

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Ashley Lodge Nursing Home
<b>Centre ID:</b>	OSV-0000009
<b>Centre address:</b>	Tully East, Kildare, Kildare.
<b>Telephone number:</b>	045 521 300
<b>Email address:</b>	ashleylodgenursinghome@yahoo.ie
<b>Type of centre:</b>	A Nursing Home as per Health (Nursing Homes) Act 1990
<b>Registered provider:</b>	Ashley Lodge Nursing Home Limited
<b>Provider Nominee:</b>	David Hyland
<b>Lead inspector:</b>	Sheila Doyle
<b>Support inspector(s):</b>	Mary O'Donnell
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	46
<b>Number of vacancies on the date of inspection:</b>	9

## About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

- Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- to carry out thematic inspections in respect of specific outcomes
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or wellbeing of residents.

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.

Please note the definition of the following term used in reports: responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

**Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.**

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

**The inspection took place over the following dates and times**

From: 20 February 2017 10:00 To: 20 February 2017 18:30

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

<b>Outcome</b>	<b>Our Judgment</b>
Outcome 02: Governance and Management	Non Compliant - Major
Outcome 03: Information for residents	Non Compliant - Moderate
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Non Compliant - Moderate
Outcome 07: Safeguarding and Safety	Substantially Compliant
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 09: Medication Management	Non Compliant - Moderate
Outcome 10: Notification of Incidents	Non Compliant - Moderate
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 12: Safe and Suitable Premises	Substantially Compliant
Outcome 13: Complaints procedures	Non Compliant - Major
Outcome 15: Food and Nutrition	Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Compliant
Outcome 18: Suitable Staffing	Substantially Compliant

**Summary of findings from this inspection**

This inspection was carried out to review progress on actions required from the previous two inspections. In addition, the findings of the inspection will inform a review of the three additional restrictive conditions of registration attached to the centre since 15 Dec 2016.

Information received by HIQA was also followed up.

Ongoing improvements were noted in the premises. Many areas had been redecorated and new and renovated furniture was evident. Infection control procedures were now robust. Staff had attended training and were knowledgeable. Additional household staff were hired and a high standard of cleanliness was evident throughout the centre.

Clinical issues such as wound management and diabetes care were well managed. However, weight management was not in line with the evidence based practice.

Safeguarding measures were in place. Restraint was in line with national guidelines. Improvement was required to ensure that responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) are managed in line with the policy in place.

While contracts of care were in place they had not been individualised to reflect the fees charged to each resident. One of five staff files reviewed was incomplete as there was no evidence of garda vetting on file for a staff member employed prior to April 2016.

Handover arrangements had been revised to ensure that staff were available to attend to residents at shift changeovers. Staffing levels especially the nursing levels, which were the same for day and night duty needed to be reviewed. Alternative arrangements for the supervision of staff had been implemented but inspectors found the arrangements in place for the supervision of staff were inadequate.

A major non-compliance was merited in relation to Outcome 2 Governance and Management because inspectors found evidence that the management structure was not sufficiently robust to assure the quality and safety of the service. The systems in place to review and monitor the quality of care were not adequate and seven of the 16 actions required from the last two inspections were still outstanding.

This is the third consecutive inspection where the management of complaints was not sufficiently robust. A major non-compliance was found because issues raised were not consistently logged and managed in line with the policy and used to inform service improvements.

These are discussed further in the report and included in the action plan at the end.

**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 02: Governance and Management***

***The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.***

**Theme:**

Governance, Leadership and Management

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

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

**Findings:**

During the course of this inspection, inspectors found that there was a clearly defined management structure with explicit lines of authority and accountability. Weekly management team meetings were attended by the operations manager, the provider nominee and the person in charge. The person in charge and the provider nominee told inspectors that progressing action plans following previous inspections was a priority for the management team.

An external specialist in infection control had been commissioned to audit the cleaning and hygiene standards and create an action plan to address the deficiencies identified by HIQA in Sept 2016. Inspectors acknowledged that improvements had occurred in this area. Inspectors also found that the necessary resources had been made available to meet the National Standards for the Prevention and Control of Healthcare Associated Infections (2009).

There was evidence of consultation with residents and their representatives on a daily basis and in a formal resident and relative forum. Other opportunities for consultation were afforded when staff were engaged in reviewing and assessing the changing needs of residents and care planning process. A resident satisfaction survey had been completed by 13 residents. Action had been taken to address the areas for improvements identified in the survey. For example patio furniture and orchard planting had been organised. New lights were due to be installed to facilitate residents to use the patio area in the evenings.

Inspectors found evidence during the course of this inspection that the management structure was not sufficiently robust to assure the quality and safety of the service. Examples included lack of knowledge of the residents accommodated at the centre, inadequate system of recording and managing monies raised during the course of a

Christmas raffle, inadequate systems of risk management, and an annual review of the centre contained information related to a different centre. In addition of 16 actions required from the last two inspections seven were still outstanding.

In addition the systems in place to review and monitor the quality of care were not adequate and inspectors held the view that there was a reliance on inspections by HIQA to identify areas of non-compliance and generate action plans for service improvements. Internal audits were not conducted as part of an audit cycle to monitor and improve the quality of care. The person in charge showed inspectors the audits she had undertaken in relation to key performance indicators such as falls, dependency levels, incidents and accidents, wounds and residents with weight loss. However although there was evidence that data was being collected there was no evidence that the collected data was collated and analysed to monitor trends and inform continuous quality improvements.

Staffing levels at the centre needed to be reviewed. The previous action plan outlined that a registered nurse would be allocated to each of the three wings on a daily basis. This was not in place on the date of this inspection and is discussed under Outcome 18. Inspectors found evidence that supervision of staff was inadequate to ensure that call bells were responded to in a timely manner and that each resident's care plans was implemented.

**Judgment:**  
Non Compliant - Major

***Outcome 03: Information for residents***  
***A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.***

**Theme:**  
Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**  
No actions were required from the previous inspection.

**Findings:**  
Following information received by HIQA, inspectors reviewed the contracts of care in place.

Some improvement was required as it was unclear, in some contracts reviewed, how much was being charged to individual residents for additional services. Inspectors also noted that all contracts were not in the centre at the time of inspection. Staff said that they had been sent out to families for signing following amendments.

Inspectors read the residents' guide and saw that it met the requirement so the regulations.

**Judgment:**

Non Compliant - Moderate

***Outcome 04: Suitable Person in Charge***

***The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.***

**Theme:**

Governance, Leadership and Management

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

No actions were required from the previous inspection.

**Findings:**

The person in charge is a registered nurse and has the required experience in nursing older people.

The person in charge had maintained her continuous professional development having previously completed courses in gerontology and management. She continued to attend training and seminars relevant to her role such as infection control and dementia care.

Other aspects of this outcome are already included under Outcome 2.

**Judgment:**

Compliant

***Outcome 05: Documentation to be kept at a designated centre***

***The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.***

**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:**

Inspectors reviewed some elements of this outcome to check if the actions required from the previous inspection were completed. Some actions required from the previous inspection had not been addressed within the given timescale.

Inspector reviewed a sample of staff files and saw that the information required under Schedule 2 was not complete in one of five files reviewed. There was no evidence of garda vetting on file. Inspectors saw that a new application was underway at the time of inspection.

The designated centre had all of the written operational policies as required by Schedule 5 of the Regulations. Inspectors were not satisfied that all had been adopted and implemented throughout the centre. This is discussed under Outcomes 7 and 13.

**Judgment:**

Non Compliant - Moderate

***Outcome 07: Safeguarding and Safety***

***Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.***

**Theme:**

Safe care and support

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

No actions were required from the previous inspection.

**Findings:**

There were measures in place to protect residents from being harmed or abused. All staff had received training on identifying and responding to elder abuse. There was a policy in place and the national policy on safeguarding vulnerable persons at risk of abuse was available to staff. The person in charge and staff who spoke with inspectors displayed sufficient knowledge of the different forms of elder abuse and all were clear on reporting procedures. Residents interviewed by inspectors said they felt safe.

Inspectors found that staff had training and the necessary skills and knowledge to work with residents who had behavioural issues. Behaviours described as problematic by staff included verbal and physical aggression. One resident who had responsive behaviours was tracked and the inspectors found that the assessment of the resident was not in line with the centre's policy. The ABC charts (assessment charts) were not completed and analysed to inform a care plan for the resident. The resident's care plan advised staff to be vigilant for triggers which may precede a violent episode, but did not identify what the triggers might be. Person-centred interventions included music or sitting in the sun room.

Some residents were prescribed sedation and psychotropic medications to manage an underlying condition. The use of these medications was monitored and regularly reviewed.

Staff had worked towards promoting a restraint free environment. However the use of

bedrails had remained relatively static for 2016. 16 residents used bedrails on the day of inspection and this represented an increase of three since September 2016. Risk assessments had been undertaken and care plans were put in place for residents who used bedrails. Safety checks were completed and there was documented evidence that these were undertaken. All forms of restraint were recorded in the restraint register and appropriately notified to HIQA.

**Judgment:**

Substantially Compliant

***Outcome 08: Health and Safety and Risk Management***

***The health and safety of residents, visitors and staff is promoted and protected.***

**Theme:**

Safe care and support

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

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

**Findings:**

Actions from the previous inspection were completed and some areas for further improvement were identified on this inspection.

Inspectors found that actions required from the previous inspection relating to infection control had been addressed. An infection control specialist had undertaken a comprehensive audit of the centre and all the audit recommendations had been implemented. Wall surfaces had been repainted and alcohol gel dispensers had been installed in each bedroom. Damaged beds, mattresses, bed tables and chairs were either repaired or replaced. Additional cleaning staff had been hired and a high standard of cleanliness was in the centre. Cleaning schedules were in place and all bathrooms were checked on an hourly basis. The CNM confirmed that she undertook a walk about inspection with cleaning staff on a regular basis. Inspectors noted that special bins had been introduced to each wing for control of malodours and the safe disposal of incontinence wear. There were suitable arrangements in place for the disposal of clinical waste.

Infection control and hand hygiene was now mandatory training for all staff. Records showed that all staff had undertaken infection control training and the induction programme for new staff included infection control and hand hygiene. Good hand hygiene practices were observed during the inspection.

Fire drill records showed that seven fire drills took place in 2016 and one in 2017. The records indicated the elements of training that took place, the staff who participated and response times. Fire safety records would be further enhanced if areas for improvement were identified and plans put in place to improve the efficiency of the drills.

All residents had a personal emergency evacuation plan which identified the level of

assistance they required in the event of an emergency evacuation. However it was not evident that any simulated evacuation had been undertaken or that fire drills were conducted to ensure that staffing levels at night were sufficient to undertake and emergency evacuation.

The centre had a comprehensive safety statement and policies and procedures relating to health and safety dated July 2016 included a risk management policy to include items set out in Regulation 26 (1).

The emergency response policy was available and there were emergency policies and procedures in place for responding to major incidents likely to cause death or injury, serious disruption to essential services or damage to property.

A risk register with identified risks that were assessed, rated and applied control measures was maintained. However inspectors noted that not all risks were identified and assessed. For example, there was an electric socket installed for the hairdressing room which also had a shower. In addition cleaning trolleys and equipment were stored in the sluice rooms when staff went on break. Arrangements were in place for investigating and learning from incidents and adverse events involving residents and staff. However improvements were required for monitoring that controls put in place to address risks were implemented. Inspectors found that the unattended trolley with cleaning chemicals was left open in the public area even though this presented a significant risk for a particular resident.

Measures in place to promote resident safety and prevent accidents to persons in the centre and on the grounds had been strengthened. A health and safety committee had been set up and records of two committee meetings were reviewed. A walk through the premises was conducted on a monthly basis and hazards and risks were identified. .

**Judgment:**

Non Compliant - Moderate

***Outcome 09: Medication Management***

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

**Theme:**

Safe care and support

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

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

**Findings:**

Inspectors focused on actions arising from inspections in 2016.

Inspectors reviewed a sample of prescription and administration records. The maximum dosage for administration of medication a 24 hour period for PRN (as required) was not consistently documented. This was also a finding in April 2016.

**Judgment:**  
Non Compliant - Moderate

***Outcome 10: Notification of Incidents***  
***A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.***

**Theme:**  
Safe care and support

**Outstanding requirement(s) from previous inspection(s):**  
No actions were required from the previous inspection.

**Findings:**  
Inspectors reviewed this outcome because of information received in HIQA regarding an incident.

Inspectors reviewed the incident log and saw that details of each incident were recorded together with actions taken. However HIQA had not been notified of one incident relating to hospitalisation of a resident.

**Judgment:**  
Non Compliant - Moderate

***Outcome 11: Health and Social Care Needs***  
***Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.***

**Theme:**  
Effective care and support

**Outstanding requirement(s) from previous inspection(s):**  
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**  
The inspectors found that generally each resident's wellbeing and welfare was maintained by a good standard of nursing care and appropriate medical and allied health care.

There were processes in place to ensure that when residents were admitted, transferred or discharged to and from the centre, relevant and appropriate information about their

care and treatment was available and maintained, and shared between providers and services.

A selection of care records and plans was reviewed. There was a documented comprehensive assessment of all activities of daily living, including personal hygiene, continence, eating and drinking, mobility, rest and sleep. There was evidence of a range of assessment tools being used to assess and monitor risks such as falls, malnutrition and risk of pressure ulcer development. Care plans were developed to address problems or if a potential risk was identified. Pressure relieving mattresses were provided and there were no residents with pressure sores. Residents were weighed on a monthly basis or more frequently if required. There was timely access to dietetic services and specialist advice was incorporated into care plans. Each resident's care plan was kept under formal review on a four monthly basis at a minimum or as required by the resident's changing needs in consultation with residents or their representatives.

The inspectors reviewed the management of clinical issues such as falls, wound care and diabetes management and found they were well managed and guided by robust policies.

Residents were satisfied with the service provided. Residents had access to GP services and out-of-hours medical cover was provided. Residents also had access to psychiatry of later life services and community palliative care services. A range of other services was available on referral including speech and language therapy (SALT), dental, chiropody services. Nursing care plans had been updated to reflect the recommendations of various members of the multidisciplinary team.

However the systems in place to ensure that care plans were implemented were found to be weak. Inspectors reviewed a sample of care plans relating to nutrition. While in the main they were specific and used to inform care delivered, inspectors saw that in one case the interventions listed were not taking place. Inspectors saw that one resident's care plan required his weight to be recorded on a weekly basis to monitor his condition because of ongoing weight loss. However inspectors saw that six weeks had elapsed since the resident had been weighed.

In addition, inspectors saw that some residents required a daily record of their fluid intake and output while others required a food diary to be maintained to monitor foods taken. Inspectors saw that several of these were incomplete, gaps in recording were evident. There did not appear to be a system in place to monitor this.

**Judgment:**

Non Compliant - Moderate

***Outcome 12: Safe and Suitable Premises***

***The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations***

**2013.**

**Theme:**

Effective care and support

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

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

**Findings:**

The centre was a single storey, purpose built nursing home. The external grounds were well maintained and residents had access to a safe secure garden. The premises were clean, well maintained, adequately heated, with adequate natural lighting and ventilation. The centre was decorated to a high standard. Stained and damaged flooring had been replaced and remedial works carried out in all bedrooms since the previous inspection. Furniture and fittings were found to be of a good standard and an order had been placed to replace a number of worn mattresses. Curtains in the sun room were faded and torn and there were plans to replace these. The building is wheelchair accessible.

Residents' private accommodation was provided in three wings in mostly single bedrooms with full en suite facilities. The size and layout of bedrooms was suited to meeting the needs of residents, including those with high dependency needs. Adequate space and storage facilities were provided to residents for personal possessions including lockable storage.

Residents had access to a large communal day room, which was comfortable and homely. The inspectors noted that the front reception area was a popular area with residents and visitors. The spacious dining room was located off the main reception and two other rooms were available for residents who required more assistance or preferred a quiet dining experience. The communal rooms and all common areas were furnished and decorated to create an interesting environment for residents.

Circulation areas, toilet facilities and shower/bathrooms had non slip flooring and were adequately equipped with hand-rails and grab rails. All walkways and bathrooms were equipped with handrails and grab-rails. Signage throughout the centre had text and pictures to help residents to identify communal rooms and to support way-finding. Toilet seats had a contrasting colour to support residents with dementia and those with visual impairment. Working call bells were accessible from each resident's bed and in each room used by residents.

Resident's bedrooms were personalised with soft furnishings and family photographs and bedroom doors had the residents name and a photograph or a picture of significance to the individual resident. The walls in communal areas displayed pictures and framed samples of old currency notes to facilitate reminisce, encourage conversations and support residents to connect with nature.

Storage space for equipment was inadequate and equipment such as bed-wedges and a high support chair and a mattress were stored in one of the bathrooms. There were

three sluice rooms, one in each wing. Inspectors found that there was no racking system for the storage of bedpans and urinals in any of the sluice rooms.

**Judgment:**  
Substantially Compliant

***Outcome 13: Complaints procedures***  
***The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.***

**Theme:**  
Person-centred care and support

**Outstanding requirement(s) from previous inspection(s):**  
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**  
A major non-compliance has been identified in relation to this outcome as this is the third consecutive inspection that the management of complaints was not sufficiently robust.

The complaints policy for the centre clearly outlined the different stages of the complaints investigation process. The independent appeals process was included and contact details for the office of the ombudsman. The complaints procedure was prominently displayed in the centre.

The complaints log was reviewed by the inspectors who saw that complaints were recorded. The results of the investigation process and actions taken on foot of a complaint were clearly laid out. The records indicated if the complainant was satisfied with the outcome, and this had been identified as an area for improvement at the last inspection. However, HIQA had received unsolicited information from various sources detailing complaints that they had raised which were not addressed. These complaints were discussed at the feedback meeting and it was evident that complaints from staff were not logged and various issues raised by residents and relatives were not logged as they were not viewed as formal complaints.

The policy had been amended to reference a nominated person, other than the person in charge, available in a designated centre to ensure that all complaints are appropriately responded to and that the person in charge maintains the records specified under in Regulation 34 (1)(f). However inspectors did not find evidence that the nominated person fulfilled the role as the audit of the complaints process was signed by the person in charge.

**Judgment:**  
Non Compliant - Major

***Outcome 15: Food and Nutrition***

***Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.***

**Theme:**

Person-centred care and support

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

No actions were required from the previous inspection.

**Findings:**

This outcome was reviewed following the receipt of some information relating to the availability of adequate choices, drinks and snacks.

Inspectors reviewed a sample of care plans relating to nutrition. While in the main they were specific and used to inform care delivered, inspectors saw that in one case the interventions listed were not taking place. In addition, inspectors saw that some residents required a daily record of their fluid intake and output while others required a food diary to be maintained to monitor foods taken. These are discussed under Outcome 11.

Otherwise inspectors saw that food was properly prepared, cooked and served, and was wholesome and nutritious. Inspectors reviewed a sample of menus and saw that adequate choices were available at each meal. Information received had suggested that residents who stayed in their room were not offered drinks mid-morning or afternoon. Inspectors saw that at the time of inspection, drinks were offered to these residents and residents spoken with said they were always offered a choice.

Inspectors visited the kitchen and saw that it was well organised and had a plentiful supply of food.

Inspectors saw that residents had been reviewed by a speech and language therapist or dietician if required. Inspectors read the treatment notes and observed practices and saw that staff were using appropriate feeding techniques as recommended. Inspectors saw that there was adequate staff to provide assistance in a discreet and sensitive manner if required.

**Judgment:**

Compliant

***Outcome 16: Residents' Rights, Dignity and Consultation***

***Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful***

*activities, appropriate to his or her interests and preferences.*

**Theme:**

Person-centred care and support

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

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

**Findings:**

This outcome was reviewed following receipt of information regarding lack of activities for residents.

On arrival in the centre inspectors saw that activities were underway in the day room. Two staff members were there and were providing hand massages and nail care to residents. Inspectors saw that the programme for other activities for the day was on display in the front hall. This included reading of newspapers, the rosary, a movie etc. Records were maintained of residents' participation in the various activities.

Residents spoken with said they were happy with the activities being provided. Some resident's liked to stay in their rooms and inspectors saw that one to one sessions were held.

Inspectors had received information regarding lack of newspapers and therefore lack of paper reading but inspectors saw that three papers were available on the day of inspection and the newspaper reading had taken place.

Inspectors saw that residents' meetings were held on a regular basis. Agenda items discussed included activities available, menu choices and outings. Inspectors saw that other issues were also discussed such a weeding the patio area. The inspector saw where this was logged for maintenance and addressed.

Residents now had access to advocacy services and some residents were availing of this at the time of inspection. Inspectors read a memorandum of understanding signed by the centre and the independent advocacy services.

A previous issue with lack of facilities for in-house voting had been addressed. The person in charge had now ensured that all residents who wished were registered to vote and could do so in the centre or in their own locality.

Religious activities took place on a weekly basis. The person in charge said that residents from all religious denominations were supported to practice their religious beliefs. Residents told inspectors how much they enjoyed this.

Inspectors were satisfied that each resident's privacy and dignity was respected. Staff were observed knocking on bedroom, toilet and bathroom doors and waiting for permission to enter. Inspectors observed staff interacting with residents in a courteous manner at all times during the inspection.

**Judgment:**

Compliant

***Outcome 18: Suitable Staffing***

*There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.*

**Theme:**

Workforce

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

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

**Findings:**

The action agreed from the previous inspection had not been fully implemented. The agreed arrangements for the supervision of staff had not been consistently implemented and supervision was not adequate to ensure that appropriate care was given and care plans were implemented.

Handover arrangements had been revised to ensure that staff were available to attend to residents at shift changeovers. All staff had attended hand hygiene and infection control training. Regular cleaning audits were carried out with significant improvements evidenced.

Adequate supervision of staff was still not evident. The action plan following the last inspection identified that there would be a qualified nurse allocated to take responsibility for the supervision of care in each of the three wings. Staff told inspectors that two nurses were usually allocated to a wing each and they normally shared responsibility for a third wing but occasionally the person in charge was available to supervise care in the third wing. Alternative arrangements for the supervision of staff included the creation of three senior care assistant posts. Despite this, inspectors were not satisfied that there was adequate supervision of staff. This was evidenced earlier in the report by failure to fully implement care plans. In addition, although random audits of call bell response times were carried out, inspectors noted that on the day of inspection a call bell from a resident's room rang for 12 minutes before it was responded to.

Copies of rosters given to the inspectors showed that staffing on the day of inspection were normal arrangements.

Staff turnover was high in the past year and the many of the staff were newly recruited.

Sick leave rates were low.

Staff outlined the daily routine to inspectors. There was a handover at each shift change and another handover to update all staff each afternoon. Healthcare assistants were allocated to a specific wing and the two nurses were allocated a wing each and they shared responsibility for a third wing. Once residents were up and about, the care assistants were allocated to other duties, such as supervision of residents in the day room, taking meals to residents and supporting residents to walk.

Records demonstrated that staff were up to date with mandatory training and had also received additional training such as wound care and cardio pulmonary resuscitation and basic life support training. Inspectors observed that staff used appropriate manual handling techniques and staff interviewed confirmed that staff adhered to the instruction on residents' manual handling charts, including the appropriate use of hoists and sliding sheets.

There were effective recruitment processes in place and staff were suitably inducted. Staff interviewed confirmed that new staff spent an initial period working with experienced staff. Annual appraisals were conducted for all staff; the process would be improved if it was linked to personal and professional development of staff.

The person in charge stated that there were four volunteers in the centre and they each had garda vetting in place and a written agreement outlining their role and level of involvement in the centre.

**Judgment:**  
Substantially Compliant

## Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

### Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

### *Report Compiled by:*

Sheila Doyle  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority

## Health Information and Quality Authority Regulation Directorate

### Action Plan



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

<b>Centre name:</b>	Ashley Lodge Nursing Home
<b>Centre ID:</b>	OSV-0000009
<b>Date of inspection:</b>	20/02/2017
<b>Date of response:</b>	10/03/2017

### Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non-compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

### Outcome 02: Governance and Management

#### Theme:

Governance, Leadership and Management

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

The systems in place to review and monitor the quality of care were not adequate. Internal audits were not conducted as part of an audit cycle to monitor and improve the quality of care. Although there was evidence that data was being collected there was no evidence that the collected data was collated and analysed to monitor trends and inform continuous quality improvements.

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

**1. 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.

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

The quality review for 2016 is now complete. This review has enabled a comprehensive evaluation of the home and the development of an action plan for 2017.

The PIC in agreement with the operations manager has developed an audit schedule. Audits for Health & Safety, Catering, Clinical Documentation, Home Management, Medication Management, HR & Finances and Infection Control are now scheduled to occur throughout the year. However if incidents increase in any of these departments then an additional audit will take place. All audits will have a METRIC statement and will focus on identifying and addressing recurring issues. Action plans with SMART objectives will be developed from each audit. A full set of independent audits have now been completed and these will form the baseline for future audits and action plans. The operations manager will supervise the delivery and timely achievement of these action plans. The introduction of a METRIC system will enable the PIC to analyse the data collated from audits and monitor trends and track results and implement improvements where needed.

A full review of the roles and responsibilities of clinical staff is now underway. This includes education for nursing staff on delegation and supervision and the identification of early warning signs of resident deterioration. The roster now identifies a team leader on each shift for each team. The mid-day and evening handovers augment the delegation. The nurse in charge of each shift gives a hand over to the PIC and on a Monday morning a report from the weekend is communicated to the team coming on duty and including the PIC (a new weekend report form has been developed for this purpose). This handover form includes the number of residents in-house, transfers, admissions, discharges, complaints, compliments, falls, wounds, incidents, notifiable events etc. This ensures continuity and enables the PIC to supervise the care for each resident. This will also be reviewed by the operations manager on a weekly basis to further ensure that all follow ups or interventions are complete.

Proposed Timescale: Immediate and ongoing

**Proposed Timescale:** 03/03/2017

**Theme:**

Governance, Leadership and Management

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

Inspectors found evidence during the course of this inspection that the management structure was not sufficiently robust to assure the quality and safety of the service. Examples included lack of knowledge of the residents accommodated at the centre,

inadequate system of recording and managing monies raised during the course of a Christmas raffle, inadequate systems of risk management, and an annual review of the centre contained information related to a different centre. In addition of 16

## **2. 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.

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

Immediately following the inspection a new system was introduced. All events which involve residents' monies will be co-ordinated and managed by two people. One will be a staff member and one will be a resident representative (e.g. relative). Records of incomings and outgoings will be retained for audit and for viewing at the request of any resident, relative or staff member. Receipts will be issued for all transactions. This will become an item on all meeting agendas in order to ensure that everyone is kept fully informed.

We now include the number of residents in the handover reports so that each shift is up-to-date.

The PIC is now working with a risk consultant on learning and reviewing the risk management system in its entirety. This includes risk identification, risk measurement, risk reduction and the development of an overall culture of risk management.

The quality review for 2016 is now complete. This review has enabled a comprehensive evaluation of the home and the development of an action plan for 2017. This includes a focus on enhancing the risk management system, staff development of all grades and subsequent implementation of safe supervision practices and enhancement of resident participation and activities.

Again this review is available for viewing by residents and their representatives. It will also be added as an item agenda on all meetings or 2017 so that the action plans can be reviewed on a regular basis.

Proposed Timescale: Immediate and Complete.

**Proposed Timescale: 10/03/2017**

## **Outcome 03: Information for residents**

### **Theme:**

Governance, Leadership and Management

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

It was unclear in some contracts how much was being charged to individual residents for additional services.

**3. 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:**

There were 3 unsigned contracts of care on the day of inspection and these are now returned. We ask that residents or their representatives return these as soon as possible after admission to the home.

The contract of care details what each resident pays for services.

Proposed Timescale: Complete and Ongoing

**Proposed Timescale: 10/03/2017**

**Outcome 05: Documentation to be kept at a designated centre**

**Theme:**

Governance, Leadership and Management

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

Some practices were not in line with the policy in place.

**4. Action Required:**

Under Regulation 04(1) you are required to: Prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.

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

All schedule 5 policies are being reviewed with staff to ensure that they are being adopted correctly.

Proposed Timescale: Immediate and ongoing.

**Proposed Timescale: 10/03/2017**

**Theme:**

Governance, Leadership and Management

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

There was no evidence of garda vetting in one of five files reviewed.

**5. 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:**

The information required under Schedule 2 of the Health Act 2007 is now complete and all files now contain up to date Garda Vetting. An induction/recruitment tracker has now been introduced so that the documentation required to be held for each staff member is monitored and tracked and obtained in a timely manner.

Proposed Timescale: Complete

Proposed Timescale: 10/03/2017

**Outcome 07: Safeguarding and Safety****Theme:**

Safe care and support

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

The assessment of residents with responsive behaviours was not in line with the centre's policy. The ABC charts (assessment charts) were not completed and analysed to inform a care plan for the resident. A resident's care plan advised staff to be vigilant for triggers which may precede a violent episode, but did not identify what the triggers might be.

**6. Action Required:**

Under Regulation 07(1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.

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

All staff including the PIC have now completed a refresher education session on responsive behaviour. This was facilitated by an education consultant. Responsive behaviours are recorded in the weekly report so that the PIC can follow up and ensure that ABC charts and care plans are being recorded and kept up-to-date.

Proposed Timescale: 10/03/2017

**Outcome 08: Health and Safety and Risk Management****Theme:**

Safe care and support

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

Not all risks were identified and assessed. For example, there was an electric socket installed for the hairdressing room which also had a shower.

Cleaning trolleys and equipment were stored in the sluice rooms when staff went on break.

Arrangements were in place for investigating and learning from incidents and adverse events involving residents and staff. However improvements were required for monitoring that controls put in place to address risks were implemented. Inspectors found that an unattended trolley with cleaning chemicals was left open in the public area even though this presented a significant risk for a particular resident.

**7. Action Required:**

Under Regulation 26(1)(a) you are required to: Ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.

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

Maintenance were alerted on the day of the inspection to replace the sockets in the hairdressing salon with waterproof sockets, and disable and blank the shower. This work was carried out that evening.

Cleaners have been informed to store trolleys in the locked store rooms while on break, and also to remove any inappropriate items from the sluice rooms. Cleaners have also been informed that the container on the trolley must be closed and the trolley kept in sight at all times. This has been added to the risk register and will be monitored daily by the PIC.

In conjunction with the risk management consultant and the operations manager the risk register is being updated and will be kept under regular review.

**Proposed Timescale:** 10/03/2017

**Theme:**

Safe care and support

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

It was not evident from fire safety records that any simulated evacuation had been undertaken or that fire drills were conducted to ensure that staffing levels at night were sufficient to undertake and emergency evacuation.

**8. Action Required:**

Under Regulation 28(1)(e) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and residents are aware of the procedure to be followed in the case of fire.

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

Simulated fire evacuations and fire drills have now been undertaken. These will take place on a 6 monthly basis.

**Proposed Timescale:** 10/03/2017

### **Outcome 09: Medication Management**

**Theme:**

Safe care and support

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

The maximum dosage for administration of medication a 24 hour period for PRN (as required) was not consistently documented.

**9. 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:**

Amendment has now been made to the individual kardex which did not have the maximum dosage for administration of PRN medication in a 24 hour period.

**Proposed Timescale:** 10/03/2017

### **Outcome 10: Notification of Incidents**

**Theme:**

Safe care and support

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

HIQA not been notified of one incident relating to hospitalisation of a resident.

**10. Action Required:**

Under Regulation 31(1) you are required to: Give notice to the chief inspector in writing of the occurrence of any incident set out in paragraphs 7(1)(a) to (j) of Schedule 4 within 3 working days of its occurrence.

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

All incidents and notifiable events are now recorded weekly through the handover from nursing staff to PIC and PIC to operations manager. In addition to this all notifiable events and timelines for reporting same are being displayed in the nurses station.

**Proposed Timescale:** 10/03/2017

## Outcome 11: Health and Social Care Needs

### Theme:

Effective care and support

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

The systems in place to ensure that care plans were implemented were found to be weak.

The interventions listed in some care plans were not taking place.

Some residents required a daily record of their fluid intake and output while others required a food diary to be maintained to monitor foods taken. Several of these were incomplete, gaps in recording were evident.

### 11. Action Required:

Under Regulation 06(1) you are required to: Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

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

The PIC has now introduced a system of recording clinical care indicators so that changes to any residents condition can be acted upon immediately. The resident with an ongoing weight loss identified by the inspectors has now had their weight management and care plan updated. A full review of this resident's care plan has taken place by the Person in Charge.

A system has been put in place for the daily recording of fluid and food intake and output charts. These charts are kept in the nurses station and are now totalled and monitored by nursing staff at the end of each shift.

Care plan audits are now part of the audit schedule.

The nutrition support team (SALT and Dietician) have been asked to review all residents and nursing staff are currently working with them on ensuring that all care plans are both up-to-date and implemented.

Proposed Timescale: Immediate and ongoing

Proposed Timescale: 10/03/2017

## Outcome 12: Safe and Suitable Premises

### Theme:

Effective care and support

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

Storage space for equipment was inadequate and equipment such as bed-wedges and a

high support chair and a mattress were stored in one of the bathrooms.

There were three sluice rooms, one in each wing. Inspectors found that there was no racking system for the storage of bedpans and urinals any of the sluice rooms.

Curtains in the sun room were faded and torn.

**12. Action Required:**

Under Regulation 17(1) you are required to: Ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.

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

New racks for the storage for the bed pans and urinals in the sluice rooms are being installed on 13/03/17. Alternative and more appropriate storage space for equipment has been allocated. The PIC together with the operations manager have agreed an up-keep schedule and the curtains identified will be replaced immediately.

Proposed Timescale: Complete

**Proposed Timescale: 10/03/2017**

**Outcome 13: Complaints procedures**

**Theme:**

Person-centred care and support

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

This is the third consecutive inspection that the management of complaints was not sufficiently robust.

**13. Action Required:**

Under Regulation 34(2) you are required to: Fully and properly record all complaints and the results of any investigations into the matters complained of and any actions taken on foot of a complaint are and ensure such records are in addition to and distinct from a resident's individual care plan.

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

In order to ensure transparency a duplicate complaints book has now been introduced. Residents and their representatives have been informed that all complaints will be written down in their presence. They will retain one copy of the complaint, the home will retain the other. The complainant will sign the duplicate copy when the complaint has been dealt with and tick whether or not they are satisfied with the outcome. This book will be monitored by the operations manager. Quarterly the complaints will be analysed to establish if there are any recurring issues.

Proposed Timescale: Immediate and Ongoing

Proposed Timescale: 10/03/2017

### Outcome 18: Suitable Staffing

**Theme:**  
Workforce

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

Inspectors were not satisfied that there was adequate supervision of staff.

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#### **14. Action Required:**

Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

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

Nursing staff and the PIC are scheduled to attend an in-house delegation and supervision workshop 12/03/17. The PIC is now identifying a team leader on each shift and for each allocation. The mid-day handovers will continue. The weekend handover report form will ensure continuity. As part of this improvement plan all staff of all grades will attend an appraisal. Daily supervision and reporting will be enhanced by the PIC through the handovers, communication with the team leaders and the tracking of clinical care indicators.

Proposed Timescale: Immediate and Ongoing.

Proposed Timescale: 10/03/2017