

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Pilgrims Rest Nursing Home
Centre ID:	OSV-0000376
Centre address:	Barley Hill, Westport, Mayo.
Telephone number:	098 27 086
Email address:	info@pilgrimsrest.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Pilgrims Rest Nursing Home Limited
Provider Nominee:	Noel Marley
Lead inspector:	Mary McCann
Support inspector(s):	
Type of inspection	Announced
Number of residents on the date of inspection:	29
Number of vacancies on the date of inspection:	6

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.

Please note the definition of the following term used in reports: responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

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 Standards for Residential Care Settings for Older People in Ireland.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration renewal decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
19 July 2017 16:30	19 July 2017 21:00
20 July 2017 09:00	20 July 2017 14:00

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

Outcome	Our Judgment
Outcome 01: Statement of Purpose	Compliant
Outcome 02: Governance and Management	Compliant
Outcome 03: Information for residents	Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Substantially Compliant
Outcome 06: Absence of the Person in charge	Compliant
Outcome 07: Safeguarding and Safety	Compliant
Outcome 08: Health and Safety and Risk Management	Substantially Compliant
Outcome 09: Medication Management	Compliant
Outcome 10: Notification of Incidents	Compliant
Outcome 11: Health and Social Care Needs	Compliant
Outcome 12: Safe and Suitable Premises	Non Compliant - Moderate
Outcome 13: Complaints procedures	Compliant
Outcome 14: End of Life Care	Compliant
Outcome 15: Food and Nutrition	Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Compliant
Outcome 17: Residents' clothing and personal property and possessions	Compliant
Outcome 18: Suitable Staffing	Compliant

Summary of findings from this inspection

This report sets out the findings of an announced registration renewal inspection, carried out by the Health Information and Quality Authority (HIQA). The current registration of this centre is due to expire on the 13 December 2017. The last inspection of the centre by the Health Information and Quality Authority (HIQA) was

an unannounced monitoring inspection completed on 25 October 2016. This inspection identified the requirement for improvements in four areas, governance and management, the risk management policy, ensuring care plans are more person centred, documentation regarding fire drills and ensuring that a drill is completed simulating night time staff levels and night time scenario. The provider and person in charge had ensured there had been significant work done in these areas and all actions were addressed. The provider had appointed a director of nursing in July 2016 who was subsequently appointed into the post of person in charge in June 2017, a competent senior nurse was also appointed as a person participating in the management of the service and a part-time human resources manager. The inspector found this had strengthened the governance within the centre. Monitoring systems were in place to ensure the quality and safety of the service. A good level of compliance was found on this inspection. Residents healthcare needs were met to a good standard. Staff had access to training and knew the residents and their care needs well. The Inspector observed that staff delivered care in a kind and unhurried way and were courteous to the residents.

Pilgrims Rest Nursing Home is a purpose built single storey bungalow style building which is registered with HIQA to accommodate 35 residents. It is situated 2 miles outside the town of Westport on the Newport Road. Facilities available include a dining room, three sitting rooms, a designated smoking room, 17 single bedrooms, sixteen of which have en-suite toilet facilities, nine twin bedrooms, four of which have en-suite toilet facilities. Three bathrooms which include toilets and a further four communal toilets are available for residents use. An enclosed garden is also available.

Documentation submitted by the centre since the last inspection was reviewed by the inspector prior to and during the inspection. The inspector also met with residents, a relative and staff members, observed practices and reviewed documentation such as care files, medical records, staff personnel files, risk and fire documentation and the complaints log. 15 resident and four relative pre-inspection questionnaires were received. On review of these, the inspector found that residents and relatives were positive in their feedback with regard to the staff, management, the overall service and care provided. Comments included 'the staff are great, they come as soon as I ring the bell, the food is lovely, I am very happy here and well looked after, if I had a worry I would tell staff'. Two suggestions were made with regard to having longer intervals between meals. This was communicated to the provider and person in charge who stated they would discuss this at residents meetings.

Post this inspection, areas which require review include completion of a risk assessment with regard to the incline into the garden, ensuring that a structured quality improvement plan is completed post audits, ensuring the directory of residents complies with regulation 19 schedule 3 of the regulations. Actions with regard to these areas are contained in the action plan at the end of the 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 Standards for Residential Care Settings for Older People in Ireland.

Outcome 01: Statement of Purpose

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The statement of purpose consisted of the aims, objectives and ethos of the designated centre. It also described the facilities and services that were to be provided for residents. The inspector noted that the statement of purpose was made available for residents, visitors and staff to read. All of the items listed in Schedule 1 of the Regulations, including the information set out in the Certificate of Registration was contained in the statement of purpose.

Judgment:

Compliant

Outcome 02: Governance and Management

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

Theme:

Governance, Leadership and Management

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

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

Findings:

The provider works in the centre on a daily basis and residents confirmed that they saw him regularly. A clearly defined management structure that identified the lines of

authority and accountability was in place. Staff spoken with by the inspector were clear about the management structure and the reporting mechanisms. The recently appointed Human resources person was responsible for organising training, recruitment and any staffing matters in conjunction with the provider and person in charge.

A quality management system was in place. The provider, person in charge and senior nurse were responsible for various areas of auditing. While the inspector could see that deficits identified had been addressed there was no formal quality improvement plan enacted post audits which showed the timescale from the deficit was identified to when it was addressed and dates for re-auditing to ensure sustainable improvement.

Audits had been completed on health and safety, falls and nutritional care. All accident and incident record were reviewed by the person in charge and any deficits identified were addressed. All staff had up to date mandatory training and the environment was clean and well maintained. Catering staff told the inspector that there were always adequate provisions available to meet the nutritional needs of residents and they could order food as required. An annual review of the quality and safety of care delivered to residents in the designated centre had been completed for 2016 and data was being collected by way of audits and surveys for the 2017 report. This was an action from the previous inspection. The report was presented in two sections and used the themes from the National Standards for Older People and highlighted areas requiring review. Section one related to quality and safety and section two capacity and capability. This review was carried out in consultation with residents and their families.

There were sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose. This was supported by a review of the rosters by the inspector which showed that the staffing levels during the inspection were the usual staffing levels. No relative or residents spoken with or in the completed pre registration questionnaires raised any issue with regard to staffing levels.

Judgment:

Compliant

Outcome 03: Information for residents

A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

A comprehensive resident's guide detailing a summary of the service provided, the complaints procedure and arrangements for visiting was available. However, an easy to

read/pictorial guide was not available which would facilitate a better understanding for residents who were cognitively impaired. The Person in Charge and provider gave a verbal commitment to address this.

The inspector reviewed a sample of residents' contracts for the provision of services and found that the contracts outlined the support, care and welfare to be provided to residents. Contracts had been agreed on admission. The fees being charged and the services provided along with any additional fees applicable to residents were documented.

Judgment:

Compliant

Outcome 04: Suitable Person in Charge

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The person in charge had recently been appointed as person in charge. She has worked as the director of nursing in the centre for the past year. She was interviewed during the inspection and was found to be knowledgeable with regard to her responsibilities under the regulations and fulfilled the criteria required by the regulations in terms of qualifications and experience.

She is a registered nurse having qualified in 2009 and holds a full-time post working five days per week and is on-call out of hours. She also holds a Master of Science in dementia care. Throughout 2016/17 she completed courses in safeguarding, medication management, manual handling, infection control, responsive behaviour and fire safety training. The person in charge informed the inspector that she had adequate time for governance supervision and management duties. During the inspection she demonstrated that she had knowledge of the Regulations and Standards pertaining to designated centres. She confirmed that there was a supportive structure in place to assist her in her role. Her registration with An Bord Altranais agus Cnáimhseachais Na hÉireann (Nursing and Midwifery Board of Ireland), was up to date.

Judgment:

Compliant

Outcome 05: Documentation to be kept at a designated centre

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

Theme:

Governance, Leadership and Management

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

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

Findings:

The action from the last inspection with regard to the risk management policy has been completed.

Records listed in Schedules 2, 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People Regulations 2013 (as amended) were available and were stored and maintained securely. A computerised documentation system is in place. The inspector reviewed a sample of these records to include fire safety, staff recruitment, accident and incident records, maintenance records and residents' care and medical files.

The centre's insurance was up to date and provided adequate cover for accidents or injury to residents, staff and visitors.

A record of visitors was maintained.

The directory of residents' required review to ensure the name address of any authority, organisation or other body, which arranged the resident's admission to the designated centre, was detailed.

A sample of staff files was reviewed and found to be compliant with the regulations. The provider confirmed in writing to the authority on the 17 July 2017 that all staff has Garda vetting in place. The provider confirmed verbally at the feedback meeting that all volunteers are also Garda vetted.

The inspector also reviewed a sample of policies and procedures as required by Schedule 5 of the regulations. All the required policies were in place.

Judgment:

Substantially Compliant

***Outcome 06: Absence of the Person in charge
The Chief Inspector is notified of the proposed absence of the person in***

charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

Deputising arrangements for the person in charge are in place. The provider and the senior nurse who has worked in the centre for over 10 years is notified to HIQA as persons participating in the management of the centre. Both of these were registered nurses and had up to date registration with An Bord Altranais agus Cnáimhseachais Na hÉireann (Nursing and Midwifery Board of Ireland),

The provider was aware of the requirement to notify the Chief Inspector of the proposed absence of the person in charge for a continuous period of 28 days. This had not occurred to date.

Judgment:

Compliant

Outcome 07: Safeguarding and Safety

Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

Measures were in place to protect residents from being harmed or suffering abuse. Staff had been provided with training in recognising and responding to elder abuse. Refresher training is completed annually. The person in charge is the dedicated officer in safeguarding for the centre. She has attended training in safeguarding and has updated the centre policy to encompass the procedures detailed in the HSE Policy on safeguarding vulnerable adults at risk of abuse. Staff spoken with were clear on their role and responsibilities in relation to reporting abuse. All voiced the review that the care of the residents was paramount and they would report any suspicion or allegation of abuse to the most senior staff on duty at the time.

Behaviour management care plans were in place to guide staff when working with residents who had responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). The records viewed confirmed that responsive behaviours were assessed and managed in the centre. Behaviour support plans were in place. The inspector read a sample of care plans and saw that they identified potential triggers and contained sufficient detail about appropriate interventions to guide staff to provide consistent person-centred approaches to care. Staff had attended training in management of responsive behaviour.

Residents had access to a secure courtyard garden and three sitting rooms and a dining room where they could spend time if they required peace and quiet or stimulation. Files examined showed that a pre-admission assessment had been completed in all cases to ensure that the centre could meet the needs of the residents. There was evidence that appropriate referrals had been made to mental health services and residents had accessed mental health services with specialist staff attending the centre. The person in charge is trained in mental health nursing and holds a Masters in dementia care.

A visitor's book was maintained and all visitors were required to sign in and out of the centre.

The provider stated that the centre was not an agent for any resident. The centre kept small amounts of pocket money in safe keeping for residents. A transparent system was in place to safeguard residents' money with documentary evidence of any payments in and out. A signature of staff and the resident or two staff was in place for all monies spent and receipts were available.

A culture of promoting a restraint free environment with an increase in the use of alternative safety measures such as low-low beds were in place. Evidence of alternatives considered or trialled was available. At the time of this inspection there were 11 residents with bedrails and/or a lap belt in place. These include nine residents with bed rails and two with lap straps. The two residents with lap straps in place have been assessed by the Occupational Therapist and the lap straps were recommended to enable correct positioning and functioning. In discussion with the person in charge on the use of bedrails she described how most were used as an enabling function, many had been requested by the resident and others were in place for the purpose of positioning or enhancing the residents' function. Care plans were in place detailing the rationale for use of the bed rails. Records indicated that restraint was only used following a safety risk assessment.

Judgment:
Compliant

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

Theme:

Safe care and support

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

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

Findings:

The action with regard to completing a simulated fire drill with night staffing levels had been completed. All new staff receive training in fire safety on their first day of employment and are required to attend at least two fire drills per year and one formal fire training session. Fire and missing person drills are carried out frequently by the person in charge and possible scenarios are discussed and practiced.

On review of the fire training records, the inspector saw that fire training had been undertaken by all staff. Staff spoken with knew what to do in the event of a fire. Completion of fire drills records required further input, as there was poor documented evaluation of learning from fire drills, for staff to evaluate what worked well or identify any improvements required. A personal evacuation plan was in place for each resident. Fire records showed that fire equipment had been regularly serviced. The fire alarm was last serviced on the 10 May 2017 and a contract is in place for quarterly servicing. The inspector found that all internal fire exits were clear and unobstructed during the inspection. Evacuation maps and procedures were displayed throughout the premises.

There was a declaration of conformity for emergency lighting and this was completed annually, last completed 17 July 2017. The provider has contracts in place for the regular servicing of all equipment and the inspector viewed records of equipment serviced. All beds, specialist chairs and hoists were serviced on the 13 July 2017. Equipment such as specialist beds, wheelchairs and mattresses were provided in accordance with residents' needs. There were moving and handling assessments available for all residents. All staff had up to date training in manual handling

The health and safety of residents, visitors and staff is promoted in the centre. The risk management policy had been reviewed since the last inspection and was found to comply with current legislation and detailed measures to control hazards including abuse, unexplained absence of a resident, injury, aggression and self harm. The person in charge holds an ISOH certificate in Health & Safety management and informed the inspector she incorporates this knowledge to improving the quality and safety systems in the centre.

An up to date safety statement dated 14 March 2017 with an accompanying risk register was also available. This register contained risk assessments in relation to environmental risks such as cleanliness and tripping hazards. While these were reviewed annually there was poor information as to what the review entailed. Also consideration needs to be given to reviewing the risk register at more frequent intervals than annually.

There was a centre-specific emergency plan that took into account a variety of emergency situations. Clinical risk assessments were undertaken, including falls risk assessment, nutritional care assessments. Neurological observations were completed

post un-witnessed falls to monitor neurological function.

Records were maintained of accidents and incidents. Factual details of the accident/incident, date event occurred, name and details of any witnesses and whether the general practitioner (GP) and next of kin had been contacted. The person in charge had reviewed each incident and ensured that assessments and care plans were reviewed where appropriate. A monthly incident report audit is completed by the person in charge.

The environment was observed to be clean. Staff who spoke with the inspector was knowledgeable in infection control procedures. Staff had access to supplies of gloves and disposable aprons and was observed using these. All staff are required to attend infection control training on an annual basis. The person in charge carries out hand hygiene and spill kit training with new staff on the first day of their employment and on an annual basis thereafter. Outbreaks of infection are managed in accordance with evidence-based practice and are reported in line with national guidelines to the Health Information and Quality Authority and local public health authorities. There was one incident of notifiable disease reported in 2017. This was well managed.

Judgment:

Substantially Compliant

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):

No actions were required from the previous inspection.

Findings:

A comprehensive medication management policy was in place. Evidence was available by way of staff signature that they had read this policy. The staff nurse who was observed administering the medication demonstrated adequate knowledge of this document. The person in charge completed medication competency assessments with nursing staff. Any deficits observed were brought to the attention of the staff member concerned and the person in charge agreed a plan re addressing same

Medication prescription sheets reviewed by the inspector were current. The practice of transcription was in accordance with professional guidance issued by An Bord Altranais agus Cnáimhseachais. They detailed the weight, an up to date photo of the resident and any known allergies. Where medications were to be administered in a modified form such as crushing, this was individually prescribed by the medical practitioner on the prescription chart. Maximum daily doses were specified for 'pro re nata' (PRN)

medication. The medication administration record sheets (MARS) identified the medications on the prescription sheet, contained the signature of the nurse administering the medication. Medications are reviewed by the residents' general practitioner on a quarterly basis.

The times of administration matched the prescription sheet. The inspector observed medication administration practices and found that nursing staff adhered to professional guidance of An Bord Altranais agus Cnáimhseachais.

Medications for residents were supplied by a local community pharmacy. There was evidence of appropriate involvement by the pharmacist in accordance with good practice, including being available to residents should they wish to discuss their prescribed medication. Medications were stored in a locked medication trolley. The temperature of the medication fridge was monitored and recorded daily and medications requiring refrigeration were stored appropriately. Handling and storage of controlled drugs was safe and in accordance with current guidelines and legislation.

All staff nurses had completed medication management training in 2016 and this is completed on an annual basis. Medications which are out of date or dispensed to a resident who no longer required the medication were securely stored. These were segregated from other medicinal products and returned to the pharmacy for disposal in a timely fashion. A record of the medications returned to the pharmacy was maintained.

Judgment:

Compliant

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:

The inspector reviewed records of accidents and incidents that had occurred since the last inspection in the designated centre. On review of these incidents and cross referencing with notifications submitted the inspector found that the centre adheres to the legislative requirement to submit relevant notifications to the Chief Inspector

Judgment:

Compliant

Outcome 11: Health and Social Care Needs

Each resident's wellbeing and welfare is maintained by a high standard of

evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

Theme:

Effective care and support

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

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

Findings:

The action from the previous action plan had been addressed. There was evidence available of consultation with the resident and where appropriate their significant other with regard to the care plans.

Pre admission assessments were completed. These detailed a brief social history, physical health status with a dependency, falls and skin integrity assessment. On admission to the centre, a comprehensive nursing assessment and additional risk assessments are carried out for all residents. For example, a nutritional to identify risk of nutritional deficit, a falls risk assessment to risk rate propensity to falling. These assessments were linked to the care plans. Care plans were clear and contained sufficient information to direct person centred care.

Where an event occurred for example a fall a reassessment was completed, and the care plan was updated to ensure that any additional control measures that may be required to mitigate the risk were documented. Where a resident was seen by a specialist service the advice of the specialist was incorporated into the care plan. A narrative record was recorded for residents each day. These records described the range of care provided on a daily basis to ensure residents well-being and documented any changes in residentst physical psychological or social wellbeing.

There were no residents with wounds on the days of inspection. The person in charge described where residents were deemed to be at risk of developing wounds preventative measures were identified including skin care regimes. Supportive equipment such as specialist cushions, mattresses and dietary supplements also formed part of the care package. Residents had good access to general practitioner (GP) services and out-of-hours cover was also readily available. A review of residents' medical notes showed that GP's visited the centre regularly. There were processes in place to ensure that when residents were admitted, transferred or discharged to and from the centre, relevant and appropriate information about their care and treatment was available and maintained, and shared between providers and services.

Access to allied health professionals to include speech and language therapist, dietetic service, physiotherapy and occupational therapy services were available.

Judgment:

Compliant

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):

No actions were required from the previous inspection.

Findings:

The centre is registered to provide care to 35 residents. It has three assisted showers and one assisted bathroom, (one of these is a dual shower and bathroom). The National Standards 2016 state that in all residential services there is a ratio of one assisted bath (or assisted shower, provided this meets residents' needs) to eight residents. The ratio available in this centre does not meet this standard. This was brought to the attention of the provider during the inspection. Facilities available include a dining room, three sitting rooms, a designated smoking room, 17 single bedrooms, sixteen of which have en-suite toilet facilities, nine twin bedrooms, four of which have en-suite toilet facilities. Three communal toilets are available for residents use (there are also there toilets in the bathrooms). An enclosed garden is also available.

Privacy curtains are in place in all shared bedrooms and residents have access to their own wardrobes and lockable bed side table. Each resident had sufficient space to store their clothing and personal belongings.

Bedrooms and communal areas were found to be clean, well ventilated and comfortably warm. Hand testing indicated the temperature of hot water did not pose a risk of burns or scalds. Separate changing facilities are provided for care and kitchen staff to enhance infection control practices. There was appropriate equipment for use by residents.

The interior corridors were painted in bright colours to assist in the resident's orientation. Bedrooms are numbered and each resident's photo and name is displayed on their door. Day rooms and other communal areas are sign posted using dementia friendly signage. Communal toilet doors are painted yellow to assist residents in recognising the entrance thus promoting their independence.

Judgment:

Non Compliant - Moderate

Outcome 13: Complaints procedures

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

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

A complaints policy was in place. This detailed a comprehensive process for dealing with a complaint which complied with the regulations. No complaints were being investigated at the time of this inspection.

The person in charge is nominated as having overall responsibility to investigate complaints. A summary of the complaints procedure was displayed prominently on entry to the centre. The inspector reviewed the complaints log and found that all complaints were recorded, investigated and resolved in a timely fashion, with the satisfaction of the complainant with the outcome of the complaint recorded. The independent appeals process if the complainant was not satisfied with the outcome of their complaint meets the requirements of the regulations. In 2016, there was a total 12 complaints received, all of which were resolved at stage 1 of the procedure. The contact details of the office of the Ombudsman was recorded in the policy.

Judgment:

Compliant

Outcome 14: End of Life Care

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

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

The management team confirmed they had good access to the palliative care team who provided advice to monitor physical symptoms and ensure appropriate comfort measures. There were no residents under the care of the palliative team at the time of this inspection. The person in charge stated that when a resident reaches the active

stage of their end of life journey, they and their family are supported by staff to ensure that all of their wishes are carried out ensuring their dignity and respect is protected. The person in charge compiles an end of life care audit where she examines the care afforded to the resident to ensure there is continuous learning.

The person in charge informed the inspector that feedback received from families has been very positive with family members stating they were very happy with the care afforded to their loved ones and that they felt supported and reassured throughout the end of life process. The annual training plan at the incorporates training on death, dying and bereavement and the palliative care team provide ongoing training to nurses on palliative medications and equipment.

Relatives were facilitated to stay overnight and snacks and drinks were available.

The third sitting room could be used as a quiet area for families and if residents or families requested could be used for waking residents. Staff stated the local parish priest was freely available to the service and knew the residents well as he attended the centre weekly. Details were available in the centre of other religious ministers.

Judgment:

Compliant

Outcome 15: Food and Nutrition

Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

Residents were provided with food and drink at times and in quantities adequate for their needs. The food was properly served with sufficient staff on duty to offer assistance to residents in a discreet and sensitive manner. The inspector met with the chef who confirmed that there were regular deliveries of fresh food and she stated she "always tried to ensure that the residents got what they wanted". Homemade brown bread and treacle currant bread were available daily.

The chef confirmed that she ordered the food and any special requests were always actioned. She confirmed that cakes and other party items were available for birthdays.

Residents were assessed for nutritional needs on admission and were subsequently reviewed regularly. Records of weight checks were maintained on a monthly basis and

more regularly where clinical status indicated this. Access to a dietician and a speech and language therapist was available to obtain specialist advice to guide care practice and assist residents with good nutritional care.

Nutritious snacks were available between meals and during the night if residents were awake. A trolley served residents mid morning and afternoon offering a choice of tea/coffee fruit, buns and biscuits. Residents confirmed their satisfaction with mealtimes and food provided when speaking with the inspector and in the pre inspection questionnaires. Relatives were also complimentary of the food provided.

A record of residents who were on special diets such as diabetic, fortified diets or those requiring a modified consistency was available for reference to catering and care staff. The chef described a clear safe process of how changes were brought to her attention and how she recorded these immediately and in a diary/ communication book for other staff.

Judgment:

Compliant

Outcome 16: Residents' Rights, Dignity and Consultation

Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

There was evidence of a good communication amongst residents, the staff team and relatives. An information board is available in the main foyer area. This board includes the activity timetable, information on advocacy services, the weekly menu, organisational structure and the complaints procedure. The centre has access to SAGE advocacy services and their contact information is displayed on the resident's notice board and on entrance for visitors.

Resident's individual religious preferences were respected and each resident was facilitated to engage in or abstain from religious practices according to their wishes. Mass took place every third Saturday and the priest visits every Saturday to say prayers. Representatives from the Legion of Mary also attend the centre weekly.

The person in charge had noted in the annual review report that some residents were

facilitated to vote, however not all residents admitted were registered to vote. The person in charge stated that this was an area which required review to ensure the rights of each resident was respected in accordance with their wishes. She informed the inspector that the administrator was liaising with the local county council re registering all residents who wished to do so.

The activity co-ordinator facilitates the residents in participating in a quarterly residents committee meeting. Residents who may not be able to voice their views due to their medical condition are represented on this committee by a relative. Suggestions voiced are brought to the management team for consideration and the person in charge ensures these are discussed with the provider and changes are enacted. Some residents have their own mobile phone and other residents have access to a cordless phone. An open visiting policy is in operation.

Staff were observed to protect the privacy and dignity by knocking on bedroom doors before entering and ensuring that curtains were drawn around the beds. During the day, residents were able to move around the centre freely.

A variety of newspapers and magazines were available to residents. An activity co-ordinator is available 7 days per week. A planned programme of activities was scheduled throughout the day. Residents spoken with were complimentary of the activities offered and some commented they enjoyed, "the chatting and the newspapers". Group activities were organised such as Sonas, exercise classes and hand massage. Staff created opportunities for one-to-one activities, for residents who were unable or chose not to participate in group activities and the activity coordinator confirmed that she attended residents individually in their bedrooms.

Judgment:

Compliant

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

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

All residents had their own wardrobe which provided adequate space for their belongings. Lockers were provided with a secure drawer were also provided. All laundry was done on site unless families requested to take home clothes to launder. where residents did not wish to have their clothing labeled this was facilitated and a blue laundry bag was provided to the resident and their laundry was laundered

individually.

Designated staff were allocated to the laundry. A property list was completed on admission and updated with four monthly intervals.

Judgment:

Compliant

Outcome 18: Suitable Staffing

There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

Theme:

Workforce

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

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

Findings:

Volunteers who worked in the centre had a signed agreement in place detailing their role and responsibilities. They also attended safeguarding and fire training.

The inspector reviewed the staff roster. Where staff were unable to work this was recorded and staff were replaced with staff who worked in the centre. No agency staff were employed. There was a planned and actual roster in place. Residents and staff interviewed indicated that they were satisfied with staffing levels. The inspector observed that staff spent time with residents and call bells were answered in a timely fashion. Based on a review of the rosters and these inspection findings and on resident and relative questionnaires the inspector found that the staff numbers and skill-mix were appropriate to meeting the assessed needs of the complement of residents accommodated.

There were 29 residents in the centre on the days of inspection, five were assessed as maximum dependency, ten as high dependency, nine as medium dependency and five as low dependency.

Two nurses were on duty until 16:00hrs each day in addition to the person in charge. One nurse was on duty thereafter. The provider also worked daily in the centre. In the morning there were five carers and four carers in the afternoon and evening. Three carers were available until 23:00hrs with two carers and one nurse on night duty. In addition to nursing and care staff there was a chef, an activity therapist, administration,

human resource, cleaning and laundry staff. The dependency level of each resident is identified on admission using the Barthel Index and documented. An audit measuring the dependency levels of residents and the staffing levels is completed each quarter by the person in charge. The management team meets on a weekly basis to discuss the running of the centre. Minutes were available of these meetings. An induction programme is provided to all staff when they commence working in the centre. The skills and competencies of each staff member are reviewed during their probationary period and on an ongoing basis as part of their annual appraisal.

A comprehensive staff training programme was on-going. All staff had up to date training in fire safety, safeguarding of vulnerable adults and manual handling. Additional training and education relevant to the needs of the residents profile had been provided for example infection prevention and control, hand hygiene, medication management communication, end of life care, dementia training, responsive behaviour, continence and basic life support to include management of choking and nutritional care. A planned training programme for the remainder of 2017 included further dementia training, manual handling, safeguarding and nutritional care.

An Bord Altranais agus Cnáimhseachais na hÉireann registration numbers were available for all registered nursing staff employed.

A daily allocation for staff nurses and care assistants was in place and this tried to ensure continuity of care. Staff are kept informed on changes to residents' health status through handover meetings, care plans and daily diaries. Regular staff meetings took place. Topics discussed include documentation, falls prevention, nutrition and day to day running of the centre to include the environment and clinical issues.

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:

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

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	Pilgrims Rest Nursing Home
Centre ID:	OSV-0000376
Date of inspection:	19/07/2017 and 20/07/2017
Date of response:	18/08/2017

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 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 directory of residents' required review to ensure the name address of any authority, organisation or other body, which arranged the resident's admission to the designated centre, was detailed.

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

1. Action Required:

Under Regulation 19(3) you are required to: Ensure the directory includes the information specified in paragraph (3) of Schedule 3.

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

Following the inspection, the directory of residents' was reviewed by the Person in Charge & the name & address of any authority, organisation or other body, which arranged the resident's admission to the designated centre is detailed for each resident. This information will be documented on all admissions in the future.

Proposed Timescale: Completed

Proposed Timescale: 14/08/2017

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:

Completion of fire drills records required further input as there was poor documented evaluation of learning from fire drills completed for staff to evaluate what worked well or identify any improvements required.

2. Action Required:

Under Regulation 28(1)(e) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and residents are aware of the procedure to be followed in the case of fire.

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

Following the inspection, the Person in Charge reviewed the template in place for documenting all fire drills. This template has now been amended to include a section which will evaluate the learning from fire drills and what worked well. Any areas that require improvement will also be documented to demonstrate quality & safety improvement.

Proposed Timescale: Completed

Proposed Timescale: 14/08/2017

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:

The centre is registered to provide care to 35 residents. It has three assisted showers and one assisted bathroom, (one of these is a dual shower and bathroom). The National Standards 2016 state that in all residential services there is a ratio of one assisted bath (or assisted shower, provided this meets residents' needs) to eight residents. The ratio available in this centre does not meet this standard.

3. 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:

The Registered Provider had drawings completed with a view to extending the Nursing Home. The building plans had not been submitted for planning approval to Mayo County Council prior to the Inspection. These plans will now be revised in order to comply with Regulation 17(2) and to ensure compliance with the National Standards for Older Persons in Residential Care Settings in Ireland (2016). Once completed the revised plans will be submitted for planning approval to the local authority.

Proposed Timescale: August 2019 (subject to planning regulation requirements).

Proposed Timescale: 14/08/2017