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## Ratoath Manor Nursing Home, OSV-0000152, 4 January 2018

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**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Ratoath Manor Nursing Home
<b>Centre ID:</b>	OSV-0000152
<b>Centre address:</b>	Ratoath, Meath.
<b>Telephone number:</b>	01 825 6101
<b>Email address:</b>	ratoath@silverstream.ie
<b>Type of centre:</b>	A Nursing Home as per Health (Nursing Homes) Act 1990
<b>Registered provider:</b>	Ratoath Nursing Home Limited
<b>Provider Nominee:</b>	Joseph Kenny
<b>Lead inspector:</b>	Catherine Rose Connolly Gargan
<b>Support inspector(s):</b>	None
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	61
<b>Number of vacancies on the date of inspection:</b>	2

## About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 2 day(s).

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

From:	To:
04 January 2018 09:45	04 January 2018 17:00
05 January 2018 09:30	05 January 2018 15:00

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	Compliant
Outcome 03: Information for residents	Compliant
Outcome 05: Documentation to be kept at a designated centre	Compliant
Outcome 07: Safeguarding and Safety	Substantially Compliant
Outcome 08: Health and Safety and Risk Management	Substantially Compliant
Outcome 09: Medication Management	Substantially Compliant
Outcome 11: Health and Social Care Needs	Substantially Compliant
Outcome 12: Safe and Suitable Premises	Non Compliant - Moderate
Outcome 14: End of Life Care	Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Non Compliant - Moderate
Outcome 18: Suitable Staffing	Substantially Compliant

**Summary of findings from this inspection**

This unannounced inspection took place to monitor the centre's ongoing compliance with the regulations and standards. The inspector also followed up on progress with completion of the action plans from the previous inspection in January 2017. The inspection findings confirmed that seven of the 11 action plans were satisfactorily completed. The four remaining actions had been progressed. Unsolicited information was received by the Health Information and Quality Authority in November 2017 regarding staffing, restraint management, management of residents' monies kept in safekeeping and additional fees charged to residents. The concerns expressed regarding management of residents' pocket money or charges of additional undisclosed fees by the provider were not substantiated. Some aspects of restraint management and staffing were found to require improvement and are discussed in the report.

The inspector met with the person in charge, staff members and residents during

the course of the inspection. Documentation records such as the centre's policies, medication management, risk management, fire safety procedures and records, audits, staff training records and residents' records were reviewed among other documentation.

There were appropriate systems in place to manage and govern the service. The provider and person in charge held responsibility for the governance, operational management and administration of services and provision of sufficient resources to meet residents' needs. Comprehensive oversight of the quality and safety of the service was demonstrated with good evidence of continuous quality improvement, resulting in positive outcomes for residents. However, refurbishment of the first floor needed to be progressed as a matter of urgency as the environment was unsuitable and impacted on residents' quality of life, comfort and individual choices. This had been highlighted on previous inspections.

Residents who spoke to the inspector expressed satisfaction with the service provided, care given and the staff team in the centre. Residents confirmed that they felt safe in the centre. All interactions by staff with residents were courteous, respectful and kind. There was evidence that residents' feedback was welcomed and valued.

All staff were facilitated to attend mandatory safeguarding training and systems were in place to ensure residents were appropriately safeguarded. Arrangements to meet residents' activation needs required improvement to ensure sufficient facilities and activity coordination staff were provided. In addition residents' individual interests and capabilities did not sufficiently inform the activities facilitated to meet their needs.

Residents' healthcare needs were met to a good standard. Residents had timely access to medical and allied health professional care to meet their needs. Staff were knowledgeable regarding residents and their individual needs.

The Action Plan at the end of this report identifies improvements that must be made to meet the requirements of 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 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):**

No actions were required from the previous inspection.

**Findings:**

A clearly defined management structure was in place which was outlined in the centre's statement of purpose document. Lines of authority and accountability were also defined and each member of the staff team were aware of their roles, responsibilities and reporting arrangements. A monthly governance meeting schedule was in place attended by the provider representative. The provider representative carried out regular unannounced visits to the centre. The provider representative attended residents' meetings, residents' celebration parties in the centre and a quarterly forum for residents' relatives. The person in charge demonstrated a high standard of service oversight. A proactive approach to risk management was demonstrated and was a standing agenda item at all meetings. Inter-team communication was promoted by staff meetings at each level, chaired by the person in charge. There was evidence that improvements progressed were made in consultation with residents and that their views were welcomed and valued.

There was good evidence of continuous quality improvement informed by ongoing monitoring of the quality and safety of the service. There was a robust system in place to ensure that the service provided was safe, appropriate to residents' needs, consistent and regularly monitored. Action plan developed from audits completed to review the quality and safety of a number of key areas were tracked and progressed to completion. A weekly review of key clinical parameters was collated by the person in charge and demonstrated low levels of falls by resident and development of pressure related skin injuries.

While sufficient resources were provided to ensure the effective delivery of resident care and service as described in the centre's statement of purpose document, refurbishment plans in progress for the first floor environment required progression to negate the negative impact on residents' quality of life.

**Judgment:**  
Compliant

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

**Findings:**  
Residents' contracts of care were revised since the last inspection in January 2017. Each resident had a contract that described the terms and conditions of their care and welfare in the centre. The inspector reviewed a sample of residents' contracts and found them to be signed and dated. The fees and additional fees to be charged including for specialist equipment such as hip protectors, falls sensor mats, chair and bed alarms were documented in the sample of contracts reviewed. Residents' activation provision was included as an additional fee levied on residents accommodated in the centre under the terms of the 'Fair Deal' scheme. A physiotherapist was employed by the provider and all residents had initial assessments completed free of charge. Follow-up consultations were provided at a significantly reduced cost.

A resident's guide was available to each resident which advised them of the services provided including summary details regarding the complaint process and arrangements for fire safety in the centre. A copy of this document was also made available in the reception area of the centre.

**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

<p><b>Outstanding requirement(s) from previous inspection(s):</b> The action(s) required from the previous inspection were satisfactorily implemented.</p> <p><b>Findings:</b> The information as required by Schedule 1 of the regulations was documented in the centre's statement of purpose document.</p> <p>Staff files reviewed contained the information as required by Schedule 2 of the regulations including evidence of completed Garda Siochana vetting procedures.</p> <p>The directory of residents as required by Schedule 3 of the regulations was maintained in an accessible electronic format. All items of information were consistently recorded for each resident in the centre.</p> <p>Other records to be maintained in respect of each resident and otherwise as described by schedules 3 and 4 of the regulations were in place and were stored securely.</p> <p>All of the written operational policies as required by Schedule 5 of the Regulations were available and up to date. These policies were accessible to staff to inform their practice.</p>
<p><b>Judgment:</b> Compliant</p>

***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

<p><b>Outstanding requirement(s) from previous inspection(s):</b> No actions were required from the previous inspection.</p> <p><b>Findings:</b> Arrangements were in place to ensure residents were safeguarded and protected from abuse. A policy informed management of any suspicions, allegations or incidents of abuse to residents. The policy was demonstrated in practice since the last inspection in January 2017. Staff spoken with by the inspector were knowledgeable regarding the different types of abuse and their responsibility to report. Staff told the inspector that there were no restrictions to them reporting any incidents that they may suspect or witness. Training records confirmed that all staff had attended mandatory training in protection of residents from abuse. All interactions observed by the inspector by staff with residents during the days of this inspection were respectful and kind. Residents</p>
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spoken with told the inspector that they felt safe and secure in the centre.

There were a small number of residents with medical condition that predisposed them to experiencing episodes of responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). There were no significant responsive behaviours evident on the days of inspection which provided assurances that residents' needs were supported. Assessments had been completed and were used to inform person-centred behavioural support care plans for these residents. The information provided in recently reviewed behavioural support care plans documented in the centre's electronic data management system identified the behaviours, triggers to the behaviours and the most effective person-centred interventions to be used to de-escalate any incidents. Residents were referred appropriately and had good access to the community psychiatric services. Use of PRN (a medicine only taken as the need arises) psychotropic medicines was documented in residents' behavioural support care plans as a last resort when other de-escalation strategies failed. Use of PRN psychotropic intervention was closely monitored by the person in charge or her deputy to ensure administration was appropriate in each case.

A restraint-free environment was promoted in the centre. Restraint use was informed by a centre-specific restraint policy that reflected the national restraint policy. Bedrails were used when alternative less restrictive equipment failed to meet residents' needs. Risk assessments were completed to ensure each resident's safety while using a bedrail and safety checking procedures were in place. Arrangements were also in place to ensure regular review of ongoing appropriateness of bedrail use. However, improvement was necessary in the records of safety checking procedures and alternative equipment to full-length bedrails tried. Low-level beds, foam floor mats and sensor alert equipment were used as alternatives to bedrails for a number of residents. Some residents used lap belts, which were attached as part of their assistive chairs and were used to promote their safety.

The provider was the agent for collection of 14 residents' social welfare pensions. The accounting process was demonstrated on the last inspection by the financial controller for the group. The procedures and processes for collection of these residents' social welfare pensions on their behalf by the provider were transparent and reflected recommended best practice. Small amounts of money for some residents' day to day expenses were kept in safekeeping on their behalf. This money was kept in a locked safe. The inspector checked a sample of documented balances against money held and found them to be accurate in each case. All entries were signed with two signatures. The system in place was found to be sufficiently robust to protect residents and staff.

**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:**

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

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

**Findings:**

The health and safety of residents, staff and visitors was protected and promoted. Health and safety and risk management was a standing agenda item on meetings at all levels. A Health and Safety committee met on a quarterly basis. The meetings were minuted. A full time maintenance person worked on-site and completed a schedule of inspections including hot water temperatures, fire safety and the environment to identify any areas for repair which were appropriately actioned.

There was a up-to-date safety statement available for the centre. A risk management policy was available and the specified risks as outlines in regulation 26 were mitigated with controls that were demonstrated in practice. A risk register was maintained that identified and assessed internal and external risks and hazards. Controls were described to mitigate potential for any adverse incidents to residents, visitors and staff. The inspector observed that all risks and hazards were identified with the exception of a door to a communal shower on the first floor and a door to a communal toilet on the ground that opened out into circulating corridors. These doors posed a risk of injury to vulnerable residents or visitors. However, there was evidence that the risk/hazard register was regularly reviewed and updated. Clinical risks such as residents using restraint, bedrails and residents engaging in smoking among others were identified with controls in place to ensure residents' safety. Potentially hazardous areas such as sluice rooms and the laundry were secured at all times to prevent unauthorized access.

All incidents and accidents involving residents, staff and visitors were logged and reviewed. All incidents or accidents that involved an injury to residents were reviewed through a serious incident review process. Areas for learning were identified and tracked through to completion to prevent recurrence.

Fire safety checking procedures were in place and no gaps were observed. Fire doors and exits were unobstructed and ramps and handrails were in place external to fire exits to ensure residents with reduced mobility could exit safely if necessary. All residents had evacuation risk assessments completed and documented. Residents' evacuation risk assessments took account of any underlying diagnosis or impairment that could delay their safe evacuation. Regular and consistent servicing of fire equipment was demonstrated that included the fire panel, fire alarm, emergency lighting, directional signage and smoke/heat sensor equipment. Documentation reviewed confirmed they were in working order. Equipment including fire extinguishers and blankets were available at various points throughout the centre. Fire evacuation drills were completed at regular intervals and reflected testing of day and night-time resources and conditions to ensure residents could be safely evacuated in an emergency. Fire safety training was completed by all staff, as confirmed by the staff training records and staff spoken with by the inspector regarding the emergency procedures in the event of a fire. Residents' bedroom doors were fitted with self closure devices.

The centre was visibly clean. Hand hygiene facilities were located throughout the premises and were used by staff as necessary. Environmental cleaning procedures were reviewed since the last inspection to ensure the procedure reflected best practice. The procedures for segregating clean and soiled linen in the centre's laundry were reviewed since the last inspection. The person in charge and the provider acknowledged that further improvements were necessary to ensure appropriate segregation of clean and soiled linen. The provider proposed to upgrade the laundry as part of a refurbishment plan. Interim measures were implemented pending completion of this work. Missing and damaged paint on wall surfaces in the laundry and stained, cracked and broken tiles on the flooring in the laundry and drying room areas were replaced. This action ensured this environment could be cleaned effectively. Wheelchair cleaning procedures had been satisfactorily implemented. An infection control policy informed procedures for management of communicable infection and infection outbreak to guide and inform staff. Staff including cleaning and laundry staff were facilitated to attend training on infection prevention and control procedures.

**Judgment:**

Substantially Compliant

***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:**

Residents were generally protected by safe medicine management practices. Action was in progress and nearing completion to ensure appropriate storage of a mobile medicine storage trolley. A medicines management policy informed practices in the centre. Residents' prescribed medicines were reviewed at least on a three-monthly basis. Administration of specified medicines such as antibiotics and psychotropic medicines was tracked as part of the weekly clinical information collated and reviewed by the person in charge. The person in charge completed medicine management audits at regular intervals. Deficits identified were corrected and learning was implemented in practice.

The inspector observed medicine administration to residents on this inspection. The nurse administered residents' medicines on a individual basis from the medicine storage trolley and recorded those taken by residents as prescribed in line with professional guidelines. All medicines to be administered in a crushed format were individually prescribed. However as found on the two previous inspections, nursing staff were administering medications prescribed for PRN (a medicine only taken as the need arises) use, although the maximum permissible amount of these medicines was not consistently indicated by the prescriber. This finding is actioned in outcome 11 of this report.

Procedures were in place to record the date of opening of residents' topical creams/ointments and oral liquid medicines to ensure they were not used beyond the timescales recommended by the manufacturer. Procedures were also in place to ensure medicines no longer used by residents in the centre were removed from the medicines trolley and discarded appropriately.

The pharmacist dispensing residents' medications was facilitated to fulfil their obligation. Residents had access to a local pharmacist and the pharmacist was available to meet with residents as they wished. The pharmacist undertook regular audits of medicine management procedures in the centre.

**Judgment:**

Substantially Compliant

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

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

**Theme:**

Effective care and support

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

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

**Findings:**

Residents healthcare needs were met to a good standard. There were 61 residents accommodated in the centre on the days of this inspection. Greater than 50% of residents had a diagnosis of dementia.

Residents were provided with timely access to appropriate services to meet their health needs. Residents had good access to a local general practitioner (GP) service. A GP surgery was located within close proximity to the centre and the GP attended residents as necessary. While residents had access to out of hours GP care, a fee was charged by the out of hours GP service to all residents including residents with medical cards. The provider had made efforts to address this charge on behalf of residents without success. Residents had access to allied health professionals including occupational therapy, physiotherapy, speech and language and dietician services. Psychiatric services attended residents in the centre as necessary. Although not attending any residents on the days of inspection, the person in charge confirmed that residents had access to palliative care services. Residents were also supported to attend out-patient appointments. Recommendations made by these services were documented in residents' care plans as found on the inspector's review of a sample of residents' care plans. As discussed in outcome 9, administration of medicines on a PRN basis by nurses did not reflect

professional practice guidelines and required review. Residents spoken with expressed their satisfaction with the service provided and staff caring for them.

The inspector found on this inspection that arrangements were in place to meet residents' assessed healthcare needs. Residents' care needs were assessed on admission and regularly thereafter using a variety of risk assessment tools to inform residents' individual needs. This information informed care plans that described the care interventions to be delivered to meet each resident's identified needs. Transfer of residents' records to an electronic data management system was in progress and at an advanced stage. Staff training support was in place. The inspector found that the information in care plans developed in the electronic data management system were clear, person-centred and informative regarding residents' care needs including behavioral support care plans. However, improvement continued to be required to the activity care plans for residents with needs that were not met in group activity arrangements as discussed in outcome 16. Arrangements were in place to ensure care plans were reviewed on a three to four-monthly basis or more often in response to residents' changing needs. Residents' care plan reviews were documented and referenced discussion with them or their relatives as appropriate.

Residents' risk of unintentional weight loss was assessed on admission and regularly thereafter. Residents with unintentional weight loss were closely monitored and their needs were met with appropriate interventions as recommended by the dietician and speech and language therapy services. Resident at risk of falling were also closely monitored. Residents' risk of falling was assessed on admission and reviewed thereafter on a four monthly basis or as their needs changed. The centre's physiotherapist reviewed all residents at risk of falling and following a fall incident. Key information on resident falls was collated and analysed to inform risk management and staffing resources. The inspector observed that there was a low incidence of residents falling and sustaining injuries necessitating their transfer to hospital for further treatment. The inspector observed staff reminding residents to wear their shoes/slippers when mobilizing. Residents were appropriately supervised by staff. Specialized equipment to reduce their risk of fall and injury was used including hip protection, low level beds and sensor floor mats.

There were no incidents of pressure related skin ulcers developing to residents in the centre. One resident had a wound that was being managed in the centre with the support of a tissue viability nurse specialist. A skin breakdown risk assessment was completed for each resident on their admission and was updated regularly thereafter. Equipment such as pressure relieving mattresses and cushions in addition to care procedures including repositioning schedules were used as prevention strategies. Arrangements were in place to ensure any residents with wounds were assessed by staff using an appropriate measurement system which assessed size, type, and exudates and included a treatment plan to inform care procedures. Wounds were photographed to monitor their progress. Tissue viability, dietician and occupational therapy specialists were available as necessary to support staff with management of wounds that were slow to heal or deteriorating.

There were procedures in place to promote residents' good health and to prevent unnecessary hospital admissions. Residents' health was promoted by annual influenza

vaccine, regular vital sign monitoring and regular exercise as part of their activation programme. Staff were trained to provide subcutaneous fluid administration to treat residents with acute episodes of dehydration. No residents were receiving this therapy on the days of inspection.

**Judgment:**

Substantially Compliant

**Outcome 12: Safe and Suitable Premises**

*The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.*

**Theme:**

Effective care and support

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

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

**Findings:**

Some aspects of the design and layout of the units on the first floor did not meet their stated purpose in terms of communal facilities provided for residents including insufficient shower/bath facilities in St Oliver's unit on the first floor and access arrangements between both floors. Significant efforts were made since the last inspection to make the fabric of the environment interesting, colourful, varied and stimulating for residents with dementia and other conditions that impacted on residents' cognitive function. However, the variety of and space available in communal areas in both units on the first floor precluded all residents sitting or dining together at the same time. There were insufficient facilities to meet residents' recreational needs on the first floor. There was no alternative area that could be freely accessed by residents to meet their relaxation or dining needs, this finding impacted negatively on their quality of life and how their needs were met. Residents' accommodation in the centre was arranged in three separate units on two floor levels. While a lift was provided for access between floors, the doors to the lift required manual operation and as such the lift was not reasonably accessible for most residents. The lift could not accommodate a stretcher or bed. The provider had already identified these areas as requiring improvement and had plans in progress to extend and refurbish the lift and first floor accommodation. Refurbishment of the laundry was also included in these plans.

Residents' accommodation on the ground floor was arranged in 17 single and two twin occupancy bedrooms. Twelve single bedrooms had ensuite toilet and hand basin facilities, four of which had an ensuite shower facility provided. Both twin bedrooms had ensuite toilet and hand basin facilities and one had an ensuite shower facility available. There were sufficient communal toilet and shower/bath facilities located at various locations to meet the toilet and wash needs of residents who did not have ensuite

bedroom facilities. Residents on the ground floor had access to a spacious communal sitting room, a dining room and a smaller quieter sitting room where they could also meet their visitors in private if they wished. Residents had access to an enclosed garden accessible from the sitting and dining rooms.

St Patrick's unit was located on the first floor. Residents' accommodation in St Patrick's unit consisted of one twin and 20 single bedrooms. Four of the single bedrooms had ensuite toilet and wash basins fitted and two of which had a shower facility. There was one twin bedroom available with an ensuite toilet and wash basin facility in this unit. There were sufficient communal toilet and shower/bath facilities located at various locations to meet the toilet and wash needs of residents who did not have ensuite bedroom facilities. Residents in St Patrick's unit had access to a sitting room, a dining room and a smoking room. This arrangement did not provide sufficient communal space to meet the sitting/dining or recreational needs of residents in this unit. Most residents in this unit had a diagnosis of dementia and did not have sufficient facilities to rest in an alternative quieter area outside of their bedrooms. Although accessible through the smoker's room, residents could access an outdoor area if they wished.

St Oliver's unit was also located on the first floor. Residents' accommodation in this unit consisted of five twin and 10 single bedrooms. Two single bedrooms had ensuite toilet, wash basin and shower facilities. Residents' washing facilities were provided for with one shower and one bath facility and required review to ensure the needs of residents who did not have ensuite bedroom facilities. Residents in St Oliver's unit had access to one sitting/dining room which was also used to meet their recreational needs. This communal room was noisy and busy. There was also insufficient space for more than ten residents to relax in a comfortable chair due to lack of space in the sitting/dining room. This arrangement did not provide sufficient communal space to meet the sitting/dining or recreational needs of residents in this unit. Most residents in this unit had a diagnosis of dementia and did not have sufficient facilities to rest in an alternative quieter area outside of their bedrooms. Residents could access an outdoor area if they wished.

A spacious oratory and hairdressing facility were located on the ground floor. The centre was warm and well ventilated.

Areas of the centre accessible to residents were found to be well maintained and in a good state of repair. The laundry area had been repainted and broken/missing floor tiles were replaced since the last inspection in January 2017. While interim arrangements had been implemented, the layout and design of this facility did not meet best practice laundry standards.

Handrails were fitted in communal circulating corridors and on both sides of corridors on the first floor with ramped floor surfaces. Additional grab-rails were fitted in communal and en-suite showers/bathrooms and toilets since the last inspection. Sufficient storage facilities were available for residents' equipment such as assistive chairs, hoists and commodes. Residents were provided with assistive equipment to meet their needs.

**Judgment:**

Non Compliant - Moderate

***Outcome 14: End of Life Care***

***Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.***

**Theme:**

Person-centred care and support

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

No actions were required from the previous inspection.

**Findings:**

A policy document was in place to inform residents' end-of-life care needs. Three residents were receiving end-of-life care on the days of inspection. Although community palliative care services were not involved in these residents' care at the time of this inspection, the person in charge told the inspector that this service was available to residents as necessary. A pain assessment tool was used to inform assessment and monitoring of residents' pain. A member of staff had advanced training in palliative care.

Residents' end-of-life wishes were documented in their care plans and referenced their spiritual, psychological and physical needs and their wishes regarding the place for receipt of care.

Arrangements were in place to facilitate residents' families to stay overnight in the centre with them when receiving end-of-life care. The centre's oratory was available to residents for funeral. A church was located in the community within close proximity to the centre. Residents had good access to religious clergy to meet their faith needs. An annual remembrance service was held to remember residents who had deceased during the year.

**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):**

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

**Findings:**

Residents were consulted in relation to the running of the centre by means of regular meetings and feedback surveys on various aspects of the service. There was evidence that their views were sought regarding some refurbishment work done to date. An independent advocate attended the centre on a one to two weekly basis and brought residents' views to the person in charge on their behalf. The person in charge and her deputy spent significant amounts of each day among residents to gain their feedback on the service provided and to ensure residents' needs were met.

Two activity coordinators had overall responsibility for coordinating residents' activation in the centre. The inspector was told that there was an arrangement in place where care staff assisted them with facilitating the scheduled activities. Four staff including the activity coordinators had completed courses in an accredited sensory based programme to support the needs of residents with cognitive impairment and dementia. However, one activity coordinator was on leave and the majority of residents did not have opportunity to attend the scheduled group or one-to-one activities on the first morning of the inspection. This finding is discussed further in outcome 18. Greater than 50% of residents in the centre on the days of this inspection had a diagnosis of dementia and resided on the two units on the first floor. A significant number of these residents' needs necessitated one-to-one interaction. Although residents past interests informed the group activities provided, the inspector observed that there was a high proportion of residents who did not participate in the group activities available on the days of inspection. For example, a music session provided on the afternoon of the first day of the inspection was attended by less than 50% of residents in the centre. A schedule of activities was displayed but did not meet the needs of residents with dementia. Although in process since the last inspection, life histories were not completed for each resident. An activity programme was not individually documented to inform the needs of residents who remained in their bedrooms, and/or had one-to-one activation needs. Facilitation of a accredited sensory based activation session was increased to four times per week since the last inspection. Residents' attendance at activities was recorded. The process for recording residents' levels of engagement in activities was been reviewed to ensure their needs were met.

The layout and space of communal areas on the first floor did not support residents to meet their recreational needs. There were sufficient facilities to facilitate one-to-one activities in both units on the first floor. A small number of residents on St Patrick's unit had hand massage in the sitting room. However there was no alternative quieter room available in either unit on the first floor. The communal sitting/dining room on St Oliver's unit was over-crowded and very noisy on both days of the inspection. The television and a CD player were on in the room. There was also insufficient space for more than ten residents to relax in a comfortable chair due to lack of space in the sitting/dining room. These findings negatively impacted on residents' quality of life and dignity. The lack of sufficient communal space is discussed and actioned in outcome 12.

Residents were facilitated to meet their religious and spiritual needs. Prayers were held each day for residents. Residents had access to clergy to meet their faith needs. Large notice boards were located in convenient locations advising residents on useful information that may be of interest to them.

The inspector observed that staff got consent from residents for all care activities and gave them choice regarding their daily activities in the centre. The inspector observed staff knocking on residents' bedroom doors and closing doors to bedrooms and toilets during personal care activities to ensure their privacy needs were met. Residents were provided with discreet assistance. The inspector observed that staff interactions with residents were respectful, courteous and supportive.

**Judgment:**

Non Compliant - Moderate

***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):**

No actions were required from the previous inspection.

**Findings:**

The numbers and skill mix of staff were reviewed on this inspection. The person in charge told the inspector that residents' dependency levels among other assessment parameters were used to inform staffing numbers and skills in the centre. There was evidence that additional staffing was employed to meet increased resident needs as necessary. However, activity coordination hours were not replaced when an activity coordinator was on planned leave during the week of the inspection. The inspection findings confirmed that this arrangement had a negative impact on the level of activities arranged and facilitated for residents.

An actual and planned staffing roster was in place. The roster reflected the staff on duty on the days of inspection. Residents spoken with confirmed that staff responded quickly to their call bells and their care needs were satisfactorily met.

Staff received an annual appraisal which was used to inform their training needs and resources. The assistant director of nursing was mostly rostered on a supernumerary basis and focused her time on supporting and supervising care of residents by staff across the centre. Recruitment policies and procedures were in place to inform practice and were supported by an induction programme for new staff to the centre.

Staff training records and discussions with staff evidenced their attendance at

mandatory and professional development training.

A sample of staff employment files were reviewed by the inspector and were found to be complete as required by Schedule 1 of the regulations. The provider confirmed that all staff including volunteers were appropriately vetted. The inspector found that all staff were well-informed and knowledgeable regarding residents' needs and their care plan interventions.

**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:***

Catherine Rose Connolly Gargan  
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>	Ratoath Manor Nursing Home
<b>Centre ID:</b>	OSV-0000152
<b>Date of inspection:</b>	04/01/2018
<b>Date of response:</b>	26/01/2018

### 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 07: Safeguarding and Safety

#### Theme:

Safe care and support

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

Improvement was necessary in the records of safety checking procedures and alternative equipment to full-length bedrails tried

#### **1. Action Required:**

Under Regulation 07(3) you are required to: Ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the

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

website of the Department of Health from time to time.

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

Safety checks are in place for residents using restraint. These checks will be reviewed to ensure completeness of the form, and ensure staff understand the function of the form and importance of seeking to reduce the use of restraint.

We will endeavour to source half-bed rails as recommended by the inspector as an alternative to full-length bedrails and trial these.

**Proposed Timescale:** 30/03/2018

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

**Theme:**

Safe care and support

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

Doors to a communal shower on the first floor a communal toilet on the ground floor that opened out into circulating corridors. posed a risk of injury to vulnerable residents or visitors.

**2. 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:**

This risk has now been included in our risk register, to include measures in place to mitigate the risk these doors pose. Signage has been put in place to alert users of the building to be careful when opening these doors from inside these rooms.

**Proposed Timescale:** 26/01/2018

**Theme:**

Safe care and support

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

Further improvements were necessary to ensure appropriate segregation of clean and soiled linen.

**3. Action Required:**

Under Regulation 27 you are required to: Ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.

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

The interim measure put in place following the last inspection will remain in place until the extension works are completed. These works will be completed by 31/12/2020.

**Proposed Timescale:** 31/12/2020

**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:**

While action was in progress and nearing completion to ensure appropriate storage of a mobile medicine storage trolley, this was not completed on the days of inspection.

**4. Action Required:**

Under Regulation 29(4) you are required to: Store all medicinal products dispensed or supplied to a resident securely at the centre.

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

We have engaged our pharmacy services to design a cupboard solution to ensure appropriate storage of our mobile medicine storage trolley.

**Proposed Timescale:** 31/03/2018

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

**Theme:**

Effective care and support

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

Improvement continued to be required to the activity care plans for residents with needs that were not met in group activity arrangements

**5. Action Required:**

Under Regulation 05(3) you are required to: Prepare a care plan, based on the assessment referred to in Regulation 5(2), for a resident no later than 48 hours after that resident's admission to the designated centre.

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

An audit of all care plans will be carried out to ensure all residents have an activity care plan in place to meet their needs including residents who cannot or wish not to participate in group activities. These care plans will be reviewed at least 3 monthly or as the residents condition changes.

All new residents will have a full and comprehensive assessment on admission and an activities care plan developed.

An SOP will be developed to guide carers and the activity coordinators to document how these activity needs have been met on a regular basis within the resident care plan. Training of this will provided to care staff and activity co-ordinators on this SOP

**Proposed Timescale:** 31/05/2018

**Theme:**

Effective care and support

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

Administration of medicines on a PRN basis by nurses did not reflect professional practice guidelines and required review.

**6. 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:**

Full pharmacy and nursing review will take place on 7th February. Following completion of this review the nursing staff will meet with the resident GP after every visit to ensure that the maximum dosage of PRN medication is charted properly.

Compliance of this will be monitored by the PIC quarterly to ensure staff are following up with the GP to ensure PRN medication is charted correctly.

**Proposed Timescale:** 28/02/2018

**Outcome 12: Safe and Suitable Premises**

**Theme:**

Effective care and support

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

Some parts of the design and layout of the units on the first floor did not meet the needs of residents on the first floor due to

- the variety of and space available in communal areas in both units on the first floor precluded all residents sitting or dining together at the same time.
- there was insufficient facilities to meet residents' recreational needs on the first floor.
- There was also insufficient space for more than ten residents to relax in a comfortable

chair due to lack of space in the sitting/dining room.

- there was no alternative area that could be freely accessed by residents to meet their relaxation needs
- there was insufficient shower/bath facilities in St Oliver's unit on the first floor
- the doors to the lift required manual operation and as such the lift was not reasonably accessible for most residents
- the laundry facilities did not reflect best practice laundry standards.

#### **7. Action Required:**

Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

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

Currently each resident has a full and comprehensive assessment on admission and at least 3 monthly of their needs to include their social needs. Based on this assessment RESIDENTS are supported by staff to use all communal areas in the home which includes 3 large day rooms, visitor sitting room, chapel, and reception seating area.

We will also trial opening the door between the two units on the first floor to see how this improves the residents day to day lives. This will be carried out on a phased basis to ensure the safety of the residents.

There are 2 communal baths and one communal shower in St Oliver's to meet residents needs.

A fully automated replacement of the lift is part of our extension works to be completed by 2020.

The interim measure put in place in the laundry following the last inspection will remain in place until the extension works are completed. These works will be completed by 31/12/2020.

**Proposed Timescale:** 31/12/2020

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

#### **Theme:**

Person-centred care and support

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

The layout and space of communal areas on the first floor did not support residents to meet their recreational needs.

#### **8. Action Required:**

Under Regulation 09(2)(a) you are required to: Provide for residents facilities for occupation and recreation.

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

Currently each resident has a full and comprehensive assessment on admission and at least 3 monthly of their needs to include their social needs. Based on this assessment residents are supported by staff to use all communal areas in the home which includes 3 large day rooms, visitor sitting room, chapel, and reception seating area.

We will also trial opening the door between the two units on the first floor to see how this improves the residents day to day lives. This will be carried out on a phased basis to ensure the safety of the residents.

Further communal space will be provided when the extension works are completed

**Proposed Timescale:** 31/12/2020

**Theme:**

Person-centred care and support

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

Some residents' activation needs were not met in accordance with their interests and capabilities.

Although in process since the last inspection, life histories were not completed for each resident.

A suitable activity programme was not individually documented to inform the needs of residents who remained in their bedrooms, and/or had one-to-one activation needs.

**9. 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:**

All resident care plans will be reviewed to ensure each resident, including those who cannot or wish not to participate in group activities, has an activity care plan in place that meets their activation needs. These care plans are prepared following their assessment of needs on admission and updated or reviewed at least 3 monthly or when a residents condition changes.

Life histories will now be sought for residents on admission and tracked by the PIC to ensure all residents have a life history in place.

**Proposed Timescale:** 31/03/2018

**Outcome 18: Suitable Staffing**

**Theme:**

Workforce

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

The arrangement not to replace activity coordination hours during periods of their planned leave negatively impacted on the standard with which residents' activation needs were met.

**10. 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:**

All planned leave by the Activity Co-ordinator will be covered going forward. As regards all unplanned leave, we will endeavour to provide cover for such leave.

**Proposed Timescale:** 26/01/2018