

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	The Cottage Nursing Home
Centre ID:	OSV-0004587
Centre address:	70 Irishtown, Clonmel, Tipperary.
Telephone number:	052 612 2605
Email address:	paddy@wnh.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Woodlands Nursing Home (Dundrum) Limited
Provider Nominee:	Paddy Fitzgerald
Lead inspector:	Louisa Power
Support inspector(s):	Ide Batan;
Type of inspection	Announced
Number of residents on the date of inspection:	24
Number of vacancies on the date of inspection:	1

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 his/her 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
- to carry out thematic inspections in respect of specific outcomes
- 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. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.

Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 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, the purpose of which was to inform a registration decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
25 February 2015 11:00	25 February 2015 17:30
25 February 2015 19:00	25 February 2015 21:30
26 February 2015 08:55	26 February 2015 16:00

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

Outcome 01: Statement of Purpose
Outcome 02: Governance and Management
Outcome 03: Information for residents
Outcome 04: Suitable Person in Charge
Outcome 05: Documentation to be kept at a designated centre
Outcome 06: Absence of the Person in charge
Outcome 07: Safeguarding and Safety
Outcome 08: Health and Safety and Risk Management
Outcome 09: Medication Management
Outcome 10: Notification of Incidents
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

Summary of findings from this inspection

The inspection was an announced inspection and took place over 2 days. The Authority had been informed a change in the registered provider in September 2014. There had been a change in the management team, including the person in charge and those participating in management.

As part of the inspection process, inspectors met with the provider nominee, person in charge, residents, relatives, visitors and staff members. Inspector observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures, risk management documentation and staff records.

The documentation submitted by the providers as part of the application process was also reviewed prior to the inspection including questionnaires completed by residents and relatives; the feedback was positive and is referenced in the body of the report.

Overall, inspectors found that residents' medical and nursing needs were met to a good standard. Residents looked well and cared for, engaged readily with inspectors and provided positive feedback on the staff, care and services provided. The inspector found evidence of good practice in a range of areas. The person in charge and staff all interacted with residents in a respectful, warm and friendly manner and demonstrated knowledge of residents' needs, likes, dislikes and preferences.

Layout in some parts of the premises posed challenges in relation to the provision of communal and private space for residents. Inspectors identified areas where maintenance practices required review. This was discussed at length with the providers who acknowledged the issues identified and outlined a phased renovation plan to address the issues. The plan had already commenced with the refurbishment of a sluice room.

A number of additional improvements were identified to enhance the substantive evidence of good practice and to comply with the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. The provider nominee arranged for two actions to be completed immediately after the inspection and the amended documents were submitted to the inspector. The outstanding required improvements are set out in detail in the action plan at the end of this report and include:

- Review of the statement of purpose
- documentation including policies and restraint
- infection prevention and control practices
- medication management
- care planning.

Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

Outcome 01: Statement of Purpose

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

Theme:

Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):

This was the centre's first inspection by the Authority.

Findings:

The written statement of purpose consisted of the aims, objectives and ethos of the designated centre and statement as to the facilities and services that were to be provided for residents. Inspectors noted that the statement of purpose was made available for residents, visitors and staff to read. The ethos of care as described in the centre's statement of purpose was actively promoted by staff.

However, the following items listed in Schedule 1 of the Regulations were not detailed in the statement of purpose:

- Information set out in the Certificate of Registration
- any separate facilities for day care
- arrangements for the management of the centre where the person in charge is in charge of more than one centre or absent from the centre.

The date of publication on the statement of purpose submitted to the Authority and reviewed by inspectors on-site was May 2012. It was not clear if the statement of purpose had been reviewed in the last year.

Judgment:

Substantially Compliant

Outcome 02: Governance and Management

The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.

Theme:

Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):

This was the centre's first inspection by the Authority.

Findings:

There was evidence of a clearly defined management structure that identified the lines of authority and accountability, specified roles, and details of responsibilities for all areas of service provision. The new management team had taken over the running of the centre in September 2014. The management team comprised the provider nominee, person in charge and assistant director of nursing.

Inspectors observed a good and supportive working relationship between the person in charge, assistant director of nursing and the provider nominee. Inspectors were satisfied that the management system in place ensured that service provided was safe, appropriate, consistent and effectively monitored.

Staff with whom the inspectors spoke were clear about the new management structure and the reporting mechanisms. Inspectors saw evidence of continued investment in the centre to ensure effective delivery of care in accordance with the statement of purpose including upgrading of sanitary facilities.

The person in charge and provider nominee informed inspectors that they were working to co-ordinate an audit plan for 2015. The results of the regular audits will form part of the annual review of quality and safety of care.

Results of audits since September 2014 were made available to inspectors. Audits were completed in pertinent areas to review and monitor the quality and safety of care and the quality of life for residents such as falls management, nutrition, assessment of residents' needs, medication management, training, restraint and care planning. The audits identified areas for improvement and audit recommendations. Improvements were brought about as a result of learning from audits such as referral to allied healthcare professionals and acquisition of new equipment.

Judgment:

Compliant

Outcome 03: Information for residents

A guide in respect of the centre is available to residents. 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.

Theme:

Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):

This was the centre's first inspection by the Authority.

Findings:

A residents' guide was available which included a summary of the services and facilities provided, procedure respecting complaints and the arrangements for visits. A sample of the written contract was included in the residents' guide which outlined the terms and conditions relating to residence in the centre. Inspectors saw copies were made available to residents

An inspector reviewed a sample of residents' contracts of care and noted that contracts were signed and dated by the resident or their representative within one month of admission. The contract set out the services to be provided, 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. Details of any additional services that may incur an additional charge were included

Judgment:

Compliant

Outcome 04: Suitable Person in Charge

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

Theme:

Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):

This was the centre's first inspection by the Authority.

Findings:

The centre was managed by a suitably qualified and experienced nurse with clear lines of authority, accountability and responsibility for the provision of service. The provider nominee outlined to inspectors that the company planned to put in place measures to further strengthen this

The management team had been in place since September 2014. The person in charge was a person in charge of more than one designated centre. Inspectors were satisfied that she was engaged in effective governance, operational management and administration of the centre. Residents required full time nursing care and the assistant director of nursing was the full-time nurse in charge.

The person in charge was a registered general nurse and had worked as a person in charge since 2007 in another designated centre for older persons. The person in charge had also completed a post graduate staff management qualification.

The person in charge provided evidence of ongoing professional development appropriate to the management of a residential care setting for older people. The person in charge was also an accredited manual handling instructor.

While speaking with inspectors, the person in charge demonstrated knowledge of contemporary clinical practice especially in relation to dementia care and restrictive practices. She provided evidence of improvements that she had implemented since September 2014 including the provision of an extended activities programme and regular audit schedule. The person in charge was fully conversant with the relevant legislation and her statutory responsibilities. As a director of the company, the person in charge had enhanced authority and responsibility for the provision of the service.

Judgment:

Compliant

***Outcome 05: Documentation to be kept at a designated centre
The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 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 2013.***

Theme:

Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):

This was the centre's first inspection by the Authority.

Findings:

The records listed in Schedules 2, 3 and 4 of the Regulations were maintained in the centre. All of the key policies as listed in Schedule 5 of the Regulations were in place. Staff with whom inspectors spoke demonstrated adequate knowledge of these policies. However, as outlined in outcome 14, the policy relating to end of life care was not fully implemented. As outlined in the relevant outcomes, a number of policies listed in Schedule 5 did not contain implementation/review dates and therefore it was not clear if these policies had been reviewed in the previous three years. The complaints policy required review to reflect a recent change in the advocacy service provision.

Records were kept securely, were accessible and were kept for the required period of time. Residents' records were kept in a secure place. The inspector found that the system in place for maintaining files and records was well organised with clear systems in place.

An inspector reviewed a sample of staff files and found that they contained all of the information required under Schedule 2 of the Regulations.

The residents' directory was maintained electronically, was up-to-date and contained all matters referred to in article 19. Entries to the nursing records were maintained in line

with relevant professional guidelines. Daily records were completed.

Residents' records as outlined in Schedule 3 were available in the centre with the majority maintained electronically. Records listed in Schedule 4 to be kept in a designated centre were all made available to inspectors.

Records relating to inspections by other authorities were maintained in the centre including documentation relating to food safety and fire safety.

The centre was adequately insured against accident or injury and insurance cover complied with the all the requirements of the Regulations.

Judgment:

Non Compliant - Moderate

***Outcome 06: Absence of the Person in charge
The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.***

Theme:

Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):

This was the centre's first inspection by the Authority.

Findings:

There had been no periods where the person in charge was absent from the centre for 28 days or more since September 2014. The provider nominee was aware of the obligation to inform the Chief Inspector if there is any proposed absence of the person in charge and the arrangements to cover for the absence.

The person in charge was a person in charge of more than one designated centre. Inspectors were satisfied that there were suitable arrangements made for the management of the centre the absence of the person in charge. The assistant director of nursing was identified as the person to act as the person in charge in her absence and was part of the management team. The assistant director of nursing was a registered nurse and had a number of years' experience of nursing older persons, including at a management level. The assistant director of nursing demonstrated good, sound clinical knowledge and that she had a good understanding of her responsibilities when deputising for the person in charge.

Judgment:

Compliant

Outcome 07: Safeguarding and Safety

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. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:

Safe care and support

Outstanding requirement(s) from previous inspection(s):

This was the centre's first inspection by the Authority.

Findings:

Inspectors found that systems were in place to protect residents from being harmed or suffering abuse. Residents were provided with support that promoted a positive approach to behaviour that challenges. A restraint-free environment was promoted.

The person in charge and all the staff spoken with confirmed that there had been no incidents of alleged, suspected or reported abuse in the centre since September 2014.

There were organisational policies in place in relation to the protection of vulnerable adults, response to allegations of abuse and whistleblowing. The policies had been last reviewed in October 2014 and were evidence based. However, the policies would not effectively guide staff if an allegation was made against the person in charge or a member of the management team.

Training records confirmed that all staff had received training in relation to responding to incidents, suspicions or allegations of abuse. Staff with whom inspectors spoke were knowledgeable of what constitutes abuse and of steps to take in the event of an incident, suspicion or allegation of abuse. Residents with whom inspectors spoke confirmed that they felt safe in the centre and that they knew who to talk to if they needed to report any concerns of abuse. There was a nominated person to manage any incidents, allegations or suspicions of abuse. Residents and staff were able to identify the nominated person.

An inspector reviewed arrangements for the management of residents' finances. Financial records that were easily retrievable were kept on site in respect to each resident. The inspector saw that an itemised record of charges made to each resident, money received or deposited on behalf of the resident, monies used and the purpose for which the money was used was maintained. Invoices were seen to be itemised.

A centre-specific policy in relation to the support of residents with behaviours that challenge was made available to the inspectors and had been reviewed in October 2014. The policy was comprehensive and evidence based. Staff with whom inspectors spoke demonstrated up to date knowledge, appropriate to their role, to support residents with behaviours that challenge.

A team had been established to support residents with behaviours that challenge. The team comprised the person in charge, assistant director of nursing and a staff nurse. The team met on a monthly basis. Minutes made available to inspectors demonstrated a positive approach to behaviour that challenge. Residents' routines had been examined to identify triggers and strategies had been implemented such as distraction techniques and enhancing active engagement in meaningful activities.

Inspectors observed that while bedrails and lap belts were in use, their use followed an appropriate assessment. A risk balance tool was used prior to the use of a bedrail or lap belt, multi-disciplinary input was sought and signed consent from residents was secured where possible.

However, based on a sample reviewed, inspectors noted that documentation in relation to chemical restraint was not in accordance with "Towards a Restraint Free Environment in Nursing Homes", a policy document published by the Department of Health. Where chemical restraint was used, nursing notes did not outline sufficient detail in relation to an episode where a PRN psychotropic medication was administered. Alternative strategies trialled were not outlined. Therefore, it was not clear from the documentation if episodes of challenging behaviour were managed in a manner that was least restrictive in this case, if alternative strategies had been ineffective and the use of restraint had been reviewed after use.

Judgment:

Non Compliant - Moderate

Outcome 08: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:

Safe care and support

Outstanding requirement(s) from previous inspection(s):

This was the centre's first inspection by the Authority.

Findings:

Overall there was evidence that the provider was committed to protecting and promoting the health and safety of residents, staff and visitors.

The health and safety policy and statement were made available to inspectors and had been last reviewed in January 2015. These documents were augmented by a range of centre-specific risk assessments, an assessment of each risk and the controls identified as necessary to reduce each risk. The risks identified specifically in the Regulations were included in the risk register. There was evidence that the risk assessments were regularly reviewed and updated.

A comprehensive emergency plan was in place, dated September 2014 and covered

events such as missing persons, medical emergencies, natural disasters and utility failure. Staff with whom inspectors spoke outlined that a member of the management team was always available with an on-call system in operation for such events.

An inspector viewed a sample of electronic incident forms and saw that accidents and incidents were identified and there were arrangements in place for investigating and learning from accidents.

Suitable fire equipment was provided throughout the centre. There was an adequate means of escape. Fire exits were unobstructed. The clear procedure for safe evacuation of residents and staff in event of fire was displayed in a number of areas. Fire records were comprehensive, accurate and easily retrievable. The training matrix and person in charge confirmed that all staff employed receive annual fire training on an ongoing basis. There was evidence of a recent fire drill in February 2015. Staff demonstrated good knowledge on the procedure to follow in event of a fire, including phased evacuation of residents and the availability of safe areas and compartments. The fire alarm is serviced on a quarterly basis, most recently in January 2015. Fire safety equipment is serviced on an annual basis, most recently in February 2015. Emergency lighting had been serviced regularly, most recently in January 2015. Records of daily inspection of fire exits and weekly checks of fire doors were made available to inspectors. Written confirmation from a competent person had been submitted prior to the inspection that all requirements of the statutory fire authority had been complied with.

A personal emergency evacuation plan (PEEP) was seen to have been developed for all residents. The PEEP took into account the number of staff required to evacuate the resident, the ideal means and route of evacuation and the location of the resident.

A designated smoking room was provided for residents, a centre-specific policy was in place for residents who smoke and each resident who smoked was individually assessed. The smoking area was mechanically and externally ventilated, equipped with fire fighting and fire detection equipment, fire resistant furniture and a fire retardant apron. Inspectors observed that residents who smoked were supervised by staff.

The training matrix confirmed that all staff were trained in the moving and handling of residents. Staff demonstrated a good understanding of the use of the hoist and contemporary moving equipments. Lifting and moving equipment was serviced in line with manufacturer's guidelines. Each resident had a personalised manual handling plan which was reviewed every four months or more frequently if a resident's condition changes. Inspectors spoke with staff who demonstrated knowledge of each resident's personalised manual handling plan and this was evidenced in practice. Hand rails and grab rails were installed throughout the centre.

Staff reported and inspectors observed access to adequate supplies of personal protective equipment (PPE) such as gloves and aprons. There was a contract in place for the disposal of clinical waste and records were maintained of removal and transport. Hand washing and sanitising facilities were readily accessible to staff and visitors. Designated hand washing facilities were provided in the laundry and sluice rooms. Access to high risk areas, such as the sluice, was seen to be restricted at all times.

There was evidence of a regular cleaning routine that adequately prevented against cross contamination. Supplies of alginate bags were provided for contaminated linen. Training in infection prevention and control had been facilitated for staff in 2014/15 and practices had been audited in February 2015. However, inspectors saw evidence that bed spacing was not planned and managed in a way that minimises the spread of healthcare associated infections in line with the standards for the prevention and control of healthcare associated infections published by the Authority.

Judgment:

Non Compliant - Moderate

Outcome 09: Medication Management

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

Theme:

Safe care and support

Outstanding requirement(s) from previous inspection(s):

This was the centre's first inspection by the Authority.

Findings:

The centre-specific policies in relation to medication management were made available to inspectors which had been reviewed in September 2014. The policies were comprehensive and evidence based. The policy was made available to staff who demonstrated adequate knowledge of this document.

Medicines for residents were supplied by a local community pharmacy. There was evidence that the pharmacist was facilitated to meet his/her obligations to residents.

Inspectors noted that medicines were stored in a locked cupboard or medication trolley. The temperature of the refrigerator used to store medicines was noted to be within an acceptable range; the temperature was monitored and recorded daily. Medicines requiring refrigeration were stored appropriately. Handling and storage of controlled drugs was safe and in accordance with current guidelines and legislation.

Staff with whom inspectors spoke demonstrated knowledge and understanding of principles in relation to safe medication management practices. An inspector observed the administration of medicines and saw that this was evidenced in practice. The practice of transcription was in accordance with professional guidance issued by An Bord Altranais agus Cnáimhseachais.

An inspector reviewed a sample of prescription and medication administration records. A number of prescription records examined did not contain the prescriber's signature for each medicine prescribed in accordance with the Medicinal Products (Prescription and Control of Supply) Regulations. Where medicines were to be administered in a modified form such as crushing, this was not individually prescribed by the medical practitioner on the prescription chart. Medication administration sheets identified the medications on

the prescription sheet and allowed space to record comments on withholding or refusing medications.

Medication incidents were identified and reported in a timely manner. There was evidence that learning from such events was implemented. For example, a chart to record regular checks of transdermal patch application site had been introduced following an incident.

Inspectors saw that there was a system in place for reviewing and monitoring safe medication management practices. A medication management audit was completed quarterly, most recently in January 2015. The audit examined a number of aspects in relation to medication management including documentation, ordering, storage, disposal, management of controlled drugs and training. There was evidence that pertinent deficiencies had been identified and actions, such as the implementation of documentation that had been designed specifically for the needs of the centre.

Staff outlined the manner in which medicines which are out of date or dispensed to a resident but are no longer needed are stored in a secure manner, segregated from other medicinal products and are returned to the pharmacy for disposal. Records confirmed that appropriate and comprehensive information was provided in relation to medication when residents were transferred to and from the centre.

Judgment:

Non Compliant - Moderate

Outcome 10: Notification of Incidents

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

Theme:

Safe care and support

Outstanding requirement(s) from previous inspection(s):

This was the centre's first inspection by the Authority.

Findings:

Inspectors noted that a comprehensive record of all incidents was maintained. Notifications to the Authority were made in line with the requirements of the Regulations.

Judgment:

Compliant

Outcome 11: Health and Social Care Needs

Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. 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.

Theme:

Effective care and support

Outstanding requirement(s) from previous inspection(s):

This was the centre's first inspection by the Authority.

Findings:

There was evidence that timely access to health care services was facilitated for all residents. The person in charge confirmed that a number of GPs were attending to the needs of the residents and an "out of hours" GP service was available if required. The records confirmed that residents were assisted to achieve and maintain the best possible health through regular blood profiling, quarterly medication review and annual administration of the influenza vaccine. Residents were referred as necessary to the acute hospital services and there was evidence of the exchange of comprehensive information on admission and discharge from hospital. In line with their needs, residents had ongoing access to allied healthcare professionals including physiotherapy, dietetics, speech and language therapy, occupational therapy, audiology and psychiatry.

Inspectors reviewed a selection of electronic care plans. There was evidence of a pre-assessment undertaken prior to admission for residents. After admission, there was a documented comprehensive assessment of all activities of daily living, including mobility, nutrition, communication, personal care, mood and sleep. There was evidence of a range of assessment tools being used and ongoing monitoring of falls and nutritional need. Each resident's care plan was kept under formal review as required by the resident's changing needs or circumstances and was reviewed no less frequently than at four-monthly intervals. The development and review of care plans was done in consultation with residents or their representatives. However, inspectors noted that care plans were not always developed to guide staff in meeting residents' assessed needs, for example epilepsy and healthcare associated infections.

Each resident had the right to refuse treatment. This was seen to be respected and documented appropriately in the electronic patient record.

Wound management was seen to be in line with national best practice. Wound management charts were maintained electronically and described the cleansing routine, emollients, dressings and frequency of dressings. The dimensions of the wound were documented and photographs were used to evaluate the wound on an ongoing basis. There was evidence of appropriate input being sought from specialist tissue viability services.

There was a strategy in place to prevent falls whilst also promoting residents' independence. An evidence-based assessment tool was used to assess residents' risk of falls on admission and at least every four months thereafter. A physiotherapist visited the centre regularly. The incidence of falls is monitored on an ongoing basis. A falls audit is completed on a quarterly basis and the inspector noted a review was completed

after each fall and preventative measures, such as hip protectors, sensor mats and ultra low beds, were implemented.

Judgment:

Non Compliant - Moderate

Outcome 12: Safe and Suitable Premises

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. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:

Effective care and support

Outstanding requirement(s) from previous inspection(s):

This was the centre's first inspection by the Authority.

Findings:

The centre is a two storey Georgian building with accommodation provided on both floors. The premises is directly accessed from the main street and the main entrance leads to the reception area and the nursing/administration office.

Ten residents were accommodated on the ground floor in four single bedrooms and three twin bedrooms. Bedrooms on the ground floor were not en-suite. There was one single toilet and a shower room with assisted toilet, shower and a wash-hand basin provided for residents' use on the ground floor. Also accommodated on the ground floor were the main kitchen and ancillary areas, dining room, recreational room, a residents' smoking room, staff toilet and staff changing facilities, sluice room, linen storage area and toilet facilities for catering staff. The laundry was located in an external area and adequate security measures were in place. There was a designated wash hand basin provided in the laundry.

The first floor is accessed by means of the main stairwell or by the passenger lift. Fifteen residents were accommodated on the first floor in five single bedrooms, two twin bedrooms and two triple bedrooms. One of the triple bedrooms was ensuite. Three further toilets are provided for residents' use and there is a shower room with assisted shower and wash-hand basin. A communal area and a small "quiet room" were provided. A recently refurbished sluice room, hairdressing salon and storage room are also accommodated on the first floor. There is an enclosed fire escape provided that is accessed from the lift lobby and exits onto the ground floor to the rear of the building. During the inspection, the shower room was undergoing renovation and was not accessible to residents.

Each bedroom provided adequate storage for personal possessions including a lockable storage space. Adequate screening was provided in shared bedrooms. The twin

bedrooms provided at least 7.5m² per resident and adequate private and communal accommodation. The layout of the twin bedrooms was suitable to meet the needs of residents. There were two bedrooms that provided accommodation for more than two residents. These bedrooms did provide at least 9.1m² per resident but these bedrooms were not laid out to meet the needs of dependent residents who require specialised equipment and in a manner that maximised the private and communal space available.

Inspectors observed that there were a number of areas which had not been adequately maintained including torn flooring, peeling paint and visible rust. Cleaning practices and décor in areas required review. The centre was adequately heated and lit.

Two communal areas and a dining room were provided for residents. The dining room on the ground floor provided seating for eight residents and meals were served in one sitting. Several residents on the first floor took their meals in the communal area on the first floor where they were seated and bed-tables were used to facilitate this.

Circulation areas, toilet facilities and shower/bathrooms were adequately equipped with hand-rails and grabrails. Emergency call facilities were in place that were accessible from each resident's bed and in each room used by residents.

A separate kitchen was provided and the kitchen was visibly clean and well-organised. There were suitable and sufficient cooking facilities, kitchen equipment and tableware.

The issues identified in relation to the premises were discussed at length with the providers. The providers demonstrated awareness of these issues and outlined that they had a long term renovation plan to address the areas identified. The plan was to be rolled out in a risk-based manner and had commenced with the sluice on the first floor.

Judgment:

Non Compliant - Moderate

Outcome 13: Complaints procedures

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

Theme:

Person-centred care and support

Outstanding requirement(s) from previous inspection(s):

This was the centre's first inspection by the Authority.

Findings:

A centre-specific comprehensive complaints policy was in place. The complaints policy identified the nominated complaints officer and also included an independent appeals process as required by legislation. A summary of the complaints procedure was displayed prominently at the main reception area and was included in the statement of purpose.

An inspector reviewed the electronic complaints log detailing the investigation, responses, outcome of any complaints and whether the complainant was satisfied. One complaint had been received since September 2014; this complaint was dealt with appropriately. The person in charge reported to inspectors that the complaints process will be audited.

Residents with whom the inspector spoke were able to identify the complaints officer, stated that any complaints they may have had were dealt with promptly and were satisfied with the complaints procedure.

Judgment:

Compliant

Outcome 14: End of Life Care

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

Theme:

Person-centred care and support

Outstanding requirement(s) from previous inspection(s):

This was the centre's first inspection by the Authority.

Findings:

The centre-specific policy on end of life care was made available to inspectors. The policy was comprehensive and evidence based. However, as outlined in outcome 5, it was not clear when this policy had been developed or last reviewed.

An inspector reviewed the care plan of a deceased resident and noted that the appropriate care had been provided and the resident's physical, emotional, social, physiological and spiritual needs had been met. The end of life care plan had been reviewed and updated following deterioration in the resident's condition. The care plan outlined the resident's preference as to place of death and this was seen to be facilitated.

Religious and cultural practices were facilitated. Members of the local clergy visited residents on a regular basis and some residents were facilitated to visit the Roman Catholic church opposite the centre. The person in charge confirmed that ministers from a range of religious denominations were facilitated to visit. Mass was celebrated on a weekly basis. Access to specialist palliative care services was available on a 24 hour basis from South Tipperary hospice home care team.

Arrangements were in place for capturing residents' end of life preferences. Discussions regarding end of life care with residents and representatives were documented and seen to be meaningful and comprehensive, capturing residents' wishes on preferred place of death, spirituality and religion at end of life and funeral arrangements. The person in

charge stated that residents were provided with the choice of a single room if they were not already in one as they reached their end of life. The inspector saw that this information was recorded in the resident's care plan and the care plans were reviewed and updated on a four monthly basis or more frequently if a resident's needs changed.

Any decisions not to attempt resuscitation were seen to be based on clear clinical rationale and discussions and decisions were clearly recorded and reviewed as appropriate.

Family and friends were suitably informed and facilitated to be with the resident at end of life. Overnight facilities were not available for families within the centre but staff stated that family members who chose to remain overnight were made comfortable. Tea/coffee and snacks were provided and available at all times.

Practices after death respected the remains of the deceased person and family members were consulted for removal of remains and funeral arrangements. Staff with whom inspectors spoke confirmed that staff members and residents were all informed and support was given when appropriate.

The end of life policy stated that residents' personal possessions were packaged in appropriate bags and boxes. However, as mentioned in outcome 5, inspectors observed evidence that this was not reflected in practice.

Judgment:

Compliant

Outcome 15: Food and Nutrition

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 discrete and sensitive manner.

Theme:

Person-centred care and support

Outstanding requirement(s) from previous inspection(s):

This was the centre's first inspection by the Authority.

Findings:

There were centre-specific policies in place in relation to meeting the nutritional and hydration needs of residents, dated September 2014.

The food served was sufficient in quantity, freshly prepared, nutritious and wholesome and was of a good standard. The inspector observed that there was a clear, documented system between nursing and catering staff regarding residents' meal choices and preferences. There was evidence of regular formal and informal meetings between the kitchen and nursing staff to discuss residents' dietary requirements. The inspector spoke with the catering staff on duty who demonstrated comprehensive

knowledge of residents' preferences and dietary needs.

There was evidence that choice was available to residents for breakfast, lunch and evening tea with respect to menu options and dining location. The menu for the day was displayed and inspectors observed staff informing residents of meal choices. A seasonal menu cycle was in operation.

Residents had a choice for breakfast; hot/cold cereals, eggs, breads, toast and beverages. Soup was served at 11:00 hrs. Lunch was served at 12:30 hrs. The evening meal was served at 16:30 hrs. A choice of snacks, such as scones, fruit, cakes and sandwiches, were available. Night staff had access to the kitchen to make hot drinks and a light snack for residents.

Residents were provided with a range of hot and cold drinks; fresh water was readily available in communal areas. Inspectors observed that staff encouraged residents to keep hydrated. Care staff were observed to record residents' fluid intake into the computerised system. Nursing staff reported monitoring the fluid balance of residents with specific requirements.

Residents were encouraged to remain independent and assistance was offered in a discreet and respectful manner. Gentle encouragement was given to residents who were reluctant to eat. Residents with whom the inspector spoke were complimentary of the meals and snacks served.

Staff with whom the inspector spoke demonstrated adequate knowledge of residents' needs in relation to diet and fluids of modified consistency and this was evidenced in practice.

Residents' weights were monitored on a monthly basis and the Malnutrition Universal Screening Tool (MUST) was also utilised in practice. The inspector saw that residents looked well, weights were stable, residents were not experiencing weight loss and nursing staff understood the relevance of weight loss when computing the MUST.

A review of the menu had been undertaken by the dietician in November 2014 and indicated that the food served was nutritionally complete. Staff had received training in nutrition and food safety, appropriate to their role.

Judgment:

Compliant

Outcome 16: Residents' Rights, Dignity and Consultation
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. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

Theme:

Outstanding requirement(s) from previous inspection(s):

This was the centre's first inspection by the Authority.

Findings:

The centre was relaxed, person centred and with a good level of visitor activity noted throughout the day. Residents reported that there was no restriction on visitors. A quiet room was provided for residents to meet visitors in private

Residents were consulted about how the centre was planned and run. A residents' meeting was facilitated and minutes from most recent meeting were made available to inspectors. Feedback sought during this meeting informed practice and suggestions, e.g. outings, were seen to be implemented.

Residents' capacity to exercise personal autonomy and choice was maximised. Staff were observed to provide residents with choice and control by facilitating residents' individual preferences in relation to their daily routine, meals and their choice of activities. Residents were facilitated to personalise their bedrooms with photographs and furniture from home. Residents' routines were documented clearly in their care plans and staff were seen to respect these. For example, some residents liked to have a nap after lunch and this was facilitated.

Residents are facilitated to exercise their civil, political and religious rights. Residents were conversant in current affairs. Mass was celebrated in the centre regularly and some residents were facilitated to visit the Roman Catholic church opposite the centre. The person in charge confirmed that ministers from a range of religious denominations were facilitated to visit.

The inspector observed televisions and radios in the communal areas. Residents also had access to televisions in their bedrooms and newspapers were delivered every day.

The inspector saw that residents received care that was dignified and respected their privacy at all times. Staff knocked and awaited permission before entering residents' bedrooms. Staff addressed residents by their preferred names. Screening curtains were used in shared rooms when personal care was delivered. CCTV cameras were not in use in areas where residents would have a reasonable expectation of privacy.

The person in charge confirmed that an independent advocacy service is available to residents when required. Inspectors observed that posters informing residents of this service were displayed.

The activities programme had been reviewed and the activities co-ordinator was not employed Monday to Friday. Activities were provided for residents including live music, nail care, current affairs, bingo, quizzes, story telling, arts and crafts, poetry and ball games. Residents can opt out of activities if they so wish.

Residents were facilitated to attend activities external to the centre. Inspectors observed

the activities co-ordinator supporting residents to go shopping or have a coffee in the town.

Judgment:

Compliant

Outcome 17: Residents' clothing and personal property and possessions
Adequate space is provided for residents' personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.

Theme:

Person-centred care and support

Outstanding requirement(s) from previous inspection(s):

This was the centre's first inspection by the Authority.

Findings:

There was adequate storage provided for residents' personal possessions. Each resident also had access to separate locked storage for valuables. A record was kept and maintained of each resident's personal property. This record was updated periodically.

Residents' personal clothing was laundered on-site and clothing was labelled to ensure that residents' own clothing was returned to them. Residents reported that their laundry was always returned to them. Inspectors observed that residents' clothing and accessories were well maintained.

There was a centre-specific policy on residents' personal property and possessions, dated October 2014. Residents with whom inspectors spoke confirmed that they could retain control over their personal possessions and clothing.

Judgment:

Compliant

Outcome 18: Suitable Staffing

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. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

Theme:

Workforce

Outstanding requirement(s) from previous inspection(s):

This was the centre's first inspection by the Authority.

Findings:

There was a planned roster in place. Based on observations, a review of the roster and these inspection findings, inspectors were satisfied that the staff numbers and skill-mix were appropriate to meeting the assessed needs of the complement of residents accommodated.

There was a registered nurse on duty at all times and a record is maintained of current registration details of nursing staff. Staff were observed to competently deliver care and support to residents that reflects contemporary evidence based practice.

A sample of staff files was reviewed and contained all of the required elements. Inspectors noted that copies of both the Regulations and the Authority's Standards were available. Staff were also able to articulate adequate knowledge and understanding of the Regulations and the Authority's Standards.

Staff training records demonstrated a proactive commitment to the ongoing maintenance and development of staff knowledge and competencies; the programme reflected the needs of residents. All staff employed had attended mandatory fire, manual handling and elder abuse training. Further education and training completed by staff included nutrition, food safety and dementia.

Regular staff meetings took place. Topics discussed included activities programme, nutrition, documentation, policies, restraint and cleaning. A weekly information sheet had been introduced to improve communication. An electronic message board was used to communicate important information to staff.

Staff were supervised on an appropriate basis. Recruitment, selection and vetting procedures were in line with best practice.

Judgment:

Compliant

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

Louisa Power
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	The Cottage Nursing Home
Centre ID:	OSV-0004587
Date of inspection:	25/02/2015
Date of response:	14/04/2015

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non-compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 01: Statement of Purpose

Theme:

Governance, Leadership and Management

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

The following items were not included on the Statement of Purpose:

- Information set out in the Certificate of Registration
- any separate facilities for day care
- arrangements for the management of the centre where the person in charge is in charge of more than one centre or absent from the centre

¹ The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.

Action Required:

Under Regulation 03(1) you are required to: Prepare a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Please state the actions you have taken or are planning to take:

We shall review our statement of purpose to ensure it contains all information set out in schedule 1 of the Health Act 2007.

Proposed Timescale: 07/05/2015

Theme:

Governance, Leadership and Management

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

It was not clear if the statement of purpose had been reviewed in the last year.

Action Required:

Under Regulation 03(2) you are required to: Review and revise the statement of purpose at intervals of not less than one year.

Please state the actions you have taken or are planning to take:

Following review of our statement we will date it and set an annual review date

Proposed Timescale: 07/05/2015

Outcome 05: Documentation to be kept at a designated centre**Theme:**

Governance, Leadership and Management

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

A number of policies listed in Schedule 5 did not contain implementation/review dates and therefore it was not clear if these policies had been reviewed in the previous three years. The complaints policy required review to reflect a recent change in the advocacy service provision.

Action Required:

Under Regulation 04(3) you are required to: Review the policies and procedures referred to in regulation 4(1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.

Please state the actions you have taken or are planning to take:

We are in the process of reviewing all policies and setting an accurate review date for each policy

Proposed Timescale: 19/04/2015

Theme:

Governance, Leadership and Management

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

Staff demonstrated awareness of the policy in relation to end of life but did not reflect elements of the policy in practice.

Action Required:

Under Regulation 04(1) you are required to: Prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.

Please state the actions you have taken or are planning to take:

We have reviewed our End-of-life policy and will ensure that practise follows policy

Proposed Timescale: 02/04/2015

Outcome 07: Safeguarding and Safety

Theme:

Safe care and support

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

It was not clear from the documentation if episodes of challenging behaviour were managed in a manner that was least restrictive in this case, if alternative strategies had been ineffective and the use of chemical restraint had been reviewed after use.

Action Required:

Under Regulation 07(3) you are required to: Ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.

Please state the actions you have taken or are planning to take:

We have completed an audit on the use of psychotropic medication. We have informed all staff of the need to employ diversional strategies to manage incidents of challenging behaviour before using psychotropic medication and reviewing effects of medication. All staff shall undertake challenging behaviour training in 2015.

Proposed Timescale: 01/08/2015

Theme:

Safe care and support

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

The policy in relation to responding to allegations of abuse would not effectively guide

staff if an allegation was made against the person in charge or a member of the management team

Action Required:

Under Regulation 08(4) you are required to: Where the person in charge is the subject of an allegation of abuse investigate the matter, or nominate a person who is a suitable person to investigate the matter.

Please state the actions you have taken or are planning to take:

We have reviewed and changed our policy in relation to responding to allegation of abuse in relation to allegations made against the person in charge and members of the management team.

Proposed Timescale: 05/04/2015

Outcome 08: Health and Safety and Risk Management

Theme:

Safe care and support

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

Bed spacing was not planned and managed in a way that minimises the spread of healthcare associated infections in line with the standards for the prevention and control of healthcare associated infections published by the Authority.

Action Required:

Under Regulation 27 you are required to: Ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.

Please state the actions you have taken or are planning to take:

We will ensure in so far as is possible that such residents are accommodated in single rooms. There is a plan in place to change our floor plan to alter the existing three bedded rooms into either double or single rooms. We will furnish HIQA with a copy of proposed floor plans as soon as they are ready (May 15). This refurbishment will then be completed as soon as possible allowing for budget restraints and resident comfort.

Proposed Timescale: 30/09/2016

Outcome 09: Medication Management

Theme:

Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

- A number of prescription records examined did not contain the prescriber's signature for each medicine prescribed in accordance with the Medicinal Products (Prescription

and Control of Supply) Regulations

- where medications were to be administered in a modified form such as crushing, this was not individually prescribed by the medical practitioner on the prescription chart.

Action Required:

Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.

Please state the actions you have taken or are planning to take:

We have reviewed all prescription records and asked each doctor to sign each medication. We have amended charts to indicate where medications are to be modified i.e. crushed.

Proposed Timescale: 31/03/2015

Outcome 11: Health and Social Care Needs

Theme:

Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Care plans had not always been developed to guide staff in meeting residents' assessed needs such as epilepsy and healthcare associated infection.

Action Required:

Under Regulation 05(3) you are required to: Prepare a care plan, based on the assessment referred to in Regulation 5(2), for a resident no later than 48 hours after that resident's admission to the designated centre.

Please state the actions you have taken or are planning to take:

We have reviewed all care plans and developed same to reflect needs

Proposed Timescale: 25/03/2015

Outcome 12: Safe and Suitable Premises

Theme:

Effective care and support

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

Triple bedrooms were not laid out to meet the needs of dependent residents who require specialised equipment and in a manner that maximised the private and communal space available.

Action Required:

Under Regulation 17(1) you are required to: Ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.

Please state the actions you have taken or are planning to take:

There is a plan in place to change our floor plan to alter the existing three bedded rooms into either double or single rooms. We will furnish HIQA with a copy of proposed floor plans as soon as they are ready (May 15). This refurbishment will then be completed as soon as possible allowing for budget restraints and resident comfort.

Proposed Timescale: 30/09/2016

Theme:

Effective care and support

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

A number of areas were adequately maintained. Cleaning practices and décor in some areas required review.

Action Required:

Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

Please state the actions you have taken or are planning to take:

We have a long term plan to completely renovate all areas of the building. To date we have refurbished an upstairs bathroom and sluiceroom, We are in the process of renovating a downstairs bathroom and sluiceroom. The downstairs lobby has been renovated. These plans will be completed as soon as possible allowing for budget restraints and resident comfort. This is an ongoing project and will possibly take 3 years to complete everything however items in most need of attention will be attended to first. A schedule of works is being drafted at will be sent to HIQA in May 15.

Proposed Timescale: 30/09/2018

Theme:

Effective care and support

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

The dining room located on the ground floor could only accommodate eight residents.

Action Required:

Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

Please state the actions you have taken or are planning to take:

We have a long term plan to completely renovate all areas of the building with a particular emphasis on providing adequate living, dining and communal space. We propose to double the living/dining space on the ground floor with a smaller area upstairs. As stated earlier floor plans will be furnished in May 15.

Proposed Timescale: 30/09/2016