Health Information and Quality Authority
Regulation Directorate

Compliance Monitoring Inspection Report
Designated Centres under Health Act 2007, as amended

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

Centre name:	Asgard Lodge Nursing Home
Centre ID:	0006
Centre address:	Monument lane Kilbride, Arklow Co Wicklow
Telephone number:	0402-32901
Email address:	asgardlodge@yahoo.ie
Type of centre:	☒ **Private** ☐ **Voluntary** ☐ **Public**
Registered provider:	James and Oonagh Tyrrell Partnership, trading as Asgard Lodge NH
Person authorised to act on behalf of the provider:	James Tyrrell
Person in charge:	Andrea Tyrrell
Date of inspection:	6 August 2013
Time inspection took place:	**Start:** 08:30 hrs **Completion:** 18:25 hrs
Lead inspector:	Linda Moore
Type of inspection	☐ **announced** ☒ **unannounced**
Number of residents on the date of inspection:	32
Number of vacancies on the date of inspection:	0

About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by Regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

- Registration: under section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of their registration.

Monitoring inspections take place to assess continuing compliance with the Regulations and Standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or wellbeing of residents.

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.

Summary of compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

This inspection report sets out the findings of a monitoring inspection, in which 11 of the 18 outcomes were inspected against. The purpose of the inspection was:

- ☐ to inform a registration decision
- ☐ to inform a registration renewal decision
- ☒ to monitor ongoing compliance with Regulations and Standards
- ☐ following an application to vary registration conditions
- ☐ following a notification of a significant incident or event
- ☐ following a notification of a change in person in charge
- ☐ following information received in relation to a concern/complaint

The table below sets out the outcomes that were inspected against on this inspection.

Outcome 1: Statement of Purpose	☐
Outcome 2: Contract for the Provision of Services	☐
Outcome 3: Suitable Person in Charge	☒
Outcome 4: Records and documentation to be kept at a designated centres	☒
Outcome 5: Absence of the person in charge	☐
Outcome 6: Safeguarding and Safety	☒
Outcome 7: Health and Safety and Risk Management	☒
Outcome 8: Medication Management	☒
Outcome 9: Notification of Incidents	☒
Outcome 10: Reviewing and improving the quality and safety of care	☐
Outcome 11: Health and Social Care Needs	☒
Outcome 12: Safe and Suitable Premises	☒
Outcome 13: Complaints procedures	☐
Outcome 14: End of Life Care	☐
Outcome 15: Food and Nutrition	☒
Outcome 16: Residents' Rights, Dignity and Consultation	☒
Outcome 17: Residents' clothing and personal property and possessions	☐
Outcome 18: Suitable Staffing	☒

This monitoring inspection was unannounced and took place over one day. As part of the monitoring inspection, the inspector met with residents and staff members. The inspector observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files.

At this inspection, the inspector also followed up on the 10 actions for improvement which were identified at the monitoring inspection of 13 August 2012. These actions included the medication policy, supervision at meal times, screening, risk management and premises issues. Five actions were completed, two actions were partly addressed and ongoing, and three actions were not addressed. These actions

mainly pertained to healthcare and the premises. While the provider and person in charge had addressed most of the issues from the previous inspection, the good practice identified at the previous inspection was not sustained.

During the inspection, the inspector identified two areas of non-compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) which caused significant concern. The provider and person in charge commenced taking action immediately to address the following risks to residents:

- weight loss and the provision of modified consistency diets

Further work was required to address these issues fully.

The provider was aware of the requirements in the *National Quality Standards for Residential Care Settings for Older People in Ireland* which needed to be put in place in relation to the premises by 2015. There were plans to address these deficits in line with the timeframe.

The healthcare needs of residents were mainly met. Residents had access to general practitioner (GP) services and to a range of other health services.

Staff knew the residents well and residents were treated with respect and dignity by staff. Residents said they were very happy in the centre.

The centre was well maintained inside and out.

Areas for improvement identified included:

- medication management
- care planning documentation
- aspects of the premises
- risk management issues
- training records
- fire safety documentation.

These items are discussed in the body of the report and are included in the Action Plan at the end of this report.

Section 41(1)(c) of the Health Act 2007

Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

Theme: Leadership, Governance and Management

Effective governance, leadership and management, in keeping with the size and complexity of the service, are fundamental prerequisites for the sustainable delivery of safe, effective person-centred care and support.

Outcome 3

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

References:

Regulation 15: Person in Charge
Standard 27: Operational Management

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

While the person in charge was a registered nurse and met the criteria set out in the Regulations the inspector was not satisfied that there was adequate management and supervisory arrangements in place. The inspector found that while the person in charge worked full-time in the centre she was not working full time in the post of person in charge instead she was rostered as the nurse on duty delivering nursing care to residents. While she was rostered as the nurse on duty she was unable to carry out her managerial role. As a result the inspector was concerned that the identified non-compliances in relation to healthcare as outlined under Outcome 11 as well as medication management and cleaning issues identified under Outcome 12 could be as a result of inadequate management and supervision.

Apart from restraint training, a nutrition conference and a leadership programme for directors of nursing, the person in charge said that due to having to work on the floor she had not had the time to keep her-self up-to-date on clinical matters since the previous inspection.

The person in charge was supported by the provider and two nurses. One of the nurses deputised for the person in charge in her absence.

She had good knowledge of the Regulations and the Authority's Standards. She demonstrated good communication with her team. She was frequently observed meeting with residents, relatives and staff.

Outcome 4
The records listed in Part 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

References:
Regulations 21-25: The records to be kept in a designated centre
Regulation 26: Insurance Cover
Regulation 27: Operating Policies and Procedures
Standard 1: Information
Standard 29: Management Systems
Standard 32: Register and Residents' Records

Inspection findings:
**Where "Improvements required" is indicated, full details of actions required are in the Action Plan at the end of the report.*

Residents' Guide

Substantial compliance ☒ Improvements required * ☐

Records in relation to residents (Schedule 3)

Substantial compliance ☒ Improvements required * ☐

General Records (Schedule 4)

Substantial compliance ☒ Improvements required * ☐

Operating Policies and Procedures (Schedule 5)

Substantial compliance ☐ Improvements required * ☒

The inspector found that many of the policies were not guiding practice. For example, behaviours that challenged, falls, medication management and restraint policies. This is evidenced further under Outcome 11.

Directory of Residents

Substantial compliance ☒ Improvements required * ☐

Staffing Records

Substantial compliance ☒ Improvements required * ☐

Medical Records

Substantial compliance ☒ Improvements required * ☐

Insurance Cover

Substantial compliance ☒ Improvements required * ☐

Theme: Safe care and support

Safe care and support recognises that the safety of service users is paramount. A service focused on safe care and support is continually looking for ways to be more reliable and to improve the quality and safety of the service it delivers.

In a safe service, a focus on quality and safety improvement becomes part of a service-wide culture and is embedded in the service's daily practices and processes rather than being viewed or undertaken as a separate activity.

To achieve a culture of quality and safety everyone in the service has a responsibility to identify and manage risk and use evidence-based decision-making to maximise the safety outcomes for service users.

Outcome 6

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

References:

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

Action(s) required from previous inspection:

The action required from the previous inspection was satisfactorily implemented.

Inspection findings

The inspector found that there were some measures in place to protect residents being harmed or suffering abuse. However, not all staff had received training in the protection of vulnerable adults.

The inspector found that all of the staff spoken to on the day of inspection were aware of the types of elder abuse and their responsibilities in reporting suspected elder abuse to the person in charge or provider. This was an improvement from the previous inspection. However, the inspector found that not all staff had received training. There was no system to ensure that all staff requiring training on identifying and responding to elder abuse had received this training.

The inspector reviewed the centre's policy on the prevention, detection and response to elder abuse and found that this policy gave guidance to staff on the types of abuse, the procedures for reporting alleged abuse and the procedures to follow when investigating an allegation of elder abuse.

Residents spoken to confirmed that they felt safe in the centre. They attributed this to the doors being locked and that staff knew their needs well.

Residents personal finances were well managed in line with the policy, this practice had improved from the previous inspection.

Outcome 7
The health and safety of residents, visitors and staff is promoted and protected.

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

Action(s) required from previous inspection:

The risk management policy did not meet the requirements of the Regulations.

Inspection findings

The inspector found that there were systems in place to promote the health and safety of residents, staff and visitors but they required improvement.

There was a health and safety statement in place which had been reviewed and it related to the health and safety of residents, staff and visitors. Some measures were in place to prevent accidents and facilitate residents' mobility, including non-slip floor covering in bathrooms and toilets. However, there were areas for improvement and these included the following:

- Adequate risk assessments had not been undertaken for one resident who smoked to ensure their safety. The resident had a care plan for smoking but it was not up-to-date to guide the care while smoking. This did not include any current supervision arrangements for this resident while smoking.

- Risk assessments and associated manual handling charts had been completed for residents and were retained in residents' files. However, the inspector found that on two occasions during the inspection staff did not use safe moving and handling practices when assisting residents to mobilise.

- Chemicals were observed in the laundry room which was left open, this could be a particular risk to residents who were cognitively impaired. This was addressed during the inspection.

- The inspector observed cleaning chemicals left unattended on a cleaning trolley which may be a risk to residents with a cognitive impairment.

- The inspector found that while there was a risk register in place, it was not kept up-to-date and did not include all risks in the centre.

- There was a risk management policy dated August 2012. The policy did not include the specific risks required by the Regulations including accidental injury, self harm, assault and the arrangements for identification, recording, investigation and learning from serious incidents. This was identified at the previous inspection and had not been fully addressed.

The inspector found that the risks associated with the hot water identified at the previous inspection were addressed.

There was an emergency plan which identified what to do in the event of emergencies such as lost of power and heat. The plan included contingency arrangements for the evacuation of residents from the building in the event of an emergency.

The inspector noted that in the interest of safety and security the centre had a sign in book for all visitors to the centre.

The inspector viewed the fire records and found that they were not maintained appropriately. There were no records to show that the fire equipment and alarms had been serviced. There was also no record that emergency lighting was serviced. The records of the fire equipment and emergency lighting servicing were subsequently submitted to the Authority. The inspector found that all fire exits were clear and unobstructed during the inspection. All staff spoken to knew what to do in the event of a fire and a fire drill had taken place in August 2012, however, there was no evidence that regular fire drills were carried out by staff at suitable intervals as required by the Regulations.

There was no documentary evidence available at the inspection to demonstrate that all staff had received up to date mandatory fire safety training. The inspector viewed the fire training records and found that they were incomplete and not up to date. Almost all staff spoken to confirmed they had received training in June 2013. Records were subsequently submitted to the Authority which showed that fire extinguisher training was carried out in June 2013 for 29 staff. However, additional training was required to bring all staff up to date.

Outcome 8
Each resident is protected by the designated centres' policies and procedures for medication management.

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

Action(s) required from previous inspection:

The action required from the previous inspection was satisfactorily implemented.

Inspection findings

Overall, the inspector found evidence of good medication management practices but there were areas for improvement.

There was a medication management policy in place which provided some guidance to staff. However, this policy was not being adhered to in practice. This policy had been revised since the previous inspection and now included the procedure for the administration of controlled medications. Contrary to the policy a number of issues were identified. The inspector found that the maximum dosage of "as required" (PRN) medication had not been prescribed for two residents. The inspector found that one nurse transcribed a prescription from the original prescription and this was not checked and signed by two nurses. There was no photographic identification for one resident who had been in the centre since June 2013. Medications that were required to be crushed were not individually prescribed.

The inspector identified issues in relation to the safe administration of medication. A nurse signed the administration sheets prior to administering the medications which was unsafe and not in compliance with An Bord Altranais agus Cnáimhseachais na hÉireann (Nursing and Midwifery Board of Ireland) professional guidelines.

While medications that required special control measures were carefully managed and kept in a secure cabinet in keeping with professional guidelines. The practice with regards to checking these medications required improvement. Nurses maintained a register of controlled drugs. Two nurses signed and dated the register, but the stock balance was checked and signed by two nurses from the same shift rather than one from each shift as per professional guidelines and the centre's policy.

The inspector found that each resident's medication was reviewed every three months by the GP. Documentary evidence of these reviews was seen by the inspector.

The system in place to identify, respond and reduce medication errors was not sufficiently robust enough. The pharmacist continued to complete audit on a regular basis however the audits focussed on the medications in use and did not include medication management practices such as administration. Therefore medication

management issues were unlikely to be picked up at audit. There were no areas for improvement at the previous audit.

Outcome 9
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

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

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

Practice in relation to notifications of incidents was not satisfactory. The provider and person in charge were aware of the legal requirement to notify the Chief Inspector regarding incidents and accidents. However, to date all relevant notifications had not been submitted to the Chief Inspector by the person in charge.

The person in charge had failed to notify the Authority of a grade two pressure sore.

Detailed records were maintained of all accidents and incidents. The person in charge monitored incidents as they occurred and discussed these at the handover with staff. Following any incident each resident was reviewed by the GP, nursing staff and physiotherapist if required. Information relating to the incident was readily available and all follow up actions were recorded, dated and signed on the back of the incident report. The person in charge reviewed the reports for each resident to determine the root cause and preventative measures were being taken to prevent a recurrence, such as seating reviews. The inspector found that this process had not taken place when a resident at risk had attempted to leave the centre without supervision in June 2013. There was no evidence that an investigation was completed in the absence of the person in charge. The person in charge informed the Authority that a review of this incident was completed following the inspection. This notification was submitted to the Authority following the inspection.

Theme: Effective care and support
The fundamental principle of effective care and support is that it consistently delivers the best achievable outcomes for people using a service within the context of that service and resources available to it. This is achieved by using best available national and international evidence and ongoing evaluation of service-user outcomes to determine the effectiveness of the design and delivery of care and support. How this care and support is designed and delivered should meet service users' assessed needs in a timely manner, while balancing the needs of other service users.

Outcome 11
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

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

Action(s) required from previous inspection:

Care plans for residents with behaviours that challenged did not adequately guide practice.

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

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

Inspection findings

The inspector found that the residents had diverse needs. The dependencies of residents had increased since the previous inspection and many were highly dependent and required full assistance. A small number of residents were mobile and independent. The inspector found that resident's needs were mainly met however epilepsy care and care planning required improvement. Nutrition management required immediate attention.

The inspector reviewed a number of residents care plans and noted that while care plans had been developed and agreed with residents generally many care plans were not based on the assessed needs of residents and did not guide practice.

Nutrition

There were policies on nutrition and hydration in place but they were not consistently guiding practice. While one resident at risk was reviewed by the dietician in June and weight had increased, not all residents identified at risk of malnutrition were assessed. The inspector noted that malnutrition universal screening tool (MUST) to assess resident's risk was incorrectly completed for two residents. One assessment was not updated since January despite ongoing weight loss. The inspector noted that three residents had lost a significant amount of weight in 2013 and were not referred for review to the dietician. While these residents were receiving supplements they continued to lose weight. One resident had lost 9kg since February 2013, another lost 6kg since February and a further resident lost 5kg since May 2013. As well as not being referred to the dietician there was no plan to manage the weight loss. There was no system to monitor these residents daily food intake. The person in charge informed the Authority that the dietician would visit the centre on 12 August 2013 to commence a review of all residents.

Epilepsy Care

There were three residents in the centre who had this condition. Two of these residents had ongoing seizures and required specific care in relation to their condition. There was no policy or procedure to guide staff in the management of epilepsy. There was no nursing assessment for any resident who had a diagnosis of epilepsy. There was no care plan or guidance for staff in relation to the management of this medical condition during and after seizures. There was no guidance for staff in responding to any potential complications or for recording epileptic activity to guide future interventions.

Falls Prevention and Management

The inspector read the policy on falls prevention and management and found that the policy did not adequately guide staff practice. There were a low number of falls and interventions had been implemented to minimise the risk of falls such as seating and supervision of residents. However, care plans that were in place for some residents identified at high risk of falling were not sufficient to guide care provision. The inspector found that residents' care plans were not updated with interventions to reduce the likelihood of reoccurrence. This was raised at the previous inspection and was not addressed.

Behaviours that Challenged

There were six residents who presented with these behaviours. Staff interacted well with these residents and detailed the plans to manage the residents' behaviour. However, one resident with these behaviours did not have a care plan to guide care. While there were care plans for another resident they were not specific to guide the care delivered. For example, the care plans did not include the use of prescribed PRN medication to manage the residents' behaviour as per the policy. While staff completed an ABC (antecedent, behaviour, consequence) chart to record incidents of behaviour that challenged, this documentation was not completed when the resident required a PRN medication to manage the behaviours.

Wound Care
There were one pressure ulcer in the centre. There was a wound management policy which guided staff in the prevention and management of wounds. The resident's wound was being managed in accordance with the centres policy. There was access to expertise in the area of wound care. However, all staff were not knowledgeable on the use of pressure relieving equipment. The inspector noted that the pressure relieving mattress had been incorrectly set for two residents. The person in charge informed the Authority that this was addressed following the inspection.

Restraint
There was good practice in the management of restraint, however, while the policy generally guided the care there were areas for improvement. There was no up-to-date record of any restraint used and the duration. The inspector found that assessments had been carried out and all risks associated with the use of the bedrail had been considered and documented. However, the records did not consistently include the specific alternative strategies that had been tried prior to the use of bedrails. The inspector reviewed a sample of care plans for residents who used restraint and found that overall they did not provide guidance to staff. For example, one resident required a lap belt which was prescribed by the occupational therapist (OT). However, there was no care plan to include the specific interventions in place for this resident.

The inspector found that there was access to medical practitioners. Residents also had access to chiropody services. The dentist had recently visited residents.

Residents had opportunities to participate in meaningful activities, appropriate to their interests and preferences. A programme of activities was widely displayed and residents spoken to commented on the various activities available to them. Activities included exercise programmes, bingo and Sonas (a therapeutic activity that is completely focused on communication). However, the inspector noted that the hairdresser's visiting the residents was advertised as 'an activity'. As a result while the hairdresser attended to residents, no other activity was scheduled. The inspector observed on the morning of the inspection that if residents who were not having their hair done sat with nothing to do. There were mixed reviews from residents about the activity provision. Some residents spoken to confirmed that they liked to sit and not get involved and that was their choice while others said they loved the chat when staff have the time, but would like to see more happening during the day. The inspector observed a number of residents sitting for long periods with nothing to do.

Outcome 12
The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

References:
Regulation 19: Premises
Standard 25: Physical Environment

Action(s) required from previous inspection:

The number of assisted toilets and showers did not meet the needs of residents.

There were inadequate staff changing facilities.

There was a lack of storage space.

The four-bedded room did not meet residents' needs for privacy, leisure and comfort or comply with the National Standards.

Inspection findings

The physical environment in the centre still did not meet the needs of current residents or the requirements of the Regulations. The providers informed the inspector that they were aware of the requirements in the Authority's Standards which needed to be put in place in relation to the premises by 2015. Planning permission was currently being sought.

The number of assisted toilets and showers still did not meet the needs of residents in the older part of the centre. There was one assisted shower room available in the centre, which contained a walk in shower, an assisted toilet and a wash-hand basin. An additional bathroom included a bath, toilet and sink but the toilet facilities were not used routinely by residents. There were an additional two showers for independent residents.

The inspector found that due to the limited number of showers and toilets in the older part of the centre, 18 residents used the one assisted shower and toilet. Staff explained that a routine was in place rather than resident choice whereby four residents showered per day due to the limited access to the showers. However, residents said they were satisfied with the access to the showers.

Residents' accommodation was provided over two floors. An extension was built in 2008 which included twelve single en suite bedrooms. Most of the bedroom accommodation apart from the four-bedded room met residents' needs for privacy, leisure and comfort. The inspector found that the four bedded room was 30M², staff said they had difficulty assisting residents and using assistive equipment in this bedroom. The provider said they had a plan to reduce this bedroom to a two bedded room by 2015. There is a lift which provided access to each floor.

While the screening had been improved in the twin bedrooms, adequate screening curtains were still not in place in the four bedded room. This had been an action from the previous inspection.

A variety of communal day and dining space was provided. There was no smoking room but residents could smoke in the conservatory.

There was inadequate storage space provided, the inspector observed that equipment and assistive devices such as hoists were stored in bedrooms.

There were inadequate staff changing facilities and all staff including the catering staff changed in the staff toilet due to the lack of changing facilities.

There was no cleaners' room in the centre; therefore, cleaning equipment was stored in a store room. As this room was not appropriately ventilated to the external air, staff prepared the cleaning materials and filled mop buckets in the laundry room which may have an impact on infection control.

Overall, during this inspection the inspector found that the premises were not clean and well maintained. The chairs that residents sat on were not cleaned to an appropriate standard. Bathrooms and floors were in a poor state of cleanliness throughout. There was no evidence of cleaning rotas in place since November 2012. The inspector observed a used commode in a resident's bedroom. Staff attributed this to the limited number of hours allocated to domestic staff to clean the centre daily. The provider said she would review the cleaning hours and rotas. The person in charge informed the Authority that the hours of cleaning were increased following the inspection. The new cleaning rota was also submitted.

There was a sluice room with a bedpan washer and a small laundry room which was sub divided into two rooms to ensure that clean and soiled laundry would be segregated at all times. The provider said the laundry room would be addressed in the renovation project.

The inspector observed that the residents had direct access to a safe and secure garden which was maintained to a very high standard. Ample car parking was provided for relatives and staff.

The kitchen was found to be well equipped. The inspector observed a plentiful supply of fresh food.

Staff were knowledgeable on hand hygiene practices and universal precautions and were observed to wash their hands regularly during the inspection.

Theme: Person-centred care and support
Person-centred care and support has service users at the centre of all that the service does. It does this by advocating for the needs of service users, protecting their rights, respecting their values, preferences and diversity and actively involving them in the provision of care. Person-centred care and support promotes kindness, consideration and respect for service users' dignity, privacy and autonomy.

Outcome 15
Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discreet and sensitive manner.

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

Action(s) required from previous inspection:

There was inadequate supervision of care for residents who required assistance while eating.

Inspection findings

As well as the issues identified under Outcome 11 relating to nutrition additional issues were identified in this outcome relation to the overall management of nutrition.

Residents' diet sheets maintained in the kitchen were not up-to-date. Information for one resident was incorrect. This was addressed during the inspection.

Kitchen staff and staff who assisted residents with their meals were not aware of these residents' special dietary requirements. Three of the residents were assessed by the speech and language therapist (SALT) as requiring a modified consistency diet however, this had not been provided to the residents which could place the resident at risk. This was raised with the person in charge during the inspection. Additional support was provided to the chef in this regard. The person in charge informed the Authority that training in dysphagia, MUST tool and modification diets would take place on 18 September to address the issues raised.

Other aspects of mealtimes also required improvement. One resident was seated in a semi-reclined position during the meal which could place this resident at risk. This was subsequently addressed. This was an issue raised at the previous inspection.

The inspector observed that while staff assisted residents in a second dining space, there was insufficient supervision in the main dining room at tea time. While there was no negative outcomes noted for residents on the day of the inspection, residents were left unattended for times during the meal.

The inspector observed that meals were well presented in appetising individual portions. Residents confirmed that they enjoyed the food particularly the choices and variety.

Residents told inspectors that they could have tea or coffee and snacks at any time. Water and juice was provided to residents daily.

Outcome 16
Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence.

References:
Regulation 10: Residents' Rights, Dignity and Consultation
Regulation 11: Communication

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

Action(s) required from previous inspection:

Screening in the four bedded room was not sufficient.

Inspection findings

Overall, the inspector found that residents' privacy and dignity was respected by staff, however, there was an area for improvement. Screening in the four-bedded room required improvement as discussed under Outcome 12.

The inspector observed staff interacting with residents in a courteous manner and addressing them by their preferred names. Staff and residents chatted with each other in a comfortable way. There was an open visiting policy and contact with family members was encouraged.

Residents religious and civil rights were supported. Mass took place monthly and residents said they were satisfied with this arrangement. Residents who wished to vote in elections were supported to do so in the centre.

There was an active residents' forum within the centre. This had improved from the previous inspection. The inspector reviewed the minutes of the residents' forum which met regularly and saw that improvements were made to the service based on recommendations from this group. This included purchasing a fish tank. All residents had access to an advocate should they wish to access this service and residents confirmed they used this service. The provider and person in charge were seen to interact well with residents and relatives.

Theme: Workforce
The workforce providing a health and social care and support service consists of all the people who work in, for, or with the service provider and they are all integral to the delivery of a high quality, person-centred and safe service. Service providers must be able to assure the public, service users and their workforce that everyone working in the service is contributing to a high quality safe service.

Outcome 18
There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

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

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

Staffing levels and skill mix in the centre were sufficient to meet the needs of the residents. However, improvements were required in the provision of training for staff and implementation of learning from training.

The provider had put in place adequate recruitment procedures and had ensured that staff were appropriately selected and vetted in accordance with the Regulations and the Authority's Standards. The inspector found that there were good induction arrangements for newly employed staff members.

The inspector examined the files of two new staff members and found that the files contained all of the information required by the Regulations.

The system to ensure that all nursing staff had the required up to date registration with An Bord Altranais agus Cnáimhseachais na hÉireann for 2013 required improvement. There was no current registration for one of the nurses available. The provider subsequently produced evidence that the staff nurse was currently registered.

The inspector found that the systems of communication were inappropriate to support staff to provide safe and appropriate care. Apart from the daily handover meetings, there had not been any staff meetings held where resident's needs were discussed since the inspection in August 2012. The person in charge informed the Authority that staff meetings would be held for nurses and care assistants on the 13 and 14 August 2013 respectively. There was no plan to ensure these meetings continued regularly into the future.

Since August 2012 a small number of staff had completed in service training in:

- behaviours that challenged
- elder abuse
- medication management
- venepuncture.

The inspector found that many of the staff had not received training in restraint management, falls prevention, wound care and nutrition to enable them to provide care in accordance with contemporary evidence-based practice. Evidence on this was discussed in Outcome 11. There was no training plan for 2013.

In addition, the inspector found that not all staff had received mandatory training. In addition to the deficits in elder abuse and fire safety training already discussed. There was no system to ensure that all staff requiring training on manual handling had also received this training. Improvements in the maintenance of training records were required. The records of the training provided were incomplete and there was no system to demonstrate which staff had received training or the number of staff that were outstanding.

Closing the visit

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

Acknowledgements

The inspectors wish to acknowledge the cooperation and assistance of the residents, relatives, provider and staff during the inspection.

Report compiled by:

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Regulation Directorate
Health Information and Quality Authority

8 August 2013

Health Information and Quality Authority
Regulation Directorate

Action Plan

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

Provider's response to inspection report *

Centre Name:	Asgard Lodge Nursing Home
Centre ID:	0006
Date of inspection:	6 August 2013
Date of response:	3 September 2013

Requirements

These requirements set out the actions that must be taken to meet the requirements of the Health Act 2007 as amended, 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*.

Theme: Governance, Leadership and Management

Outcome 4: Records and documentation to be kept at a designated centre

The provider is failing to comply with a regulatory requirement in the following respect: Many of the operational policies did not guide the practice. This included the policy on behaviour management, falls, medication management and restraint.
Action required: Put in place all of the written and operational policies listed in Schedule 5 of the Regulations.
Reference: Health Act, 2007 Regulation 27: Operating Policies and Procedures Standard 29: Management Systems

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

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: Schedule 5 Policies are currently under review and will be updated by 30 September 2013. Any change in policy will be formally discussed at the next nurses meeting.	30 September 2013

Theme: Safe care and support

Outcome 6: Safeguarding and safety

The provider is failing to comply with a regulatory requirement in the following respect: Not all staff had received training on identifying and responding to elder abuse.	
Action required: Make all necessary arrangements, by training staff or by other measures, aimed at preventing residents being harmed or suffering abuse or being placed at risk of harm or abuse.	
Reference: Health Act, 2007 Regulation 6: General Welfare and Protection Standard 8: Protection	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: All staff have watched HSE DVD Recognising and Responding to Elder Abuse and all staff have read local policy and procedure. Management sit down with staff at induction and discuss the DVD and local policy. We have scheduled Abuse training for 10/10/2013. We have identified who has not attended abuse training in the last year and have given notice to ensure attendance. We have two in house Abuse trainers who will train all staff.	Complete 10/10/2013

Outcome 7: Health and safety and risk management

The provider is failing to comply with a regulatory requirement in the following respect: Improvements in relation to fire records, training and drills were required as outlined in Outcome 7.
Action required: Make adequate arrangements for the maintenance of all fire equipment.
Action required: Provide suitable training for staff in fire prevention.
Action required: 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 saving life.
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: i) Fire equipment is maintained by external contractor who has provided up to date certificates. Maintenance was up to date, however, records had not been supplied. Management will ensure that up to date records are provided and available to the inspector in future. ii) Fire training is arranged twice a year and attendance is compulsory. Next fire training has been arranged for 16/10/2013 at 2pm. iii) Management will carry out fire drills at least twice a year. Fire drill was carried out by management on 06/09/2013 without warning and staff response was excellent.	Complete 16/10/2013 Complete

The provider is failing to comply with a regulatory requirement in the following respect: The risk management policy did not meet the requirements of the Regulations.

Some risks were not identified and control measures put in place as outlined under Outcome 7.
Action required: Put in place a comprehensive written risk management policy and implement this throughout the designated centre.
Action required: Take all reasonable measures to prevent accidents to any person in the designated centre and in the grounds of the designated centre.
Reference: Health Act, 2007 Regulation 31: Risk Management Procedures Standard 26: Health and Safety Standard 29: Management Systems

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Risk management policy has been updated. Management and staff are proactive in identifying risk and responding to prevent accidents. We will ensure that it is always recorded on the risk register. Risk assessment for the Resident who smokes has been updated. Manual Handling Charts are up to date and further manual handling training will be provided on 02/10/2013. Staff involved in the occasion where a resident was transferred with the brakes off the wheelchair are advised to only transfer with the brakes locked. Washing powder in the laundry is locked away. Domestic staff have been advised of their responsibility to supervise their trolley at all times. Environmental audit has been completed and will be done annually at a minimum. Risk register will be updated on an ongoing basis.	Complete Complete 02/10/2013 Complete Complete Complete Complete

Outcome 8: Medication management

The provider is failing to comply with a regulatory requirement in the following respect: The medication policy did not guide and inform staff practice. Medications were not administered as per professional guidelines and the centres policy.

Action required: Put in place appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents and ensure that staff are familiar with such policies and procedures.	
Reference: Health Act, 2007 Regulation 33: Ordering, Prescribing, Storing and Administration of Medication Standard 14: Medication Management	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Medication policies are all up to date. Meeting was held for Nurses on 13/08/2013 and issues that were identified on inspection were addressed. Nurses are adhering to policy and procedures. Maximum PRN doses are stated on all medication kardex's. Transcribed medication is signed by two Nurses. Photograph is in place on the residents file who did not have it. GP has prescribed to crush specific medications under special instructions on each medication. Nurses will not sign a medication until a resident has taken it. PIC will complete a medication management competency assessment on Nurses going forward, to ensure ongoing compliance and reduce the risk of error. One Nurse form Day shift and one Nurse from Night shift check controlled drugs twice a day.	 Complete Complete Complete Complete Complete Complete/ Ongoing Complete

Outcome 9: Notification of incidents

The person in charge is failing to comply with a regulatory requirement in the following respect: The person in charge had not notified the Authority of all incidents as required by the Regulations.
Action required: Give notice to the Chief Inspector without delay of the occurrence in the designated centre of any serious injury to a resident.

Reference: Health Act, 2007 Regulation 36: Notification of Incidents Standard 29: Management Systems	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Notifications will be sent to the Chief Inspector without delay. All notifications are up to date. Notification NF03/ NF05 were sent 07/08/2013.	Complete

Theme: Effective care and support

Outcome 11: Health and social care needs

The provider has failed to comply with a regulatory requirement in the following respect: A high standard of nursing practice was not delivered to residents in relation to the management of residents with epilepsy and weight loss.
Action required Put in place suitable and sufficient care to maintain each resident's welfare and wellbeing, having regard to the nature and extent of each resident's dependency and needs.
Action required Provide a high standard of evidence-based nursing practice.
Reference: Health Act, 2007 Regulation 6: General Welfare and Protection Standard 13: Healthcare

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: All Residents with epilepsy have a care plan that is specific to their needs. Epilepsy policy is completed. All Residents with a MUST score are risk assessed every week and all 'at risk' residents have a care plan developed to ensure that their needs are being responded to. All MUST scores were	Complete

reviewed and Dietician visited on 12/8/2013 and she reviewed all residents. Dietician will visit every 3 months and will review over the phone as required. SLT reviewed residents on 30/8/13 and will review residents on an ongoing basis/ on referral.	Complete

The person in charge is failing to comply with a regulatory requirement in the following respect: The care plans did not consistently reflect the assessed needs of residents in the areas of: ▪ Falls ▪ Wound care ▪ Restraint ▪ Nutrition ▪ Behaviours that challenged.	
Action required: Set out each resident's needs in an individual care plan developed and agreed with the resident.	
Reference: Health Act, 2007 Regulation 8: Assessment and Care Plan Standard 10: Assessment Standard 11: The Resident's Care Plan Standard 13: Healthcare	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Care plans are developed and reviewed in accordance with the changing needs of the residents. Care plans have been reviewed by staff nurses and information is more robust and specific to the resident. Care plans are developed and agreed with the Resident or NOK. A resident who had a fall had their care plan updated and agreed. Care plans will be updated on all residents following a fall in order to avoid reoccurrence. A sticker determining the correct titration of pressure mattress according to the individuals weight is now displayed on all mattress's. It will be changed in line with change in weight. Restraint register has a column to document when restraint is released. Care plan for a resident who has a lap belt, prescribed by OT, is in place. Nutrition care plans are complete for residents. Dietician/ SLT	Complete Complete Complete Complete

recommendation are incorporated into care plans. Weekly weights are been taken and MUST score updated as per policy. Kitchen staff fortify meals for residents at risk/ low BMI. All residents with behaviour that challenges has an assessment, care plan and challenging behaviour log to determine patterns. When PRN medication is administered, challenging behaviour log is completed on an ongoing basis. Residents/ Families will be further consulted for their input on our activities programme. PIC will do a survey and speak 1:1 with residents and families of residents to decide on further development of our activities programme. PAL assessments will be completed on residents with a cognitive impairment to support activity and intervention planning for these residents.	Complete Complete 18/10/2013

Outcome 12: Safe and suitable premises

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

The multi-occupancy four-bedded room did not meet residents' current needs for privacy, leisure and comfort. Aadequate screening curtains were not in place in the four bedded room.

The premises and equipment/furniture were not clean and well maintained.

There was inadequate storage space provided.

The number of assisted toilets and showers did not meet the needs of residents in the older part of the centre.

The laundry room was very small in size.

There were inadequate staff changing facilities.

There was no cleaners' room in the centre which impacted on infection control.

There was no costed plan provided to the Authority to demonstrate how the multi occupancy four-bedded room would be addressed by 2015.

Action required:

Provide a sufficient number of toilets having regard to the number of dependent residents in the home.

Action required:

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

Action required: Provide suitable changing and storage facilities for staff.	
Action required: Ensure suitable provision for storage of equipment in the designated centre.	
Action required: Keep all parts of the designated centre clean and suitably decorated.	
Action required: Provide residents with privacy to the extent that each resident is able to undertake personal activities in private.	
Reference: Health Act, 2007 Regulation 19: Premises Standard 25: Physical Environment	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: We have sufficient toilets to facilitate the needs of all residents. We have reviewed our systems in relation to using showers and have found that we meet the requirement as set out in the Regulations. We have adapted a new routine in relation to which showers will be used for residents to ensure compliance. Our 4 bed room is due to be downsized to two single rooms en suite with showers which will further allow for less demand on this assisted bathroom. Screening in the 4 bed room consists of fixed and mobile screens to ensure a residents privacy and dignity. Screen which required repair on inspection day was repaired immediately. The size of the rooms are suitable, with the exception of the 4 bedroom. This is being addressed by planning permission which we have obtained, to downsize this room and provide other facilities. We have made provision in our plans to provide suitable changing and storage facilities for our staff. We make every effort to manage equipment. We have made provision for a store room in our plans. Provider makes every effort to appropriately store equipment when it is not in use. Provider will put a vent in the storage area where the Domestic equipment is maintained. We have contacted our architect with a	Complete Complete Planning File is with the Council and we are awaiting feedback. 05/9/2013

view to her drawing up plans to incorporate a separate cleaning room. This work will be carried out with our extension plans. We feel the nursing home is decorated to a high standard. We have completed a cleaning audit and reviewed our cleaning systems and increased the housekeepers hours with good results. Cleaning templates have been updated to ensure all areas are covered. We intend to build a new laundry.	Complete It is our intention to have extension and renovations carried our by July 2015 at the latest.

Theme: Person-centred care and support

Outcome 15: Food and nutrition

The provider is failing to comply with a regulatory requirement in the following respect: Not all residents were provided with appropriate and safe assistance with eating and drinking. Three residents on modified consistency diets did not have their specific needs met.
Action required: Provide appropriate assistance to residents who, due to infirmity or other causes, require assistance with eating and drinking.
Action required: Provide each resident 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.
Reference: Health Act, 2007 Regulation 20: Food and Nutrition Standard 19: Meals and Mealtimes

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**

Provider's response: We provide assistance appropriate to the residents needs. Level of assistance may change and we respond to this. Dietician and SLT have visited since the Inspection. MUST training and food modification training has been arranged to refresh staff knowledge. Every Resident is provided with food and drink in quantities adequate for their needs. It is always properly prepared, cooked and served and is wholesome and nutritious. Choice is offered at each mealtime. We also take into account any special dietary requirements. We have individual breakfast cards, set on trays for each Resident's preferences. We have a 3 week menu plan for lunch and tea and we pride ourselves on food quality and the level of choice offered to the residents. An up to date list of modifications and preferences is maintained in the kitchen and will be adjusted according to change. SLT/ Dietician recommendations are integrated into the care plans. Catering staff manage a list of Residents preferences. Staff are congnisant of safe feeding guidelines and will always ensure that Residents are upright and alert in order to assist them safely. Teatime supervision is provided by a Nurse or a HCA. Residents who eat in the dining room are on normal consistencies, do not require 1:1 supervision and can manage their meals independently. If they are high risk they are facilitated in the lounge for closer supervision. Nurses or HCA's are competent to respond to the residents needs.	Complete 18/09/2013 Complete Complete Complete Complete

The provider is failing to comply with a regulatory requirement in the following respect: Some residents did not have sufficient opportunities for occupation and recreation.
Action required: Provide facilities for the occupation and recreation of each resident.
Reference: Health Act, 2007 Regulation 10: Residents' Rights, Dignity and Consultation Standard 4: Privacy and Dignity Standard 18: Routines and Expectations

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**

Provider's response: We have a full activities programme and strongly encourage visits from family and friends. Our activities programme is developed in participation with the residents committee. Residents are very happy with the choice of activities offered and when consulted, residents unanimously agreed that activities in the morning would not be of interest. We will review this by consulting with Residents/ Families. PIC will do a survey and speak 1:1 with residents and families of residents to decide on further development of our activities programme. PAL assessments will be completed on residents with a cognitive impairment to support activity and intervention planning for these residents. We will also discuss this topic at the next Residents committee meeting.	Complete 18/10/2013

Theme: Workforce

The provider is failing to comply with a regulatory requirement in the following respect: Staff had not been provided with sufficient education and training to enable them to provide up-to-date care in accordance with contemporary evidence-based practice.	
Action required: Provide staff members with access to education and training to enable them to provide care in accordance with contemporary evidence-based practice.	
Action required: Supervise all staff members on an appropriate basis pertinent to their role.	
Reference: Health Act, 2007 Regulation 17: Training and Staff Development Standard 24: Training and Supervision	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response We will review our training which will include Medication management MUST training, dysphagia management, food modifications Manual Handling Abuse Training	 11/9/2013 18/9/2013 02/10/2013 10/10/2013

Fire Training Further training in other areas will be developed.	09/10/2103

The person in charge is failing to comply with a regulatory requirement in the following respect: Improvements in the maintenance of training records were required.	
Action required: Provide staff members with access to education and training to enable them to provide care in accordance with contemporary evidence-based practice.	
Reference: Health Act, 2007 Regulation 17: Training and Staff Development Standard 24: Training and Supervision	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Training matrix has been developed. Going forward, all training will be added to this system.	Complete