

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Glendale Nursing Home
<b>Centre ID:</b>	OSV-0000228
<b>Centre address:</b>	Shillelagh Road, Tullow, Carlow.
<b>Telephone number:</b>	059 918 1555 or 059 918 1500
<b>Email address:</b>	nursinghome@glendale.ie
<b>Type of centre:</b>	A Nursing Home as per Health (Nursing Homes) Act 1990
<b>Registered provider:</b>	Glendale Care Limited
<b>Provider Nominee:</b>	John Mangan
<b>Lead inspector:</b>	Catherine Rose Connolly Gargan
<b>Support inspector(s):</b>	Ide Cronin
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	45
<b>Number of vacancies on the date of inspection:</b>	15

## 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 monitor compliance with specific outcomes as part of a thematic inspection. This monitoring inspection was un-announced and took place over 1 day(s).

**The inspection took place over the following dates and times**

From: 28 January 2016 09:15 To: 28 January 2016 18:45

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

<b>Outcome</b>	<b>Our Judgment</b>
Outcome 01: Statement of Purpose	Compliant
Outcome 02: Governance and Management	Non Compliant - Moderate
Outcome 07: Safeguarding and Safety	Compliant
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 09: Medication Management	Non Compliant - Moderate
Outcome 10: Notification of Incidents	Compliant
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 13: Complaints procedures	Non Compliant - Moderate
Outcome 14: End of Life Care	Non Compliant - Moderate
Outcome 16: Residents' Rights, Dignity and Consultation	Non Compliant - Moderate
Outcome 18: Suitable Staffing	Substantially Compliant

**Summary of findings from this inspection**

This monitoring inspection was unannounced and took place to monitor ongoing compliance with the regulations and in response to unsolicited information received by the Authority. Areas referenced in the information received included; access to healthcare, complaints management, staffing, safeguarding and safety and end of life care of residents. This information was substantiated by non-compliant inspection findings in governance and management, complaints management and end of life care of residents. Inspectors also followed up on progress with completion of four action plans from the last inspection of the centre in July 2014 and found two were satisfactorily completed. Action plans referencing non-compliance with medication management and governance and management were not satisfactorily completed.

The collective feedback from residents and relatives was one of satisfaction with the service and care provided. Community and family involvement is encouraged with residents saying their relatives/visitors felt welcome at any time.

Staff were observed to be respectful and responsive to residents

The clinical governance and management structure in the centre required substantial improvement. I inspectors found that the systems in place to monitor the quality and safety of clinical care and the quality of life for residents were not adequate. The management of complains also required improvement.

Residents had satisfactory access to healthcare, medical and allied health professionals and their care needs were met. However, improvement was required with documenting their care needs and the interventions necessary to address identified needs.

Consultation with residents regarding their end of life wishes and review of their care plans required improvement.

While medication administration practices met professional standards, prescribing of medications to be administered in crushed format was not adequate.

There was adequate staff numbers and skill mix to meet the needs of residents on the day of inspection, however the staffing resources required review in order to adequately supervise residents and meet their social needs in the evenings.

The Action Plan at the end of this report identifies improvements that must be made to meet the requirements of 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.

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):**

No actions were required from the previous inspection.

**Findings:**

There was a written statement of purpose available that accurately describes the centre and reflected the service and care provided.

A copy of the centre's statement of purpose and function updated in January 2016 was forwarded to the Authority. This document was reviewed and the inspector found that it contained the information as required by schedule 1 of the Regulations.

The statement of purpose and function accurately described the range of needs that the designated centre meets and the services provided.

**Judgment:**

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):**

Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**

The governance and management structure changed in 2014 with a new provider and management team. However, the process of creating governance structures and establishing the management team was still in progress and not fully embedded. The inspectors found that due to the changes in the management team to date, a clearly defined clinical management structure needs to be fully implemented with clearly defined roles and lines of authority and accountability. An operations manager recently joined the management team to support the administrative day to day running of the centre. The centres' assistant director of nursing was deputising for the person in charge on the day of inspection. The provider nominee and other members of the board of directors were also on-site. The provider and management team expressed their strong commitment to achieving good standards in quality person-centred care through continuous improvement of the service provided.

Inspectors found that the system in place to monitor the quality and safety of care and the quality of life for residents required substantial improvement. The inspectors observed that some aspects of clinical care were reviewed. For example, prescribed antipsychotic, antidepressant and anxiolytic medications were reviewed on a monthly basis and included a clinical evaluation of each resident. However, there was no evidence that this review positively informed medication management practices.

The provider attends the centre on average, twice weekly or more often if required. He had completed a comprehensive report of the the Quality of the Service for 2015 and identified service improvements for 2016. Dementia care was identified as an area for development. The plan was to assign a part of the centre to residents with dementia and develop the environment to promote their independence and enhance their quality of life. While this quality review was comprehensive, further audits were required to robustly inform priorities future improvements/developments in the service.

**Judgment:**

Non Compliant - Moderate

***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):**

No actions were required from the previous inspection.

**Findings:**

The training records viewed by the inspectors showed that staff received ongoing training in the prevention of abuse and safeguarding vulnerable residents. Staff spoken with confirmed to inspectors that they had received this training and were aware of

what to do if they suspected or were informed of an allegation of abuse. The provider told the inspectors that he maintained a no-tolerance policy to any form of abuse in the centre. The inspectors observed notices to that effect in the reception area.

There were no allegations of abuse under investigation at the time of this inspection. The inspectors observed that no allegations of abuse were recorded or notified to the Authority since the last inspection in July 2014.

Some residents presented with episodes of behaviours that challenge related to their medical condition. The inspectors observed a staff member managing care of one such resident. Care provided in this instance was respectful and gentle and the situation was satisfactorily de-escalated. The deputy person in charge led on developing behavioural support plans for residents.

There was evidence in care plans of evidenced based assessments and treatment plans for residents who exhibited behaviours that challenge. The majority of staff had attended training on dementia care and managing behaviours that challenge. The deputy person in charge advised inspectors that this training was ongoing to completion by all staff. There were no residents prescribed medications PRN (as required) as a chemical restraint. The inspectors saw that bedrails were currently being used for many residents, some of which were requested by residents to support their mobility and comfort while in bed. Bedrail assessments were completed on residents with bed rails in use. There was evidence of alternatives tried to ensure bedrail use was appropriate.

These assessments were reviewed on a regular basis and there was documentary that residents were being checked while bedrails were in use. The deputy person in charge was working towards reducing the use of bedrails with low low beds, additional equipment and further education for staff.

**Judgment:**  
Compliant

***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):**  
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**  
Overall the health and safety of residents and others was promoted and protected. Fire safety policies and procedure were viewed by an inspector and were found to be centre-specific. The centre was compartmentalised for fire safety purposes and compartments were protected with fire doors. Fire safety management procedures were in place and included a daily check of the escape routes. The inspectors observed no fire doors were

held open on this inspection by wedges. The inspectors were told that magnetic units fitted to hold doors open on corridors released to allow the doors to close on activation of the fire alarm. Inspectors also observed that wooden fire doors to the outside of the building had been replaced with glass doors improving protection and visibility for residents.

Training records confirmed that fire training was provided to staff on various dates by the deputy person in charge who had attended additional training to enable him to train staff. Regular fire evacuation drills were undertaken which demonstrated effective evacuation and improvements for the future. Each resident had an evacuation assessment and a plan completed to meet their emergency evacuation needs. Staff spoken with indicated that they were aware of what to do in the event of fire.

The centre-specific health and safety statement was dated January 2014 and required review in 2016. The provider advised that this process was currently taking place and all health and safety and risk management advisory documentation was being reprinted in head office for distribution to the centres owned by the provider.

The risk management policy and risk register viewed by the inspectors referenced numerous safe working practice procedures and hazard identification sheets with control measures. However, not all hazards to residents in the centre as observed by inspectors on this inspection were identified with appropriate controls in place to mitigate the level of risk they posed. For example;

- an area of corridor accessible to residents did not have handrails fitted
- areas of the floor surface on some corridors was uneven and the edges of a service duct in one area of corridor posed a trip risk
- a door to an internal garden and smoking hut was heavy and difficult for residents to open, especially residents in wheelchairs.

Risk management procedures were in place and included risk of abuse, violence and aggression, self harm, unexplained absence of a resident, accidental injury to residents, visitors or staff as required by the regulations. The inspectors observed additional procedures were in place to address the risk of vulnerable residents leaving the centre unaccompanied. Exit doors were alarmed to alert staff on opening. Staff had completed a missing person drill and each resident had a missing person profile completed to assist the emergency services with their safe recovery if necessary. A checking procedure to ensure all residents were accounted for was completed and documented by a staff nurse every two hours.

The inspectors saw that numerous clinical risk assessments were completed for each resident including falls risk, pressure related skin damage, continence, moving and handling and risk assessments for individual residents who smoked. Smoking aprons were available to protect vulnerable residents who smoked. The provider utilised sensor alarms to support residents at risk of falls. The inspectors observed use of these alarms when residents were in bed and also resting in chairs during the day in the sitting areas and at mealtimes. Accidents and incidents involving residents were recorded and were found to be responded to appropriately on an individual basis to prevent re-occurrence. Care plan documentation outlined strategies to mitigate clinical risks while also supporting residents' independence. Low-beds and crash mats were also used to prevent injury when appropriate.

The premises were visibly clean. Personal protective equipment such as gloves and aprons were readily available and hand sanitisers were located at the entrance and throughout resident and staff areas. The inspectors observed that staff took opportunities to cleanse their hands using the alcohol gels provided as appropriate on this inspection. The laundry was viewed by an inspector and confirmed that the system for managing residents' clean and used laundry had been revised since the last inspection. The laundry system was now consistent with the recommendations of the prevention and control of healthcare associated infections standards. The laundry has an entrance and an exit door which was used appropriately.

**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):**

Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**

Inspectors observed that medications were stored, and disposed of appropriately in line with An Bord Altranais Guidance to Nurses and Midwives on Medication Management (2007). Residents' prescribed medications were being reviewed at least on a three-monthly basis.

An inspector observed medication administration in the dining room. The nurse administering medications wore a red apron to inform others of her role and to avoid disturbance. The inspector observed that the nurse administered and recorded medications as prescribed in line with professional guidelines. Residents' medication prescriptions contained all required prescribing information with the exception of prescriptions for residents who required their tablets to be crushed. Each medication administered as a crushed preparation was not prescribed to be administered in that format, which did not meet the prescribing legislative requirements. This non-compliance was found on the last inspection in July 2014 and was the subject of an action plan which was not satisfactorily completed.

A medicines information sheet was completed for each resident by the pharmacist that included the name and a photograph of each medicine prescribed for them, indications for use and possible side effects. Each resident's allergy status was clearly indicated. Prescriptions were transcribed and were in line with professional guidelines for this practice.

A separate record was maintained for each resident that included details of courses of

antibiotic, anti-psychotic, anti-depressant and anxiolytic medications administered.

**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):**

No actions were required from the previous inspection.

**Findings:**

Incidents as described in the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 were reported in accordance with the requirements of the legislation. The provider and the deputy person in charge were aware of their legal requirements regarding notifications to the Chief Inspector including serious injury to residents.

Quarterly notification requirements were forwarded to the Authority as required.

**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):**

No actions were required from the previous inspection.

**Findings:**

There were 44 residents in the centre and one resident was in hospital on the day of this inspection. 13 residents were assessed as having maximum dependency needs, 18 had high dependency needs, nine had medium and four had low dependency needs. 23 residents had a diagnosis of dementia.

Residents told inspectors that they received good care. The inspectors found that the healthcare needs of residents including residents with a diagnosis of dementia were generally met, however some areas of clinical practice required improvement.

The inspector found on this inspection that arrangements were in place to meet residents' assessed health and social care needs. Residents' care needs were assessed using validated risk assessment tools. While there were no deficits identified in residents' care, some residents' assessed care needs was not documented in a care plan or lacked sufficient detail to support consistent, appropriate staff interventions. Daily progress notes were completed and were generally linked to care plans, however the content required improvement. This finding was discussed and demonstrated to the deputy person in charge and the provider. While care plans in place were reviewed regularly by staff, there was an absence of documentation supporting consultation with residents and/or their next of kin to ensure the care and support provided reflected the assessed needs and wishes of residents.

Residents' documentation confirmed they had timely access to access to allied health, general medical and specialist medical services as required. A dietician attended the centre as required and assessed residents with or at risk of unintentional weight loss and set out recommendations to supplement their intake as appropriate. Residents' weights were checked on a monthly basis or more often if necessary. Residents' weights were monitored and assessed to facilitate identification and timely interventions. Reference sheets were available outlining residents' special diets including diabetic, modified consistency diets and thickened fluids.

The inspectors reviewed the wound care provided in the centre. Wounds were assessed using an appropriate measurement system with assessed size, type, exudate and included a treatment plan. Photographic evidence was also obtained. However, the treatment plan was not reflected in care practice for one pressure related skin injury. Staff practices as documented in daily progress notes did not reflect contemporary evidence based care of pressure related skin injury.

**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):**

No actions were required from the previous inspection.

**Findings:**

There was a written operational policy and procedure for making, handling and

investigation of complaints. The complaints procedure contained an appeals process. The complaints procedure was on display in the main foyer and at other locations in the centre.

Inspectors reviewed the complaints log and found that the process for the management of complaints required improvement. The deputy person in charge advised inspectors that most complaints were managed at a local level. Complaints that could not be resolved locally were escalated up to the provider. However the inspectors noted that in some cases, documentation had not been adequately completed. In a sample viewed by inspectors, the outcome of the complaint was not recorded and it was not evident if the issue was resolved or whether the complainant was satisfied or not. In one instance it was unclear what process was used and details of the investigation and action taken were not recorded.

**Judgment:**

Non Compliant - Moderate

***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):**

No actions were required from the previous inspection.

**Findings:**

There was a policy available detailing end-of-life care procedures to guide staff. The policy in the centre is that all residents avail of advanced intervention including hospital admission unless documented otherwise.

Inspectors observed that care plans referenced the religious, social and spiritual needs of residents. Individual religious and cultural practices were facilitated. There was a small non-denominational oratory available to residents for group or individual prayer and quiet reflection.

While care needs were identified on admission and documented accordingly, there was limited evidence of any advance planning to ensure the expressed preferences of residents were taken into account prior to them becoming unwell. Therefore decisions concerning future healthcare interventions required review to ensure each resident had an opportunity to share their wishes before they became ill and unable to fully participate in decisions about their care. Resident's preferences with regard to their transfer to hospital is of a therapeutic benefit were not consistently documented in the end-of -life care plans.

There were issues of capacity to make decisions that staff had to consider, as some

residents were highly dependent, had dementia or a combination of complex conditions. There was a policy on consent however; the process was unclear regarding obtaining a valid consent in accordance with legislation and current best practice guidelines. There was evidence in medical records that end-of life care and decisions regarding resuscitation were documented by the GP. However, there was inconsistent evidence of discussion or input from residents or relatives in some residents' records or on a separate consent form to confirm this decision. Inspectors did not observe that these decisions were reviewed or updated regularly as residents' health improved to assess the validity of this clinical judgement on an ongoing basis.

**Judgment:**

Non Compliant - Moderate

***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:**

Person-centred care and support

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

No actions were required from the previous inspection.

**Findings:**

There was an open visiting policy and contact with family members was encouraged. There was also ample private space available for residents to meet with their visitors. Residents and relatives commended staff on how welcoming they were to all visitors. Residents could receive visitors in private if they wished and many were seen to visit in the reception area in the centre as well as in the lounges and in residents' bedrooms.

There was a suggestion box available in the reception area. Residents' satisfaction surveys had been completed prior to this inspection as a method of eliciting the views of the residents.

Inspectors were satisfied that staff treated residents with respect and ensured their privacy and dignity needs were met. During discussions with the provider and management team, a strong emphasis was placed on these values. Staff were observed knocking on bedroom, toilet and bathroom doors and waiting for a response to enter. These findings were also confirmed by residents who spoke with inspectors. Inspectors observed staff interacting with residents in an appropriate and respectful manner. Many residents told inspectors that they were happy because all the staff were kind and caring towards them.

There was an additional charge to the fee for activities in the centre. An activity assessment tool was used to ensure each resident had opportunity to participate in

activities that met their interests and capabilities. A structured program of activities was in place and was clearly displayed. An activities coordinator was employed on a full-time basis and worked from Monday to Friday. The inspector spoke with the activity coordinator who confirmed the range of activities in the weekly program. The activity schedule provided for both cognitive and physical stimulation. As part of the inspection, inspectors spent a period of time observing staff interactions with residents. Inspectors used a validated observational tool (the quality of interactions schedule, or QUIS) to rate and record at five minute intervals the quality of interactions between staff and residents in a communal area over a thirty minute period. The scores for the quality of interactions are +2(positive connective care), +1 (task orientated care, 0 (neutral care), -1 (protective and controlling), -2 (institutional, controlling care). The observation took place in the lounge area in the afternoon. The inspector observed during the period of observation that the staff member knew the residents well and connected with each resident on a personal level.

The centre had a minibus which is used to provide occasional day trips for residents to places of their choice. Links were being developed with the local community and volunteers assisted with providing entertainment for the residents.

However, the inspectors observed that supervision and activation arrangements for residents resting in the sitting room and lobby area in the evening required improvement to ensure their needs were met. In addition, activity provision over the weekend required review as 53% (23) of residents in the centre had a diagnosis of dementia and there was no co-ordinated activities provided during the weekend period.

A residents' committee met on a regular basis, this enabled residents an opportunity to have an input in the running of the centre and express their views if they wished to do so. Minutes of the last meeting viewed by an inspector indicated that residents were satisfied with food, laundry arrangements and their bedrooms. Since the last inspection in July 2014, a quality of life committee had also been put in place which further enhanced communication between the provider, residents and their relatives.

Residents confirmed and inspectors observed that residents religious and civil rights were supported. Religious ceremonies were celebrated which included weekly Mass. Inspectors observed some residents also spent some quiet time in the oratory. Inspectors saw that residents had access to televisions and radios. Newspapers were available and the news topics were discussed each day if residents choose to join the group.

**Judgment:**

Non Compliant - Moderate

***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):**

No actions were required from the previous inspection.

**Findings:**

The inspectors found that the numbers and skill mix of staff were appropriate to the assessed needs of residents on the day of inspection. A minimum of two registered nurses were on duty at all times. Residents confirmed that there were staff available in sufficient numbers and with the appropriate skills and competencies to meet their personal and health needs. They spoke positively about staff and confirmed they were caring, responsive to their needs, and treated them with respect and dignity.

Staff observed and spoken with by inspectors demonstrated an understanding of their role and responsibilities in the delivery of person-centred care to residents. They demonstrated that they were knowledgeable about residents' individual needs, fire procedures and the process for reporting suspicions or allegations of abuse.

Staff told the inspector that they were well supported by the provider and that a good team spirit had been fostered among staff in the centre. The inspectors noted that there were staff meetings arranged and that a range of topics were discussed.

However, supervision of staff was not supported by a formal appraisal system to allow each staff member to be informed of their progress and strengths, and have opportunity to address development needs. This finding was also evidenced in the areas of deficit in staff practices as outlined in this report.

There was a recruitment policy in place and inspectors were satisfied that staff recruitment was in line with the Regulations. The inspector viewed four staff files which contained full and satisfactory information and documents as specified in Schedule 2 of the Regulations including records of nurses' registration with An Bord Altranais agus Cnáimhseachais Na hÉireann.

Staff were facilitated to attend professional development and mandatory training requirements as evidenced by the centre's training records given to inspectors.

**Judgment:**

Substantially 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:***

Catherine Rose Connolly Gargan  
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 report<sup>1</sup>

<b>Centre name:</b>	Glendale Nursing Home
<b>Centre ID:</b>	OSV-0000228
<b>Date of inspection:</b>	28/01/2016
<b>Date of response:</b>	09/03/2016

### 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 02: Governance and Management

#### Theme:

Governance, Leadership and Management

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

The management structure was being developed and did not have clearly defined roles and lines of authority and accountability.

#### **1. Action Required:**

Under Regulation 23(b) you are required to: Put in place a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and

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

details responsibilities for all areas of service provision.

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

Due to the recent appointment of a General Manager which is a new post, the management structure was in the final stages of development on the date of the Hiqa inspection. This has now been completed and includes clearly defined roles and lines of authority and accountability for all persons participating in management .

**Proposed Timescale:** 09/03/2016

**Theme:**

Governance, Leadership and Management

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

The system in place to monitor the quality and safety of clinical care and the quality of life for residents was not adequate.

**2. Action Required:**

Under Regulation 23(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

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

A system is now in place to monitor the quality and safety of clinical care and the quality of life for residents. This system includes inter alia, weekly data collection which is reviewed by GM and DOC and corrective action completed if and deficits in care identified. Daily meeting of the NIC, Catering supervisor, DOC and GM to discuss priority issues. A schedule of audits is now in place which is overseen by the GM.

Corrective actions identified as a result of these audits will be taken immediately and staff will be given "opportunities for learning" by ensuring and deficits in care will be discussed at handovers, staff meetings etc. Adverse incidents are fully investigated; staff will be given opportunities to reflect on their practice to ensure that a culture of continuous learning is created. All residents individual care plans are reviewed by RN monthly and a full Multidisciplinary review is completed four monthly.

Annual surveys are carried out on the quality of life and the quality of care by residents, and relatives. Also an annual survey on the quality of food is carried out.

A new initiative commenced in October 2015 is the "Quality of life meeting" members include two residents, three representatives of relatives, representatives of staff and management and advocate. This forum is a rich source of information on the quality of service we offer our residents and many initiatives have resulted as a result of this collaboration.

On 11th February an independent expert audited our dementia offering which included Dementia Care Mapping, activity audit and environment audit. We are awaiting audit report and will immediately compile action plan to improve our service offering as required.

**Proposed Timescale:** 09/03/2016

## 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:**

Not all hazards to residents in the centre were identified with appropriate controls in place to mitigate the level of risk they posed

**3. Action Required:**

Under Regulation 26(1)(a) you are required to: Ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.

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

- 1.All hazards are now included in the risk register and appropriate controls put in place to mitigate the level of risk they posed
- 2.The area of corridor accessible to residents will be fitted with handrails
- 3.Uneven floor surface and the edges of a service duct rectified
- 4.Door to an internal garden and smoking hut has been adjusted to make exit more accessible residents who use a wheel chair and bell now in situ which will enable resident to call for assistance

Proposed Timescale: 1: completed , 2: completed before 1st March, 3: completed 1st April , 4: Completed

**Proposed Timescale: 01/04/2016**

## 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:**

Each medication administered as a crushed preparation was not prescribed to be administered in that format by the prescriber.

**4. 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:**

At time of the inspection prescription sheet were being changed to a new format and the medications which were prescribed as crushed were not included in the new format

All medications including formulation to be administered are now included in new prescription sheets which are all signed and dated by GP

**Proposed Timescale:** 09/03/2016

### **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:**

Some residents' assessed care needs were not reflected in a care plan to inform appropriate staff interventions to be taken.

**5. 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:**

All residents' assessed care needs are now reflected in a care plan to inform appropriate staff interventions to be taken and all interventions are followed in practice. This is completed on a multidisciplinary team basis involving, resident and/or NOK, Nurses, member of the management team, Health care assistants, activities coordinator, GPs, other healthcare disciplines such as dietician, Tissue viability Nurse, Speech and language therapist etc. Care plan audit is completed weekly by a member of the management team.

Individual Care plans are reviewed at least monthly

**Proposed Timescale:** 09/03/2016

**Theme:**

Effective care and support

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

While care plans in place were reviewed regularly by staff, there was no evidence of consultation with residents and/or their next of kin, to ensure the care and support provided reflected the assessed needs and wishes of residents.

**6. Action Required:**

Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.

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

A full review of residents care is now completed at least every four months or sooner if resident condition necessitates, in consultation with residents and/or relative and relevant members of the multidisciplinary team.

**Proposed Timescale:** 09/03/2016

**Theme:**

Effective care and support

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

Wound care treatment plans were not reflected in practice. Staff practices as documented in daily progress notes did not reflect contemporary evidence based care of pressure related skin injury.

**7. Action Required:**

Under Regulation 06(1) you are required to: Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

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

1. Staff practices as documented in daily progress notes now reflect contemporary evidence based care of pressure related skin injury. Wound care progress reports now more descriptive which accurately describes wound condition.
2. Wound care and pressure area care audits will be carried out 2 weekly which will be reviewed by DOC
3. All RNs will complete wound care training before 1st may 2016

Proposed Timescale: 1, completed , 2 1may 2016

**Proposed Timescale:** 01/05/2016

**Outcome 13: Complaints procedures**

**Theme:**

Person-centred care and support

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

Documentation relating to complaints management was not adequately completed for all complaints.

**8. Action Required:**

Under Regulation 34(1)(f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into the

complaint, the outcome of the complaint and whether or not the resident was satisfied.

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

Policy on complaints updated to include the General manager who will conduct an audit of complaints monthly

DOC will sign off all complaints and ensure that all complaints are resolved to the satisfaction of the complainant

All staff have received training in relation to dealing with complaints

**Proposed Timescale:** 09/03/2016

**Outcome 14: End of Life Care**

**Theme:**

Person-centred care and support

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

There was limited evidence of any advance planning to ensure the expressed preferences of residents regarding their end of life wishes were taken into account prior to them becoming unwell.

There was inconsistent evidence of discussion or input from residents or relatives in some residents' records or on a separate consent form to confirm this decision. Inspectors did not observe that these decisions were reviewed or updated regularly as residents health improved to assess the validity of clinical judgements on an ongoing basis.

**9. Action Required:**

Under Regulation 13(1)(a) you are required to: Provide appropriate care and comfort to a resident approaching end of life, which addresses the physical, emotional, social, psychological and spiritual needs of the resident concerned.

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

Advance plans which includes expressed preferences of residents regarding their end of life wishes are now in place. Some residents do not wish to be consulted on this issue and their rights are respected. The next of Kin opinion is sought when resident is unable for whatever reason to express a view.

Care plan training in this area completed for all RNs in this area, Care plan are extensively reviewed by RN as resident condition changes and four monthly

**Proposed Timescale:** 09/03/2016

**Outcome 16: Residents' Rights, Dignity and Consultation**

**Theme:**

Person-centred care and support

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

Supervision and activation arrangements for residents resting in the sitting room and lobby area in the evening required improvement to ensure their needs were met.  
Activity provision at weekends required review.

**10. Action Required:**

Under Regulation 09(2)(b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests and capacities.

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

Supervision and activation arrangements for residents resting in the sitting room and lobby area are now in place, which includes HCA having specific assignment for supervising sitting rooms. We have also utilised another sitting room which is proving beneficial for high dependency residents.

**Proposed Timescale:** 09/03/2016

**Outcome 18: Suitable Staffing**

**Theme:**

Workforce

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

Supervision of staff was not supported by a formal appraisal system

**11. Action Required:**

Under Regulation 16(1)(b) you are required to: Ensure that staff are appropriately supervised.

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

New management structure will ensure that all staff have supervision pertinent to their role

All staff have been formally appraised which includes KPIs to be achieved in 2016

**Proposed Timescale:** 09/03/2016