

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Abbot Close Nursing Home
<b>Centre ID:</b>	OSV-0004682
<b>Centre address:</b>	St. Marys Terrace, Askeaton, Limerick.
<b>Telephone number:</b>	061 601 888
<b>Email address:</b>	info@abbotclose.ie
<b>Type of centre:</b>	A Nursing Home as per Health (Nursing Homes) Act 1990
<b>Registered provider:</b>	Abbot Close Nursing Home Limited
<b>Provider Nominee:</b>	Denis McElligott
<b>Lead inspector:</b>	Caroline Connelly
<b>Support inspector(s):</b>	None
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	60
<b>Number of vacancies on the date of inspection:</b>	1

## **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 monitor ongoing regulatory compliance. 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:
03 May 2017 10:45	03 May 2017 18:45
04 May 2017 08:50	04 May 2017 16:00

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

<b>Outcome</b>	<b>Our Judgment</b>
Outcome 01: Statement of Purpose	Compliant
Outcome 02: Governance and Management	Non Compliant - Moderate
Outcome 04: Suitable Person in Charge	Compliant
Outcome 06: Absence of the Person in charge	Compliant
Outcome 07: Safeguarding and Safety	Compliant
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 09: Medication Management	Substantially Compliant
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 12: Safe and Suitable Premises	Substantially Compliant
Outcome 13: Complaints procedures	Substantially Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Compliant
Outcome 18: Suitable Staffing	Compliant

**Summary of findings from this inspection**

This report sets out the findings of an unannounced monitoring inspection following an application to vary a condition of registration. The provider had applied to vary the number of beds the centre was registered for from 61 beds to 65 beds. As part of the inspection the inspector met with the residents, the person in charge, the provider, relatives, two Clinical Nurse Manager's (CNM), the Human Resources (HR) manager, administration staff and numerous other staff members. The inspector observed practices, the physical environment and reviewed all governance, clinical and operational documentation such as policies, procedures, risk assessments, reports, residents' files and training records to inform this application. The provider, person in charge and the staff team generally displayed good knowledge of the regulatory requirements and they were found to be committed to providing person-centred care for the residents.

There had been a number of changes to management and governance of the centre since the previous inspection. The person in charge was new to the centre and had been in post approximately 6 months and an interview had been conducted with him prior to the inspection in the HIQA office. There was also two new CNM's in post and an interview was conducted with them during this inspection. They all displayed adequate knowledge of the standards and regulatory requirements. One of the CNM's deputised in the absence of the person in charge and the provider is in the centre on a very regular basis. The inspector was satisfied that there was a clearly defined management structure in place but as the clinical managers were all new to their roles, effective management systems were being developed and implemented.

The inspector spoke to many residents and relatives throughout the inspection. The collective feedback from residents and relatives was one of satisfaction with the service and care provided. The inspector saw numerous visitors in and out of the centre during the two day inspection. There was an Alzheimer's tea day held on the second day of the inspection which was a great success and a very lively atmosphere was noted throughout the centre. There was a residents committee which facilitated the residents' voice to be heard and this was run by the activity staff and person in charge.

There was evidence of residents' needs being met and the staff supported residents to maintain their independence where possible. Resident's health and social care needs were met. Residents had comprehensive access to (GP) services, to a range of other health services, and the nursing care provided was found to be evidence-based. Residents could generally exercise choice in their daily life and were consulted on an ongoing basis. Residents could practice their religious beliefs.

The provider had converted an activity/ storage room into two twin bedrooms with full en-suite facilities, these rooms were seen by the inspector to be of a good size, were bright and had adequate storage facilities for residents' belongings. Appropriate lighting and call bell system were in place. The screening was noted not to fully encircle one bed. New railing and curtains were ordered during the inspection and the inspector was given evidence of same. The provider had applied to increase resident numbers from 61 to 65 with the addition of these four extra beds.

The inspector saw a number of improvements had been undertaken since the previous inspection including improvements in fire safety and the addition of door hold backs which were attached to the fire alarm system improvements in smoking in the centre with the introduction of a smoking shelter outside the centre which replaced a smoking room in the centre. Improvements were seen in medication management and in the general organisation and management of care. The inspector did identify aspects of the service requiring improvement. These included improvements with care planning, provision of equipment in the smoking area, the provision of an annual review for 2017, improvements in complaints documentation. These are discussed under the outcome statements. The related actions are set out in the Action Plan under the relevant outcome.

These improvements are required to comply with the Health Act 2007 (Care and

Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland 2016. The provider was required to complete an action plan to address these areas.

**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 and function was viewed by the inspector, and it clearly described the service and facilities provided in the centre. It identified the staffing structures and numbers of staff in whole time equivalents. It also described the aims, objectives and ethos of the centre. This ethos was reflected in day-to-day life, through the manner in which staff interacted, communicated and provided care.

The statement of purpose included the registration date, expiry date and the conditions attached by the Chief Inspector to the designated centre's registration under Section 50 of the Health Act 2007. The arrangements for the management of the centre in the absence of the person in charge, was not included. This was identified to the management team by the inspector during the inspection and was rectified. Following the amendment the updated statement of purpose was found to meet the requirements of legislation.

**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 centre is owned and operated by Windmill nursing home group which consists of five nursing homes. There are two registered providers and one of the providers is in the centre on a very regular basis. Since the previous inspection in February 2016 there have been a number of changes to the governance and management of the centre which included changes to the person in charge. The person in charge was new to the centre and had been in post approximately 6 months and an interview had been conducted with him prior to the inspection in the HIQA office. There was also two new CNM's in post since the last inspection and an interview was conducted with them during this inspection. They all displayed adequate knowledge of the standards and regulatory requirements. One of the CNM's deputised in the absence of the person in charge. The inspector was satisfied that there was now a clearly defined management structure in place. However all the nursing team were new to their posts and were still settling into their managerial roles and management systems were being implemented. The lines of accountability and authority were now clear and all staff were aware of the management structure and were facilitated to communicate regularly with management through staff meetings and daily handover meetings held at 12.00hrs daily to discuss all aspects of residents care and any issues in the centre.

The inspector saw that there were systems being put in place for monitoring the quality and safety of care provided to residents. These included internal audits and reviews such as privacy and dignity, infection control audit, fire safety audit, restraint audit and medication audit. These audits had taken place in 2016 and 2017 and audit outcomes and corrective actions were documented. There was no evidence of how the findings of these audits had resulted in any changes to practices. The person in charge acknowledged that further actions and audits were required and due to changes in the whole management systems these were ongoing.

There was evidence of consultation with residents and relatives through residents meetings chaired by activity staff and person in charge. The inspector saw the minutes of the last meeting held on 07 March 2017 where 16 residents attended. Issues discussed included meal times, staffing levels, call bells and name badges. The person in charge said items were followed up and actions taken fed back to residents on subsequent meetings but this was not evident on the minutes of the meeting. A comment card had been developed to get resident and relatives views on the care and service provided, this is to go out to all families with the invoices in the next number of weeks.

The provider was aware of his responsibility to conduct an annual review of the quality and safety of care delivered to residents in the designated centre and a very comprehensive annual review was forwarded to the inspector after the previous inspection in February 2016. The review for 2015 included analysis of falls, complaints, pressure sores, activities, profiles of the residents. The report also contained the yearly overview and achievements for 2015. However an annual review had not been undertaken by the provider in accordance with the standards to date for 2016. This is a

requirement of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

**Judgment:**

Non Compliant - Moderate

***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 was new to his role since the previous inspection. An interview had been conducted with him in the HIQA office and displayed good knowledge of the standards and regulatory requirements.

The inspector interacted with the person in charge throughout the inspection process. There was evidence that the person in charge was engaged in the governance, operational management and administration of the centre on a day-to-day basis. The inspector was satisfied that he was a registered nurse, was suitably qualified and had a minimum of three years experience in nursing of the older person within the previous six years, as required by the regulations. He demonstrated a commitment to his own professional development. Staff, residents and relatives all identified him as the person who had responsibility and accountability for the service and said he was very approachable, easily available to them and were confident that all issues raised would be managed effectively.

**Judgment:**

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):**

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

**Findings:**

There had been a change with respect to the person in charge last year and the provider had notified HIQA in relation to same. This demonstrated the awareness of the responsibility to notify HIQA of any absence or proposed absence for 28 days or more.

Deputising arrangements were in place to cover for the person in charge when he was on leave. There are two new CNM's in post since the last inspection. The inspector met and interviewed the CNM's during the inspection and they demonstrated an awareness of the legislative requirements and their responsibilities. They were found to be suitably qualified nurses and were experienced in residential care of the older adult. A number of staff nurses also took responsibility for the centre at weekends, evenings and night time with the backup of the CNM's, person in charge and provider on call as required.

**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:**

The inspector found that there were measures in place to protect residents from suffering harm or abuse. Staff interviewed demonstrated a good understanding of safeguarding and elder abuse prevention and were clear about their responsibility to report any concerns or incidents in relation to the protection of a resident. The inspector saw that safeguarding training was on-going on a regular basis in-house and the person in charge from another centre had attend the national safeguarding training and was providing this training. Training records confirmed that staff had received this mandatory training. The training was supported by a policy document on elder abuse which defined the various types of abuse and outlined the process to be adopted to investigate abuse issues should they arise. Residents indicated that they could speak to the person in charge or any member of staff if they had any concerns and confirmed that they felt safe and were well looked after in the centre.

The inspectors viewed the systems in place to safeguard residents' money and these were easily explained to the inspector. The centre was acting as an agent for some

residents and record keeping was clear and up to date. There were two signatures for all transactions and receipts were maintained. A tally of a random selection of residents' property tallied with records. Two competent administration staff had full responsibility for the residents' accounts and there was evidence of audit of these accounts by the person in charge which was a requirement from the previous inspection. The inspector was satisfied that there was a robust system in place.

A policy on managing responsive behaviours was in place. The inspector saw training records and staff confirmed that they had received training in responsive behaviours and specialist dementia training in 2015, 2016 and some in 2017. There was evidence that efforts were made to identify and alleviate the underlying causes of behaviour that posed a challenge. The support of the community psychiatry service was availed of as appropriate to residents needs as was discussed under outcome 11. The records of residents who presented with responsive behaviours were reviewed by the inspector. Behavioural charts were maintained identifying triggers, behaviours and actions taken. Some comprehensive responsive behaviour care plans were in place directing staff on the best approach to take and what effective de-escalation methods to use. However there were some inconsistencies noted in that not all behavioural plans were comprehensive and this will be discussed more under outcome 11 Health and Social Care Needs.

Since the last inspection the inspector saw that the number of residents using bedrails had substantially reduced and efforts had been made to promote a restraint free environment via the purchasing of low profiling beds and alarm mats. There was evidence in residents' notes of an assessment completed for the need for restraint and other alternatives having been tried. The use of chemical restraint had also been reduced since the last inspection and there was evidence that alternatives were trialled prior to administering restraint. There was evidence of regular checks taking place. Training on restraint had been provided to staff in 2016 and 2017.

**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 inspector saw that the fire policies and procedures were centre-specific. The fire safety plan was viewed and found to be comprehensive. There were notices for residents and staff on "what to do in the case of a fire" appropriately placed throughout

the building. Staff demonstrated an appropriate knowledge and understanding of what to do in the event of fire. The inspector saw that fire training was provided to staff during November and December 2016 and in March and April 2017. The person in charge told the inspector and records showed that fire drills were undertaken, the last fire drill was undertaken as part of the fire training in November 2016. The inspector examined the fire safety register with details of all services and tests carried out. All fire door exits were unobstructed and fire fighting and safety equipment had been tested in August 2016 and the fire alarm was last tested in April 2017. The inspector saw that there was not evidence of quarterly servicing of emergency lighting, the person in charge said this had been undertaken on an annual basis but he would have the company who checked the fire alarm check it on a quarterly basis going forward.

There had been great improvements in fire safety since the previous inspection. Fire hold backs had been installed on fire doors that are connected to the fire system with automatic closure in the case of a fire. There is no longer a smoking room in the building. This had been replaced with a smoking shelter outside. The shelter was seen and although the provider had smoking aprons and metal ashtrays in place, there was no fire blanket available. The smoking shelter was not in a visible area of the nursing home and there was no nurse call system in place to alert staff if a resident got into difficulty. The provider had made contact with a supplier who was to fit a call system in there.

Accidents and incidents were recorded on incident forms and were submitted to the person in charge and there was evidence of action in response to individual incidents. There were reasonable measures in place to prevent accidents such as grab-rails in toilets and handrails on corridors. There was a centre-specific emergency plan that took into account all emergency situations and detailed where residents could be relocated to in the event of being unable to return to the centre. Clinical risk assessments were undertaken, including falls risk assessment, assessments for dependency, assessments for malnutrition and assessments for pressure ulcer formation. The provider has contracts in place for the regular servicing of all equipment and the inspector viewed records of equipment serviced which were up-to-date.

The inspector found the premises was clean and the cleaning staff demonstrated good knowledge of infection control procedures. Personal protective equipment, such as gloves, aprons and hand sanitizers were located throughout the premises. All hand-washing facilities had liquid soap and paper towels available. Infection control training was on-going and staff demonstrated good hand hygiene practice as observed by the inspector. Arrangements for the disposal of domestic and clinical waste management were appropriate.

The health and safety of residents, visitors and staff were promoted and protected. The health and safety statement seen by the inspector was centre-specific and up-to-date. The risk management policy as set out in Schedule 5 included some of the requirements of Regulation 26(1). The policy covered, the identification and assessment of risks and the precautions in place to control the risks identified. It included the measures and actions in place to control the following specified risks, 1) Abuse and 2) the unexplained absence of a resident. However it did not include 3) accidental injury to residents or staff, 4) aggression and violence, and 5) self-harm and therefore was found not to meet

the requirements of legislation. The risk register was up to date and it identified and outlined the management of clinical and environmental risks.

Records viewed by the inspector indicated that staff had received up to date moving and handling training. Hoists were serviced on a regular basis as required by legislation and records of same were seen by the inspector.

**Judgment:**

Non Compliant - Moderate

***Outcome 09: Medication Management***

***Each resident is protected by the designated centre's policies and procedures for medication management.***

**Theme:**

Safe care and support

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

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

**Findings:**

There had been a number of positive changes seen in the administration and management of medications in the centre since the previous inspection. The timing of medication rounds had been streamlined and each nurse on duty was responsible for administration of medications to specific groups of residents. Nurses had undertaken updated medication management training. The centre-specific policies on medication management were made available to the inspector. The policies included the ordering, receipt, administration, storage and disposal of medicines. The policies were comprehensive and evidence based. The policies were made available to nursing staff who demonstrated adequate knowledge of this document. Medicines for residents were supplied by a community pharmacy who staff reported provided a very comprehensive service to the centre. Staff confirmed that the pharmacist was facilitated to meet his/her obligations as per guidance issued by the Pharmaceutical Society of Ireland and had made themselves available to residents.

Medicines were securely stored in a locked cupboard or medication trolley. Medications requiring refrigeration were stored securely and appropriately. The temperature of the medication refrigerator was noted to be within an acceptable range; the temperature was monitored and recorded daily. Controlled drugs were stored in accordance to best practice guidelines and nurses were checking the quantity of medications at the start of each shift. The inspector did a count of controlled medications with the nurse which accorded with the documented records.

Medication administration was observed and the inspector found that the nursing staff did adhere to professional guidance issued by An Bord Altranais agus Cnáimhseachais and adopted a person-centred approach. Staff reported and the inspector saw that no residents were self-administering medication at the time of inspection.

The inspector reviewed a sample of residents' medicine prescription records and they were maintained in a tidy and organised manner, they were clearly labelled, they had photographic identification of each resident and they were legible. There was evidence that residents' medicine prescriptions were reviewed regularly by a medical practitioner as well as a pharmacist. Where medicines were to be administered in a modified form such as crushing, this was prescribed in a special instruction sheet included with the medication prescription but was not individually prescribed by the prescriber on the prescription chart. This could lead to errors as not all medications can be crushed and nursing staff could be administering them as such. The maximum dose for 'as required' medicines was specified by the prescriber.

**Judgment:**

Substantially 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):**

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

**Findings:**

Residents generally had a choice of General Practitioner (GP) and most residents continued to have their medical care needs met by the GP they had prior to their admission to the centre. Out-of-hours medical cover was available via a doctor on call service. The inspector saw one of the GP's in the centre during the inspection and a sample of medical records reviewed confirmed that resident's were generally reviewed as required. Specialist medical services were also available when required. Reviews and on-going medical interventions as well as laboratory results were evidenced. Residents also had access to allied healthcare professionals including physiotherapy, occupational therapy, dietetic, speech and language therapy, dental, podiatry and ophthalmology services. Residents in the centre also had access to the specialist mental health services and were reviewed regularly and as required.

The inspector saw that residents had a nursing assessment completed on admission. The assessment process involved the use of a variety of validated tools to assess each resident's risk of deterioration. For example, risk of malnutrition, falls, level of cognitive impairment and pressure related skin injury among others. There was evidence of

regular review of resident's assessments on a four monthly basis. Residents had a care plan developed within 48 hours of their admission based on their assessed needs. The inspector reviewed a number of care plans for residents and although some care plans were seen to be very comprehensive and person centred there were a number of inconsistencies noted. Other care plans seen were not personalised or did not contain sufficient information to direct care. There was a lack of care plans to direct care at end of life stage and care plans to direct social aspects of care. The person in charge said this process was a work in progress. The management team agreed further work and review was required, to ensure all plans were personalised and to ensure they directed the provision of person centred care. As discussed under outcome 7 Safeguarding and Safety comprehensive plans to meet the needs of residents with responsive behaviours were not always in place.

Nursing staff told the inspector that a detailed hospital transfer letter was completed when a resident was transferred to hospital. Residents at risk of developing pressure ulcers had care plans and pressure relieving mattresses and cushions to prevent ulcers developing. The inspector reviewed the care of a resident with pressure sores and saw that scientific measurements and assessments were taking place on dressing changes. Staff had access to support from the tissue viability nurse and recommendations put in place were followed by staff.

There were systems in place to ensure residents' nutritional needs were met, and that the residents received adequate hydration. Residents were screened for nutritional risk on admission and reviewed regularly thereafter. Residents' weights were checked on a monthly basis and more frequently if evidence of unintentional weight loss was observed. Residents were provided with a choice of meals at mealtimes and the inspector saw staff assist residents with eating and drinking. This was undertaken in a discrete and sensitive manner. Residents were complimentary about the food provided. Nutritional supplements were administered as prescribed. There was an effective system of communication between nursing and catering staff to support residents with special dietary requirements. Staff were made aware of residents who required specialised diets or modified diets and were knowledgeable regarding the recommendations of the dietician and SALT.

**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):**

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

**Findings:**

Abbot Close Nursing Home is a purpose built two-storey centre which was established in 2006. It is registered to care for people over the age of eighteen. It comprises of 47 single rooms and nine twin bedrooms. All rooms have full en suite facilities. There is an assisted bathroom on the first floor which is also used as a hairdressing salon. There are two dining rooms, one of which is in the dementia care unit. There are several seating areas throughout with many residents favouring to sit in the foyer which is the focal point of the building.

A lift provides access between the floors. The layout, furnishings and décor are comfortable and meet with residents' satisfaction. There is a large kitchen and laundry. There are two enclosed garden areas which residents can easily access and there is ample car parking for visitors. The design and layout of the centre were in line with the statement of purpose and promoted the residents dignity, independence and wellbeing. Overall, it was well maintained and since the last inspection a lot of decorative upgrade had taken place particularly in the dementia specific unit to create a more homely feel.

The centre is registered to provide care to 61 residents and the provider has applied to vary this condition to provide residential services to 65 Residents. The provider had converted an activity/ storage room into two twin bedrooms with full en-suite facilities, these rooms were seen by the inspector to be of a good size, were bright and had adequate storage facilities for residents belongings. Appropriate lighting and a call bell system were in place. The screening was noted not to fully encircle one bed. New railing and curtains were ordered during the inspection and the inspector was given evidence of same.

The inspector saw evidence of the use of assistive devices, for example, hoists, wheelchairs, walking aids, clinical monitoring equipment and specialist seating provided for residents' use. Service records were in date for all of equipment in use. There was a functioning call-bell system in place.

As identified on previous inspections, the communal space in the main part of the centre was limited. This was an issue that had already been identified by the provider and he told the inspector there were plans to build on a conservatory off the main sitting room. However on this inspection work on this conservatory had not commenced to date and the provider did not have a start date.

**Judgment:**

Substantially Compliant

***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 comprehensive written complaints policy was available in the centre and the inspector saw that the complaints procedure was hung in a prominent place at the entrance to the centre. The complaints procedure did not identify a complaints appeals process nor did it identify the person nominated by the provider to ensure all complaints are appropriately responded to. Therefore it did not fully meet the requirements of regulation. The procedure also did not include details for the ombudsman as now required.

Residents and relatives the inspector met said that they had easy access to the nurses and the person in charge to whom they could openly report any concerns and were assured issues would be dealt with. The person in charge stated that he monitored complaints or any issues raised by being readily available and regularly speaking to residents, visitors and staff. Records showed that although complaints were documented on the computer system there was not always evidence of the investigation and actions recorded with the complaint. There was evidence of a comprehensive follow up letter to the complainant outlining actions taken but this was kept separately from the complaint and the satisfaction of the complainant was not recorded as required by the regulations. Although the inspector was satisfied that complaints were being addressed. The process around complaints recording required review to ensure there was a robust system around the management and recording of complaints. This is to be in keeping with the requirements of legislation where all complaints and the results of the investigations and any actions taken on foot of a complaint should be documented. Evidence is to be made available of actions taken and whether the complainant was satisfied or not. Complaints should be used for learning and to inform improvements required in practices,

**Judgment:**

Substantially 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:**

Residents' religious preferences are facilitated through regular visits by clergy to the centre with mass held once a week and administration of sacrament of the sick on a regular basis. Residents were facilitated to exercise their civil, political and religious rights. The inspector was told that residents were enabled to vote in national referenda and elections as the centre registered to enable polling. The inspector observed that residents' choice was generally respected and control over their daily life was facilitated in terms of times of rising /returning to bed and whether they wished to stay in their room or spend time with others in the communal room.

Respect for privacy and dignity was evidenced throughout both days of inspection. Staff were observed to knock on doors and get permission before entering bedrooms. Screening was provided in twin bedrooms to protect the residents privacy. However in the new two twin rooms screening did not fully encompass one of the beds and the provider immediately ordered further screening. Staff were observed communicating appropriately with residents who were cognitively impaired as well as those who did not have a cognitive impairment. Effective communication techniques were documented and evidenced in some residents care plans. Residents were treated with respect. The inspector heard staff addressing residents by their preferred names and speaking in a clear, respectful and courteous manner. Staff paid particular attention to residents' appearance, dress and personal hygiene and were observed to be caring towards the residents. Residents choose what they liked to wear and the hairdresser visited regularly and was there during the inspection.

A number of visitors were observed throughout both days of inspection where staff members knew the names of visitors and vice versa. Staff took time to talk with family members both when they visited and when they rang to enquire about their relative. Visitors told the inspector that they were always made welcome. They said that if they any concerns they could identify them to the person in charge and were assured they would be resolved. Residents had access to the daily newspaper and residents were observed enjoying the paper. Residents had access to radio, television, and information on local events

There was evidence of consultation with residents and relatives through residents meetings chaired by activity staff and person in charge. The inspector saw the minutes of the last meeting held on 07 March 2017 where 16 residents attended. Issues discussed included meal times staffing levels call bells and name badges. The person in charge said items were followed up and actions taken fed back to residents on subsequent meetings but this was not evident on the minutes of the meeting. A comment card had been developed to get resident and relatives views on the care and service provided, this is to go out to all families with the invoices in the next number of weeks.

There was a staff member allocated to the function of activity co-ordinators on a full time basis who fulfilled a role in meeting the social needs of residents. There was a

comprehensive programme of activities available to residents which included Sonas, art and crafts, bingo, sing-songs, exercise sessions, religious activities, trips out and other more individualised activities. Residents and relatives told the inspectors how much they enjoyed the activities. There was a ex member of staff who was a volunteer at the centre and helped out with the activities. There was an Alzheimer's tea day held on the second day of the inspection which was a great success and a very lively atmosphere was noted throughout the centre.

**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:**

There had been a turnover of staff since the previous inspection including the senior nursing team, a number of nurses and care staff. There is now a new person in charge and two new CNM's and a number of new nurses and care staff. The management team said it was difficult at the start and the centre went through an unsettled period. They stated that they now feel there is a stable and effective team in place. Residents and relatives generally spoke positively of staff and indicated that staff were caring, responsive to their needs and treated them with respect and dignity. This was seen by the inspector throughout the inspection in the dignified and caring manner in which staff interacted and responded to the residents. The inspector observed warm and appropriate interactions between staff and residents and observed staff chatting easily with residents.

Systems of communication were in place to support staff with providing safe and appropriate care. There were handover meetings each day to ensure good communication and continuity of care from one shift to the next. The inspector sat in on the handover meeting that took place at 12.00hrs on the first day of the inspection. The meeting proved a very effective mode of communicating residents needs with the whole team and an opportunity for care staff to feed back to the person in charge and nursing staff.

The inspector found staff to be well informed and knowledgeable regarding their roles, responsibilities and the residents' needs and life histories.

Mandatory training was in place and staff had received up to date training in fire safety, safe moving and handling, safeguarding vulnerable persons and responsive behaviours. Other training provided included restraint procedures, HACCP, dementia specific training and infection control. Nursing staff confirmed they had also attended clinical training including blood- letting, medication management and wound care.

Duty rosters were maintained for all staff and during the two days of inspection the number and skill-mix of staff working during the day and evening was observed to be appropriate to meet the needs of the current residents.

The inspector met the HR manager and reviewed a sample of staff files which included all the information required under Schedule 2 of the Regulations. Registration details with An Bord Altranais for 2017 for nursing staff were seen by inspector. The HR manager confirmed Garda vetting was in place for all staff and no staff commenced employment until this was in place. A file was kept for the volunteer that worked in the centre. The company were doing recruitment campaigns to ensure there were adequate and appropriately trained staff in the centre.

**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:***

Caroline Connelly  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority

## Health Information and Quality Authority Regulation Directorate

### Action Plan



### Provider's response to inspection report<sup>1</sup>

<b>Centre name:</b>	Abbot Close Nursing Home
<b>Centre ID:</b>	OSV-0004682
<b>Date of inspection:</b>	03/05/2017
<b>Date of response:</b>	01/06/2017

### 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 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 had not been undertaken by the provider in accordance with the standards to date for 2016. This is a requirement of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

#### 1. Action Required:

Under Regulation 23(d) you are required to: Ensure there is an annual review of the

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

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.

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

PIC and provider have now compiled the annual review for 2016. Please see attached for your attention.

Proposed Timescale: Completed

**Proposed Timescale:** 01/06/2017

**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:**

There was no evidence of quarterly servicing of emergency lighting

**2. 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:**

This has been now outsourced to Keltron Safety System (We had some issues with our fire safety service provider) we lost a few months sourcing a new contractor. Keltron have already set about reviewing our fire equipment, means of escape and all arrangements relating to fire.

Proposed Timescale: Completed

**Proposed Timescale:** 01/06/2017

**Theme:**

Safe care and support

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

The new smoking shelter was seen and although the provider had smoking aprons and metal ashtrays in place, there was no fire blanket available. The smoking shelter was not in a visible area of the nursing home and there was no nurse call system in place to alert staff if a resident got into difficulty.

**3. 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:**

The fire blankets were purchased and have now been placed in the smoking shelter. The Nurse call System has now been installed and connected to the main nurse call system by our electrician

Proposed Timescale: Completed

**Proposed Timescale:** 01/06/2017

**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:**

Where medicines were to be administered in a modified form such as crushing, this was prescribed in a special instruction sheet included with the medication prescription but was not individually prescribed by the prescriber on the prescription chart. This could lead to errors as not all medications can be crushed and nursing staff could be administering them as such.

**4. Action Required:**

Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.

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

The PIC has initiated this action already along with CNM`s, Nurses and GP`s. More advanced information will be discussed with the GP's and Pharmacist regarding the crushing of medications in the next review.

**Proposed Timescale:** 30/08/2017

**Outcome 11: Health and Social Care Needs**

**Theme:**

Effective care and support

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

There was no evidence of resident or relative involvement in the care planning process.

**5. Action Required:**

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

family.

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

The "Named Nurses Concept" is being introduced. All of our nurses are being reminded of the importance of involving NOK/resident/ relatives. This process will commence immediately by contacting the NOK/resident/relatives by the next reviews.

**Proposed Timescale:** 30/08/2017

**Theme:**

Effective care and support

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

There were some inconsistencies in some care planning practices in that a number of care plans were not personalised or did not contain sufficient information to direct care. There was a lack of care plans to direct care at end of life stage and care plans to direct social aspects of care.

**6. Action Required:**

Under Regulation 05(1) you are required to: Arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2).

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

A "Named Nurse Concept" is being introduced in order to enhance person centred care plan development. All our nurses have been educated and made aware of the importance of creating person centred care plans.

End of life stage care plans have been now developed and will be carried out by the Nurses accordingly.

**Proposed Timescale:** 30/08/2017

**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:**

As identified on previous inspections, the communal space in the main part of the centre was limited. This was an issue that had already been identified by the provider and he told the inspector they plan to build on a conservatory off the main sitting room. However on this inspection work on this conservatory had not commenced to date and the provider did not have a start date.

**7. 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 Provider has made plans to extend the current day room.  
This extension is in the form of a conservatory  
Planning permission is already in place and the providers are hoping to commence this work as soon as the funding will allow.

**Proposed Timescale:** 30/09/2017

**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 complaints procedure on display in the reception area did not include an appeals procedure.

**8. Action Required:**

Under Regulation 34(1) you are required to: Provide an accessible and effective complaints procedure which includes an appeals procedure.

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

The complaints procedure is now updated with all relevant information`s and placed in the reception area.

Proposed Timescale: Completed

**Proposed Timescale:** 01/06/2017

**Theme:**

Person-centred care and support

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

The process around complaints recording required review to ensure there was a robust system around the management and recording of complaints and the complaints 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.

**9. 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:**

Complaints log book has been reintroduced and we have encouraged all the staff to use it accordingly. The PIC has added a complaints procedure to the Epic Care records. This

template will ensure that the complaint is investigated with a satisfactory outcome to the residents satisfaction.  
(The complaint is closed out correctly)

Proposed Timescale: Completed

**Proposed Timescale:** 01/06/2017