents' representative group are acknowledged, responded to and recorded, including actions taken in response to issues raised. Action taken in response to the issues raised clearly demonstrates change and improvement on all matters significant to and affecting the quality of life of the resident. Where there is evidence of continued deficits and poor outcomes for residents these are clearly dealt with.
Action required: The person in charge shall collect and audit clinical and non-clinical data for the purposes of ongoing quality monitoring and continuous improvement and take appropriate action in response to any findings of concern.

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: Quality assurance systems in place include resident surveys, internal audits, data collection, residents' advocates' survey, quality of life survey, residents' forum, staff meetings. Deficits identified will be addressed and corrective action plan implemented.	 In place 1 November 2012

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

The findings did not support the operation of a transparent, adequately managed, objective and effective complaints management system, or that complaints were welcomed and viewed as a valuable source of reflection, learning and continuous improvement.

Action required:

The person in charge will ensure that all complaints and comments are fully recorded, investigated and explored with staff for feedback and future learning. Measures required for improvement that are in line with best practice and are evidence based are identified, implemented and evaluated and there is clear evidence of this.

Action required:

Inform complainants promptly of the outcome of their complaints and details of the appeals process. Maintain a record detailing the investigation and outcome of the complaint and whether or not the complainant was satisfied.

Action required:

Ensure that the centre provides an environment that is conducive to residents, staff, family members, advocates and visitors being able to raise issues and complaints verbally and in writing in a spirit of openness and partnership and without fear of dismissal of their concerns or of adverse consequences.

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 are responded to as per the complaints policy, all complaints are welcomed and viewed as an opportunity for learning and improvement.	Ongoing

8. The person in charge has failed to comply with a regulatory requirement in the following respect: Inspectors identified ongoing deficits and were not satisfied that care plans and care delivery records presented as one integrated and consistent plan and record of care that actually ensured each resident received the care that was required and planned for.
Action required: The person in charge will ensure that the care plan is based on an accurate, current comprehensive evidence-based nursing assessment, reflects the assessment findings, the resident's actual needs and sets out in detail the action to be taken by staff for each individual resident, thereby ensuring the provision of suitable and sufficient care.
Action required: The care plan and supporting risk assessments are re-evaluated and updated in a timely and safe manner as indicated by the residents' changing needs and significant events. All elements of the care plan, assessment, planned care, and carers' care delivery record are clearly understood and communicated to staff and demonstrate an integrated, consistent and safe plan of care.
Action required: The person in charge shall ensure that the standard of care planning and nursing documentation is the subject of regular audit. There is clear evidence of this.
Action required: Provide each resident with a high standard of evidence-based nursing practice.

Action required:

Put in place suitable and sufficient care to maintain each resident's holistic welfare and wellbeing, having regard to the nature and extent of each resident's dependency and needs.

Reference:

Health Act, 2007
Regulation 6: General Welfare and Protection
Regulation 8: Assessment and Care Plan
Regulation 9: Health Care
Standard 13: Healthcare
Standard 11: The Resident's Care Plan
Standard 10: Assessment
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: Multi-disciplinary team approach to compiling care plans is adapted. Care plans and risk assessments are re-evaluated in response to residents' changing needs to maintain residents' holistic welfare and wellbeing. Residents' care needs and plans are communicated to care staff by nurse handover report, communcation book, MDT meetings, staff meetings and supervision. Implementation of the planned care is supervised by: (1) allocated nurse who supervises HCAs (2) members of management team who supervise care delivered by care team. Specific care planning training completed by all nurses, additional care planning training will be undertaken.	 In place and ongoing Completed and ongoing 1 November 2012

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

Failing to have necessary arrangements and all reasonable measures in place aimed at preventing residents from being harmed or suffering injury or being placed at risk of harm or injury from falls.

Action required:

The person in charge will ensure that all staff are familiar with, adhere to and implement the centre-specific, evidence-based falls prevention and management programme.

Action required:

Put in place appropriate systems/interventions and plans of care aimed at preventing residents being harmed or sustaining injury or being placed at unnecessary risk of accident and injury. There is clear evidence of their consistent implementation.

Action required:

Put in place appropriate and effective arrangements for reviewing serious or untoward accidents, incidents or adverse events involving residents including falls. The review identifies patterns and trends, any findings of concern, the required improvements and informs care and practice to avoid repeat occurrences.

Reference:

Health Act, 2007
Regulation 6: General Welfare and Protection
Regulation 35: Review of Quality and Safety of Care and Quality of Life
Regulation 31: Risk Management Procedures
Standard 26: Health and Safety
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:	
Falls management training planned based on the centre-specific policy.	14 November 2012
Falls management plan of care based on best practice interventions implemented resulting in dramatic reduction in number of falls.	Ongoing
Data collection and reviews of adverse incidents are in place to improve care and avoid repeat occurences.	Ongoing

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

Given the size and layout of this premises and the number and dependency levels of the residents adequate staffing and skill mix were not maintained at all times.

There was no evidence of supervision or governance of staff.

Action required:

The person in charge will ensure that the numbers and skill mix of staff are at all times appropriate to the assessed needs of residents, and the size and layout of the designated centre.

Action required:

The person in charge will ensure that management systems and adequate staffing are in place which ensure all staff are appropriately supervised on a regular basis.

Action required:

The person in charge will ensure that at all times there are formal systems in place to ensure that care is supervised and monitored by a competent registered nurse so that care and services are delivered in accordance with best practice and the needs of the resident as set out in their plan of care. These systems clearly identify deficits and omissions in care and the recording of care; corrective action is taken where deficits are identified.

Action required:

Develop and implement a robust staff appraisal system that is appropriate to the specific needs of the centre and addresses issues raised in care and practice. Each staff member is informed of their progress and has an opportunity to rectify limitations and develop capabilities and strengths. The appraisal system clearly establishes that staff have the required competencies to fulfil their role; a corrective plan is in place to address any findings of concern.

Action required:

Provide staff members with access to education and training to enable them to meet the needs of the residents and provide care in accordance with contemporary evidence-based practice. An evaluation of comprehension and learning is undertaken post training to establish that staff are suitably confident to carry out their role.

Reference:

Health Act, 2007
Regulation 16: Staffing
Regulation 17: Training and Staff Development
Standard 23: Staffing Levels and Qualifications
Standard 29: Management Systems

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: Staff roster now includes planned on-call staff to cover absent staff. Management supervision of staff in place. Nurse supervision formalised to ensure care delivery in accordance with best practice. Staff appraisals, training needs identified, performance development plans in place for all staff. Preformance improvement plan in place for staff who are not performing to required standard.	 25 October 2012 Ongoing 1 November 2012 1 December 2012

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

Recruitment practice was not compliant with the Regulations; there was evidence of poor and unsafe recruitment procedures.

Staffing shortages did not facilitate the effective induction of new staff.

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.

Action required:

The person in charge will ensure that adequate arrangements are in place to ensure that all staff receive effective induction training specific to the needs of the centre, and there is clear evidence of the satisfactory completion of induction.

Action required:

The provider will ensure that each staff member's file shall include and confirm the terms and conditions of their employment including:

- the date on which they commence and shall cease employment
- the position they hold, the work that they perform, the number of hours for

which they are employed each week and any other records in relation to their employment.
Reference: Health Act, 2007 Regulation 18: Recruitment Regulation 16: Staffing Standard 23: Staffing Levels and Qualifications Standards 22: Recruitment

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Recruitment procedures will comply with Schedule 2. Satisfactory induction training will be put in place. Staff files will include and confirm terms and conditions of employment.	 Immediate Immediate and ongoing Immediate

12. The provider has failed to comply with a regulatory requirement in the following respect: While there was evidence of policy review this did not translate into improvements in care and practice as policies were not implemented.
Action required: The provider shall ensure that all written operational policies and procedures of the designated centre are reviewed in line with best practice, regulatory and legislative changes and any recommendation made by the Chief Inspector. Ensure that all policies have a current evidence base, are centre-specific, have a clear implementation date and clearly set out for staff centre-specific roles, responsibilities, procedures and reporting mechanisms.
Action required: The person in charge will ensure that staff have available to them, are familiar with and implement all policies and procedures in practice to guide and inform a high standard of evidence-based nursing practice. There is clear evidence of this.

Reference:

Health Act, 2007
Regulation 6: General Welfare and Protection
Regulation 17: Training and Staff Development
Regulation 27: Operating Policies and Procedures
Standard 29: Management Systems

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Staff will be familiarised with policies and procedures.	14 November 2012

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

The inspection findings supported deterioration with evidence of poor and unsafe medication management practices.

Action required:

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

Action required:

The provider shall ensure that an accurate record is maintained in a safe and accessible place, of each drug and medicine administered in respect of each resident, giving the date of the prescription, dosage, name of the drug or medicine, method of administration, signed and dated by a medical practitioner and the nurse administering the drugs and medicines in accordance with any relevant professional guidelines.

Action required:

The provider shall ensure that each resident benefits from his/her medication to maintain their health and quality of life. The provider shall ensure that the resident by virtue of adequate review or assessment does not suffer unnecessarily from excessive, inaccurate, unrequired, inappropriate or inadequate medication treatment regimes.

Reference:	
Health Act, 2007 Regulation 33: Ordering, Prescribing, storing and Administration of Medicines Regulation 25: Medical Records Standard 13: Healthcare Standard 14: Medication Management Standard 15: Medication Monitoring and Review	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response:	
Medication management policy in place. Staff training in place.	In place
Records will be maintained in accordance with relevant professional guidelines.	Ongoing
Medication is recorded and administered as prescribed. New dispensing pharmacy in place by 12 November 2012	12 November 2012

14. The person in charge has failed to comply with a regulatory requirement in the following respect: Inspectors were not satisfied that all relevant and accurate information about the resident was exchanged when a resident was temporarily absent from the centre.	
Action required: There is clear policy and procedure to ensure that all relevant and accurate information about each resident who is temporarily absent from the designated centre for treatment at another designated centre, hospital or other place, is provided to the receiving designated centre, hospital or other place.	
Reference: Health Act, 2007 Regulation 29: Temporary Absence and Discharge of Residents Standard 10: Assessment	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response:	
Policy in relation to a resident's temporary absence from the centre wll be adhered to.	Immediate

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

The end-of-life policy was comprehensive; end-of-life care, however, was problematic and the wishes and requirements of residents were not addressed in any meaningful way.

Action required:

The person in charge will ensure that all staff are familiar with and implement the centre-specific end-of-life policy. Identify, document and facilitate each resident's end-of-life wishes and preferences unless the resident expressly does not wish to discuss such matters.

Action required:

The person in charge will ensure that decisions regarding resuscitation are clearly documented, signed and dated on the resident's record, integrated into the residents care plan, reviewed as appropriate and effectively communicated to all staff.

Action required:

Following the death of a resident, support is provided to other residents; there is clear evidence of this.

Reference:

Health Act, 2007
Regulation 14: End of Life Care
Regulation 10: Residents' Rights, Dignity and Consultation
Standard 16: End of Life Care
Standard 2: Consultation and Participation

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: Staff will provide end-of-life care as outlined in the end-of-life policy.	Ongoing

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

Catering staff did not demonstrate a sound knowledge of food safety management systems, the required outcomes and risk factors.

Action required:

Put in place and ensure that staff implement at all times written operational policies and procedures relating to the health and safety, including food safety, of residents, staff and visitors. Staff receive relevant training in it so that they have a sound understanding of the requirement for such procedures, the required outcomes, the risks and action to be taken when the required outcomes are not met.

Reference:

Health Act, 2007
Regulation 30: Health and Safety
Regulation 17: Training and Staff Development
Standard 24: Training and Supervision
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: Training in food safety management planned.	1 November 2012

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

Inconsistencies continued in relation to residents with specific dietary requirements; practice required ongoing monitoring to ensure that improvement was sustained and residents received the required care and nutritional support.

There was evidence to support that there were lingering problems with the quality of meals in general and residents' access to snacks and refreshments at times of their choosing and preference.

Action required:

The person in charge shall ensure that each resident is provided with food and drink in quantities adequate for their needs, which is properly prepared, cooked and served; is wholesome and nutritious; offers choice at each mealtime; is varied and takes account of any special dietary requirements; and is consistent with each resident's individual needs.

Action required:

Provide meals, collations and refreshments at times as may reasonably be required by residents.

Action required:

Ensure that there are clearly defined management structures that identify the lines of accountability and that authority specifies roles, and details responsibilities for all areas of activity including support services such as catering staff.

Action required:

Implement and monitor the implementation of comprehensive and effective policy and practice in relation to residents' nutritional and fluid intake.

Reference:

Health Act, 2007
Regulation 20: Food and nutrition
Standard 19: Meals and Mealtimes
Standard 29: Management Systems

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response:	
Food and drink to meet residents' individual needs and at reasonable times required by residents is provided.	Ongoing
Management structures and roles in catering are implemented.	Completed
Nutritional and fluid intake policies and procedures under review.	14 November 2012
Twenty-five staff attended training in food fortification and supplementation.	Completed

Any comments the provider may wish to make:

Provider's response:

The managemenent and staff of Melview Nursing Home are committed to enhancing the care given to residents and continue to focus on quality of life measures that contibute to the wellbeing of all residents. We acknowledge the Authority's guidance with our efforts to continously improve the services offered at Melview Nursing Home.

Provider's name: Dermot Dougan

Date: 19 October 2012