

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Ratoath Manor Nursing Home
<b>Centre ID:</b>	OSV-0000152
<b>Centre address:</b>	Ratoath, Meath.
<b>Telephone number:</b>	01 825 6101
<b>Email address:</b>	ratoath@silverstream.ie
<b>Type of centre:</b>	A Nursing Home as per Health (Nursing Homes) Act 1990
<b>Registered provider:</b>	Ratoath Nursing Home Limited
<b>Provider Nominee:</b>	Joseph Kenny
<b>Lead inspector:</b>	Mary O'Donnell
<b>Support inspector(s):</b>	Angela Ring
<b>Type of inspection</b>	Unannounced Dementia Care Thematic Inspections
<b>Number of residents on the date of inspection:</b>	60
<b>Number of vacancies on the date of inspection:</b>	3

## **About Dementia Care Thematic Inspections**

The purpose of regulation in relation to residential care of dependent Older Persons is to safeguard and ensure that the health, wellbeing and quality of life of residents is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer and more fulfilling lives. This provides assurances to the public, relatives and residents that a service meets the requirements of quality standards which are underpinned by regulations.

Thematic inspections were developed to drive quality improvement and focus on a specific aspect of care. The dementia care thematic inspection focuses on the quality of life of people with dementia and monitors the level of compliance with the regulations and standards in relation to residents with dementia. The aim of these inspections is to understand the lived experiences of people with dementia in designated centres and to promote best practice in relation to residents receiving meaningful, individualised, person centred care.

**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: 19 July 2016 07:30 To: 19 July 2016 16:00

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

<b>Outcome</b>	<b>Provider's self assessment</b>	<b>Our Judgment</b>
Outcome 01: Health and Social Care Needs	Substantially Compliant	Substantially Compliant
Outcome 02: Safeguarding and Safety	Non Compliant - Moderate	Substantially Compliant
Outcome 03: Residents' Rights, Dignity and Consultation	Substantially Compliant	Non Compliant - Moderate
Outcome 04: Complaints procedures	Substantially Compliant	Compliant
Outcome 05: Suitable Staffing	Substantially Compliant	Non Compliant - Moderate
Outcome 06: Safe and Suitable Premises	Non Compliant - Moderate	Substantially Compliant
Outcome 07: Health and Safety and Risk Management		Non Compliant - Moderate
Outcome 08: Governance and Management		Compliant

**Summary of findings from this inspection**

This inspection report sets out the findings of a thematic inspection which focused on specific outcomes relevant to dementia care. The inspection also followed-up on progress with the completion of actions required to address non-compliances with the regulations from the previous monitoring inspection and a focused fire safety inspection, both of which were carried out in January 2016. The majority of required actions from both inspections had been progressed and completed with some exceptions. The works were in progress to upgrade fire safety doors and construct ramps at some exit doors were due for completion by mid August 2016. Sixteen of the seventeen action plans from the monitoring inspection were completed. A further

review of staffing levels and skill mix was required to ensure that the staffing arrangements met the needs of the residents.

As part of the thematic inspection process, providers were invited to attend information seminars given by HIQA. In addition, evidence-based guidance was developed to guide the providers on best practice in dementia care and the inspection process.

Prior to the inspection, the person in charge completed the provider self-assessment and scored the service against the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland. The previous table outlines the self-assessment and inspectors' rating for each outcome.

Inspectors met with residents, relatives and staff members during the inspection. They tracked the journey of four residents with dementia within the service. They observed care practices and interactions between staff and residents who had dementia using a validated observation tool. Inspectors also reviewed documentation such as care plans, medical records and staff rosters and training records.

Rathoath Manor is registered for 63 places. On the day of inspection 37 of the 60 residents had a formal diagnosis of dementia or were suspected to have dementia. The centre does not have a specific dementia care unit but many of the residents with dementia lived on the first floor and the inspection focused on St. Oliver's and St. Patrick's units, on the first floor.

Concerted efforts had been to create a warm homely environment for residents with dementia. The physical environment had been enhanced with the use of colour and free access to attractive outdoor areas. The daily routine was largely determined by the residents. Staff were sensitive to the needs of each resident and worked at a pace to support residents with dementia. The degree of positive connective care observed was dependent on the staffing levels in the units. The staffing levels in the centre, especially in St. Patrick's unit required review.

Although it is acknowledged that the hours of the activity co-ordinator were increased since the last inspection, there was still only one person available for the three units and the social needs of residents, especially residents with advanced dementia were not met.

Matters requiring review are discussed throughout the report and the action plan at the end of the report contains actions that are required to be completed 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

**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: Health and Social Care Needs***

**Theme:**

Safe care and support

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

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

**Findings:**

On the previous inspection on 6 January 2016 deficits were found in relation to care planning. The action plans in relation to care planning were completed. A sample of care plans viewed were found to be sufficiently detailed to inform interventions necessary to meet residents' assessed needs. The majority of care plans held documentary evidence that residents or where appropriate their next of kin were involved in care plan development and reviews.

On the previous inspection there were deficits in making medical referrals and follow up referrals to allied health professionals. Inspectors found that residents now had timely referral and access to medical and allied health care, including referral for follow-up by dietetic services.

The inspectors were satisfied that facilities were in place so that each resident's wellbeing and welfare was maintained by appropriate medical and allied healthcare services. Residents, were encouraged to keep as independent as possible and inspectors observed residents moving freely around the corridors. Residents' healthcare needs were met. A GP provided a service to residents, additional services from allied health professionals such as physiotherapy, chiropody, dietician, speech and language and tissue viability services were provided. All residents had regular nutritional screening and regular weight monitoring; there was evidence of follow up by dietician for residents with the recommendations incorporated into care plans. This was addressed since the last inspection.

Optical services were accessed locally. Mental health services were provided by community psychiatric services and regular reviews by a psychiatrist were evident. The services of a clinical psychologist were also used to assist in the provision of care to residents with behaviours that challenge. Dental services were accessed locally when required. Although residents had an oral assessment, routine referrals were not made for dental checkups. Staff acknowledged this an area for improvement.

The inspectors saw that residents had a comprehensive nursing assessment completed pre admission and on admission. Common Summary Assessment forms were on file for

some residents. The assessment process involved the use of a variety of validated tools to assess each resident's risk of deterioration. For example, risk of malnutrition, falls, level of cognitive impairment and pressure-related skin injury among others. Each resident had a care plan developed within 48 hours of their admission based on their assessed needs. The inspectors found that the care plans were person-centred and individualised. Generally, there were care plans in place that detailed the interventions necessary by staff to meet residents' assessed healthcare needs. Nurses, health care assistants, residents and relatives who spoke with inspectors demonstrated appropriate levels of knowledge about care plans.

Staff provided end of life care to residents with the support of their general practitioner and the community palliative care team. Inspectors noted that nearly all the residents had an 'End of life' care plan in place. The sample of care plans reviewed outlined the physical, psychological and spiritual needs of the residents, including residents' preferences regarding their preferred setting for delivery of care. Single rooms were available for end of life care. A nurse with specialist qualifications in palliative care was an additional resource to support staff to provide good quality end of life care. Inspectors noted that staff trained to use syringe drivers and administer subcutaneous fluids to treat dehydration were some of the measures in place to avoid unnecessary hospital admissions.

A number of residents were admitted to the centre with pressure ulcers. Residents had access to specialist tissue viability nurses who provided expert advice and guidance to manage wounds effectively. Inspectors tracked wound care and found that the majority of wounds were either healed or healing. Two residents with pressure ulcers were appropriately managed, and their care plans which were updated to reflect specialist advice were implemented. Pressure relieving mattresses and cushions were provided and changes of position were appropriately documented.

There was a centre-specific, up-to-date medication management policy detailing procedures for safe ordering, prescribing, storing and administration of medicines and handling and disposal of unused or out-of-date medicines. Nursing staff with whom the inspectors spoke, demonstrated good practice regarding administration of medicines. Photographic identification was in place for all residents as part of their prescription/drug administration record chart. Controlled drugs were maintained in line with best practice professional guidelines. The medication trolley was securely maintained and a nurses' signature sheet was in place as described in professional guidelines.

Inspectors reviewed prescription and administration records and found that times did not correspond in all cases. Crushed medications were seen to be prescribed as crushed by the GP, however, the maximum doses was not in place for as required medications on the sample of drug charts seen by the inspectors. Good practice was noted however in the procedure for the administration of PRN anti-psychotic medication where two nurses had to assess its administration requirements and rationale.

**Judgment:**  
Substantially Compliant

## ***Outcome 02: Safeguarding and Safety***

### **Theme:**

Safe care and support

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

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

### **Findings:**

In January 2016 two areas of non compliance were found.

\*There was no documentary evidence to support actions taken to reduce bedrail use.

\*Twelve members of staff had not attended protection of vulnerable adults training.

Inspectors found that the action plans to address these non compliances were completed.

Inspectors reviewed the policy for adult protection and found that it met with the requirements in the Regulations. The inspectors reviewed staff training records and saw evidence that all staff had received up to date mandatory training on detection and prevention of elder abuse. Staff interviewed were familiar with the policy and knew what to do in the event of an allegation, suspicion or disclosure of abuse, including whom to report incidents to. There were no allegations of abuse in the centre currently being investigated.

The centre maintained day to day expenses for a number of residents and the inspectors saw evidence that complete financial records were maintained. Inspectors reviewed the systems in place to safeguard residents' finances which included a review of a sample of records of monies handed in for safekeeping. Money was kept in a locked safe in the administration office, all lodgements and withdrawals were documented in a ledger and a running balance was maintained. All entries were signed and checked by two staff. The system was found to be sufficiently robust to protect residents and staff.

A policy on managing responsive behaviours was in place. The inspectors saw training records and most staff had undertaken responsive behaviours and specialist dementia training. Six staff were due to attend training in two weeks time included two new staff and four staff who required refresher training.

There was evidence that efforts were made to identify and alleviate the underlying causes of behaviour that challenged (responsive behaviours). The support of the community psychiatry service and clinical psychologist was availed of as appropriate to residents needs. Discussion with the person in charge and staff and observations of the inspectors found there was evidence that residents who presented with responsive behaviours were responded to by staff in a dignified and person-centred way by the staff using effective de-escalation methods as highlighted in their records. Inspectors noted that the relaxed pace which staff provided when interacting with residents, residents freedom of movement within the centre and the fact that residents on all the wards had access to a secure outdoor area created an optimal environment to minimise the risk of residents developing behaviours that challenge.

There was a centre-specific restraint policy which aimed for a restraint free environment. The inspectors saw that the person in charge and staff promoted a reduction in the use of bedrails, alternatives such as low beds, crash mats and bed alarms were in use for a number of residents. However, improvements were required on the regular review of the use of restraint, which the nursing staff had already identified.

**Judgment:**  
Substantially Compliant

### ***Outcome 03: Residents' Rights, Dignity and Consultation***

**Theme:**  
Person-centred care and support

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

**Findings:**  
Activity provision was an issue on the previous inspection and although the action plan was implemented the social needs of all residents were not met.

Staff worked to ensure that residents received care in a dignified way that respected their privacy. Staff were observed knocking on bedroom and bathroom doors. They closed doors and bed screens when delivering personal care. Inspectors observed staff interacting with residents in an appropriate and respectful manner, and it was clear that staff knew the residents well. Generally residents were free to choose how they spent their day, where they took their meals, what clothes they wore and who they associated with. All residents were addressed by their preferred name and the day was structured to suit the residents.

Considerable work had been done to create a more homely, colourful and interesting place for residents to live. Art and craft pieces were on display and there were rummage boxes and soft toys to stimulate residents with a cognitive impairment. Signage to support way-finding was evident on doors to communal rooms. Many of the signs were placed too high for residents to see. The day rooms were arranged to create spaces for residents to interact and socialise. Residents on the three units, including residents with dementia on the first floor had unrestricted access to secure, well maintained gardens with seating areas. Residents' families were encouraged to bring in objects to personalise their bedrooms and photographs and pictures were posted on the walls. Inspectors noted that some residents' rooms were not personalised. One resident who was case tracked had bare walls and no chair in her room. The quilt on her bed had a hole in it. She did not have a call bell or access to an overhead light.

Issues identified on the previous inspection included the lack of privacy when using bathrooms and toilets. Inspectors found that privacy locks were provided in all



bathrooms and toilets. Residents also had privacy locks on their bedroom doors and a secure facility in their bedrooms for valuables.

On the previous inspection activity provision were found to be inadequate and residents were not given opportunities to participate in meaningful, purposeful activities to suit their assessed needs, preferences and capacities. Twenty one additional hours of activity were provided since the previous inspection. Activity staff were employed from Monday - Saturday and the additional hours were provided from 5pm - 8pm six days a week. However one activity co-ordinator had responsibility for facilitating activities for residents in the three wards and the social needs of some residents, especially the more dependent residents were not met.

The activity co-ordinator was responsible for assessing and identifying suitable activities for individual residents. The activity schedule included activities arranged for the mornings and afternoons and included music, art and crafts, sensory stimulation and religious activities. The activity coordinator was enthusiastic and she knew the residents well. She said her time as a care assistant had given her an opportunity to really get to know the residents. She tried to support care staff to engage socially with the residents. But staff said that opportunities to engage socially with residents were dependent on the availability of staff and the dependency of residents on any given day. Inspectors observed that staff wore brightly coloured clothes instead of uniforms and many staff on St Oliver's engaged socially with residents. They chatted read the newspapers and the inspector observed many instances of positive connective care during the periods of formal observation. There were adequate staff there to supervise and provide assistance there at meal times. This had been an issue on the previous inspection.

An inspector joined residents having their lunch in St. Patricks and saw that a choice of meals was offered. Staff were observed providing assistance to residents in a timely professional manner, staff sat and talked with residents during the meal. Residents received the correct diet and modified meals were attractively served. Mealtimes in the dining room were social occasions with attractive table settings and promoted the dignity of residents. Although positive care was observed, the staff were too busy to avail of opportunities to connect with residents throughout the day and the majority of interactions were associated with the completion of care tasks.

Residents had opportunities to participate in some meaningful activities appropriate to their interests and needs. The activities coordinator completed a hobbies and interests social assessment for each resident; however it was not evident that this formed part of the resident's overall plan of care. There were long periods of time where some residents had no opportunity to engage in meaningful activities and some reported they would welcome more activities. Whilst acknowledging the need for periods of rest, inspectors observed that residents with more advanced dementia were not socially engaged or stimulated. The records for two residents who were case tracked showed that since 1 May 2016 they had each attended a weekly live music event and had two other social activities, such as a hand massage and a card game. Although it is acknowledged that the hours of the activity co-ordinator were increased since the last inspection, there was still only one person available for the three units and the social needs of residents with dementia were not being met.

Inspectors noted that the fee for social activities had increased for all residents. However the standard of activity provision and social engagement had not been developed sufficiently to benefit all residents.

The centre is located in the village, and staff told inspectors that family members were encouraged to take residents out and maintain contacts with their community. Residents had access to national and local newspapers. They also had access to televisions, radios and telephones. Broadband access was available on the ground floor. The provider had plans to make broadband and Skype available to residents on the first floor in the near future.

A resident advocate visited the centre at least on a weekly basis and represented the views of residents at the monthly residents' meetings. The meetings were attended by residents and some relatives. A range of issues were discussed and there was evidence that issues raised were actioned. Independent advocates from SAGE were available to residents and one resident was availing to the service at the time of inspection. Residents confirmed that they were facilitated to exercise their civil, political and religious rights. Residents' right to refuse treatment or care interventions were respected. Residents were satisfied with opportunities for religious practices.

**Judgment:**

Non Compliant - Moderate

***Outcome 04: Complaints procedures***

**Theme:**

Person-centred care and support

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

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

**Findings:**

The complaints policy for the centre clearly outlined the different stages of the complaints investigation process. The independent appeals process was included and contact details for the office of the ombudsman. The complaints procedure was prominently displayed in the centre and clearly outlined the independent appeals process. The residents guide also held details of the complaints policy and independent appeals process was included and contact details for the office of the ombudsman. The complaints log was reviewed by the inspectors who saw that complaints were being recorded. The results of the investigation process and actions taken on foot of a complaint were clearly laid out. The outcome and whether the resident was satisfied was recorded and dated, this was addressed since the last inspection. Relatives and residents to whom the inspector spoke said the person in charge and staff were open and felt they could bring issues to them and they would be resolved. There was evidence that complaints were used to inform service improvements.

**Judgment:**

Compliant

**Outcome 05: Suitable Staffing****Theme:**

Workforce

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

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

**Findings:**

In January 2016 the inspectors requested a review of the number and skill mix of staff to ensure they are appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre. On this occasion inspectors found that staffing levels especially on St. Patricks ward had not increased as the numbers and dependencies of residents increased. A further review of the number and skill mix of staff is required to ensure they are appropriate to the needs of the residents in the three units.

On the previous inspection some staff had not completed mandatory fire safety, protection of vulnerable adults or safe moving and handling training. Training records viewed confirmed that all staff had completed mandatory training. Staff interviewed had a good understanding of fire safety and safeguarding of vulnerable adults. Good manual handling practices were observed throughout the inspection.

Inspectors attended morning handover meetings and observed good communication and continuity of care from one shift to the next. In discussions with staff, they confirmed that they were supported to carry out their work by the person in charge and the management team. The inspectors found staff to be well informed and knowledgeable regarding their roles, responsibilities and the residents' needs and life histories. There was evidence that residents knew staff well and engaged easily with them in personal conversations.

Residents and relatives spoke very positively of staff and indicated that staff were caring, responsive to their needs and treated them with respect and dignity.

The numbers and skill-mix of staff on the day of the inspection was adequate to meet the assessed needs of residents in St. Oliver's, however this was not the case in St. Patricks where the number and dependency levels of residents had recently increased and there had been no corresponding increase in staff levels. The residents and staff told inspectors that there were too few staff on duty. Inspectors observed that staff focused on care tasks and did not have time to interact with residents in order to meet their social and emotional needs. The director of clinical governance explained that the centre had gone through a period of staff shortages and had recently recruited nursing staff which were currently being inducted. The inspectors requested that they keep the

staffing levels and skill mix under constant review to ensure they are meeting the needs of the residents. Staff rosters were in place and they reflected the actual staffing on the day of inspection. Two staff who were absent with short notice were replaced by relief staff on the day.

Mandatory training was in place and staff had received up to date training in fire safety, safe moving and handling. Other training provided, included dementia specific training including responsive behaviours/behaviours that challenge. The provider encouraged staff to develop professionally. Inspectors met a nurse was due to begin the second year of a Masters programme in Palliative Care. A newly appointed nurse told inspectors she was due to begin a Graduate Diploma in gerontology in September. There was evidence that staff with specialist knowledge and education used their skills and knowledge to develop policies to support good practice in the centre.

**Judgment:**

Non Compliant - Moderate

***Outcome 06: Safe and Suitable Premises***

**Theme:**

Effective care and support

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

No actions were required from the previous inspection.

**Findings:**

Ratoath

The centre has three specific residential units, the ground floor, and St. Oliver's and St. Patricks on the first floor. The location, design and layout of the centre was suitable for its stated purpose and met residents' individual and collective needs in a comfortable and homely manner. The inspectors found the centre to be warm, well maintained and suitably decorated. Residents in all the units had good access to indoor and outdoor areas and to external gardens with colourful hanging baskets, flower beds and suitable garden furniture. The grounds were well maintained. Sitting and dining rooms were spacious enough with good natural lighting and were decorated in a homely and warm fashion. On the ground floor there were other smaller areas for residents' use or to meet with visitors in private.

There is a lift available to assist people to navigate between two floors. There is a chapel on site which is used regularly by residents. There are communal areas in all three areas, with the largest being on the ground floor which is used to host larger activities and parties. There is also a hairdressing salon on site and a smoking room on each floor. Residents in each unit also had access to a secure well maintained outdoor area.

Corridors and door entrances used by residents were wide and spacious to facilitate movement and aids used and required by residents. Bedrooms were spacious to accommodate personal equipment and devices required by existing residents. Handrails and grab rails were provided where required in circulating areas and in bathrooms. The safety of residents in St Patricks would be enhanced by an additional grab rail in the ramped corridor area. This is discussed further in Outcome 7.

Bedroom accommodation was provided with mostly single room accommodation. The size and layout of bedrooms met the needs of the residents. Privacy screening was designed in shared rooms to enable the screen to close fully around the resident's bed.

Inspectors were informed that St. Oliver's has adopted a dementia-specific approach to care and the progress towards this was apparent on the inspection. Examples of this include symbols and signage to orientate residents and the use of colour throughout the unit. Most of the bedrooms were personalised to suit the individual resident.

Inspectors noted that the design for residents with dementia could be further enhanced by the creation of a quiet room on the first floor. The use of pictures and photographs on bedroom doors could be developed further to support residents to locate their rooms. The level at which signage was placed should be reviewed. Consideration should also be given to control of stimuli such as noise. Noise levels caused by doors banging was noted especially in St. Patrick's.

Furniture and equipment seen in use by residents was in good working condition. Mobility aids that included remote control beds and hoists were available to promote safe moving and handling practices. However inspectors noted that some of the high support chairs used by less able residents were worn and required upholstering or replacement.

**Judgment:**  
Substantially Compliant

### ***Outcome 07: Health and Safety and Risk 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 followed up on the progress of actions following a focused fire safety inspection on 20 January 2016  
The provider's response detailed the proposed works required to provide a satisfactory level of fire safety to the occupants of the centre. The majority of required actions had been progressed and completed with the exception of those related to fire doors and

provision of ramps at exit doors. The provider had upgraded the emergency lighting system and added in central test units and additional fire detection units. These were now linked to a central electrical unit. Fire doors were in the process of being upgraded and the final phase, the provision of ramps at fire exits to facilitate the evacuation of residents using assistive mobility devices was due for completion by mid August 2016. Inspectors walked the premises and saw that the works to provide safe means of escape from the centre were completed or at an advanced stage.

\*The door identified on an escape route that was previously secured with a key operated lock was now fitted with a magnetic lock which was linked to the fire alarm.

\*The curtains at the exit from the lounge, that could potentially impede the use of the exit had been removed.

\*New emergency lighting had been provided in various areas, including the lounge identified on the previous inspection as not having emergency lighting.

\*The exits from the chapel and from the lounge / dining space now had exit signage.

\*The fire procedure within the emergency plan had been reviewed and now reflected the instructions displayed on the signage throughout the centre.

\* Combustible materials stored under the emergency stairwell had been removed. There were combustible materials stored in rooms and cupboards and the estates manager told inspectors that the doors to these rooms and cupboards were due to be upgraded in order to contain fire and smoke. This work was due for completion within four weeks.

Inspectors discussed procedures and reviewed documentation which showed that each fire door now had a number. This facilitated a system for checking the condition of fire resistant doors and the hold open devices on fire resistant doors. The system also included the checking of magnetic locks and their interface with the fire detection and alarm system on doors along escape routes and that all evacuation aids were present and in serviceable condition. Fire resistant doors were identified that required remedial attention. The estates manager and builders who spoke with inspectors confirmed that this work was in progress and due for completion within the next four weeks. They also detailed plans for installation of ramps and grab rails in areas where steps at some final exits rendered the exits unsuitable for occupants using mobility aids such as wheelchairs or walking frames. This was the final part of the fires safety works was on target for completion by mid August 2016.

There was a system in place regular fire safety checks of fire routes, the fire panel, emergency lighting fire alarms and fire safety equipment. The inspectors noted that the daily fire safety checks were not consistently documented. Three dates in July 2016 were blank.

Fire drills were noted as an issue on the previous inspection, specifically, the records relating to same did not demonstrate the adequacy of the arrangements in place within

the centre in the event of a fire. On this occasion, inspectors spoke to numerous staff and found them to be knowledgeable with respect to the principles of fire safety. Inspectors reviewed records relating to fire safety training and fire drills and found that staff, including night staff were trained and given the opportunity to participate in drills. Fire drills now included simulated evacuation of St. Oliver's, the largest unit and records showed that the evacuation with night time staffing levels had been simulated as part of the fire drill programme.

There was evidence of learning from fire drills to ensure that the staffing provision, equipment provision (evacuation aids etc.), the fire safety training provision to staff and evacuation procedure were adequate at all times within the centre.

Inspectors also observed that the risk posed to residents from five ramped areas on corridor surfaces was now identified; risk assessed and the measures to mitigate the risk documented in the risk register. Inspectors noted that the safety of residents in St. Patricks could be enhanced if there was a second set of grab rails in the ramped areas on the corridor.

A judgment of moderate non compliance was made because the ongoing works to upgrade fire doors and absence of ramps at some final exit doors posed a moderate risk to the safety and welfare of residents.

**Judgment:**

Non Compliant - Moderate

***Outcome 08: Governance and Management***

**Theme:**

Governance, Leadership and Management

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

**Findings:**

The annual review of the quality and safety of care delivered to residents in the designated centre was now available. The report was informed by the views of residents and relatives and also included statistical and quantitative data to inform future quality improvements.

Operational and management arrangements were described and in place. A new assistant director of nursing had been recruited in May 2016 and inspectors found that she was suitably qualified and experienced to support the person in charge and ensure the centre was consistently managed and effectively governed. The recruitment of four staff to fill vacant nurse posts was now completed. Two new nurses were working full time and two more nurses were due to begin their induction later this month.

**Judgment:**

Compliant

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## 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:***

Mary O'Donnell  
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>	Ratoath Manor Nursing Home
<b>Centre ID:</b>	OSV-0000152
<b>Date of inspection:</b>	19/07/2016
<b>Date of response:</b>	05/08/2016

#### 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 01: Health and Social Care Needs

**Theme:**

Safe care and support

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

Although residents had an oral assessment, routine referrals were not made for dental check ups.

**1. Action Required:**

Under Regulation 06(2)(c) you are required to: Provide access to treatment for a resident where the care referred to in Regulation 6(1) or other health care service

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

requires additional professional expertise.

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

Each resident in the home has an oral health assessment on admission, 6 monthly or if there is a change in their condition This assessment is carried out in-house by nursing staff. Based on this assessment the resident may be referred to the dentist to access treatment. Furthermore, referrals to dentist can be made following a assessment by other Allied Healthcare Professionals i.e. SALT.

Assurances that residents oral health is being assessed at a minimum of 6 monthly is done through the monthly care plan audits carried out by the PIC.

Results of these audits are presented to nursing staff and actions required assigned to appropriate staff members to ensure gaps are remedied in a timely manner.

**Proposed Timescale:** 30/09/2016

**Theme:**

Safe care and support

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

The maximum doses was not in place for as required medications on the sample of drug charts seen by the inspectors.

**2. 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:**

The GP's as the prescribers will be requested to prescribe and chart the maximum doses of each medication. The PIC will continue to monitor and audit the kardex with the pharmacist every 3 months, to ensure staff are proactive in following up with GP on this matter.

**Proposed Timescale:** 30/11/2016

**Outcome 02: Safeguarding and Safety**

**Theme:**

Safe care and support

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

Improvements were required on the regular review of the use of restraint, which the nursing staff had already identified.

### **3. 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 will continue to promote a restraint free environment in our home and ensure restraint is only used in line with national guidelines.

Staff nurses review the restraint management care plan on an ongoing basis and at least monthly. These reviews assess if the care plan is effective. If effective the resident will continue to require restraint, this review and restraint assessment is signed and dated by the staff nurse.

If the Care Plan is identified as ineffective and or restraint is deemed not appropriate or required, the staff nurse immediately commences re assessment of the resident.

Assurances that restraint usage and restraint management care plans are being carried out in line with national guidelines and Silver Stream Group policy and procedure is the responsibility of the PIC, and is monitored by the PIC through completion of monthly care plan audits and also through tracking of restraint use in the home.

Results of these audits are presented to nursing staff and actions required assigned to appropriate staff members to ensure gaps are remedied in a timely manner.

**Proposed Timescale:** 31/08/2016

## **Outcome 03: 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:**

Although it is acknowledged that the hours of the activity co-ordinator were increased since the last inspection, there was still only one person available for the three units and the social needs of residents with dementia were not being met.

### **4. Action Required:**

Under Regulation 09(2)(a) you are required to: Provide for residents facilities for occupation and recreation.

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

We have increased activities hours on the basis of our last inspection. However we are in the process of reviewing our activities to enhance the activity and recreational experience for our residents and special attention will be given to our residents with dementia. We want to create a culture of inclusiveness whereby all staff are

encouraged to part take in activities with our residents, this will all be documented in the care plans.

**Proposed Timescale:** 31/03/2017

### **Outcome 05: Suitable Staffing**

**Theme:**

Workforce

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

In St. Patricks unit the number and dependency levels of residents had recently increased and there had been no corresponding increase in staff levels. The residents and staff told inspectors that there were too few staff on duty. Inspectors observed that staff focused on care tasks and did not have time to interact with residents in order to meet their social and emotional needs.

**5. Action Required:**

Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

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

The staffing plan for the home is developed annually as part of the Annual Business Plan for the home (& reviewed periodically throughout the year). The RQIA 2009 document "Staffing Guidance for Nursing Homes" is used to undertake the review. The review is carried out by the Group Clinical Operations & Governance Manager, the Person in Charge (PIC) and the Assistant Director of Nursing and the Group Finance Manager.

As per the RQIA guideline document the following are considered during the review

- 1) The ratio of staff to residents
- 2) The dependency levels of residents
- 3) The role of the Group Clinical Governance Team, and the PIC
- 4) The competency and experience of staff
- 5) Staff training
- 6) Workload (Care Quality Indicators-Dependency level changes, Falls rate, Pressure Sore incidence, New Admission rates, results of audits)
- 7) Categories of Care

In addition to this, we receive feedback from our residents through our resident and relative meetings and through complaints.

We have taken on board resident and staff feedback which was received by the inspectors during the inspection and will carry out a comprehensive review of staffing levels based on the RQIA 2009 document "Staffing Guidance for Nursing Homes" which incorporates the "Rhys Hearn model".

Prior to this comprehensive analysis, it is noted that Based on the Rhys Hearn model we are within the staffing levels in the home overall and specifically within the St Pats unit where the feedback was received.

Since the inspection one resident who was admitted to the unit just prior to the inspection, and who required much assistance and greater attendances has been discharged to another healthcare setting. This should ease the workload of staff.

Staffing levels will continue to be reviewed at each admission and discharge and changed based on the needs of the residents.

**Proposed Timescale:** 30/09/2016

### **Outcome 06: Safe and Suitable Premises**

**Theme:**

Effective care and support

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

Some of the high support chairs used by less able residents were worn and required upholstery or replacement.

Not all residents rooms were personalised. One resident who was case tracked had bare walls and no chair in her room. The quilt on her bed had a hole in it. She did not have a call bell or access to an overhead light.

**6. 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:**

In regards to the identified resident room please note that this has now been personalised to include newly painted walls, replacement quilt, pictures mounted, armchair provided. Furthermore, access to the call bell and overhead light has been provided.

All high support chairs have been reviewed and one high chair will be re upholstered. To source an upholster this will take 6 weeks in the meantime we will have a temporary cover/throw put on the chair.

**Proposed Timescale:** 15/09/2016

### **Outcome 07: 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:**

Some fire safety works due for completion by mid August 2016 were outstanding:

\*Some fire resistant doors required remedial attention.

\*The installation of ramps and grab rails in areas where steps at some final exits rendered the exits unsuitable for occupants using mobility aids such as wheelchairs or walking frames.

The daily fire safety checks were not consistently documented. Three dates in July 2016 were blank.

**7. Action Required:**

Under Regulation 28(1)(c)(i) you are required to: Make adequate arrangements for maintaining all fire equipment, means of escape, building fabric and building services.

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

All fire safety works including ramps and fire resistant doors due for completion mid August will be completed on schedule.

Daily checks are been completed Monday to Friday gaps have been identified at weekends, going forward where checks have not been documented this will be notified to the responsible staff member and the HR process will be instigated

**Proposed Timescale:** 20/08/2016