

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Hillview Nursing Home
Centre ID:	OSV-0000238
Centre address:	Tullow Road, Carlow.
Telephone number:	059 913 9407
Email address:	hillviewnursinghome@eircom.net
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Hillview Convalescence & Nursing Home Limited
Provider Nominee:	Catherine O'Byrne
Lead inspector:	Siobhan Kennedy
Support inspector(s):	Sheila Doyle
Type of inspection	Unannounced
Number of residents on the date of inspection:	50
Number of vacancies on the date of inspection:	4

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 following receipt of unsolicited information. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
14 March 2016 14:00	14 March 2016 18:30
15 March 2016 09:30	15 March 2016 15:30

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

Outcome	Our Judgment
Outcome 02: Governance and Management	Non Compliant - Major
Outcome 05: Documentation to be kept at a designated centre	Non Compliant - Moderate
Outcome 07: Safeguarding and Safety	Non Compliant - Moderate
Outcome 08: Health and Safety and Risk Management	Non Compliant - Major
Outcome 09: Medication Management	Non Compliant - Moderate
Outcome 10: Notification of Incidents	Non Compliant - Moderate
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 12: Safe and Suitable Premises	Non Compliant - Moderate
Outcome 13: Complaints procedures	Non Compliant - Moderate
Outcome 16: Residents' Rights, Dignity and Consultation	Non Compliant - Moderate
Outcome 18: Suitable Staffing	Compliant

Summary of findings from this inspection

The purpose of the inspection was threefold:

- To follow up on unsolicited information received by the Health Information and Quality Authority (the Authority).
- To assess the fitness of a staff member as a person participating in management.
- To assess progress in relation to the matters arising from the previous inspections on 20 November 2013 and 5 November 2014.

During the inspection of November 2013 inspectors found that the safeguarding policies/procedures and the robustness of the investigation process into allegations of abuse was insufficient to protect residents.

The Authority received unsolicited information in December 2015. This alleged that measures to protect residents from being harmed or suffering abuse were not in

place and appropriate action was not taken in response to allegations of abuse. The provider/person in charge at the request of the Authority carried out an investigation into these allegations.

The provider/person in charge was unable to fully investigate some allegations due to limited information/details and or a lapse in time from the alleged occurrences. Investigation of the other incidents which had taken place at the time of occurrence had not been fully substantiated. However, the provider/person in charge put in place measures to protect residents, for example, undertook a review of staffs' roles and responsibilities, made changes within the staffing team, provided opportunities for further training, increased staff supervision, retrospectively notified the Authority and initiated disciplinary procedures.

During this inspection, inspectors examined documentation, communicated with staff and residents and observed practices and in the main, found that measures were in place to protect residents from abuse. Staff were knowledgeable in protecting residents from abuse. They understood their duty to report any incident and were aware of the reporting mechanisms within the centre. In addition, residents confirmed that they felt safe living in the centre.

However, inspectors found that while there was evidence of aspects of the investigation process it was not comprehensive, for example conclusions about the allegations/complaint were made without having a logical flow to the evidence supporting the complaint and there were gaps in the policies and procedures to guide management and staff in the investigation process and disciplinary procedures.

A staff member who has been designated as a person participating in management was interviewed by the inspectors and this was satisfactory.

Other matters arising from the previous inspections were reviewed and found to be addressed with the exception of medication management.

The findings of this inspection were as follows: –

- There was evidence of good nursing care, however, appropriate allied health care had not been followed up.
- Medicinal products were not administered in accordance with the directions of the prescriber.
- Measures and controls were not put in place to minimise risks.
- Infection-control precautions were not fully implemented.
- All fire safety precautions were not in place.
- The premises did not conform to the matters set out in the legislation.
- Documentation in respect of investigations and records pertaining to staff working in the designated centre were not maintained in accordance with the legislation and records were not kept safe.
- Residents' privacy and dignity was not respected at all times.
- Inspectors found from an examination of the staff rosters, communication with staff on duty and residents that the levels and skill mix of staff at the time of inspection were sufficient to meet the needs of residents. Since the last inspection an additional staff member was rostered on night duty.

The centre was not fully in compliance with the Health 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.

The judgements in respect of the outcomes are highlighted in the table above and the actions required to address the non-compliances are outlined in the action plan of this report.

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 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):

No actions were required from the previous inspection.

Findings:

The provider is also the person in charge. She is a registered general nurse with many years of experience of working with older people. She was on duty throughout the inspection and facilitated the inspection process by being available to the inspectors and providing information and documentation.

The inspectors found that there was a clearly defined management structure that identifies the lines of authority and accountability and specifies roles and details responsibilities for the areas of care provision. This was outlined in the statement of purpose and staff were familiar with their duty to report to line management.

A staff member who has been designated as a person participating in management was knowledgeable during an interview with the inspectors and had a good comprehensive understanding of the legislation underpinning the residential home.

Residents and staff who communicated with the inspectors during the inspection were positive in respect of the provision of facilities and services and considered that there were sufficient staff on duty to meet the needs of residents. They highlighted that efforts were made to ensure that there was good communication between staff and residents and/or their representatives.

All the staff who communicated with the inspectors were aware of residents' needs and conditions, confirmed that they had participated in handover and general meetings in order to communicate residents' needs to incoming staff and were satisfied that they work as a staff team in order to provide consistent care to residents.

The provider/person in charge informed the inspectors that all incidents/accidents were reviewed and if necessary, corrective action taken to mitigate against the risk of re-occurrence of the incident.

There was evidence of consultation with residents and their representatives in a range of areas, for example, the assessed needs of residents, the care planning and review process, involvement in social and recreational activities and meals provided.

Although audits were carried out and analysed for example in relation to accidents, complaints and skin care a report of an annual review of the quality and safety of care was not available to the inspectors.

Judgment:

Non Compliant - Major

***Outcome 05: Documentation to be kept at a designated centre
The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.***

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

Inspectors examined the policy and procedure in relation to disciplinary action and found that it had not been fully implemented in accordance with the guidance. For example, it was stated "that any disciplinary action should be given in writing to an employee following a meeting and the written document should specify the nature of misconduct, any period of time given for improvement, the penalty and how long it will last". However, this procedure was not implemented.

Furthermore it stated "that information should be retained regarding the employee's defence, findings of the investigation process, action taken and reason for action", however, inspectors found that this procedure had not been implemented following an investigation.

Inspectors found that no disciplinary records (following the implementation of the disciplinary procedures) were retained in staff files.

The disciplinary policy did not reference a verbal warning and therefore did not guide staff in relation to the criteria for issuing a verbal warning.

Confidential information was stored in an unlocked drawer in a unit stored in the oratory.

An examination of records pertaining to staff working in the designated centre identified that these were not fully maintained in accordance with schedule 2 of the legislation, for example there were gaps in some staff members employment and Garda vetting.

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):

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

Findings:

During the renewal of registration inspection 20 November 2013 it was identified that the policy in respect of safeguarding did not protect residents from abuse and the investigation process was not sufficiently robust.

In this inspection inspectors found that the policy and procedure highlighted measures to protect residents from abuse, however, the investigation process was not comprehensive.

In December 2015 the Authority received unsolicited information. This alleged that measures to protect residents from being harmed or suffering abuse were not in place and appropriate action was not taken in response to allegations of abuse dating back to 2013. The provider/person was informed of the allegations and was requested by the Authority to carry out an investigation.

The provider/person in charge highlighted that it was not possible to fully investigate 4 of the allegations due to insufficient detail being provided and possibly lapse of time, however, did communicate with staff and some residents regarding the likelihood of the incidents and judged that there was no case to address.

With regard to the additional allegations made known via the unsolicited information the provider/person in charge concluded that the allegations were unfounded.

In respect of allegations which the provider/person in charge had been made aware of at the time of their occurrence (2013) these were investigated and could not be fully substantiated. However the provider/person in charge initiated disciplinary procedures in respect of one of the incidents and a further incident identified by the provider/person in charge.

In light of the allegations, the provider/person in charge put in place additional measures to protect residents. Inspectors learned that at this time there were a number of residents being accommodated who had behaviours that were challenging and the provider/person in charge reviewed staffs' roles and responsibilities, made changes within the staffing team, provided opportunities for training in safeguarding, dementia and behaviours that challenge, requested staff to report behaviours that were challenging, increased staff supervision and retrospectively notified the Authority of the alleged incidents.

During this inspection inspectors found that measures were in place to protect residents from abuse. Staff were knowledgeable in protecting residents from abuse. They described the various types of abuses and they understood their duty to report any incident and were aware of the reporting mechanisms within the centre. In addition, residents confirmed that they felt safe living in the centre.

However, from a review of the documentation inspectors found that while there was evidence of investigations into the allegations at the time of their occurrence (2013) they were not comprehensive. For example conclusions about the allegations/complaints were made without having a logical flow to the evidence supporting the complaint. Inspectors reviewed the complaints policy and procedure and found that it had not been fully implemented in accordance with the legislation in respect of the allegations made by the complainant. See outcome 13 for details and action plan.

Inspectors examined the designated centre's disciplinary policy/procedure which was reviewed in January 2015. This did not provide the necessary details and steps to guide staff and management. See outcome 5 for details and action plan.

There was no preliminary screening carried out in order to determine if any staff members should be suspended during the period of the investigations. There was no evidence of a referral to the Health Service Executive designated officer for the protection of residents from abuse.

Inspectors reviewed the procedures in place for responding to behaviours that challenge. Staff members informed inspectors that the number of residents being accommodated displaying behaviours that challenge had reduced in recent years. Training had been provided to staff and additional training was planned. There was a policy in place which provided guidance to staff. Inspectors saw that behaviour assessments had been completed. These included details of possible triggers and interventions. During the inspection staff approached residents with behaviour that challenged in a sensitive and appropriate manner and the residents responded positively to the techniques used by staff. Additional support and advice were available to staff from the psychiatry of later life services.

A restraint-free environment was promoted and inspectors saw that appropriate risk assessments were in place and there was evidence that alternatives had been considered before restrictive devices were used. Alternatives available included low beds, crash mats and sensor alarms. Regular checks were carried out when bed rails were in use.

Judgment:
Non Compliant - Moderate

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

Theme:
Safe care and support

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

Findings:

The matters arising from the previous inspection 20 November 2013 related to the following matters: –

- Having an up to date health and safety statement.
- Taking appropriate clinical action following an incident or accident.
- Assessing smoking arrangements.
- Securing the premises between the dining room and access to the external laundry.
- Having appropriate fire fighting equipment.

Inspectors found that these matters had been satisfactorily addressed.

In the main, inspectors found that the health and safety of residents, visitors and staff was promoted and protected, however, the risk management policy and procedure had not been fully implemented.

While there was a risk register it did not identify all of the hazards with the result that an assessment of the risks had not been carried out and measures and actions were not put in place to control the risks identified.

The following risks had not been identified as a risk and therefore not risk assessed with measures put in place to control where necessary any risk identified:

- A portable electrical hob plate and a toaster located in the dining room.
- A record of hot water temperatures was not maintained in accordance with the designated centre's policy on risk management.
- A liquid had been decanted into a spray container which was left on a handrail in the communal area located on the first floor.

There was no evidence of learning (investigations and recordings) from the incidents of allegations of abuse highlighted in outcome 7.

Although inspectors saw evidence of infection prevention and control measures for example strategically placed hand sanitisers throughout the designated centre infection-control precautions were not fully implemented. For example inspectors observed the following: –

- Clean linen was stored on open shelves in shower/bathrooms
- Slings for hoists/handling belts were stored on a trolley containing clean linen which was stored in shower/bathrooms.
- Numerous small holes in the wall cladding of sanitary facilities.
- A sanitary facility was not left in a clean condition during the afternoon of the second day of the inspection.
- Rusted/corroded equipment including handrail in the shower room, shower head tubing, showering chair and commodes.

The inspectors saw that generally fire safety precautions were in place. For example these included the installation of a fire panel, designated fire compartments, fire fighting equipment which was available at appropriate intervals throughout the designated centre and personal emergency evacuation plan (PEEP) for each resident that identified the resident's mobility levels and requirements for assistance in the event of an emergency evacuation.

In general, fire doors were fitted with electronic magnetic hold open devices which would close in the event of an emergency situation however, inspectors saw that some of these fire doors were held open by pieces of furniture or in one area by mobility aids and therefore would not close in the event of an emergency. Other fire doors were held open but were not connected to the fire alarm system.

There was evidence that fire drills were conducted as part of staff fire safety training, however, all staff had not participated in annual fire safety training and some of these staff members were rostered on night duty. The provider/person in charge assured the inspectors that an opportunity for training would be scheduled as soon as practicable for these staff members and prior to carrying out a night duty.

Three signed emergency fire exits located to the rear of the designated centre directed residents, staff and visitors to an enclosed external patio and garden which had an increased gradient. Inspectors saw that this fire evacuation pathway had been blocked by garden furniture and a padlock on a gate which was rusted. The key for this gate was not carried by the staff member who was the designated fire marshal on duty but was located in the main office. Furthermore, the fire assembly point located to the side of the designated centre could not be accessed by this evacuation pathway as it had been blocked off by a wall and railing. The pathway was not suitable for residents using a wheelchair as it was partially grass with some broken and uneven pavements.

Inspectors noted that combustible items were stored underneath a stairwell even though a notice highlighted that items should not be stored in this area.

A number of fire extinguishers did not identify the date of the service/next service on the equipment.

The external fire assembly signage was partially covered by shrubbery/ivy.

There were a number of ceiling lamp shades which had scorch marks.

Judgment:
Non Compliant - Major

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

Findings:
Inspectors did not inspect against this full outcome but followed up on actions required from previous inspections. Inspectors found that some improvement was required regarding medications to be crushed prior to administering and the checking of medications that required strict controls. This was a matter identified in the previous inspection.

Inspectors reviewed a sample of prescription and administration records and saw that actions required from the previous inspection had been addressed. The maximum dose that could safely be administered within a 24 hour period for medications prescribed as required (PRN), was now documented. Inspectors also observed that each medication was individually signed by the prescriber.

However inspectors noted that some medications that residents required in a crushed state were not individually prescribed that way. In addition, inspectors saw that although two nurses were checking the quantity of medications that required strict controls at the change of shifts, the two nurses who checked were on the same shift. This is not in line with national guidelines.

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:

An accident and incident log was reviewed by inspectors and it was found that all incidents requiring notification to the Chief Inspector had been appropriately submitted other than an issue identified relating to the quarterly notifications.

It was noted that the complete records for the use of restraint in the designated centre had not been notified at the required quarterly intervals. This was discussed with the person in charge who agreed to address and forward the information retrospectively.

Judgment:

Non Compliant - Moderate

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):

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

Findings:

The matters arising from the previous inspection were satisfactorily actioned. These related to care plans being generic as opposed to relating to the specific requirements of each individual resident and end of life care plans not devised for residents.

Inspectors were satisfied that each resident's wellbeing and welfare was maintained by a high standard of nursing care and appropriate medical and allied health care. Improvement was required however to ensure that the recommendations of allied healthcare professionals were reflected in the care plans.

The arrangements to meet each resident's assessed needs were set out in individual care plans. There was evidence that relatives and residents were involved at development and review. On admission to the centre each resident's needs were comprehensively assessed. Risks assessments were completed for a number of areas such as falls and pressure area care. Each resident had a care plan completed that identified their needs and the care and support interventions that would be implemented by staff to meet their assessed needs. However inspectors noted that these were not

consistently updated to reflect recommendations by other health professionals. For example, a resident had been reviewed by a speech and language therapist and specific recommendations were made regarding the type and texture of the diet suitable for the resident. These changes had not been incorporated into the care plan.

Inspectors reviewed the management of a sample of clinical issues such as diabetic care and wound management and found they were well managed.

A full range of other services was available on referral including speech and language therapy (SALT) and occupational therapy (OT) services. Physiotherapy services were available on site. Chiropody, dental and optical services were also provided. Inspectors reviewed residents' records and found that some residents had been referred to these services and results of appointments were written up in the residents' notes.

A review of residents' records indicated that they were weighed regularly and a nutritional assessment tool was used to monitor residents' nutritional status. There was evidence that food charts were used to monitor the intake of residents as a component of the nutritional assessment process. At the previous inspection it was noted that it was not always evident from a sample of records reviewed what actions were taken following completion of the food charts. This had been addressed and inspectors saw where follow on action was taken as required. Inspectors reviewed a sample of care plans of residents who had recent weight loss and were satisfied that appropriate plans were in place to address this.

Inspectors were satisfied that caring for a resident at end-of-life was regarded as an integral part of the care service provided. This centre had undertaken extensive improvements as part of the thematic inspection process the previous year and in response to the training provided by the Authority. Inspectors found that there were care practices and facilities in place so that residents received end-of-life care in a way that met their individual needs and wishes. Inspectors also saw that residents' dignity and autonomy were respected. Having reviewed a sample of care plans the inspectors were satisfied that each resident or their relative had been given the opportunity to outline their wishes regarding end of life.

Judgment:

Non Compliant - Moderate

Outcome 12: Safe and Suitable Premises

The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:

Effective care and support

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

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

Findings:

The matter arising from the previous inspection related to the communal sitting area on the first floor not having a resident alarm bell system for use by residents, relatives or staff in an emergency. An alarm system was installed in this area. The provider/person in charge informed the inspectors that an alarm system was also installed in the oratory and the hair dressing room.

The designated centre is a two-storey building accommodating 54 residents. There are 32 single bedrooms and 11 twin rooms. Communal and bedroom accommodation exists on both floors.

Residents' bedroom accommodation has ensuite (toilet and wash hand basin) facilities. Communal space includes a spacious hallway, sitting room, conservatory and a dining room. A recreational room is located on the first floor.

Inspectors noted that there was insufficient storage facilities with the result that the cleaning trolley was stored in the designated sluice room. A vacuum cleaner, slings for hoists and handling belts was stored in the communal sitting area located on the first floor.

There was no designated visitor's room and the oratory was used for this purpose, however the oratory was being used for storage.

The designated centre was not maintained to a high standard as the following was noted: –

- There were aspects of the centre (residents' bedrooms and communal spaces) which were in need of redecoration/refurbishment and this was particularly necessary considering the needs of residents with dementia.

Inspectors were informed and saw that a refurbishment programme had commenced.

- Locks were not easy to operate on the doors of sanitary facilities.
- There was insufficient extraction in the designated smoking room.
- A cupboard door was missing from a shelved worktop in the dining room.
- In some instances, over head lighting in residents' bedroom was broken or there were no bulbs in the light fitting.
- Garden furniture was rusted.
- The door handles on the some bedroom and ensuite doors were loose.

Externally the premises was not clean and tidy for example in the designated staff smoking and bin areas items such as pieces of furniture had not been disposed of appropriately.

Inspectors were informed that servicing of beds took place on an annual basis however the documentation on some beds showed that this had not occurred since 2013.

Ample car parking was available.

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):

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

Findings:

The matter arising from the previous inspection related to the insufficiency of completing the complaints log with details of the complainant, specifics of the complaint, the outcome of the investigation and level of satisfaction or otherwise for the complainant.

Inspectors reviewed complaints since the last inspection and found that the above deficits had been addressed, in respect of the complaints made.

However, the complaint/allegation detailed in outcome 7 had not been entered into the complaint log.

Furthermore there was no evidence that the complainant had been informed of the outcome of the complaint, the details of the appeals process. The evidence highlighted that this allegation/complaint had not been fully and properly recorded.

The nominated person by the registered provider did not ensure that all complaints had been appropriately responded to and that the nominated person maintained the records specified in the regulation.

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
<p>Outstanding requirement(s) from previous inspection(s): No actions were required from the previous inspection.</p> <p>Findings: Inspectors found that each resident's privacy and dignity was not respected.</p> <p>While there was curtain screening available in some twin bedrooms it was insufficient to ensure the privacy of residents.</p> <p>A resident's wardrobe showed the name of another resident who was not accommodated in the bedroom.</p> <p>There were no locks on the ensuite facilities in the single bedrooms.</p> <p>There was communal use of residents' toiletries.</p> <p>Inspectors examined the system for managing laundry as the laundry facilities are external to the main part of the designated centre and can be accessed from a door in the communal dining room. Inspectors were informed that there is a policy and procedure in respect of transporting soiled/dirty linen to the laundry facility which was carried out without entering the dining room, however, inspectors saw that clean items of laundry were returned to the designated centre via the dining room as residents were having their lunch time meal.</p>
<p>Judgment: Non Compliant - Moderate</p>

<p><i>Outcome 18: Suitable Staffing</i> <i>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.</i></p>
<p>Theme: Workforce</p>
<p>Outstanding requirement(s) from previous inspection(s): The action(s) required from the previous inspection were satisfactorily implemented.</p> <p>Findings:</p>

The matter arising from the previous action related to insufficient staffing at night, however, since this was highlighted an additional staff nurse has been rostered on night duty which now means that 2 nurses and 2 care assistants are rostered on night duty.

From communication with residents and staff the inspectors found that the levels and skill mix of staff at the time of inspection were sufficient to meet the needs of residents.

There was evidence that staff had opportunities to participate in training appropriate to their role and responsibility.

Staff nurses and senior care staff explained to the inspectors the processes and procedures for supervising staff.

They confirmed that the morale in the centre is good that some staff members put this down to individual members working as a team. Inspectors heard residents' alarm bells sounding and noted that they were promptly responded to by staff.

Inspectors saw that residents chose the time that they wished to get up and seek assistance with personal care and dressing and this was facilitated by the care team. Some residents in discussions with the inspectors confirmed that staffing levels were satisfactory and that staff were supportive and helpful. Residents were full of praise for the staff team and spoke highly of their ability to deliver care in a friendly and supportive manner. Inspectors observed staff interacting with residents and this was carried out in a respectful manner.

Staff who communicated with the inspectors demonstrated that they had a good knowledge of the residents in the centre and were familiar with the standards underpinning residential care.

Judgment:

Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Siobhan Kennedy
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Action Plan

Provider's response to inspection report¹

Centre name:	Hillview Nursing Home
Centre ID:	OSV-0000238
Date of inspection:	14/03/2016
Date of response:	20/04/2016

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:

An annual review of the quality and safety of care was not available.

1. Action Required:

Under Regulation 23(d) you are required to: Ensure there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.

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

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

We will prepare an annual review of the quality and safety of care delivered to residents in our Home to ensure that such care is in accordance with relevant standards set out by the Authority under section 8 of the Act and approved by the Minister under 10 of the Act. It will be prepared in consultation with residents and their families and a copy of the review will be made available to residents and to the Authority.

Proposed Timescale: 30/06/2016

Outcome 05: Documentation to be kept at a designated centre

Theme:

Governance, Leadership and Management

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

The disciplinary policy/procedure had not been implemented regarding conducting meetings with staff members prior to the issuing of a warning.

The written document specifying the nature of misconduct did not identify the period of time given for improvement or how long the penalty would last.

There was no written information retained regarding the employee's defence, findings of the investigation process, and reason for initiating the disciplinary procedure.

The disciplinary policy did not reference a verbal warning and therefore did not guide staff and management in relation to the criteria for issuing a verbal warning.

Disciplinary records were not retained in the documentation pertaining to staff working in the designated centre.

2. Action Required:

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

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

Our disciplinary procedure has now been reviewed and has been implemented regarding conducting meetings with staff members prior to the issuing of a warning. The written document specifying the nature of misconduct will now identify the period of time given for improvement or how long the penalty would last. Going forward there will be written information retained regarding the employees defence, findings of the investigation process, and the reason for initiating the disciplinary procedure. The disciplinary policy now references a verbal warning and will guide staff and management in relation to criteria for issuing a verbal warning. Disciplinary records will be retained in the documentation pertaining to staff working in the nursing home.

Proposed Timescale: 20/04/2016

Theme:

Governance, Leadership and Management

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

An examination of records pertaining to staff working in the designated centre identified that these were not fully maintained in accordance with schedule 2 of the legislation, for example there were gaps in some staff members' employment and Garda vetting.

3. Action Required:

Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

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

All records set out in Schedule 2, 3 and 4 are kept in the nursing home and are available for inspection by the Chief Inspector. All relevant information pertaining to schedule 2 will be included in all staff files.

Proposed Timescale: 12/04/2016

Theme:

Governance, Leadership and Management

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

Records were not kept in such a manner as to be safe as confidential information was stored in an unlocked door in a unit located in the oratory which was also designated as a visitor's room.

4. Action Required:

Under Regulation 21(6) you are required to: Maintain the records specified in paragraph (1) in such manner as to be safe and accessible.

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

All records specified in paragraph (1) will be kept in a safe and easily accessible manner. Proper storage facilities will be provided for the maintenance of records to ensure that they are retained in a safe, confidential and secure manner and that the quality of the records will be protected from damage.

Proposed Timescale: 20/04/2016

Outcome 07: Safeguarding and Safety

Theme:

Safe care and support

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

An investigation was not comprehensive, for example, conclusions about the complaint were made without having a logical flow to the evidence supporting the complaint.

There was no preliminary screening carried out in order to determine if any staff members should be suspended during the period of the investigations.

There was no evidence of a referral to the Health Service Executive designated officer for the protection of residents from abuse.

5. Action Required:

Under Regulation 08(3) you are required to: Investigate any incident or allegation of abuse.

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

We will ensure that a preliminary Screening takes place. The preliminary Screening will take account of all relevant information which is readily available. If an abusive act could have occurred and if there are reasonable grounds for concern a report on the Preliminary Screening will be submitted to the Quality Improvement Meeting team with a recommendation regarding proposed/required actions to determine if any staff members should be suspended during the period of investigations.

We are committed to providing staff with the necessary supervision, support and training to enable them to provide the highest standards of care for our residents. The operation of policies, protocols, procedures and guidelines will help to ensure that staff are aware of the standards that are expected from them and are protected from situations which may render them vulnerable to allegations of abuse. We will liaise with other agencies as appropriate e.g. HIQA, HSE and Gardaí.

Proposed Timescale: 12/04/2016

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:

There was no evidence of learning from allegations of abuse with regard to the investigating and recording process.

6. Action Required:

Under Regulation 26(1)(d) you are required to: Ensure that the risk management policy set out in Schedule 5 includes arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.

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

We will act on the outcome of all investigations. Using the Quality Management System (Corrective and Preventative system) to take all appropriate measures to prevent any reoccurrence of such or similar incidents. The Quality Improvement Meetings analysis all complaints with the intention of eliminating the adverse action and to make continuous improvement.

Proposed Timescale: 12/04/2016

Theme:

Safe care and support

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

The risk register did not contain all of the identified hazards and therefore hazards identified by the inspectors had not been assessed.

7. 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:

The risk register will contain all of the identified hazards. All identified hazards will be risk assessed. All staff will be aware of any hazards identified and the control measures in place

Proposed Timescale: 12/04/2016

Theme:

Safe care and support

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

Measures and controls were not put in place to minimise the risks identified by inspectors as follows:

- A portable electrical hob plate and a toaster located in the dining room
- A record of hot water temperatures was not maintained in accordance with the designated centre's policy on risk management.
- A liquid had been decanted into a spray container which was left on a handrail in the communal area located on the first floor.

8. Action Required:

Under Regulation 26(1)(b) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the risks identified.

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

The above items have been risk assessed and controls put in place and all staff have been made aware of these.

Proposed Timescale: 20/04/2016

Theme:

Safe care and support

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

Infection-control precautions were not fully implemented as follows:

- Clean linen was stored on open shelves in shower/bathrooms.
- Slings for hoists, handling belts and a clean linen trolley were stored in shower/bathrooms.
- Numerous holes were noted in the wall cladding of sanitary facilities.
- A sanitary facility was not left in a clean condition during the afternoon of the second day of the inspection.
- Rusted/corroded equipment including a handrail in the shower room, shower head tubing, showering chair and commodes were in the sanitary facilities.

9. Action Required:

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

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

All staff will receive education and training and regular updates on the risks of infection. An infection Control Nurse has been appointed with the purpose of ensuring compliance with The National Standards for infection and prevention control procedures. Our maintenance and cleaning programme will be reviewed and checked weekly with corrective action requests been raised when non-conformance is found and brought to the attention at our Quality Improvement Meetings

Proposed Timescale: 30/05/2016

Theme:

Safe care and support

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

Some fire doors were held open by pieces of furniture or in one area by mobility aids and therefore would not close in the event of an emergency.

Other fire doors were held open but were not connected to the fire alarm system.

10. Action Required:

Under Regulation 28(1)(a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.

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

All escape routes will continue to be checked regularly as part of our prevention programme to ensure they are not obstructed by furniture etc.

Proposed Timescale: 20/04/16 and on going

Proposed Timescale: 20/04/2016

Theme:

Safe care and support

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

All staff had not participated in annual fire safety training and some of these staff members were rostered on night duty.

11. Action Required:

Under Regulation 28(1)(d) you are required to: Make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.

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

Recently employed staff will receive fire training which will include suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, firefighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.

All pathways at the rear of the building are now free of obstruction and the designated fire Marshall on duty will carry the keys of the exit gate at all times. The locks on both of these gates have been replaced. A new evacuation pathway has been put in place to the left of the building. To the right of the building the wall and railing has been moved to provide clear exit from the rear of the building.

Proposed Timescale: 15/04/2016

Theme:

Safe care and support

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

Fire equipment and the means of escape had not been adequately maintained as follows: –

- Three signed emergency fire exits located to the rear of the designated centre directed residents, staff and visitors to an enclosed external patio and garden with an increased gradient. This evacuation pathway was blocked with garden furniture sitting in the patio area and by a wall and railing.
- This external evacuation pathway lead to a garden gate which had a rusted a padlock. The key for this gate was located in the main office and not held by the designated fire marshal on duty.
- The pathway was not suitable for residents using a wheelchair as it was partially grass with some broken and uneven pavements.
- Combustible items were stored underneath a stairwell even though a notice highlighted that items should not be stored in this area.
- A number of fire extinguishers did not identify the date of service/next service on the equipment.

12. 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:

Fire equipment and means of escape will be maintained as follows:

All evacuation pathways have been cleared and furniture removed.

The key for gate to external evacuation pathway will be held by the designated fire Marshall on duty and rusted lock has been replaced. Pathways will be cleared of grass and uneven pavements will be repaired. All fire extinguishers will now identify the date of service and the next service on the equipment.

Combustible items have been removed from underneath the stairwell.

Proposed Timescale: 30/05/2016

Theme:

Safe care and support

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

Adequate precautions had not been taken against the risk of fire as a number of ceiling lamp shades were sitting at an angle to the electric bulb and a number of these had scorch marks.

13. Action Required:

Under Regulation 28(1)(a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.

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

Precautions will be taken against the risk of fires. All ceiling lamps will be checked to ensure they are sitting at an angle to the ceiling bulb that will prevent scorch marks. Any lampshades with scorch marks have been replaced.
Proposed Timescale: 20/04/2016 and on-going

Proposed Timescale: 20/04/2016

Theme:

Safe care and support

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

The external fire assembly signage was partially covered by shrubbery/ivy.

14. Action Required:

Under Regulation 28(3) you are required to: Display the procedures to be followed in the event of fire in a prominent place in the designated centre.

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

A piece of ivy has been removed from the corner of the fire assembly signage.
Proposed Timescale: 20/04/2016 and on-going

Proposed Timescale: 20/04/2016

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:

Some medications that residents required in a crushed state were not individually prescribed that way.

15. 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:

Medication administered in crushed format will be prescribed for each individual resident (as applicable) and each individual drug (as applicable) under the prescriber's direct responsibility and as per our medication policy. We will ensure that "crushed /open capsule" is documented beside each individual drug.

Proposed Timescale: 20/04/16 and ongoing

Proposed Timescale: 20/04/2016

Theme:

Safe care and support

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

Although two nurses were checking the quantity of medications that required strict controls at the change of shifts, the two nurses who checked were on the same shift.

16. Action Required:

Under Regulation 29(4) you are required to: Store all medicinal products dispensed or supplied to a resident securely at the centre.

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

As per our Medication Management Policy two nurses from different shifts will check our control drugs at the change of shifts

Proposed Timescale: 20/04/2016 and on going

Proposed Timescale: 20/04/2016

Outcome 10: Notification of Incidents

Theme:

Safe care and support

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

The Chief Inspector was not notified at quarterly intervals of the occurrences of any occasion when restraint was used.

17. Action Required:

Under Regulation 31(3) you are required to: Provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of any incident set out in paragraphs 7(2) (k) to (n) of Schedule 4.

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

The Chief Inspector will be notified at quarterly intervals of the occurrence of all occasions when restraint in used.

Proposed Timescale: 20/04/2016 and on going

Proposed Timescale: 20/04/2016

Outcome 11: Health and Social Care Needs

Theme:

Effective care and support

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

The recommendations of allied healthcare professionals were not set out in resident's individual care plans and implemented.

18. 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:

All recommendations from Allied Healthcare Professionals will be set out in resident's individual care plans on epicare and implemented.

Proposed Timescale: 20/04/2016 and ongoing

Proposed Timescale: 20/04/2016

Outcome 12: Safe and Suitable Premises**Theme:**

Effective care and support

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

There was insufficient storage facilities with the result that the cleaning trolley was stored in the designated sluice room. A vacuum cleaner, slings for hoists and handling belts was stored in the communal sitting area located on the first floor.

There was no designated visitor's room as the oratory was used for this purpose. The oratory was also used for storage.

The designated centre was not maintained to a high standard as the following was noted: –

- Aspects of the centre (residents' bedrooms and communal spaces) were in need of redecoration/refurbishment and this was particularly necessary considering the needs of residents with dementia.
- Locks were not easy to operate on the doors of sanitary facilities.
- There was insufficient extraction in the designated smoking room.
- A cupboard door was missing from a shelved worktop in the dining room.
- In some instances, over head lighting in the resident's bedroom was broken or there was no bulb in the light fitting.
- Garden furniture was rusted.
- The door handles on some bedroom and ensuite doors were loose.

Externally the premises was not clean and tidy, for example, in the designated staff smoking and bin areas items such as pieces of furniture had not been disposed of appropriately.

Beds were not serviced on an annual basis.

19. 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:

Refurbishing and maintenance is ongoing. We will continue to liaise with maintenance manager to complete the above list.

Proposed Timescale: 20/04/2016 and on going

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Proposed Timescale: 20/04/2016

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:

The complaint/allegation highlighted in outcome 7 had not been entered into the complaint log.

20. 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:

All complaints/concerns will be recorded in the complaints book and brought to the Quality Improvement Meeting for analysis.

Proposed Timescale: 20/04/2016 and on going

Proposed Timescale: 20/04/2016

Theme:

Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in

the following respect:

There was no evidence that the complainant had been informed of the outcome of the allegations/complaints or was provided with details of the appeals process.

21. Action Required:

Under Regulation 34(1)(g) you are required to: Inform the complainant promptly of the outcome of their complaint and details of the appeals process.

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

The outcome from the complainant or concern investigation is recorded in the Complaint or Concern book and whether or not the staff member was satisfied and brought to the Quality Improvement Meeting.

Proposed Timescale: 20/04/2016 and on going

Proposed Timescale: 20/04/2016

Theme:

Person-centred care and support

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

The complaint detailed in Outcome 7 had not been fully and properly recorded.

22. Action Required:

Under Regulation 34(2) you are required to: Fully and properly record all complaints and the results of any investigations into the matters complained of and any actions taken on foot of a complaint are and ensure such records are in addition to and distinct from a resident's individual care plan.

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

We operate a complaint or concerns procedure that meets the requirements of the Health Act SI 415 2013 and National Quality Standards for Residential Care Settings for Older People in Ireland (Health Information and Quality Authority 2009.The complaint/allegation highlighted in Outcome 7 has been retrospectively noted and recorded with all relevant information in our complaints log, along with a notation regarding follow up with the complainant. Going forward we will ensure that all staff complaints are fully and properly recorded.

Proposed Timescale: 20/04/2016 and on-going

Proposed Timescale: 20/04/2016

Theme:

Person-centred care and support

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

The nominated person by the registered provider did not ensure that all complaints had

been appropriately responded to.

The nominated person by the registered provider did not maintain the records specified in the regulation.

23. Action Required:

Under Regulation 34(3) you are required to: Nominate a person, other than the person nominated in Regulation 34 (1)(c), to be available in a designated centre to ensure that all complaints are appropriately responded to and that the person nominated under Regulation 34 (1)(c) maintains the records specified under in Regulation 34 (1)(f).

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

We operate a complaint or concerns procedure that meets the requirements of the Health Act SI 415 2013 and National Quality Standards for Residential Care Settings for Older People in Ireland (Health Information and Quality Authority 2009. The nominated person will ensure that all complaints are appropriately responded to. The nominated person will maintain the records specified in the regulation.

Proposed Timescale: 20/04/2016 and on-going

Proposed Timescale: 20/04/2016

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:

Residents were able to exercise choice in the following matters: –

- There was communal use of residents' toiletries.
- Clean items of laundry were returned to the designated centre via the dining room as residents were having their lunch time meal.
- While there was curtain screening available in some twin bedrooms it was insufficient to ensure the privacy of residents.
- A resident's wardrobe showed the name of another resident who was not accommodated in the bedroom.
- There were no locks on the ensuite facilities in the single bedrooms.

24. Action Required:

Under Regulation 09(3)(a) you are required to: Ensure that each resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.

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

We will continue to ensure that all resident's toiletries are returned to their rooms after use.

As per our policy clean linen will only be returned to rooms when dining room is empty. We will review curtain screening placement in our double rooms to maintain resident

privacy and dignity.

We will ensure that resident's wardrobes contain only information relevant to the resident occupying the room.

Door locks on all ensuites in single rooms have been fitted.

Proposed Timescale: 30/05/2016