Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People

Name of designated centre:	Oaklodge Nursing Home
Name of provider:	B & D Healthcare Company Limited
Address of centre:	Churchtown South, Cloyne, Midleton, Cork
Type of inspection:	Unannounced
Date of inspection:	03 & 04 May 2018
Centre ID:	OSV-0000261
Fieldwork ID:	MON-0023747

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

Oaklodge Nursing Home is a single-storey building set in a scenic rural area. There is 24-hour nursing care available which is led by the nurse in charge, who is experienced in older adult care. Nurse managers, healthcare assistants, chefs, cleaning staff, administration staff and activity personnel support the delivery of care. There are a number of communal areas available to residents including a conservatory, a large dining room, a sitting room and visitors' room. There is a well equipped hairdressing/beauty room and an oratory available to residents. There are fifty-one bedrooms in the centre which is registered to accommodate 65 residents. Bedroom accommodation is composed of 43 single occupancy rooms, four double rooms, two three-bedded rooms and two four-bedded rooms. The majority of rooms have en-suite facilities, a telephone, a large television, nurse call-bell system and individual thermostatic controls for the under-floor heating system. There are two assisted bathrooms available for residents in addition to the en-suite facilities. Two enclosed patio areas are located off the north corridor area with suitable seating and water features. The north and south corridors are similar in layout and and are linked by a central corridor. The south corridor leads to the dementia-specific secure unit which has a separate sitting area. Resident in this unit avail of a large room outside the unit for meal times. While most bedrooms in this unit are single occupancy with en-suite toilet and shower areas, there is also a three-bedded room and a four-bedded room on this unit, similar to the bedroom layout on the north corridor. A specific garden area has been carefully planned and designed for residents with dementia. Residents are assessed prior to admission. Care plans are developed for each individual and are person-centred. Residents are encouraged to partake in the development of their plan of care which is based on elements of their life story and medical history. A range of activities is organised and facilitated including mass and external outings. Residents have access to general practitioner (GP) services and the pharmacist visits weekly. Allied health services are available such as physiotherapy, dietitian, speech and language therapy and palliative care services. A contract is signed on admission and any extra fees are specified.

The following information outlines some additional data on this centre.

Current registration end date:	12/07/2019
Number of residents on the date of inspection:	64

How we inspect

To prepare for this inspection the inspector or inspectors reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
03 May 2018	10:30hrs to 17:45hrs	Mary O'Mahony	Lead
04 May 2018	10:00hrs to 16:30hrs	Mary O'Mahony	Lead

Views of people who use the service

Residents said that they enjoyed living in the centre due to the care they received and the fact that they were consulted about their daily care and preferences. They had access to a variety of meaningful and entertaining activities. They told the inspector that visitors were unrestricted. They were familiar with the person in charge and staff. Residents expressed satisfaction with all aspects of care. Residents said that they felt safe, they were treated well and were encouraged to become involved in proposed changes or improvements. Residents said that they were aware of the advocacy service and knew how to contact the service if necessary. They were consulted on a daily basis, during the annual survey and also at the two-monthly residents' meetings. A number of residents said that they went out at weekends and that staff went with them to attend outpatient appointments. Resident praised staff members who guided them in chair-based exercise sessions and concerts. Community events were organised and transport was made available to residents to enable them to attend external events.

Capacity and capability

There were effective management systems in this centre, ensuring good quality care was delivered. Where issues arose in the areas of medicine management and fire safety these were further discussed under the 'Quality and safety' dimension of this report.

The governance structure in place ensured clear lines of accountability. Staff spoken with were aware of their responsibilities. The person in charge was supported by an assistant person in charge. They were both involved in the day-to-day running of the centre and were knowledgeable regarding residents' needs. They were available to meet with residents, family members and staff which supported an open communication culture. This meant that concerns were brought to the attention of the management staff promptly.

Good audits and quality improvement plans meant that the provider had an effective system in place to provide an overview of the service provided. Nevertheless, the inspector found some inconsistencies in residents' care plan records which presented a risk to the delivery of appropriate care to all residents and indicated that audit of documentation practices was not sufficiently robust, as it did not highlight these errors. In addition, while complaints and concerns were documented in the complaints book, the outcome of all complaints was not clearly identified. Again this indicated gaps in the auditing, learning and review process by management to ensure improved outcomes for residents. Feedback from residents' meetings and

residents' surveys were included in the annual review of the safety and quality of care in the centre. This was seen to be generally positive and action was taken to address any issue of concern. Managers were aware of the regulatory requirement to notify HIQA of certain adverse occurrences. A review of accidents and incidents in the centre indicated that they were managed appropriately. Residents' contracts were seen to specify the room number and type of room to be occupied by the resident which provided a sense of security for residents.

Effective recruitment practices were in place to ensure that staff had the required skills to carry out the duties of their respective roles. Appraisals were undertaken annually and where performance issues were identified there were seen to be addressed in line with the staff handbook guidelines. Staff and volunteers had the required Garda Síochána vetting (GV) in place. A sample of staff files reviewed contained the documents required under Schedule 2 of the Regulations, although not all were sufficiently detailed. Training provision ensured that staff developed the skills required to deliver safe and effective care to residents. For example, staff had received specific training in the protection and safeguarding of older people to ensure that they were able to recognise the signs of abuse and were knowledgeable of the actions required to safeguard residents. Where diversion from best practice had been identified following the provision of training, the inspector found that a number of measures were taken to safeguard residents and ensure that all staff were aware that there was zero tolerance of abusive interactions.

Staffing levels were reviewed on an on-going basis so that the numbers and skill-mix were sufficient to meet the assessed needs of residents. Continuity of care for residents was supported by the identification of key workers for residents. Minutes of management and staff meetings indicated that there was clear and comprehensive communication in the team about residents' changing needs. This ongoing communication fostered a person-centred culture.

Regulation 14: Persons in charge

The person in charge fulfilled the requirements of the Regulations.

Judgment: Compliant

Regulation 15: Staffing

Staffing levels were adequate and were reflected in the roster viewed on inspection.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had received the required training and were knowledgeable of this.

Judgment: Compliant

Regulation 21: Records

The references available for staff did not contain sufficient detail.

Judgment: Substantially compliant

Regulation 23: Governance and management

The audit system had not identified incorrect or insufficient recording of information.

Judgment: Substantially compliant

Regulation 24: Contract for the provision of services

Contacts contained the required information and they were clear and unambiguous.

Judgment: Compliant

Regulation 3: Statement of purpose

The statement of purpose was reviewed on an annual basis.

Judgment: Compliant

Regulation 30: Volunteers

Volunteers files were in order.

Judgment: Compliant

Regulation 31: Notification of incidents

Notifications were made to HIQA as required by regulation.

Judgment: Compliant

Regulation 34: Complaints procedure

Not all complaints were properly documented. The satisfaction or not of each complainant was not always recorded.

A complaint was not dated and the person writing down the complaint was not identified.

Judgment: Not compliant

Quality and safety

Overall, residents were facilitated in experiencing a good quality of life which was respectful of their wishes and choices. Residents were supported in their personal development by daily participation in meaningful activities. For example, a number of residents described how they went out visiting with relatives and how arrangements were made for them to stay out overnight, if that was their choice. Staff were seen to encourage residents to engage in activities appropriate to their abilities and assessed needs. Residents appeared happy and confident when engaging with staff.

The holistic needs of residents were supported by care plans. These were individualised, mainly computerised, and staff spoken with had a good knowledge and understanding of the needs and personal choices of residents set out in their care plans. Appropriate resources were available for example; medical practitioners attended the centre regularly and allied health services such as physiotherapy and

speech and language therapy were available as necessary. Clinical assessments took place using standardised tools and these were reviewed four monthly or according to changing needs. On reviewing a small sample of residents' care plans, the inspector found that while documentation was well maintained inconsistencies were seen in the details related to the assessment of care needs on a least three occasions.

Residents' views were considered and surveys were undertaken. Contact information for an independent advocate was displayed in the centre. Residents' meetings took place every couple of months. These meetings provided an opportunity for feedback on areas such as activities, laundry and meals. The person in charge was available for informal, daily consultation which helped residents to feel that their views mattered to the management team. The centre provided areas for residents to meet with visitors in private and those visitors spoken with confirmed this.

Nursing staff demonstrated a good understanding of safe administration of medicines to residents. Controlled drugs were appropriately stored and the monitoring of stock was documented. Medication management audits were in place and the use of psychotropic medicines was reviewed regularly. The person in charge confirmed that appropriate arrangements were in place in relation to pharmacy services. The inspector reviewed documentation around prescribing and administering medicines and found that following non compliance: the daily maximum dose was not set out for a number of medicines. The inspector also found that a label had been applied to one medicine container which occluded the name, dose and expiry date of that medicine. This presented a risk to residents as the staff member administering the medication was not able to identify the type, dose and expiry date of the medicine, as required under the policy on medication management and the guidelines for nurses from An Bord Altranais.

The premises was well maintained, modern, clean and spacious. Residents' enjoyed gathering in the large communal rooms or having the choice of privacy in their bedrooms. In the dementia unit, while improvements had been undertaken since the previous inspection, not all residents were accommodated in suitable bedroom accommodation to meet their specific needs. The management of hazards in the centre was supported by policies and procedures relating to risk management and an up-to-date health and safety statement and risk register had been developed. This promoted a culture of safety awareness and risk minimisation. Where risks were present reasonable controls were in place which did not negatively impact on residents' rights to free movement and choice. An emergency plan and personal emergency evacuation plans (PEEPS) had been developed for residents. Regular checks of fire safety equipment were in place including checks of the fire alarm and fire extinguishers. Nevertheless, while emergency exits were unobstructed, certification was not available for the regulatory quarterly emergency lighting service.

Safeguarding and appropriate care for residents with dementia was supported by regular training and up-to-date policies. A number of staff spoken with were clear in their understanding of what constituted abuse and the procedure for reporting information. Residents who experienced behaviour issues related to the effects of

their dementia were seen to have appropriate care plans in place. Residents and staff spoken with were aware of who to approach if they witnessed unacceptable practice. Residents retained control over their personal belongings and secure storage was provided in each bedroom for the safekeeping of personal items. Where the provider acted as an agent for residents' money, records were appropriately maintained with receipts provided and documentation was counter-signed. Staff actively promoted the independence of residents and where restraints, such as bedrails, were in use appropriate risk assessments had been undertaken. A register was in place which indicated that regular monitoring was undertaken whenever bedrails were used, particularly at night.

Regulation 11: Visits

Visitors had unrestricted access to their relative where this was acceptable to the resident.

Judgment: Compliant

Regulation 12: Personal possessions

Residents had adequate storage space for their belongings.

Judgment: Compliant

Regulation 17: Premises

Premises issues had been partially addressed since the previous inspection. The two four-bedded and three-bedded rooms had been redecorated and the beds had been realigned to maximise the available space. Residents in the dementia unit had been afforded the use of a large dining/activity/sitting space. However, shared rooms did not afford optimal privacy and dignity for residents particularly for residents with dementia who were disturbed by the presence of other residents or visitors in the bedrooms.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

There was a varied and suitable choice of meals available and management staff were actively engaged in ongoing improvement at the time of inspection by attending study days and inviting qualified personnel to speak with staff.

Judgment: Compliant

Regulation 26: Risk management

There was a system in place to identify and minimise risks. Risk management and health and safety issues were discussed and addressed at the management meetings.

Judgment: Compliant

Regulation 27: Infection control

The centre was clean and staff were seen to use personal, protective equipment where necessary. There were opportunities for hand-washing and the application of hand sanitiser throughout the centre.

Judgment: Compliant

Regulation 28: Fire precautions

All documents were not available in line with fire safety requirements to certify that servicing had been completed on a quarterly basis.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

Medication practices required audit and review. Labelling of all medicines did not support safe practice.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

There were inconsistencies noted in a small sample of care plans reviewed.

Judgment: Substantially compliant

Regulation 6: Health care

Healthcare needs were met to a good standard.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Responses to behaviour that resulted from the behaviour and psychological symptoms of dementia (BPSD) were not always in line with the centre's policy or best evidence-based practice

Judgment: Not compliant

Regulation 8: Protection

Staff had the required training and were knowledgeable of how to reports allegations of abuse. Management took the necessary steps to record allegations.

Judgment: Compliant

Regulation 9: Residents' rights

Residents were availing of meaningful activities. They enjoyed music, physiotherapy, artwork, various group exercises, individual therapy, outings and religious practice among others. Residents had a consultation process, a forum for concerns,

access to advocacy, access to outdoors and open visiting.
Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 30: Volunteers	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

ACompliance Plan for Oaklodge Nursing Home OSV-0000261

Inspection ID: MON-0023747

Date of inspection: 03 & 04/05/2018

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant 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 document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: All Regulation records will be audited to ensure all details required under regulation 21 are obtained and safely retained	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Review of the Audit systems to be commenced with outcomes and learnings be compiled monthly in consultation with the Electronic Care planning provider. Monthly Audits will be reviewed at the Clinical governance meetings and an outcome follow up plan will be developed to ensure all highlighted issues are addressed. This was commenced at the next Clinical Governance meeting of the 31st May 2018.	
Regulation 34: Complaints procedure	Not Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: All complaints and incidents reported will be reviewed by clinical governance to ensure that all forms are completed correctly and accurately. Follow up will be put in place and reviewed to ensure that learning outcomes have been achieved. This process was commenced at the next Clinical Governance meeting of the 31st May 2018. Training to staff in relating to complaint management to be introduced .	

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Review of the Privacy and Dignity of those in shared accommodation to be carried out and audited to ascertain what would affirm the privacy and dignity of all residents.
We will look at the possibility of providing a system which would reduce room access to the resident group that reside in the room only e.g Fob Access or another suitable system to be researched.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The quarterly electrician checks were carried out on the 10th May
A review of all aspects of the regulation 28 will be undertaken to ensure full compliance.
Presently we have an external contractor looking at all maintenance processes with a view to streamlining the processes to ensure all check are in place and in date.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:

Pharmacy provider Advised of the concerns to ensure understanding of need for compliance.
Ongoing Staff training on Medication management via HSEland and from pharmacy provider. Training Planned for the 14th June and the 9th July 2018.

Audit learnings & outcomes to be actioned in a timely manner 29th June 2018.
.
Medication Error reporting to be encouraged and managed to foster a culture of learning and appropriate management of events.
Good communication with Pharmacy provider to be maintained to ensure a good working relationship and team approach to management of the pharmacy service to our residents with Quarterly team meeting. Last meeting was on the 02/05/2018 next to be arranged for September 2018.

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:

Care plan audits to carried out and a follow up procedure to be put in place to ensure care plans & Assessment are appropriate and person centered and up to date. 29th June 2018.

Training on Care planning and assessment to be given to all nursing staff.
Auditor training by the Care Monitor provider to be given to the management team and this is arranged for the 29th June 2018.

Regulation 7: Managing behavior that is challenging	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behavior that is challenging:

Ensure Responsive behavior training to be given to all staff and to be ongoing within the service.

Training given on the 24th May as planned.

Incidents reported to be completed and follow in line with the center policy for all incidents of Responsive behaviors and will be part of the regular Clinical Governance meeting commencing the 31st May 2018.

DON requested from the Board of Management to have a full review of the culture in Oaklodge and to resource the introduction of an organizational wide culture change project. It has been agreed to invite an external person namely a Member of the HSE Protection of the Elderly Social worker to carry out an assessment of the culture. The Board of management have agreed to meet with all staff following receipt of the finding of the assessment to inform them of the plan to address the findings. A strategic training plan for all staff will be developed and implemented.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	30/10/2018
Regulation 21(1)	The registered provider shall 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.	Substantially Compliant	Yellow	30/11/2018
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate,	Substantially Compliant	Yellow	30/09/2018

	consistent and effectively monitored.			
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Substantially Compliant	Yellow	30/07/2018
Regulation 29(2)	The person in charge shall facilitate the pharmacist concerned in meeting his or her obligations to a resident under any relevant legislation or guidance issued by the Pharmaceutical Society of Ireland.	Substantially Compliant	Yellow	30/09/2018
Regulation 29(5)	The person in charge shall 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.	Substantially Compliant	Yellow	30/09/2018
Regulation 34(1)(f)	The registered provider shall provide an accessible and effective complaints	Not Compliant	Yellow	30/09/2018

	procedure which includes an appeals procedure, and shall 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.			
Regulation 34(2)	The registered provider shall ensure that all complaints and the results of any investigations into the matters complained of and any actions taken on foot of a complaint are fully and properly recorded and that such records shall be in addition to and distinct from a resident's individual care plan.	Not Compliant	Yellow	30/09/18
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and	Substantially Compliant	Yellow	30/11/2018

	where appropriate that resident's family.			
Regulation 7(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.	Not Compliant	Orange	30/09/2018