Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	Athlunkard House Nursing Home
Name of provider:	Athlunkard Nursing Home Ltd
Address of centre:	Athlunkard, Westbury, Clare
Type of inspection:	Unannounced
Date of inspection:	26 January 2023
Centre ID:	OSV-0000729
Fieldwork ID:	MON-0038350

About the designated centre

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

Athlunkard House is a modern purpose built two-storey purpose nursing home. It can accommodate up to 103 residents. It is located in a residential area in Co. Clare on the outskirts of Limerick city. It is situated close to many amenities including St. Nicholas church and a local shopping centre. Athlunkard house accommodates male and female residents over the age of 18 years for short term and long term care. It provides 24 hour nursing care and caters for older persons who require general nursing care, dementia care, physical and intellectual disabilities, palliative care, respite and post operative care. Bedroom accommodation is provided on both floors in 89 single and seven twin bedrooms. All bedrooms have en suite bathroom facilities. There is a lift provided between floors. There is a variety of communal day spaces provided including a dining room, day room and visitors rooms provided on each floor. Residents also have access to two secure enclosed garden areas.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	88

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 26 January 2023	10:00hrs to 19:15hrs	Claire McGinley	Lead
Thursday 26 January 2023	10:00hrs to 19:15hrs	Una Fitzgerald	Support

What residents told us and what inspectors observed

Residents in this centre appeared to enjoy a good quality of life, facilitated by staff who knew them well. A walk around the centre found the care environment to be comfortable and to facilitate a good quality of life. Inspectors spoke with residents on the day of the inspection. Residents told the inspectors that 'they were happy living here'. Residents who could not share their lived experience with the inspectors appeared to be relaxed and comfortable in the company of staff and other residents.

On arrival at the centre, inspectors met with the person in charge. Following an introductory meeting, inspectors walked through the centre with a member of the management team.

On the morning of inspection, residents were observed to be up and about the ground floor of the centre, having breakfast in the dining room, chatting with visitors in the foyer, chatting with other residents, and watching television in the sitting room. An activities schedule was on display on both floors and residents were observed enjoying a variety of group activities. The communal rooms observed were supervised by a member of staff at all times.

The centre was registered to accommodate 103 residents. On the day of inspection there were 88 residents living in the centre. Accommodation for residents was provided over two floors in 89 single room accommodation and seven double room accommodation, with lift access between floors. The centre was well maintained, well lit, warm and comfortable. Inspectors observed resident's rooms being painted, and observed that screens, used to ensure resident privacy in twin room accommodation were in the process of being upgraded. Inspectors found that that some bedrooms had been personalised and had a locked storage space for personal possessions.

Inspectors observed the lunchtime dining experience of residents. Inspectors were informed that there were two dining settings, the first at 12.00 and the second at 12.50. Tables were set with the daily menu was on display on the tables. A choice of main meal and dessert was available. Staff were observed serving and assisting residents in a dignified manner.

In the main, the premises was observed to be clean, however, there was a build up of dust debris behind fire doors and in a small number of resident rooms. Resident equipment observed was visible clean. Storage of goods and equipment was organised. The cleaning staff were knowledgeable about their role and the cleaning trolley observed was clean. Inspectors reviewed the laundry process and observed that the laundry was clean and organised, with a flow to ensure dirty laundry did not contaminate clean laundry.

Inspectors spoke with a number of visitors who expressed their satisfaction with the

quality of care provided, and with the visiting arrangements within the centre.

The following sections of this report detail the findings with regard to the governance and management of the centre and how this supports the quality and safety of the service provided to residents.

Capacity and capability

This was an unannounced risk inspection carried out by inspectors of social services to assess compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). Inspectors followed up on actions taken by the provider to address issues of compliance found on the last inspection in August 2022. Notifications and unsolicited information received by the Office of the Chief Inspector was also reviewed.

The findings of this inspection were that action was required by the registered provider to ensure adequate staffing resources to ensure a safe, consistent and quality service was provided to residents living in the centre. Non-compliance continued to be identified with Regulation 5; Individual assessment and care planning, Regulation 23; Governance and management, Regulation 21; Records and Regulation 34; Complaints procedures.

Athlunkard Nursing Home limited is the registered provider of Athlunkard House Nursing Home. The person in charge was supported by a regional manager, assistant director of nursing, clinical nurse managers and a team of nursing, healthcare assistant, activity, housekeeping, catering, administration and maintenance staff. The centre also had access to human resources, finance, quality and facilities management support.

A review of the rosters found that the clinical management support for the person in charge and the staff nurse positions were not as described in the centre's statement of purpose. The provider had failed to ensure that there was adequate resources in place to support the delivery of the service. The vacancies on the day of inspection included an assistant director of nursing post, eight staff nurses and a housekeeping supervisor. Inspectors were informed that ongoing recruitment campaigns were in place and that agency nursing staff were being utilised to ensure adequate staff nurse numbers on each shift. However, on occasion the assistant director of nursing was required to cover vacant nursing shifts and clinical nurse managers did not have any supervisory time allocated to them. This impacted on the oversight and monitoring of the quality and safety of the service, particularly in relation to infection prevention and control, clinical documentation, and supervision of staff.

Staff training records provided to the inspectors identified that staff had up-to-date fire training, managing behaviours that is challenging training, and manual handling training. However, it was noted that a number of staff nurses did not have up-to-date basic life support training. This training was appropriate to the staff nurse role

as there was an automated external defibrillator on-site and a number of residents were assessed as requiring advanced life support intervention, in the case of an emergency.

A sample of staff records were reviewed. Inspectors found that induction records were recorded for new staff. However, the files were not maintained in line with the requirements of Schedule 2 of the regulations. For example, documentary evidence of relevant qualifications or accredited training was not available in all records and gaps were identified in staff employment history.

A complaint policy was in place, and information regarding the complaints process was on display within the centre. Complaints were recorded on an electronic system. Inspectors found that generally, complaints reviewed were appropriately investigated, and the outcome was recorded.

Regulation 15: Staffing

On the day of inspection, the number and skill mix of staff was appropriate with regard to the needs of the current residents, and the size and layout of the designated centre.

The staffing was supported and dependent on agency staff to ensure safe staffing levels. This reliance on agency staff in addressed under Regulation 23(a); Governance and Management.

Judgment: Compliant

Regulation 16: Training and staff development

Some staff did not have access to appropriate training. Some staff nurses had not received up-to-date basic life support training. Inspectors acknowledge that training to ensure compliance with the regulations was booked on the day of inspection.

Judgment: Substantially compliant

Regulation 21: Records

Records reviewed were not maintained in line with the requirements of Regulation 21. For example, staff files did not contain all of the information required under Schedule 2 of the regulations.

- A full employment history together with a satisfactory history of any gaps in employment
- Documentary evidence of relevant qualifications

Staff training records provided were not updated with training that had been completed. For example, medication management training had not been updated on the training record although it had been completed within the last year.

Judgment: Substantially compliant

Regulation 23: Governance and management

The provider had failed to ensure there was staffing resources in place to support the person in charge. At the time of inspection, the support structure in place to support the person in charge was insufficient. There was one full time assistant director of nursing vacancy. In addition, there were multiple registered nurse vacancies on the rotas. While the inspectors found that on the day of inspection there were sufficient staff on duty to deliver the direct care, the overall finding from this inspection were that there remained a significant shortfall in the number and availability of registered nurses required to continuously staff the centre. The inspectors acknowledge that the centre is utilising agency to ensure the rotas are complete. However, the provider did not present a clear time-bound staffing strategy to have sufficient nurses in place or no effective risk management systems in place to manage the risk. At the time of inspection, the provider had the risk associated with the over reliance of agency staff rated as a low risk. In addition, this lack of staffing resource resulted in the requirement of the clinical nurse manager filling vacant nursing shifts, impacting on their role and responsibility in terms of management supervision and oversight.

The management systems in place did not ensure that the service provided was consistently and effectively monitored. While the inspectors found that management systems such as auditing were in place, the shortfall in management resources was causing a delay in timely action taken to address the risks identified. For example, an action plan to address risks identified in a nutrition, housekeeping and infection control audit had not been addressed.

Judgment: Not compliant

Regulation 31: Notification of incidents

Notifications, as set out in Schedule 4 of the regulations, were submitted to the Chief Inspector within the required time frames.

Judgment: Compliant

Regulation 34: Complaints procedure

The inspectors reviewed the complaint management system and found that it contained the detail required under Regulation 34.

Judgment: Compliant

Regulation 4: Written policies and procedures

The registered provider had ensured that policies and procedures set out in Schedule 5 of the regulations, were available to staff and were reviewed at intervals not exceeding three years.

Judgment: Compliant

Quality and safety

Inspectors found that the provision of good quality care was negatively impacted by the lack of nurse management support and oversight in the centre. The lack of supervisory hours was impacting on the supervision and oversight of care delivered.

While there was an electronic care planning system in place, the oversight of the documentation was not sufficient. While the provider had taken some action to comply with regulations in respect of resident's assessments and care plans, such as, the completion of a comprehensive nursing assessment on admission, the action taken was not sufficient to achieve full regulatory compliance.

The inspectors found that care plans did not always contain the information required to guide the care. While inspectors acknowledge that the needs of residents were known to the staff, the detail required to direct the care was not always recorded. This is a risk to resident's care, as agency staff, who may not be familiar with the needs of residents did not have access to a plan of care that clearly described the plan of care for residents. This risk increases when the staffing resource in the centre is reliant on the use of agency staff to ensure a full complement of staff are on duty.

Residents had access to a general practitioner (GP) and health and social care professionals. Where residents require further allied health and specialist expertise,

this was facilitated through a system of referral. However, recommendations made by the tissue viability nurse specialist, specific to wound management, were not adhered to.

Inspectors found that the provider had taken action to ensure potential safeguarding incidents were appropriately managed to ensure residents were safe. Residents told inspectors that they felt safe in the centre and would not hesitate to bring their concerns to any member of the care staff.

The provider had systems in place to monitor environmental restrictive practices to ensure that they were appropriate and there was sufficient evidence to show that the centre was working towards a restraint-free environment, in line with local and national policy. Records showed that where restraints were used, these were implemented following a risk assessment.

The provider had systems in place to monitor fire safety precautions and procedures within the centre. Annual up-date fire training had taken place. Fire drills were completed. Records documented the scenarios created and how staff responded. Appropriate documentation was maintained for weekly, monthly and yearly checks and servicing of fire equipment.

Interactions between residents and staff were observed to be kind, dignified and respectful. Residents were encouraged to exercise choice and had choice in a variety group and of one to one activities. Residents right to privacy was upheld. Residents were supported to maintain their individual style and appearance. For example; residents were well presented, multiple residents had makeup applied and were wearing decorative scarves and jewellery. Residents had access to radio, television, newspapers and other media. Residents had access to an independent advocacy service.

Regulation 11: Visits

The registered provider had ensured that visiting arrangements were in place and were not restricted.

Judgment: Compliant

Regulation 17: Premises

The inspectors were satisfied that the premises was appropriate to the number residents and was designed and laid out to meet the needs of the current residents.

Judgment: Compliant

Regulation 28: Fire precautions

The provider had systems in place to monitor fire safety precautions and procedures within the centre in compliance with Regulation 28.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Care plans were not consistently updated and reviewed to guide care. For example;

- a care plan for a resident with a wound did not reflect the progress or deterioration of the wound to ensure appropriate wound care.
- a resident with pain that required frequent pain management did not have a care plan in place to guide staff. This risk to residents increased when agency staff, who would not be familiar with the residents, were on duty delivering nursing care.

Judgment: Substantially compliant

Regulation 6: Health care

Inspectors found that recommendations from allied healthcare professionals were not acted upon in a timely manner to ensure best outcomes for residents. For example, advice received from a Tissue Viability Nurse Specialist to promote a residents wound healing was not adhered too.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

The provider had systems in place to monitor environmental restrictive practices to ensure that they were appropriate and there was sufficient evidence to show that the centre was working towards a restraint-free environment in line with local and national policy. Records showed that where restraints were used these were

implemented following a risk assessments.

Judgment: Compliant

Regulation 8: Protection

A policy for safeguarding vulnerable adults at risk of abuse was in place. All staff had appropriate vetting completed by an Gardai Siochana prior to commencement of work in the centre. Staff spoken with displayed good knowledge of the different kinds of abuse and what they would do if they witnessed any type of abuse. The training records identified that staff had participated in training in adult protection.

Judgment: Compliant

Regulation 9: Residents' rights

Residents had opportunities to participate in activities in accordance with their interests and capacities, in compliance with Regulation 9.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Athlunkard House Nursing Home OSV-0000729

Inspection ID: MON-0038350

Date of inspection: 26/01/2023

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: All existing nursing staff completed Basic Life support training immediately following the inspection. Recently recruited nursing staff are scheduled to complete the training in April 2023.	
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: By the 20th March 2023, All staff files were reviewed and updated to ensure that they are maintained in line with regulation 21. By the 20th March 2023, The training matrix will be reviewed and updated to unsure it identifies the training completed by staff.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management:	

A comprehensive staffing gap analysis was completed following the inspection and in response a second ADON was recruited. This person took up post on 20th March 2023.

Both ADONs are supernumerary to best support the PIC and also to provide management and supervision in the centre over the 7-day week.

Two CNMs are rostered in the centre to complement the management team. Both CNMs provide a mixture of supernumerary and clinical hours.

The centre has remained focused on recruiting to fill all outstanding vacancies and as of 31st March 2023, all nurse vacancies have been filled.

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
Following the inspection, the approach to care planning was revised. This now ensures that the care needs of all residents are fully assessed and clearly documented in care plans thereby providing the most appropriate instructions for staff to follow when delivering care.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
Post-inspection, resident care plans were reviewed and updated and all recommendations from allied healthcare professionals are acted upon in a timely manner to ensure best outcomes for residents.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	30/04/2023
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Substantially Compliant	Yellow	20/03/2023
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	20/03/2023
Regulation 23(c)	The registered provider shall ensure that	Not Compliant	Orange	20/03/2023

	management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.			
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Substantially Compliant	Yellow	20/03/2023
Regulation 6(2)(b)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the resident agrees to medical treatment recommended by the medical practitioner concerned, the recommended treatment.	Substantially Compliant	Yellow	20/03/2023