Health Information and Quality Authority
Regulation Directorate

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

Centre name:	Acorn Lodge
Centre ID:	0188
Centre address:	Ballykelly Cashel Co Tipperary
Telephone number:	062 64244
Email address:	acornhealthcare@eircom.net
Type of centre:	☒ **Private** ☐ **Voluntary** ☐ **Public**
Registered provider:	Acorn Healthcare Ltd
Person authorised to act on behalf of the provider:	Mary O'Connor
Person in charge:	Mary O'Connor
Date of inspection:	18 September 2013
Time inspection took place:	**Start:** 09:40hrs **Completion:** 21:05hrs
Lead inspector:	Mary Moore
Support inspector(s):	Noelene Dowling
Type of inspection	☐ **announced** ☒ **unannounced**
Number of residents on the date of inspection:	45 (plus two admissions were expected on the day of inspection)
Number of vacancies on the date of inspection:	5

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 inspectors met with residents and staff members including the person in charge/nominated registered provider. Inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, health and safety records, the fire register, policies and procedures and staff files.

This inspection was the fourth inspection of the centre by the Authority. On each inspection inspectors have been satisfied as to the provider's commitment to the provision of safe quality services to the residents.

Feedback received from residents has been consistently positive and actions arising from inspection findings have been substantially addressed by the provider.

This inspection was unannounced and inspectors found that the centre was organised, adequately staffed and the person in charge/nominated registered provider was on duty as indicated on the roster. The premises was well maintained, visibly clean, adequately heated, lighted and ventilated. There were 45 residents living in the centre on the day of inspection with two further residents expected that day. Inspectors saw that residents looked well, had a high level of personal grooming, had flexibility in their daily routines with many enjoying a late breakfast and were facilitated by staff in a dignified manner to function as independently as possible.

Inspectors were again satisfied that the provider was committed to the ongoing review and improvement of the care and services provided to residents and that staff shared this ethos of care and service. However, while there was substantial evidence of good practice, based on the regulatory areas inspected, a number of improvements were identified as required. These were discussed with the provider during the inspection, at verbal feedback and are outlined in the action plan at the end of this report. The provider articulated its commitment to take action as appropriate to effect the improvement required. The required improvements included:

- medication management practices
- care planning
- equitable access to timely and responsive medical review and treatment for all residents
- recruitment procedures and staff records.

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 2

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

References:

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

Action(s) required from previous inspection:

The action required from the previous inspection was satisfactorily implemented.

Inspection findings

Based on a sample of contracts seen the inspector saw that the action that emanated from the last inspection had been addressed and that charges for services provided but not included in the basic fee were clearly outlined for each resident in the contract.

However, the contract did not set out the overall basic fee for the provision of care and services, any monies received from state support schemes and the residual fee for which the resident was liable as applicable to each resident.

The contract was dated to reflect the date of admission but not the date that the contract was signed as agreed with each resident or their representative as appropriate. It was therefore not evident from the contract that it had been agreed within one month of the resident's admission to the centre.

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

The person in charge was a registered general nurse and evidence of her current registration with her regulatory body was in place. The person in charge had worked in the centre since 2001 and has had overall responsibility for its operational and clinical governance since 2003. As one of two directors of Acorn Healthcare Ltd, as nominated registered provider, and person in charge, she had enhanced autonomy, accountability and responsibility for the provision of the service and was seen to exercise her role and responsibilities.

The person in charge worked fulltime and was present in the centre on average five days per week. She was seen by inspectors to be visible, accessible, approachable and actively engaged in the supervision and delivery of care and services to residents. Throughout the inspection she demonstrated her knowledge of each resident and her regulatory requirements.

There was evidence that the person in charge engaged in continuing professional development relevant to her role and had successfully completed further recent education on nutrition, medication management, healthcare associated infection prevention and control, manual handling, fire safety and evacuation training.

Outcome 5
The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.

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

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

The person in charge confirmed that she had not been absent from the centre for any period that required notification to the Chief Inspector. Suitable arrangements were in place for the replacement of the person in charge on a routine or unexpected basis and this was evident from the staff roster.

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:

No actions were required from the previous inspection.

Inspection findings

The person in charge confirmed that there had been no incident of alleged, suspected or reported abuse in the centre.

There was a good policy in place for the prevention, detection and management of abuse. However, inspectors recommended its review and expansion to incorporate:

- the invoking of protective measures as relevant to each situation such as increased supervision or disciplinary action
- other possible abusive situations other than staff/resident
- guidance for staff in the event of an allegation of abuse against management.

Staff training was facilitated in house, however, training records indicated that six staff had not had refresher training since 2010 and two staff were listed as having not attended training.

The inspector saw transparent and accountable records for the management of residents' finances and personal property.

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 action required from the previous inspection was partially implemented.

Inspection findings

There was a comprehensive centre-specific health and safety statement in place developed in consultation with an external consultant. The health and safety statement incorporated a broad range of appropriate, centre-specific health and safety risk assessments.

A fire register was maintained and certificates seen indicated that the emergency lighting was inspected and tested in February 2013 and fire fighting equipment was inspected and tested in April 2013. However, while staff reported that the fire detection system was inspected and serviced at the required intervals certificates were not in place to support this, the most recent certificate seen was dated March 2013. Procedures were in place for the inspection and testing of the fire detection system by maintenance staff and fire doors and escape routes were inspected daily. Inspectors saw that these were clearly indicated and free of obstruction. Fire training for staff was completed annually by an external person and on induction with newly recruited staff. Certificates were seen in individual staff files confirming participation in training including a fire evacuation drill. Evacuation assistive devices were in place to assist in the safe and timely evacuation of dependent residents. However, despite the attention given to fire training the staff training records indicated that at least 14 staff had not attended the training provided in November 2012.

The provider had taken action in response to the previous action plan in relation to the designated smoking room. Inspectors saw that a fire blanket and fire extinguisher were available in the room, the call bell was accessible, a fire retardant apron was in place and was seen to be used, and a large fire rated glass viewing panel had been inserted into the fire door to allow for visibility and supervision of the room. Risk assessments had been completed on residents who utilised the smoking room but the assessment was generic and did not address specific risks such as the use of a lighter in the smoking room. Four residents were seen to utilise the room at the time of inspection and consequently space was limited and inspectors saw that access to and safe movement within the room was limited. It was recommended that the provider review the room contents in line with the risk assessments and the number of residents utilising the room and perhaps remove some furniture temporarily to reduce the risk and enhance safe access and movement for all residents. A door wedge was seen to be intermittently used to hold open the fire door of the smoking room and while this was seen to be used to facilitate resident access, it negated the function of the fire door and an alternative intervention such as an electronic disability access door opener should be considered.

There was an emergency plan in place, and the plan incorporated a preventative component in the monitoring of maintenance and the identification of risks or defects as they arose. A generator was available on site. An emergency pack in the event of evacuation was maintained at the front desk and included innovative hypothermia prevention management kits for more vulnerable residents.

There was a comprehensive centre-specific policy in place for the prevention and management of a missing person.

The premises was visibly clean, well maintained, dedicated maintenance staff were employed and the premises internally and externally was seen by inspectors to be free of any obvious risks or hazards.

Staff were seen to have the equipment necessary for infection prevention and control and were knowledgeable as to its use and the correct implementation of infection control procedures. Road transportation documents were in place attesting to the removal of clinical risk waste by a licensed contractor.

Inspectors saw that residents were supplied with a good range and standard of equipment as appropriate to their care and comfort and records were in place confirming the inspection and maintenance of equipment in July 2013.

Training records indicated that staff training in manual handling was within mandatory requirements; the most recent training had been provided in June 2013. Hoists had been subjected to a thorough examination in July 2013.

A food safety policy was in place and regular measures were taken by the provider to update staff knowledge on HACCP (Hazard Analysis and Critical Control Points) food safety systems. Catering facilities were monitored by the relevant Environmental Health Officer (EHO) and the most recent inspection report dated August 2013 indicated substantial compliance with the relevant legislation.

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:

No actions were required from the previous inspection.

Inspection findings

Medication management practice was not in line with local policy, regulatory requirements and regulatory guidance primarily due to the practice of nurse transcribing.

There was a comprehensive centre-specific medication management policy in place that was referenced to the relevant legislation and best practice literature. However, it was not implemented in practice.

Medication prescription records were routinely transcribed by nursing staff and not in an emergency or unusual situation only, as stipulated in the policy. Transcribing practice was not in line with regulatory body guidance and it was not evident from

the prescription that it was transcribed as there was no signature of the transcribing nurse or the nurse checking the accuracy of the transcription.

While the inspector saw that photocopies of prescriptions were in resident's records for a random sample of transcribed prescriptions reviewed, some transcribed prescriptions were in daily use for prolonged periods without having been signed and dated by the relevant general practitioner (GP) - the acceptable timeframe specified in the local policy for all faxed, telephone or transcribed orders was 72 hours. Other transcribed records seen were signed but not dated by the relevant GP, some were both signed and dated.

The maximum dosage of medication required on an "as required" (PRN) basis was not at all times stated.

There was no medical authorisation seen for medication confirmed by nursing staff as administered in an altered format (crushed).

The route of administration was generally not stated.

The practice of transcribing was not the subject of audit as recommended in regulatory body guidance.

The inspector was satisfied that the receipt, storage, administration and management of controlled drugs were in line with legislative requirements - a stock balance check was maintained and was seen to be correct. However, staff spoken with confirmed that with the exception of the morning changeover, the stock balance check was performed by two nurses from the same shift and not a nurse from each shift as required by regulatory body guidance.

The inspector saw that the medication trolley when not in use was securely stored in the nurses' station. Itemised signed and countersigned records were maintained of all medications returned to the pharmacy.

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

Notifications submitted from the centre to the Chief Inspector were reviewed on receipt and again prior to the inspection. The inspector was satisfied that a record of all incidents occurring in the designated centre was maintained, that each record satisfied the requirements of Schedule 3 of the Regulations and incidents where required had been notified to the Chief Inspector by the person in charge.

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 10
The quality of care and experience of the residents are monitored and developed on an ongoing basis.

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

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

There was a system in place for the monitoring and review of the quality and safety of the care and services provided to residents. A clinical governance team was in place and convened approximately every quarter to review aspects of care and service such as falls, complaints, infection control, staff induction and the results from the collation and analysis of clinical indicators; the most recent meeting had taken place on 6 August 2013. It was evident that any findings of concern such as weight loss and repeat falls were identified and interventions agreed on an individualised resident basis such as the provision of hip protectors and the use of nutritional supplements. The provision of pressure relieving equipment in line with each resident's assessed risk, weight and MUST score (malnutrition universal screening tool) was monitored to ensure that the appropriate equipment was in place.

The centre had participated in the current Halt Programme (a national survey of healthcare associated infection in long-term care) with evidence of feedback and follow-up with GP's.

However, the inspection findings did not clearly demonstrate how the recommendations of the review process were integrated into the care plan and practice so as to ensure improved clinical and quality of life outcomes for residents; this is discussed further in Outcome 11.

While inspectors saw that the person in charge was present in the centre daily and residents spoken with confirmed that their requests and needs were attended to (this is discussed further in Outcome 16) the system of review did not include a formal review/ consultation with residents and/or their representatives the findings of which would result in a report made available to residents and their representatives.

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:

No actions were required from the previous inspection.

Inspection findings

Inspectors saw that residents looked well and those spoken with reported feeling well. Inspectors saw that staff were informed of, attentive and responsive to residents needs. Records reviewed indicated that residents had access to other healthcare professionals and services including speech and language therapy, occupational therapy, dietetics and chiropody. All residents had recently had a full dental review and follow-up treatment as required and permitted by the resident. Resident health and well being was also promoted by the regular monitoring of residents' vital signs and weights and the administration of seasonal flu vaccine.

Monitoring and intervention was also evident from the minutes of the meetings of the clinical governance team as previously discussed.

However, deficits were identified in two core areas fundamental to regulatory requirements and the maintenance of each resident's wellbeing and welfare. Timely access to GP review and the comprehensive assessment and setting out in an individualised care plan each resident's health and social care needs.

Based on a sample of medical records reviewed inspectors saw that not all residents were facilitated to have access to timely and responsive medical review including timely review following their admission to the centre.

As part of the ongoing development of services the person in charge reported that a computerised system of care planning had been introduced approximately two months prior to the inspection. Staff had received training on the use of the system and had been given protected time by the provider to implement the system. In practice inspectors saw evidence of protective and preventative interventions such hip-protectors, low-low beds, swallow care plans, the provision of pressure relieving equipment and a broad range of assistive devices. However, overall based on a sample of care plans reviewed in consultation with staff, inspectors were satisfied that the care plans currently:

- did not demonstrate evidence that they accurately reflected the resident's needs
- were not adequately supported by the agreed risk assessment tool
- did not reflect or correlate to the care evidenced in practice
- were not sufficient to ensure the provision of suitable and sufficient care.

While recognising that this was a recently implemented system given the gaps identified a review of the implementation of the system was required.

In line with this review an agreed format was required to ensure that an adequate nursing record of each resident's health and condition and treatment given, on a daily basis, signed and dated by the nurse on duty in accordance with any relevant professional guidelines was completed and maintained. The current nursing narrative record was seen not to be completed daily for each resident.

There was a comprehensive policy and procedure on the use of restraint that was referenced to the literature and nationally agreed best practice guidelines. However, there was evidence to indicate that the use of bedrails was not at all times supported by evidence based policy specifically where the risk assessment and nursing opinion identified a risk and contraindicated the use of bedrails.

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 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:

No actions were required from the previous inspection.

Inspection findings

Inspectors saw and residents spoken with confirmed that they had flexibility in their daily routines.

The design and layout of the building promoted the privacy and dignity of each resident as private single en suite accommodation was provided and residents came and went freely to and from their rooms. Adequate provision was made for the storage of personal possessions and bedrooms were personalised in a manner that was individualised to the occupant and included personal, family, sporting and religious mementos or in some cases personal items of furniture from their own home. Residents spoken with enjoyed sharing their life experience with inspectors and used such mementos in the process.

Inspectors saw that staff encouraged and facilitated residents to maximise their independence, paced themselves to match the resident's abilities and were patient, kind and respectful when providing assistance; more independent residents were seen to enjoy the well maintained external grounds.

Staff spoken with said that the structured format of the residents' committee had not been popular or beneficial. Residents continued to have access to an advocate who had established relationships with the residents and engaged with them on a one-to-one basis and brought any concerns or issues to the attention of the person in charge.

Inspectors saw a high level of visitor activity with no apparent restrictions - regular and frequent visitors were integrated into the fingerprint recognition main access system.

Inspectors observed that residents had good access to televisions, radios and a variety of newspapers.

An oratory was available on site and a group of residents met each evening to say the rosary.

Two staff members were current Sonas licensed practitioners (a therapeutic communication activity primarily for older people with dementia that focuses on sensory stimulation and is delivered through individual and group activity). A quality assurance certification process for the effective delivery of the Sonas programme. The designated activities coordinator was on leave but alternative arrangements had been made by the provider to facilitate activity and engagement in the interim such as chair based activities. It was evident that residents were facilitated to continue to enjoy established hobbies and activities.

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:

The action required from the previous inspection was not satisfactorily implemented.

Inspection findings

While inspectors saw that staff were fully occupied attending to residents' needs and requests they were satisfied that the numbers and skill-mix of staff were adequate to meet these needs. Inspectors observed that staff were readily available to residents, prioritised and came to the assistance of residents if engaged in another task and engaged easily and respectfully with residents. Ancillary services such as catering, environmental hygiene, administration and maintenance were adequately resourced. Staff spoken with confirmed that "twilight" nursing hours continued up to 10pm and recommenced at 7am to address peak activity times.

The roster was clearly presented, well maintained, planned for a month and reflected the planned and actual working time of each staff member; from it the inspector saw that staffing levels and skill-mix were consistently maintained.

There was a registered nurse on duty at all times, however, evidence of registration for 2013 was not in place for a significant number of nurses employed (five of twelve).

A sample of staff files reviewed did not contain all of the documents required by regulation and as specified in Schedule 2 of the Regulations. Two staff files of five reviewed did not have evidence of Garda Síochána vetting. Staff reported that it had been sought and processed locally but at the time of inspection had not been returned, self declarations were in place in the interim. However, four of six files reviewed contained no evidence to support the person's fitness to undertake the work that they were to perform in the centre. One file had a self-declaration and one had confirmed evidence from a GP that they were so fit. There was evidence that the provider had taken action in response to the last inspection findings but based on the findings above the action had not been satisfactorily addressed. This regulatory requirement was again discussed at verbal feedback and it was requested that evidence of physical and mental fitness be obtained for all recently recruited staff and on a phased basis for historical staff. The timeframe for the latter, however, would have to recognise that the action was outstanding since November 2012.

One staff file seen contained no references, one contained one, one contained two. Two files contained the required three references including a reference from the person's most recent employer. References that were in place were of a testimonial "to whom it may concern" format and there was no evidence of their verification by the provider.

There was evidence to support that persons providing services to residents on a regular basis were vetted but the process of vetting required standardisation to ensure that it was adequate.

There was evidence to support that the person in charge and nursing staff were adequately involved on a daily basis in delegation to, and the supervision of staff. Staff spoken with confirmed that a formal robust induction process for new staff had recently been implemented. Staff spoken with were familiar and knowledgeable of each resident's needs and care requirements.

The providers' commitment to the provision of safe quality services was evident in the commitment to staff education and training and training records indicated that recently completed education included medication management, nutrition, the management of dysphagia, hand hygiene, infection prevention and control, the use of pressure relieving equipment, venepuncture, and refresher food hygiene training. Five care staff had successfully completed Care of the Older Person Further Education and Training Awards Council (FETAC) Level 5. Some gaps were identified in mandatory training requirements and these have been discussed previously in the relevant outcomes.

Closing the visit

At the close of the inspection visit a feedback meeting was held with the provider/person in charge and the administration officer 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:

Mary Moore
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

23 September 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:	Acorn Lodge
Centre ID:	0188
Date of inspection:	18 September 2013
Date of response:	9 October 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 2: Contract for the provision of services

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

It was not evident from the contract that it had been agreed within one month of the resident's admission to the centre.

Action required:

Agree a contract with each resident within one month of admission to the designated centre; the date the contract is signed as agreed is evident.

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

Action required: Ensure each resident's contract deals with the care and welfare of the resident in the designated centre and includes details of the services to be provided for that resident and all fees to be charged.
Reference: Health Act, 2007 Regulation 28: Contract for the Provision of Services Standard 1: Information Standard 7: Contract/Statement of Terms and Conditions

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The contract of care has been reviewed and up-dated to incorporate the date that the contract is signed. The Contract now clearly sets out the overall basic fee for the provision of care and services, any monies received from the state support schemes and the residual fee for which the resident is liable as applicable to each resident.	Completed

Theme: Safe care and support

Outcome 6: Safeguarding and safety

The provider is failing to comply with a regulatory requirement in the following respect: Inspectors recommended the review and expansion of the policy on protection as outlined in the body of the report. Training records indicated that all staff had not attended training on protection while others had not had a timely update.
Action required: In line with these inspection findings review and expand the policy on and procedures for the prevention, detection and response to abuse.
Action required: Make all necessary arrangements, including the training and timely retraining of staff, 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 Standard 9: The Resident's Finances	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The Policy on Recognising and Responding to Elder Abuse has been up-dated to reflect invoking of protective measures, other possible abusive situations and guidance in the event of an allegation of abuse against management. Training on Recognising and Responding to Elder Abuse has been arranged for all staff. This will commence on Thursday 17 October 2013 and be repeated for the following three Thursdays thereafter.	Completed 7 November 2013

Outcome 7: Health and safety and risk management

The provider is failing to comply with a regulatory requirement in the following respect: While staff reported that the fire detection system was inspected and serviced at the required intervals certificates were not in place to support this. Staff training records indicated that at least 14 staff had not attended fire training in November 2012. Risk assessments for residents who smoked were somewhat generic and did not address specific risks such as the use of a lighter in the smoking room. A door wedge was used at intervals to hold open the fire door of the smoking room.
Action required: Take all reasonable measures to prevent fire and accidents to any person in the designated centre including the completion of individualised risk assessments for the consumption of tobacco.
Action required: Take adequate precautions against the risk of fire, including the provision of suitable fire containing equipment.

Action required: Make adequate arrangements for reviewing fire precautions, and testing fire equipment, at suitable intervals.
Action required: Ensure, by means of fire training, fire drills and fire practices at suitable intervals, that the staff are aware of the procedure to be followed in the case of fire, including the procedure for saving life.
Reference: Health Act, 2007 Regulation 31: Risk Management Procedures 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:	
All necessary fire certificates are now on site and available for inspection.	Completed
An individualised risk assessment has been completed for each resident who smokes and a corresponding care plan developed to meet any individualised needs or address any measures required specific to the individualised risks associated with smoking.	Completed
The designated smoking room has a fire extinguisher and fire blanket available in the room. A smoking apron is available to residents. Appropriate ashtrays are also available. The couch has been removed from the room (armchairs remain) to facilitate safe access and egress and to allow residents movement within the room. The door wedge has been removed.	Completed
Fire Safety Training will be arranged for staff requiring same.	30 November 2013

Outcome 8: Medication management

The provider is failing to comply with a regulatory requirement in the following respect: Medication management practice was not in line with local policy, regulatory requirements and guidance primarily due to the practice of nurse transcribing. Transcribing practice was not in line with regulatory body guidance or local policy.

Transcribed prescriptions were in daily use for prolonged periods without having been signed and dated by the relevant General Practitioner (GP).

The practice of transcribing was not the subject of audit.

The maximum dosage of medication required on a PRN basis (medication that is not scheduled or required on a regular basis) was not at all times stated.

There was no medical authorisation seen for medication confirmed by nursing staff as administered in an altered format (crushed).

The stock balance check for controlled drugs was performed by two nurses from the same shift and not a nurse from each shift as required by regulatory body guidance.

Action required:

Put in place suitable arrangements and appropriate procedures in accordance with current regulations, guidelines and legislation for the ordering, prescribing, transcribing, storing and administration of medicines to residents and ensure staff are familiar with and implement such procedures and policies.

Action required:

Maintain, in a safe and accessible place, a record 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.

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: The activity of transcribing has been reviewed and a standard procedure adopted. The Acorn Lodge medication management policy has been updated to clearly outline the procedure to be followed when a nurse is transcribing. Each prescription transcribed by a nurse will be independently reviewed and checked by a second nurse. Both nurses will sign the transcribed	Completed

prescription sheet. The transcribed prescription will not be used to administer medications until it has been signed and dated by the medical officer/general practitioner. Acorn Lodge are currently in discussions with the pharmacy with regard to the systems for the generation of prescriptions possibility in the future.	 On-going.

Theme: Effective care and support

Outcome 10: Reviewing and improving the quality and safety of care

The provider is failing to comply with a regulatory requirement in the following respect: The system of review did not include a formal review/ consultation with residents and/or their representatives the findings of which resulted in a report that was made available to residents and their representatives.	
Action required: 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. Make a report in respect of any review conducted by the registered provider for the purposes of Regulation 35(1), and make a copy of the report available to residents and, if requested, to the Chief Inspector.	
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: An independent advocate holds residents council meetings. However, the current residents prefer not to attend these meetings, therefore the independent advocate provides one to one consultations with individual residents and small group meetings. The advocate then provides verbal feedback to the person in charge / assistant director of nursing and smaller issues are addressed immediately and larger issuues are discussed at the clinical governance meetings. A satisfaction survey has been developed and will be supplied to residents and/or family members/representatives to identify any deficiencies in the current service and provide an opportunity for learning.	 Completed. 31 October 2013

Outcome 11: Health and social care needs

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

Not all residents were facilitated to have access to timely and responsive medical review including timely review following their admission to the centre.

Inspectors were satisfied that the care plans currently:

- did not demonstrate evidence that they accurately reflected the resident's needs
- were not adequately supported by the agreed risk assessment tool
- did not reflect or correlate to the care evidenced in practice
- were not sufficient to ensure the provision of suitable and sufficient care.

The current nursing narrative record was seen not to be completed daily for each resident.

There was evidence to indicate that the use of bedrails was not at all times supported by evidence-based policy.

Action required:

Facilitate all appropriate health care and support each resident on an individual basis to achieve and enjoy the best possible health. Provide appropriate medical care by a medical practitioner of the residents' choice or acceptable to the residents.

Action required:

Set out each resident's needs in an individual care plan developed and agreed with the resident. Keep each resident's care plan under formal review as required by the resident's changing needs or circumstances and no less frequent than at three-monthly intervals. The care plan is an accurate reflection of the resident, their assessed needs, and the evidence based nursing actions required to meet those needs.

Action required:

Complete, and maintain in a safe and accessible place, an adequate nursing record of each resident's health and condition and treatment given, on a daily basis, signed and dated by the nurse on duty in accordance with any relevant professional guidelines.

Action required:

Provide a high standard of evidence based nursing practice in relation to the use of bedrails.

Reference: Health Act, 2007 Regulation 6: General Welfare and Protection Regulation 9: Health Care Regulation 8: Assessment and Care Plan Regulation 25: Medical Records 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: All GPs caring for Residents at Acorn Lodge have been spoken with and written to requesting regular/ timely reviews of Residents in order to facilitate me as the provider to comply with my obligation under the Health Act. Nurses are now completing a daily narrative note on each residents health, condition and any treatment given. Nurses are currently being facilitated with supernumery time to review and up-date all residents assessments and care plans. A comprehensive assessment of all the needs of each resident (18 domains / activities of living) is currently being completed. This will include the use of focused assessments and validated tools. Each resident will have a detailed care plan put into place that will include their abilities, problems/needs, likes, dislikes, preferences, any risks associated with the domain, any aids or equipment used/required and any allied heathcare professionals recommendations (if any). This will include assessment of the use of bedrails and a corresponding care plan to meet any needs the resident may have or address any measures required specific to the individualised risks associated with the use of bedrails. Residents will have a comprehensive assessment and care plan review carried out every three months or where there is a change to the residents care or condition.	Completed. Completed 30 November 2013

Theme: Workforce

Outcome 18: Suitable staffing

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

Evidence of registration for 2013 was not in place for a number of nurses employed.

A sample of staff files reviewed did not contain all of the documents required by regulation and as specified in Schedule 2 of the Regulations.
Action required: Maintain, in a safe and accessible place, details of the qualifications and a copy of the certificate of current registration of each member of the nursing staff employed.
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: Put in place recruitment procedures to ensure the authenticity of the staff references referred to in Schedule 2 of the Regulations.
Action required: Ensure volunteers working in the designated centre are vetted appropriate to their role and level of involvement in the designated centre.
Reference: Health Act, 2007 Regulation 24: Staffing Records Regulation 18: Recruitment Regulation 34: Volunteers Standards 22: Recruitment Standard 23: Staffing Levels and Qualifications

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: There is now evidence of registration for 2013 for all nurses employed in Acorn Lodge. To ensure authenticity of staff references, Acorn Lodge have developed a reference form that will be sent to identified referrees for all new employees. From now on, Acorn Lodge will retain a copy of the garda clearance form with details of when it was forwarded to Nursing Homes Ireland.	 Completed Completed Completed.

All staff without a fit to work statement has been requested to furnish same within one month. All volunteers that volunteer for only one or two weeks in Acorn Lodge must provide garda clearance from their school/college. Volunteers that volunteer on an on-going basis or for longer periods of time will be subject to the same procedure for garda clearance as employees.	8 November 2013 Completed.