

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Patterson's Nursing Home
Centre ID:	OSV-0005573
Centre address:	Lismackin, Roscrea, Tipperary.
Telephone number:	050 543 130
Email address:	pattersonsnursinghome@eircom.net
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Elizabeth Patterson
Provider Nominee:	Elizabeth Patterson
Lead inspector:	Caroline Connelly
Support inspector(s):	None
Type of inspection	Unannounced Dementia Care Thematic Inspections
Number of residents on the date of inspection:	26
Number of vacancies on the date of inspection:	2

About Dementia Care Thematic Inspections

The purpose of regulation in relation to residential care of dependent Older Persons is to safeguard and ensure that the health, wellbeing and quality of life of residents is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer and more fulfilling lives. This provides assurances to the public, relatives and residents that a service meets the requirements of quality standards which are underpinned by regulations.

Thematic inspections were developed to drive quality improvement and focus on a specific aspect of care. The dementia care thematic inspection focuses on the quality of life of people with dementia and monitors the level of compliance with the regulations and standards in relation to residents with dementia. The aim of these inspections is to understand the lived experiences of people with dementia in designated centres and to promote best practice in relation to residents receiving meaningful, individualised, person centred care.

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 compliance with specific outcomes as part of a thematic inspection. 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:
10 August 2017 10:30	10 August 2017 18:00
11 August 2017 09:10	11 August 2017 16:30

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

Outcome	Provider's self assessment	Our Judgment
Outcome 01: Health and Social Care Needs	Compliance demonstrated	Non Compliant - Moderate
Outcome 02: Safeguarding and Safety	Compliance demonstrated	Non Compliant - Moderate
Outcome 03: Residents' Rights, Dignity and Consultation	Substantially Compliant	Non Compliant - Major
Outcome 04: Complaints procedures	Compliance demonstrated	Non Compliant - Major
Outcome 05: Suitable Staffing	Substantially Compliant	Non Compliant - Moderate
Outcome 06: Safe and Suitable Premises	Substantially Compliant	Non Compliant - Moderate
Outcome 08: Governance and Management		Non Compliant - Major

Summary of findings from this inspection

This inspection report sets out the findings of a thematic inspection which focused on specific outcomes relevant to dementia care.

As part of the thematic inspection process, providers were invited to attend information seminars given by the Health Information and Quality Authority (HIQA). In addition, evidence-based guidance was developed to guide the providers on best practice in dementia care and the inspection process. Prior to the inspection, the person in charge completed the provider self-assessment and compared the service with the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 and the National Standards for

Residential Care Settings for Older People in Ireland.

During this inspection the inspector focused on the care of residents with a dementia in the centre. The inspection also considered progress on some findings following the last inspection carried out on in July 2016 and to monitor progress on the actions required arising from that inspection. The inspector met with residents, relatives, the provider who is also the person in charge, the nurse in charge, a General Practitioner (GP) and numerous staff members during the inspection. The inspector tracked the journey of a number of residents with dementia within the service, observed care practices and interactions between staff and residents who had dementia using a validated observation tool. The inspector also reviewed documentation such as care plans, medical records, staff files, relevant policies and the self assessment questionnaire which were submitted prior to inspection. Prior to the inspection HIQA had received information in the form of a concern in relation to care practices and management of residents finances. The provider was required to complete a provider led enquiry and these issues were also looked into during the inspection.

The centre did not have a dementia specific unit however, at the time of inspection there were 15 of the 26 residents residing in the centre with a formal diagnosis of dementia. The inspector observed that many of the residents required a good level of assistance and monitoring due to the complexity of their individual needs but also observed that some residents functioned at varying levels of independence. The inspector saw that residents' overall healthcare needs were generally met and they had access to appropriate medical and allied healthcare services. The inspector found that staff were knowledgeable about residents' likes, dislikes and personal preferences. Staff interacted with residents in a respectful, kind and warm manner. The inspector spoke with residents, who confirmed that they felt safe and were generally happy living in the centre. They were very complimentary about staff with one resident saying "staff are fantastic, really kind including the provider and her husband". Overall, the inspector found the person in charge and staff team was very committed to providing a caring service for residents. However the inspector found the quality of residents' lives could be further enhanced by the provision of a choice of interesting things for them to do during the day. There were limited activities available in the centre. The staff member allocated to the function of activity co-ordinator had finished a number of weeks prior to the inspection and had not been replaced at the time of the inspection. The provider assured the inspector she had advertised the role. A number of residents told the inspector that some days could be very long with little to do except watch the television. One resident explained how she enjoyed bingo but this currently was not taking place in the centre. There were external musicians who came in from time to time and residents enjoyed them. There were no organised activities on during the two days of the inspection and although the inspector observed good interactions between staff and residents including one staff member singing with a resident, residents spent long periods of the day sitting in the day room or in their bedrooms with little to do except watch TV or read their newspapers.

The person in charge had submitted a completed self assessment tool on dementia care and submitted it to HIQA along with relevant policies and procedures prior to the inspection. The person in charge had assessed the compliance level of the centre

through the self assessment tool and the findings and judgments of the inspector did not concur with the provider's judgments and further improvements were required. Although progress was made by the provider in implementing some of the required improvements identified on the inspection in July 2016, many of the findings at that time were again evident on this inspection. Such as contracts of care, lack of follow through on audits and the provision of an annual review.

The overall atmosphere in the centre was homely, comfortable and in keeping with the overall assessed needs of the residents who lived there. A lot of work had been undertaken on the premises including the reduction of a three bedded room to a two bedded room and a six bedded room to a single room and a four bedded however this was not completed fully at the time of the inspection. Residents' privacy and dignity continued to be compromised in the multi-occupancy rooms as screening around the beds had not been put in place. Following the registration inspection in July 2016 the provider had submitted costed time bound plans to HIQA for the work to be completed by the end of July 2017 but the project had overrun. The provider assured the inspector that this would be completed in the next number of weeks. New wardrobes had been put in place in altered rooms and residents now had their own wardrobes. Although the inspector found that a number of improvements required from the previous inspection had generally been implemented there were a number that had not been and required further action. The provision of activities and the follow through on resident's weights and care planning also required review. These are discussed throughout the report and the Action Plan at the end of this report identifies areas where 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.

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: Health and Social Care Needs

Theme:

Safe care and support

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

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

Findings:

This outcome sets out the inspection findings relating to healthcare, assessments and care planning. The social care of residents with dementia is discussed in Outcome 3. There were a total of 26 residents in the centre on the day of this inspection, 15 of these residents had a formal diagnosis of dementia. Residents had a choice of General Practitioner (GP) but most residents have their medical care needs met by a local GP who visited the centre on a very regular basis and the inspector met the GP during the inspection and saw regular medical reviews documented in residents files. Residents 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, with visits from community mental health nurses and outpatient appointments facilitated to see psychiatrists as required. There were processes in place to ensure the safe admission, transfer and discharge of residents to and from the centre.

The inspector focused on the experience of residents with dementia in the centre on this inspection and tracked the journey of four residents with dementia and also reviewed specific aspects of care such as nutrition, social care and end of life care in relation to other residents. There was evidence of regular nursing assessments using validated tools for issues such as falls risk assessment, dependency level and risk of pressure ulcer formation. These assessments were generally repeated on a four-monthly basis or sooner if the residents' condition had required it. Care plans were developed based on the assessments. The person in charge and staff demonstrated an in-depth knowledge of the residents and their physical, social and psychological needs and this was reflected in the person-centred care plans available for each resident. Nursing notes were completed on a daily basis and there was evidence of residents or their representative's involvement in the discussion, understanding and agreement to their care plan when reviewed or updated.

Residents' additional healthcare needs were generally met. There were systems in place to ensure residents' nutritional needs were met, and that they residents received adequate hydration. Residents were provided with a choice of nutritious meals at mealtimes and all residents spoken to be complimentary about the food provided. There was an effective system of communication between nursing and catering staff to

support residents with special dietary requirements. Mealtimes in the dining room were observed by the inspector to be a social occasion. Staff sat with residents while providing encouragement or assistance with their meal. However a lot of residents continued to have meals on lap tables beside their chairs in the day room where they spent the day. Nursing staff told the inspector that if there was a change in a resident's weight, nursing staff would reassess the resident, inform the GP and referrals would be made to the dietician and speech and language therapy (SALT). However the inspector found that residents' weights were not always recorded on a regular basis. The inspector reviewed the care of one resident who had a wound and had lost a substantial amount of weight and although the resident had been seen by the dietician in July and requested a weight to be recorded as soon as possible the resident was not weighed until three weeks later. There was no comprehensive plan in place to address the weight loss, there was no supplementation of the residents diet and no referral back to the dietician. During the inspection an urgent request for a review was made and some supplementation of the resident's diet had commenced.

There were arrangements in place to review accidents and incidents within the centre, and residents were regularly assessed for risk of falls. Care plans were in place and following a fall, the risk assessments were revised and care plans were updated to include interventions to mitigate risk of further falls. 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 pressure relieving mattresses and cushions to prevent ulcers developing. Nursing staff advised the inspector that there were no residents with pressure sores or major wounds at the time of inspection. Staff had access to support from the tissue viability nurse if required.

There was a centre-specific, up-to-date medication management policy detailing procedures for safe ordering, prescribing, storing and administration of medicines and handling and disposal of unused or out-of-date medicines. Nursing staff with whom the inspector spoke demonstrated some good practice regarding administration of medicines. Photographic identification was in place for all residents as part of their prescription/drug administration record chart. Controlled drugs were maintained in line with best practice professional guidelines and they were checked and counted at the beginning of each shift. The inspector saw evidence of this checking process and the count undertaken by the inspector was found to tally with records in the centre. The medication trolley was securely maintained and a nurses' signature sheet was in place as described in professional guidelines.

Medications were delivered in monitored dosage units and these were checked by nursing staff to verify that what was delivered corresponded with prescription records. The inspector reviewed prescription and administration records. The person in charge and staff reported to the inspector that the pharmacist is generally accessible regarding advice relating to drug interactions, dosages, crushing of medicines and possible alternatives in prescriptions and regularly liaised with the relevant general practitioners (GPs) regarding prescriptions. Comprehensive medication management audits were completed on a regular basis by the pharmacist and these were evidenced during inspection. However, there were no action plans put in place by the centre following the medication audits undertaken by the pharmacy and issues identified had not been corrected. This was ongoing with many issues identified repeatedly on audits. The

inspector found that this practice had not been rectified and this was again identified at the last inspection and no further action has been taken.

The inspector found that not all PRN medications had the maximum dose recorded on the prescription chart. However residents who required their medications to be crushed were not individually prescribed as such therefore nurses could be administering medications in a crushed format that were not prescribed as such by their GP.

There were appropriate procedures for the handling and disposal of unused and out of date medications. There was a medication fridge in the centre and this was locked, kept in a locked room and daily temperatures were recorded. There was a system in place for recording medication errors and near misses.

Judgment:

Non Compliant - Moderate

Outcome 02: Safeguarding and Safety

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 by the inspector 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 was told that safeguarding training was ongoing. However training records were not available to confirm that staff had received this mandatory training. The action in relation to training records is under outcome 5 Staffing. There was 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.

The centre maintained day to day expenses for a number of residents and the inspector saw evidence that complete financial records were maintained. The inspector reviewed the systems in place to safeguard residents' finances which included a review of a sample of records of monies handed in for safekeeping. Money was kept in a locked area in the nurse's administration office. Monies were stored in envelopes with the name of the resident. All lodgements and withdrawals were documented in a duplicate book and were signed for by two staff members. However, there was no rolling balance maintained and it was difficult to ascertain from the book what the resident's current balance was. There was no system of spot checking or auditing of residents' finances by the management team to ensure the system was sufficiently robust to protect residents or staff. The provider was a pension agent for a number of residents and a sample of records viewed indicated inadequate records of financial transactions. These residents did not have personal bank accounts and the inspector saw that sums of money were

being held within the nursing home account for a number of residents and not in a separate resident account. This system did not facilitate residents to accumulate interest on their savings and their finances were not fully protected. The provider reassured the inspector that this would be addressed.

There was a policy on responsive behaviour and staff had been provided with training in the centre on behaviours that challenge which was confirmed by staff, however again training records were not available and some new staff said they had not received training. There was evidence that residents who presented with responsive behaviour were reviewed by their GP and referred to psychiatry of old age or other professionals for full review and follow up as required. The inspector saw evidence of positive behavioural strategies and practices implemented to prevent responsive behaviours. The records of residents who presented with responsive behaviours were reviewed by the inspector who found that these were managed in a very dignified and person-centred way by the staff using effective de-escalation methods as outlined in residents' care plans.

There was a policy on restraint which was updated since the last inspection. There was evidence that the use of restraint was generally in line with national policy. Where bedrails were required for a resident, the inspector saw evidence that there was a comprehensive assessment completed. Consent was obtained from residents for the use of restraint and there was evidence of regular checking of residents. There were 13 residents out of the 26 residents using bedrails at the time of the inspection which the inspector found to be a high number. The person in charge said they were looking to try to reduce the use of bedrails.

Judgment:

Non Compliant - Moderate

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

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

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

Findings:

Residents were facilitated to exercise their civil, political and religious rights including the rights of residents to participate in the election process. Residents were kept informed of local and national events through the availability of newspapers, radio and television. Mass was held in the centre once a week and residents of other denominations were also facilitated to practice their faith.

Residents were consulted with on a daily basis and this was evidenced during both days of inspection and issues discussed were documented. Since the previous inspection more regular resident meetings had taken place and also a meeting for relatives took

place in march 2017 to outline the plans for the renovation of the building. Residents gave positive feedback regarding communication and involvement in their care and welfare and the ease of access to the management team to discuss all issues.

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 generally treated residents with respect and spoke to residents in a dignified and person-centred way. However, the inspector found that the privacy and dignity of a number of residents in the centre could be compromised by the lack of screening curtains in the multi-occupancy bedrooms. Beds had been moved around but the curtains were not altered accordingly. The provider assured the inspector that these were on order but were not in place during the inspection. The screens around some of the beds in other shared bedrooms also did not fully encircle the beds therefore did not protect the privacy and dignity of the residents. A limited number of mobile screens were available and the person in charge said these were used in these areas.

As part of the inspection, the inspector spent periods of time observing staff interactions with residents. The inspector used a validated observational tool (the quality of interactions schedule, or QUIS) to rate and record at five minute intervals. The inspector spent time observing interactions during the afternoon on the first day and morning of the second day. These observations took place in the communal room. Overall, observations of the quality of interactions between residents and staff in the communal area for a selected period of time indicated that the majority of interactions were of a positive or neutral nature with good interactions seen between staff and residents. However the inspector found and residents confirmed that there were very little organised activities going on in the centre. The centre had employed an activities coordinator who left in July 2017 this post had not been replaced. The person in charge assured the inspector she had advertised the role. The inspector found the quality of residents' lives could be further enhanced by the provision of a choice of interesting things for them to do during the day. There were limited activities available in the centre and a number of residents told the inspector that some days could be very long with little to do except watch the television. One resident explained how she used to enjoy bingo but this currently was not taking place in the centre. There were external musicians who came in from time to time and residents enjoyed them. There were no organised activities on during the two days of the inspection and although the inspector observed good interactions between staff and residents including one staff member singing with a resident, residents spent long periods of the day sitting in the day room or in their bedrooms with little to do except watch TV or read their newspapers. This was discussed with the provider at the end of the inspection who confirmed she currently was advertising for a replacement activities coordinator.

Visiting was encouraged outside of mealtimes and space was available for residents to receive visitors in private if they wished. Feedback from relatives via the staff survey said they were always made welcome in the centre.

Judgment:

Non Compliant - Major

Outcome 04: Complaints procedures

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

A written complaints policy was available in the centre and the inspector saw that the complaints procedure was displayed in a prominent place outside the office. There was a nominated person to deal with complaints in the centre and a second nominated person to monitor and ensure that all complaints were appropriately responded to. There was an independent appeals person nominated and the policy had been updated to include the facility to refer to the Ombudsman if required.

The inspector reviewed the complaints log and found that there was a complaints process in place to ensure the complaints of residents, their families or next of kin including those with dementia were listened to and acted upon. A number of complaints were documented were dealt with and the outcome and satisfaction of the complainant was recorded as required by the regulations. However HIQA had received a copy of a written complaint sent to the provider on 01 June which the complainant received no response to. The provider was out on leave and did not make provision for a response. A provider led enquiry was sent out to the provider in relation to same, there was also a delay in the completion of this.

At the time of the inspection, the inspector saw that there was an investigation ongoing into the complaint and information was sent to the inspector following the inspection. There was evidence that the main part of the complaint was resolved to the complainant's satisfaction. However the inspector was not satisfied that there was a robust enough system around complaints to ensure they were responded to in a timely manner and the policy in place had not been followed by the provider in this instance.

Judgment:

Non Compliant - Major

Outcome 05: Suitable Staffing

Theme:

Workforce

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

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

Findings:

Residents spoke positively about staff and indicated that staff were caring, responsive to their needs, and treated them with respect and dignity. Staff demonstrated an understanding of their role and responsibilities to ensure the delivery of person-centred care to the residents. The inspector saw very person centred interactions between staff and residents. There was evidence of good communication amongst staff with staff attending handover meetings. The inspector viewed minutes of staff meetings that had taken place in the past but there had been no recent staff meetings due to the recent absence of the person in charge.

The staff available reflected the regular duty rota. Residents confirmed to the inspector that staff members were available to meet their needs. The actual and proposed staff rosters were reviewed by the inspector and confirmed staffing levels on the day of the inspection were aligned with day-to-day staffing levels.

Staff were encouraged to maintain their continued professional development. Moving and handling training was taking place in the centre during the inspection with infection control training planned for later in the week. There was evidence of some staff having had mandatory training in their staff files. However it was difficult to establish what training was due for renewal or updating as there was not a comprehensive training matrix in place showing when all staff last had the training. New staff told the inspector they had not received responsive behaviour training and other mandatory training was not in date. A system of annual staff appraisals was also in place and the inspector saw evidence of this on the staff files for appraisals during 2016.

There was a policy for the recruitment, selection and vetting of staff and the person in charge and staff confirmed that there was very little turnover of care staff but there had been a high turnover of nursing staff since the previous inspection. The inspector viewed a sample of staff files. There were a number of items missing from the staff files looked at by the inspector. These included Garda Vetting for one staff and a reference for another staff member. These were forwarded to the inspector following the inspection. Gaps in CV's were also seen and a more robust recruitment process must be put in place to ensure all staff have the appropriate vetting completed and records in place prior to commencing employment. This is to ensure the safeguarding of the residents and compliance with legislative requirements.

Judgment:

Non Compliant - Moderate

Outcome 06: Safe and Suitable Premises

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:

The centre is a one-storey building catering for 28 residents including residents with dementia. It is set in a rural location on the outskirts of Roscrea town. There are grounds to the front with parking and a small enclosed concreted garden area to the rear of the building. The main entrance leads to a hallway with a small seating area for residents and visitors.

Communal facilities available for residents include a sitting room, a dining room and some seating areas on the corridors. The centre also provided a nurses' office, kitchen, sluice room and a staff changing room. Private accommodation comprised of four single bedrooms with en-suite toilet facilities and seven twin-bedded rooms, four of which have en-suite toilets. Other shared bedrooms consisted of at the time of the inspection two five-bedded rooms. There were three assisted toilet/shower rooms.

The premises were generally homely and comfortable; however, as identified on previous inspections there had been three multi-occupancy rooms which did not meet residents' individual privacy and dignity and collective needs in a comfortable and homely way. Following the previous inspection the provider outlined various options she was currently exploring to address this and a final action plan was submitted to HIQA identifying that works would be completed by the end of July 2017. The centre received a condition of registration pertaining to these plans. On this inspection the inspector saw that the premises had undergone a number of changes. A three bedded room had been reduced to a two bedded room and new wardrobes had been purchased and provided. An old kitchen/ storage room had been converted to a second two bedded room which again provided new wardrobes and ample space for residents' belongings. A bed had been removed from the six bedded room and the partitioning off of the room had commenced to convert the room to a four bedded room and a single room. However the new entrance to the four bedded room was not completed and therefore it remained as a five bedded room. In the second five bedded room individual wardrobes were now provided and the positioning of beds was also changed. In all of the changed rooms further work was required in the provision of appropriate screening around resident's beds. The impact on residents' privacy and dignity in the multi-occupancy rooms including the lack of appropriate screening is discussed fully and actioned under Outcome 16 Residents Rights, Dignity and Consultation. Overall, the inspector found that a lot of improvements had happened and residents told the inspector they were happy with their new twin bedroom. However further action is required as the renovation of the first five bedded multi-occupancy room had not been completed in accordance with the action plan and time scale submitted to HIQA. The current layout of the second five bedded multi-occupancy room did not fully meet the needs of the residents and will not meet legislative requirements in the future.

Some of the residents had personalised their bedrooms with family photographs, pot plants and favourite ornaments.

Cleaning staff were working in an unobtrusive manner which did not disturb residents. Cleaning equipment was appropriately stored. The environment was generally well maintained and there were measures in place to control and prevent infection.

Calls bells were provided and there were adequate sluice room facilities available. Appropriate assistive equipment was provided to meet residents' needs such as hoists, seating, specialised beds and mattresses. The inspector viewed the servicing and

maintenance records for the equipment and found they were up to date.

A safe enclosed garden area was made available to residents. It was well maintained and had suitable garden furniture for residents use. Residents were seen going in and out to this area and confirmed how much they enjoyed it. There was ample car parking to the front and side of the centre.

The communal areas were bright, homely and domestic in character however further attention was required to ensure the physical environment was designed in a way that was consistent with some of the design principles of dementia-specific care. Signage and cues were not always available to assist residents with perceptual difficulties and to assist residents to locate facilities independently.

Judgment:

Non Compliant - Moderate

Outcome 08: Governance and Management

Theme:

Governance, Leadership and Management

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

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

Findings:

The person in charge also holds the post of the provider. For the purpose of clarity in the report the provider/person in charge will be referred to as the person in charge. The person in charge and the staff team displayed adequate knowledge of the regulatory requirements and they were found to be committed to providing person-centred care for the residents. There was evidence of good consultation with residents. Residents were consulted with on a daily basis by the person in charge and staff. Formal residents' meetings were facilitated and actions were taken in relation to issues raised. Residents spoken with confirmed this to be the case.

There was a quality assurance programme in place where some audits were undertaken such as audits of falls, complaints and medication audits. However, the inspector found that there was not a clear system following completion of an audit if corrective action was identified. Responsibility did not appear to be assigned to a staff member and a timeline documented for either completion or review of progress of the actions required. As previously outlined under medication management this was evidenced where issues were identified in the medication audit that required corrective action and the inspector found during the inspection that these issues had not been rectified and remained ongoing. The inspector also found that the auditing programme should be further developed to include more clinical areas and documentation management. There was also no system of spot checking or auditing of residents finances by the management team to ensure the system was sufficiently robust to protect residents and staff. The inspector concluded that further development of the audit and quality assurance system

was required, to ensure the quality and safety of care and the quality of life for residents was continually evaluated. This had been highlighted on the previous inspection but no further action had been taken. The inspector found as also identified as a non compliance on the previous inspection there was not an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act. This action had not been completed despite an action plan response saying it would be put in place.

The inspector found there were deficits in the current governance and management of the centre. The Clinical Nurse Manager who had been in the centre and part of the management team had resigned in March and had not been replaced. Due to unplanned leave there had been periods where the person in charge was not in the centre although she was available for advice on the phone. No contingency plans had been put in place to address this absence. There was evidence of a lack of action taken in response to many non-compliances identified on the last inspection and many areas remained non-compliant on this inspection. The person in charge is counted as a nurse on duty when she is in the centre and there is no supernumerary time to undertake her managerial and regulatory duties. This lack of managerial time and lack of support from a management team was particularly evident with the non response to a complaint about the care in the centre, non action in response to non-compliances identified at the previous inspection and limited time for any quality assurance.

The inspector saw that contracts of care were securely maintained in the centre. Samples of contracts of care for residents were examined by the inspector and were seen to be signed and dated by either the resident or their next of kin in line with best practice. The contracts detailed services to be provided, fees to be charged as well items that incurred additional fees. However, although the contracts outlined what services incurred additional fees, it was difficult to establish from the contract what the charge was for these additional fees. The person in charge said she discusses this fully with the resident and families when signing the contract but this also needs to be clearly documented on the contract. However it was evident that people were paying different charges for extra services and this was not outlined.

Overall the inspector found that there was not a robust governance structure in place. The governance of the centre required immediate review and action. There was not a clearly defined management system in place. The person in charge was not supported in her role nor did she have adequate management time to undertake her managerial and regulatory responsibilities. Managerial roles were not clearly outlined and the structure did not specify roles, and detail responsibilities for all areas of service provision.

Judgment:
Non Compliant - Major

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 report¹

Centre name:	Patterson's Nursing Home
Centre ID:	OSV-0005573
Date of inspection:	10/08/2017
Date of response:	05/11/2017

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 01: Health and Social Care Needs

Theme:

Safe care and support

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

The inspector found that residents' weights were not always recorded on a regular basis. The inspector reviewed the care of one resident who had a wound and had lost a substantial amount of weight and although the resident had been seen by the dietician in July and requested a weight to be recorded as soon as possible the resident was not weighed until three weeks later. There was no comprehensive care plan in place to address the weight loss; there was no supplementation of the resident's diet and no

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

referral back to the dietician.

1. 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:

As is the procedure in the nursing home, on admission a full assessment of resident is taken, this includes weight and is recorded in the care plan and also in monthly weight book.

On re admission from hospital this process is now to be repeated and if resident is showing an decline in weight or if nursing staff feel it necessary a weekly recording of weight will be taken. Weighing will take place first thing in the morning or before resident goes to bed. It will be the duty of two appointed carers to maintain this practice and they will be advised accordingly. They will be instructed to report their findings to the nurse in charge and also record same in a special section of the monthly recording weight book. If it is necessary a dietician will be contacted and they advise/recommendations will be followed.

All residents are weighed on a monthly basis, and this is common practice in the Nursing home. It takes place on the first Monday of every month and if for any reason a resident is not present it will be done on that residents return. All finding are documented in care plans.

We find to weight residents in the morning gives a true reading of their weights.

The resident this refers to was in hospital for a time period and records show this, supplementary drinks given as prescribed on his return. As he was in a lot of discomfort with his wound and this meant moving was difficult thus making weighting frequently uncomfortable for him. Both hospitals reported no weight was recorded for this patient during his admission.

Proposed Timescale: 01/10/2017

Theme:

Safe care and support

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

Medications that required crushing were not all individually prescribed as such which could lead to errors in administration.

2. 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:

As stated in above we will hold meetings with nursing staff and outline their responsibility when administering the required dosage of medication to resident and following the directions laid out by pharmacist. A weekly check done by nurse on duty on the day designated to ensure to correct procedure is been followed.

Proposed Timescale: 01/10/2017

Theme:

Safe care and support

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

Comprehensive medication management audits were completed on a regular basis by the pharmacist and these were evidenced during inspection. However, there were no action plans put in place by the centre following the medication audits undertaken by the pharmacy and issues identified had not been corrected.

3. Action Required:

Under Regulation 29(2) you are required to: 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.

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

Going forward following a medications audit, a nurses meeting will be held with all nursing staff, going through the audit and an action plan drawn up. All nurses fully comply with the findings and a copy of the audit and plan given to each nurse. More information shared with nursing staff regarding protocol of medications, dispensing same, and recording of and the maximum dosage.

Proposed Timescale: 01/10/2017

Outcome 02: Safeguarding and Safety

Theme:

Safe care and support

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

The system in place to manage residents finances was not sufficiently robust to protect residents or staff. The provider was a pension agent for a number of residents and a sample of records viewed indicated inadequate records of financial transactions. These residents did not have personal bank accounts and the inspector saw that sums of money were being held within the nursing home account for a number of residents and not in a separate resident account. This system did not facilitate residents to accumulate interest on their savings and their finances were not fully protected.

4. Action Required:

Under Regulation 08(1) you are required to: Take all reasonable measures to protect residents from abuse.

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

All resident's finances will be handled by their relatives and on admission this will be outlined and all responsibility for same. The provider will not be acting as a pension agent for any resident. Any monies accumulated by the resident while in the centre will be documented and counter signed by staff members in a deposit book. This system is already in place.

Pension cards held by provider in charge has been given back to residents/ or their relatives, and a system put in place to settle bills accordingly for care.

Proposed Timescale: 01/10/2017

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

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

There were limited activities available in the centre and the staff member allocated to the function of activity co-ordinator had resigned a number of weeks ago and the person in charge was currently advertising for a replacement. At the time of the inspection there were no organised activities taking place for the residents.

5. Action Required:

Under Regulation 09(2)(b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests and capacities.

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

The activities coordinator only resigned on 28th July as already outlined and at the time of the visit we were advertising the job role.

An activities co coordinator is now appointed and she took up her roll on 18th Sept and the full list of her weekly activities in the Nursing home are as follows:

Arts & crafts (Decorating home for the season)

Painting

Welcome to our home notice board- pictures and memories displayed

Board games

Bingo

Physiotherapy (done by an external company)

Exercise class

Baking (Apple Tarts) as this is the season for apples.

Hand massages & nail painting

Floor Hoops

Resident council meeting

Reminisce time

One to one's.

Reflexology been provided by a volunteer.

Also music is provided on a 2-4 week basis depending on the availability of the musician. All the residents enjoy his company.

Her duty also entails arranging resident meetings/ relatives meeting and the nurse in charge, the secretary and one other member of staff will be invited to attend these.

Our activities co coordinator has settled in and all the residents are responding well to her. She has decorated the home with their crafts/paintings and all the visitors are able to appreciate the work been done with no extra charge to the resident.

Mass is provide on a weekly basis as outlined in the report.

All these activities took place prior to the visit of the inspector.

Proposed Timescale: 18/09/2017

Theme:

Person-centred care and support

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

The positioning of beds in two of the multi-occupancy bedrooms did not ensure the privacy and dignity of the residents

The screens around some of the beds in the shared bedrooms did not fully encircle the beds therefore did not protect the privacy and dignity of the residents. A limited number of mobile screens were available but not in sufficient numbers.

6. Action Required:

Under Regulation 09(3)(b) you are required to: Ensure that each resident may undertake personal activities in private.

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

Screens around the beds are now in place, due to on-going renovations these were unable to be in place. At no time was the privacy or dignity of the resident in compromised as portable screens were been used by staff members. We at all times are very conscious of the rights of the resident and fully understand the need for them to undertake personal activities in private.

Proposed Timescale: 05/10/2017

Outcome 04: Complaints procedures

Theme:

Person-centred care and support

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

There was not a sufficiently robust complaints procedure in place to ensure all complaints were responded to promptly and in line with the centres policy.

7. Action Required:

Under Regulation 34(1)(d) you are required to: Investigate all complaints promptly.

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

The complaint been referred to above was received during the summer of 2017, it arrived just following the person in charge accident and at any other time this would have been dealt with immediately. Phone calls were made to the parties involved but they did not respond and no forwarding address was supplied in their written letter. This was the first time in 26 years of business a written complaint was ever received, and the person in charge in no longer carries out nursing duties, her role is solely management and supported by necessary staff.

Proposed Timescale: 05/10/2017

Outcome 05: Suitable Staffing

Theme:

Workforce

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

It was difficult to establish what training was due for renewal or updating as there was not a comprehensive training matrix in place showing when all staff last had the relevant training. New staff told the inspector they had not received responsive behaviour training and other mandatory training was not in date

8. Action Required:

Under Regulation 16(1)(a) you are required to: Ensure that staff have access to appropriate training.

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

Training matrix is now up to date and any outstanding training is booked and will take place in the coming weeks.

Proposed Timescale: 31/10/2017

Theme:

Workforce

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

There were a number of items missing from the staff files looked at by the inspector. These included Garda Vetting for one staff and a reference for another staff member. These were forwarded to the inspector following the inspection. Gaps in CV's were also seen and a more robust recruitment process must be put in place to ensure all staff have the appropriate vetting completed and records in place prior to commencing employment.

9. Action Required:

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

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

Going forward all new staff will have completed Garda vetting prior to starting employment and no person works in the facility without obtaining same. Current staff members and new staff members will be encourage to complete or been in the process of completing Fetac Level 5 courses.

Current updating of staff files has taken place and going forward all new staff members will need to have all documentation in place prior to starting work.

Proposed Timescale: on going

Proposed Timescale:

Outcome 06: Safe and Suitable Premises

Theme:

Effective care and support

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

There were a number of items identified with the premises that did not conform to the

matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

1) The renovation of the first five bedded multi-occupancy room had not been completed in accordance with the action plan and time scale submitted to HIQA

2) Further attention was required to ensure the physical environment was designed in a way that was consistent with some of the design principles of dementia-specific care. Signage and cues were not always available to assist residents with perceptual difficulties and to assist residents to locate facilities independently.

3) The current layout of the second five bedded multi-occupancy room did not meet the needs of the residents and will not meet legislative requirements in the future.

10. 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:

HIQA did not agree this action plan with the provider despite affording the provider two attempts to submit a satisfactory response.

Proposed Timescale:

Outcome 08: Governance and Management

Theme:

Governance, Leadership and Management

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

There was not a clearly defined management system in place the inspector found the current governance and management of the centre required improvement. The person in charge was not supported in her role nor did she have adequate management time to undertake her managerial and regulatory responsibilities. Managerial roles were not clearly outlined and the structure did not specify roles, and details responsibilities for all areas of service provision.

11. Action Required:

Under Regulation 23(b) you are required to: Put in place a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

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

HIQA did not agree this action plan with the provider despite affording the provider two attempts to submit a satisfactory response.

Proposed Timescale:
<p>Theme: Governance, Leadership and Management</p> <p>The Registered Provider is failing to comply with a regulatory requirement in the following respect: There were not management systems in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.</p> <p>12. Action Required: Under Regulation 23(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored.</p> <p>Please state the actions you have taken or are planning to take: HIQA did not agree this action plan with the provider despite affording the provider two attempts to submit a satisfactory response.</p>
Proposed Timescale:
<p>Theme: Governance, Leadership and Management</p> <p>The Registered Provider is failing to comply with a regulatory requirement in the following respect: There was no annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.</p> <p>13. Action Required: Under Regulation 23(d) you are required to: Ensure there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.</p> <p>Please state the actions you have taken or are planning to take: The Registered Provider going forward will introduce an annual review and assess our performance, rate same, draw up a plan for the coming year and any areas we need to improve. A comprehensive audit schedule will be implemented to enable regular monitoring of quality, safety, capacity and capability in the nursing home. Action plans will be developed based on any identified areas of non-compliance.</p>
Proposed Timescale: 31/12/2017
<p>Theme: Governance, Leadership and Management</p>

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

It was difficult to establish from the contract what the charge was for additional fees. The person in charge said she discusses this fully with the resident and families when signing the contract but this also needs to be clearly documented on the contract. However it was evident that people were paying different charges for extra services and this was not clearly outlined.

14. Action Required:

Under Regulation 24(2)(b) you are required to: Ensure the agreement referred to in regulation 24 (1) relates to the care and welfare of the resident in the designated centre and includes details of the fees, if any, to be charged for such services.

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

Going forward, we clearly explain the charges for the extra expenses in the contract of care and everyone is always in full understanding of them. These will be signed and copies of same given to relatives and one keep on file. All files all be updated accordingly.

Proposed Timescale: 01/12/2017