

Health Information and Quality Authority
Social Services Inspectorate

Inspection report
Designated centres for older people



Centre name:	Rickard House
Centre ID:	0087
Centre address:	Dunardagh
	Temple Hill
	Blackrock, County Dublin
Telephone number:	01 2833900
Fax number:	N/A
Email address:	chayden@rickardhouse.ie
Type of centre:	<input type="checkbox"/> Private <input checked="" type="checkbox"/> Voluntary <input type="checkbox"/> Public
Registered providers:	Daughters of Charity
Person in charge:	Caitriona Hayden
Date of inspection:	29 November 2011
Time inspection took place:	Start: 08:45 hrs Completion: 18:00 hrs
Lead inspector:	Linda Moore
Support inspector:	N/A
Type of inspection:	<input type="checkbox"/> Announced <input checked="" type="checkbox"/> Unannounced
Purpose of this inspection visit:	<input type="checkbox"/> Application to vary registration conditions <input type="checkbox"/> Notification of a significant incident or event <input type="checkbox"/> Notification of a change in circumstance <input type="checkbox"/> Information received in relation to a complaint or concern <input checked="" type="checkbox"/> Follow-up inspection

About the inspection

The purpose of inspection is to gather evidence on which to make judgments about the fitness of the registered provider and to report on the quality of the service. This is to ensure that providers are complying with the requirements and conditions of their registration and meet the Standards, that they have systems in place to both safeguard the welfare of service users and to provide information and evidence of good and poor practice.

In assessing the overall quality of the service provided, inspectors examine how well the provider has met the requirements of the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

Additional inspections take place under the following circumstances:

- to follow up matters arising from a previous inspection to ensure that actions required of the provider have been taken
- following a notification to the Health Information and Quality Authority's Social Services Inspectorate of a change in circumstance for example, that a provider has appointed a new person in charge
- arising from a number of events including information received in relation to a concern/complaint or notification to the SSI of a significant event affecting the safety or wellbeing of residents
- to randomly "spot check" the service.

All inspections can be announced or unannounced, depending on the reason for the inspection and may take place at any time of day or night.

All inspection reports produced by the Health Information and Quality Authority will be published. However, in cases where legal or enforcement activity may arise from the findings of an inspection, the publication of a report will be delayed until that activity is resolved. The reason for this is that the publication of a report may prejudice any proceedings by putting evidence into the public domain.

About the centre

Description of services and premises

Rickard House is a single-story purpose-built residential centre with 27 places for older people. There are 24 single bedrooms with en suite bathrooms and one three-bedded room with en suite facilities. There are two sitting rooms, a dining room, kitchen, treatment/therapy room, hairdressing room, a large chapel and two conservatories. There is a kitchenette, a small area for making tea and coffee in the conservatory and a small laundry room. There are toilet facilities near the communal areas, three assisted bathrooms, one shower room and a visitors' toilet. The nurses' station and nurses' office are located near the main entrance.

The centre is located on 15 acres of garden with mature trees and is built around a small secure garden. Car parking is available at the front and side of the centre.

Rickard House was established to provide long-term care, convalescence and respite care to the sisters of the Daughters of Charity, the Vincentian priests, the parents of the religious sisters and others as approved by the Provincial of the Daughters of Charity.

Location

The centre is located close to the villages of Blackrock and Dun Laoghaire in south Dublin. It is situated in the grounds of the headquarters of the Daughters of Charity of St. Vincent De Paul in Ireland. There are shops, churches and bus routes close by as well as the local train station.

Date centre was first established:	8 September 1982
Number of residents on the date of inspection:	25 + 1 in hospital
Number of vacancies on the date of inspection:	1

Dependency level of current residents	Max	High	Medium	Low
Number of residents	6	8	7	4

Management structure

The registered Providers of Rickard House as the Daughters of Charity. The person nominated to act on behalf of the Provider is Sr. Catherine Prendergast the Provincial Leader, who is also the chairperson of the Board of Management. The Person in Charge, Caitriona Hayden is known as the Director of Nursing and she reports to Sr. Catherine Prendergast. A Clinical Nurse Manager Grade 2 (CNM2) deputises when the Person in Charge is on leave. The nurses, care assistants, catering, household, maintenance staff and volunteers report to the Person in Charge.

Staff designation	Person in Charge	Nurses	Care staff	Catering staff	Cleaning and laundry staff	Admin staff	Other staff
Number of staff on duty on day of inspection	1	3	5	2	4	1	3*

* Provider visited the centre to meet the inspector, 1 Activity staff and 1 Maintenance

Background

This was the second inspection of Rickard House Nursing Home carried out by the Health and Information Quality Authority (the Authority). The first inspection was a registration inspection on 26 and 27 January 2010. This centre is registered. The action plan from that inspection report highlighted 11 issues to be addressed.

This additional inspection report outlines the findings of a follow up inspection that took place on 29 November 2011. The inspection was unannounced and focused on the actions of the inspection of 26 and 27 January 2010. The inspector met the provider, person in charge and a number of staff and residents.

Summary of findings from this inspection

This was an unannounced follow up inspection which focused on areas identified for improvement at the follow up inspection in 26 and 27 January 2010 and to monitor compliance with the Regulations.

The inspector found that the provider and person in charge had been proactive in responding to the action plan from the previous inspection. Five of the eleven actions identified had been fully completed and six of the actions were partly addressed. The provider applied to vary the conditions of the previous registration and this was viewed at this inspection.

Improvements made since the previous inspection included:

- all staff had received training in fire prevention
- the system for reviewing the quality of care provided had been improved
- the statement of purpose was revised in line with the Regulations
- the Residents' Guide was amended and a contract was drafted

The inspector met residents, the provider, the person in charge and staff on duty. Records were examined including care plans, medical records, staff records including training records, and policies.

Improvements were still required in the development of care plans and the management of restraint and pressure area management. Areas for improvement are discussed further in the report and are included in the Action Plan at the end of the report.

Issues covered on inspection

Education and Training

The provider and person in charge were committed to providing ongoing training for staff. Staff participated in annual performance appraisals and these were used to inform the training needs of staff. In-service sessions had been undertaken in 2010 and 2011 including training on restraint, management of nutrition and the management of behaviours that challenged and dementia. All staff were up-to-date on training in the protection of vulnerable adults, manual handling and cardio pulmonary resuscitation (CPR). Sixteen care assistants had undertaken Further Education and Training Awards Council (FETAC) Level 5 and two care assistants were in the process of completing the programme. Staff said they enjoyed doing this course and described how it helped them in their work.

Actions reviewed on inspection:

1. Action required from previous inspection:

Develop appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing, administration and disposal of medicines to residents.

This action was partly addressed.

The inspector found evidence of good medication management processes. Medications were stored safely, but there were some areas for improvement. While the medication management policies which provided guidance to staff had been reviewed since the previous inspection, they needed to reflect more accurately the local practices in place. They did not include the process for self administration, despite the fact that there was one resident who was self administering medications. The medication policy stated that two nurses would check and administer controlled medications on night duty, this was not the practice as there was only one nurse on night duty.

The inspector observed that medication was administered in accordance with An Bord Altranais guidelines in most regards. However, the inspector noted that the nurse did not refer to the prescription for the administration of Warfarin, the resident's prescription was subsequently located in the resident's file.

2. Action required from previous inspection:

Develop a risk management policy which reflects and guides the practice in place in accordance with the Regulations.

This action was partly completed.

The risk management policy which was developed since the previous inspection was centre-specific but did not entirely guide the practice in place in accordance with the Regulations. Risks were appropriately identified and recorded. There was a risk register in place, which included risks such as falls, equipment, violence and aggression and fire and the control measures to manage these risks. Incident and accident forms were used to record all accidents and incidents including falls. The inspector read all incident reports for 2011 and noted that these forms did not include the preventative measures to minimize the risk of reoccurrence. The inspector found that the arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents were not defined in the policy or clearly established in the centre.

3. Action required from previous inspection:

Inform the inspector when the fire training and fire drills have taken place.

This action was completed.

There were good systems in place to manage fire safety. Staff spoken with were clear about the procedure to follow in the event of a fire. Service records showed that the fire equipment was serviced in November 2011. Fire alarm systems are checked every Tuesday. Emergency lighting was tested, weekly, monthly and three-monthly. The fire panels were in order and the inspector noted that fire exits were unobstructed. There were daily routine inspections of fire exits carried out. The inspector read the training records and found that all staff had participated in the mandatory fire warden training in February 2011. There were regular fire drills held three to four-monthly.

4. Action required from previous inspection:

Put in place an independent appeals process.

Maintain a register of complaints which includes action taken and outcomes for the residents.

This action was partly addressed.

The inspector found evidence of good complaints management but this required some improvement.

The complaints policy was read by the inspector and details of the complaints procedure were posted publicly near the entrance. The procedure provided clear guidelines on how to make a complaint or express a concern, and how these would be addressed. A named complaints officer was identified. However, the policy still did not identify the independent appeals process. The inspector reviewed the complaints log, which showed there had not been any written complaints and all verbal complaints were recorded and responded to. Records did not include the complainant's level of satisfaction with how the complaint was managed.

5. Action required from previous inspection:

Establish and maintain a system to review the quality and safety of care and quality of life of residents in the centre.

This action was addressed.

The inspector found that there was considerable work in this area since the previous inspection. There were processes in place to review and monitor the quality of care of residents. These needed to be embedded and further established.

The person in charge had completed an audit on, falls, medication management, call bells, resident equipment and hand hygiene. The person in charge also collected monitoring data such as residents who used psychotropic medications, residents with severe pain, accidents and complaints and she reported these findings to the clinical governance committee on a six-weekly basis. The person in charge had begun to use this information to improve the service. A comparison of falls for the first six months in 2010 and 2011 showed a 90% reduction with 30 falls recorded in 2010 to 3 in 2011. This process could be further enhanced if other areas of clinical care were included in the audit, and if the information was shared with staff for learning purposes.

6. Action required from previous inspection:

Update the written statement of purpose stating the aims objectives and ethos of the centre, the facilities and services provided and a statement of matters listed in Schedule 1 of the Regulations.

This action was completed.

The inspector was satisfied that the statement of purpose accurately described the service that was provided in the centre and met the requirements of Schedule 1 of the Regulations.

The inspector observed that the service's capacity to meet the diverse needs of residents, as stated in the statement of purpose, was reflected in practice. In particular the inspector noted that the "residents, physical, emotional and spiritual needs were met" as described in the statement of purpose. This was confirmed by residents to the inspector throughout the inspection.

The statement was kept under review by the provider and the person in charge and would be made available to residents on admission. This could be enhanced further by making this readily available for residents.

7. Action required from previous inspection:

Keep the residents care plan under formal review as required by the residents changing needs and circumstances.

This action was progressed but not completed.

The inspector found a good standard of evidence-based nursing care and appropriate medical and allied healthcare. However, some significant improvements were still required in the development of care plans, wound care and the management of restraint.

Pre-admission assessments were completed by the person in charge to ensure the needs of potential residents could be met. The person in charge told the inspector that she went to the hospital or home to meet prospective residents and the inspector read the most recent assessment completed.

The centre had sufficient general practitioner (GP) cover. Out-of-hours GP services were provided by a doctor on-call service. A review of residents' medical notes showed that GPs visited the centre regularly and the person in charge informed the inspector that GPs were available by phone any time to offer advice to staff. The sample of medical records reviewed also confirmed that the health needs and medications of residents were being monitored on an ongoing basis and no less frequently than at three-monthly intervals.

Residents could access a range of additional health services such as physiotherapy on a fortnightly basis, speech and language therapy, dietician, chiropody and optical care. The inspector reviewed residents' care plans and they contained details of referrals and appointments with the various health services. For example, one included a recent assessment by a tissue viability specialist. Residents attended a weekly exercise class and residents were seen walking about during the day.

All residents had a care plan, a nursing assessment and a range of risk assessments such as falls risk, pressure sore and weight loss. The inspector read a number of care plans and noted that one care plan which was written with the resident was comprehensive and guided the care to be delivered. However, this was not the case for all other care plans reviewed. They did not guide the care to be delivered and the information was limited from a clinical perspective in that the care which was delivered was not reflected in the care plans. The assessments and care plans were not reviewed on a three-monthly basis or updated to reflect the residents' changing needs and circumstances. This was an area that required considerable improvement. For example, residents who were at risk had a falls risk assessment completed but had no falls care plan. Staff told the inspector that training for staff in care planning had commenced in February 2011 and there was also a training session on the evening of the inspection. Staff said the new assessment and care planning process was only recently formalised and they had not yet updated all residents' care plans.

Restraint

The inspector reviewed the practice in relation to the use of restraint. From a review of resident's records and talking to staff, it was noted that restraint management required some improvement. Bedrails were in use for 14 residents. The person in charge told the inspector that the national policy on the use of restraint was being rolled out. She said that one staff member had attended training on this policy and she planned to train the other staff. Residents had a consent form for restraint signed by the nurse, GP and family or religious representative. There were no assessment forms for bedrails and there was no documentary evidence of alternatives tried prior to the use of bedrails. Residents who had bedrails in place did

not have a care plan to guide the care delivered. The inspector noted that monitoring of the use of bedrails at night time was not documented. Staff said that residents were checked hourly throughout the night but they did not record hourly checks.

Wound Care

There was one resident who had a pressure sore in the centre. The inspector had concerns about the documentation and lack of staff awareness of the management of pressure care. The inspector spoke to the person in charge, staff nurses and carers in relation to wound care. A review of this resident's records showed that there was no skin assessment completed for any resident. One resident with a wound had a pressure sore risk assessment completed, which identified a high risk. There was a wound care assessment partly completed for this resident after the dressing change. This assessment did not include the size of the wound - therefore it would be difficult to monitor the progress of the wound. A review of the resident's file showed that this resident had been reviewed by the GP and the tissue viability specialist but there was no wound care plan to guide the care to be delivered. Staff said they routinely turned the resident every two hours, but this was not specified in a care plan. The inspector read the turning charts and noted there were gaps of up to four hours when this resident was not turned. A pressure care policy was in place, but the staff were not familiar with it and while it was evidenced based it did not guide practice.

While many residents had pressure relieving mattresses in place, the three that were examined by the inspector were not set correctly and were too hard and therefore may have negative outcomes for residents. There was no policy or guideline to assist staff to set this equipment correctly. Staff said they did not have a process established to check to see if the settings were appropriate to meet an individual resident's needs.

8. Action required from previous inspection:

Agree and sign off the resident's guide and ensure it is in line with the regulations.

This action was completed.

A Residents' Guide was developed since the last inspection. The inspector found that it met the Regulations, while this had been provided to the residents and a copy of the recent inspection report was not supplied to each resident.

9. Action required from previous inspection:

Develop a contract for all of the residents in line with the regulations and issue it to them.

The inspector was satisfied that this action was partly addressed.

Contracts were agreed on the 24 November 2011 at the clinical governance committee. The inspector read the sample contract and noted that it set out the overall care and services provided to the residents and the fees charged, including any additional fees charged. The provider and person in charge planned to issue these to the residents.

10. Action required from previous inspection:

Provide each resident with access to locked storage in their bedrooms to ensure they can retain control over their possessions.

This action was addressed.

Since the previous inspection, all residents had been provided with locked storage in their bedrooms to ensure they can retain control over their possessions. Many residents said that while this was provided they did not need to use it. They commented that they always felt that their possessions were safe in the centre.

11. Action required from previous inspection:

Provide training to all staff on the prevention, detection and response to abuse.

Update the policy on for the prevention, detection and response to abuse.

This action was partly addressed.

The inspector found that measures were in place to protect residents from being harmed or abused. All staff had received training on identifying and responding to elder abuse since the previous inspection. A policy was available which gave guidance to staff on the assessment, reporting and investigation of any allegation of abuse. However, this policy required some amending to guide practice, this did not include the need to contact the next of kin if there was an allegation of abuse or notify the Authority in line with the requirements of the Regulations. The staff spoken to displayed sufficient knowledge of the different forms of elder abuse and all were clear on reporting procedures.

Residents spoken to confirmed that that they felt safe in the centre. They primarily attributed this to the staff being available to them at all times and the safety procedures in place such as the locking systems on the exit doors and call bells.

Report compiled by:

Linda Moore

Inspector of Social Services
Social Services Inspectorate
Health Information and Quality Authority

7 December 2011

Chronology of previous HIQA inspections	
Date of previous inspection:	Type of inspection:
26 and 27 January 2011	<input checked="" type="checkbox"/> Registration <input type="checkbox"/> Scheduled <input type="checkbox"/> Follow-up inspection <input type="checkbox"/> Announced <input checked="" type="checkbox"/> Unannounced

Provider's response to inspection report *

Centre:	Rickard House
Centre ID:	0087
Date of inspection:	29 November 2011
Date of response:	20 December 2011

Requirements

These requirements set out what the registered provider must do to meet the Health Act, 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

1. The provider has failed to comply with a regulatory requirement in the following respect:

The policy on and procedures for the prevention, detection and response to abuse did not guide practice as it did not include the need to notify the Authority.

Action required:

Revise the policy and procedures for the prevention, detection and response to abuse to guide practice.

Reference:

Health Act, 2007
Regulation 6: General Welfare and Protection
Standard 8: Protection

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

Please state the actions you have taken or are planning to take with timescales:	Timescale:
<p>Provider's response:</p> <p>Since the inspection, this policy has been reviewed and appropriate amendments made. All staff have been informed. All staff will continue with Elder Abuse Training. The Director of Nursing, Clinical Nurse Manager and Sister Servant will be attending an Adult Safeguarding Training Seminar in February 2012.</p>	Complete

<p>2. The provider has failed to comply with a regulatory requirement in the following respect:</p> <p>The operational policies relating to the ordering, prescribing, storing and administration of medicines did not guide the practice.</p>	
<p>Action required:</p> <p>Put in place appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents and ensure that staff are familiar with such policies and procedures.</p>	
<p>Reference:</p> <p>Health Act, 2007 Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines Standard 14: Medication Management</p>	
Please state the actions you have taken or are planning to take with timescales:	Timescale:
<p>Provider's response:</p> <p>Since the Inspection all staff nurses have been updated in the above. Our policy on self-administration will be completed in January. This is presently be done with our GPs, Pharmacy and Bord Altranis Guidelines. No resident will be self-administering medication until this policy is rolled out. Local practices have been reflected more accurately in the revised policy. All staff nurses again have been made aware of our Warfarin policy which was agreed with our pharmacist and GPs and are our administration of Warfarin is now reflecting good practice.</p>	January 2012

3. The provider has failed to comply with a regulatory requirement in the following respect:

A high standard of evidence based nursing practice was not in place in relation to restraint and wound care management.

Action required:

Provide a high standard of evidence based nursing practice.

Reference:

Health Act, 2007
Regulation 6: General Welfare and Protection
Standard 13: Healthcare

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

Timescale:

Provider's response:

Since the inspection our restraint policy has been revised. Staff have been informed. Residents have been spoken to as well as family members. The use of restraint is minimal as most residents use bedrail/s for repositioning purposes. Other alternatives will be explored if needed. One staff member has attended the National Guidelines on Restraint Study day and this will be rolled out to all staff in January. An assessment tool for the use of bedrails will be developed.

The wound care policy will be revised with further staff education on same using the national best practice and evidence based guidelines for wound management as well as European Pressure Ulcer Prevention Guidelines.

January 2012

4. The person in charge has failed to comply with a regulatory requirement in the following respect:

Care plans were not reviewed as required by the resident's changing needs or circumstances and did not set out the resident's needs.

Action required:

Keep each resident's care plan under formal view as required by the resident's changing needs or circumstances and no less frequent than at three-monthly intervals.

Reference: Health Act, 2007 Regulation 8: Assessment and Care Plan Standard 10: Assessment Standard 11: The Resident's Care Plan	
Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: Since the inspection all residents care plans and clinical risk assessments have been updated to reflect the individual needs of each resident. Care plan workshops that commenced earlier in the year completed at the end of November so all staff have now been re-educated in the care plan documentation to reflect the professional care that is being provided. In June 2012 a clinical audit of care plan documentation will be complied to review and reflect on the standard of documentation.	Complete and ongoing

5. The provider has failed to comply with a regulatory requirement in the following respect: The risk management policy did not include the arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents and this was not formalised in the centre.	
Action required: Revise the risk management policy to include the arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents and implement this process.	
Reference: Health Act, 2007 Regulation 31: Risk Management Procedures Standard 29: Management Systems	
Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: The risk management policy that is currently in place will again be revised to incorporate the Regulations and the policy will include incident types, investigations and learning outcomes. Our current incident form will be developed to include the preventative measures that may minimise the risk of reoccurrence	End of January 2012

6. The provider has failed to comply with a regulatory requirement in the following respect:

The complaints policy did not include an independent appeals process.

The complainant's satisfaction with the outcome of the complaint was not recorded.

Action required:

Put in place an independent appeals process.

Action required:

Implement a process to ensure the complainant's satisfaction with the outcome of the complaint is recorded.

Reference:

Health Act, 2007
Regulation 39: Complaints Procedures
Standard 6: Complaints

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

Timescale:

Provider's response:

The complaints policy has been reviewed and updated to include an independent appeals process. Staff are aware of this.

Complete

Any comments the provider may wish to make:

Provider's response:

I wish to acknowledge the professional manner in which Linda Moore carried out the inspection and the help and support which she offered us in this process. In particular I would like to acknowledge the continuous guidance she provided to the Ms Caitriona Hayden, Director of Nursing. We will endeavour to uphold the standards and regulations and look forward to working in collaboration with the Authority.

Provider's name: Sr. Catherine Prendergast

Date: 20 December 2011