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Rivervale Nursing Home, Old Birr Road, Rathnaleen, Tipperary.

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**Health Information and Quality Authority
Regulation Directorate**

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



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|---|--|
| Centre name: | Rivervale Nursing Home |
| Centre ID: | OSV-0000425 |
| Centre address: | Old Birr Road, Rathnaleen, Tipperary. |
| Telephone number: | 067 50426 |
| Email address: | rivervalenh@gmail.com |
| Type of centre: | A Nursing Home as per Health (Nursing Homes) Act 1990 |
| Registered provider: | Rivervale Nursing Home Ltd |
| Provider Nominee: | |
| Lead inspector: | Julie Hennessy |
| Support inspector(s): | Louisa Power |
| Type of inspection | Unannounced |
| Number of residents on the date of inspection: | 37 |
| Number of vacancies on the date of inspection: | 6 |

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.

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 Quality 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: 11 November 2015 07:30 To: 11 November 2015 15:30

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

| Outcome | Our Judgment |
|---|--------------------------|
| Outcome 02: Governance and Management | Non Compliant - Moderate |
| Outcome 04: Suitable Person in Charge | Compliant |
| Outcome 05: Documentation to be kept at a designated centre | Non Compliant - Major |
| Outcome 07: Safeguarding and Safety | Non Compliant - Major |
| Outcome 08: Health and Safety and Risk Management | Non Compliant - Major |
| Outcome 09: Medication Management | Non Compliant - Major |
| Outcome 11: Health and Social Care Needs | Substantially Compliant |
| Outcome 18: Suitable Staffing | Non Compliant - Moderate |

Summary of findings from this inspection

This report sets out the findings of an unannounced monitoring inspection. The purpose of the inspection was to monitor on-going compliance with the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations (as amended) and to follow up on failings identified at the previous inspection.

The previous inspection of this centre was carried out on 1 December 2014 and focused on the prevention and control of healthcare associated infections. At the previous inspection, the provider had not ensured that procedures, consistent with the National Standards for the Prevention and Control of Healthcare Associated Infections were implemented by staff and the failing was found to be at the level of major non-compliance at that time. At this inspection, inspectors found that overall significant improvement had been made to address the failings previously identified. However, further improvement was required in relation to the prevention and control of healthcare-associated infections including in relation to an understanding of isolation procedures and practices, care planning and the monitoring and oversight of healthcare-associated infections.

However, of the eight outcomes inspected, four outcomes were found to be at the level of major non-compliance and these related to recruitment practices, management of challenging behaviour, fire safety and medication management.

Under outcome 5, recruitment procedures did not ensure that the information required under the Regulations was met prior to new staff commencing in the centre. A vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012, a written reference from their most recent employer and the current registration details of all nursing staff were not on file for all staff.

Under outcome 7, staff had not received training in the management of behaviour that challenges. Positive behaviour support plans were not adequate to guide staff to support residents with behaviour that challenges. Measures were not in place to identify and alleviate the underlying causes of behaviour that challenges. The use of restrictive practices was not in line with national policy.

Under outcome 8, it was not demonstrated that adequate fire precautions were in place. Fire drill records examined did not contain sufficient detail to adequately review the fire precautions in place for an evacuation of the centre. In addition, the arrangements in place for containing fires were inadequate as fire doors in bedrooms and living rooms were wedged open at night.

Under outcome 9, unsafe medicines management practices, especially in relation to the modification of compliance aids following receipt, were observed. Medicines were not administered to residents as prescribed and the prescriber was not appropriately informed where medicines were withheld. Medicines requiring refrigeration were not stored securely.

Other non-compliances related to governance and management of the centre, gaps in mandatory staff training and care planning. These are discussed in the body of the report and the required actions are outlined in an action plan at the end of this report.

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 Quality 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:

Inspectors reviewed the effectiveness of the management structure. The provider nominee is a registered nurse and demonstrated that she was fully involved in the running and operation of the centre. The provider nominee was present for this inspection.

The provider had demonstrated a willingness to address the failings identified at the previous inspection. Resources had been allocated to the centre in accordance with the statement of purpose and for the prevention and control of healthcare associated infections. Since the previous inspection for example, the laundry room had been re-configured and an additional hand wash sink had been installed in that room. The provider had also invested in staff training and in seeking the advice of external infection control specialists.

However, inspectors found a number of areas for development relating to governance and management of the centre. It was not clearly demonstrated that there were clear lines of accountability, specific roles and responsibilities for all areas of care provision. In addition, the person in charge was included in the daily rota and it was not demonstrated that this arrangement facilitated the effective operation, management and administration of the designated centre. This matter had been previously discussed with the provider. This is evidenced by gaps in medication management, mandatory training, the completion of required daily checks necessary to ensure the safety of residents and as discussed below, gaps in auditing and the annual review.

There were gaps in the knowledge of both the provider and person in charge of their responsibilities under the Regulations. For example, the provider told inspectors that she was aware that training in behaviour that challenges for all staff was mandatory training but due to difficulties maintaining staffing levels, was not planning on organising this

training until such difficulties were resolved. The person in charge told inspectors that required checks of the medication fridge and monthly fire drills had not been carried out because of the same difficulties.

Inspectors reviewed the management systems in place to ensure that the service provided was safe, appropriate, consistent and effectively monitored. Audits were being completed by the person in charge. While there was evidence of learning from infection control audits, other audits required improvement. It was not demonstrated that audits contributed to the monitoring and review of the quality and safety of care being delivered to residents. In addition, it was also not clear how audits assessed the standards of care being delivered as audits were not carried out using an accredited tool or against a specific policy, standard, national or best practice guidance. Medication management audits did not identify pertinent deficiencies and no actions had been identified in the most recent audits reviewed.

The annual review did not meet the requirements of the Regulations. The annual review did not assess whether care was delivered in accordance with relevant standards set by the Authority, nor had it been prepared in consultation with residents and their families. There was no plan in place to address any areas of concern.

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 with the required experience in the area of nursing older people and worked full-time in the centre. The person in charge demonstrated that she participated in continuous professional development and had attended courses in relation to food and nutrition and end of life care. She had also completed a 12-week accredited CPD module in infection prevention and control in a third-level university.

Failings relating to the role of the person in charge have been already discussed and addressed under Outcome 2, governance and management.

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):

No actions were required from the previous inspection.

Findings:

As a result of identified failings, aspects of this outcome were assessed on this inspection.

A sample of staff records were reviewed on this inspection. However, the information required under Schedule 2 of the Regulations had not been obtained for all staff. For example, a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 was not on file for one staff, nor was a written reference from their most recent employer. The current registration details of all nursing staff were not on file. Inspectors found that the lack of appropriate vetting of staff is at the level of major non-compliance.

Inspectors reviewed other records and documentation kept at the designated centre. While daily nursing notes and care plans were clear and directed the care to be given to residents, other documentation was disjointed and difficult to retrieve.

Inspectors observed that a number of policies were out of date (dated 2010), including policies related to fire prevention and risk management. In addition, the fire prevention policy did not outline the procedures to be followed in this centre in sufficient detail.

As outlined in Outcome 11: Medication management, the policy in relation to medicines management was not comprehensive. The policy did not outline the ordering, receipt and storage of medicines as required by Schedule 5. The policy did not include administration of medicines via non-oral routes.

As outlined in Outcome 11: Medication management, medication administration records were not always accurate. The records did not contain sufficient space to record all medicines administered and the time of administration was inaccurately recorded at times. Where a dose range was prescribed to be administered (e.g. 3.75mg-7.5mg), the actual dose administered was not recorded on the medication administration record.

Judgment:
Non Compliant - Major

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:
Only the aspects relating to positive behaviour support and the use of restrictive practices were examined as part of this inspection. Residents were provided with support that promoted a positive approach to behaviour that challenges. A restraint-free environment was promoted.

A centre-specific policy in relation to the management of behaviour that is challenging was made available to inspectors and had been reviewed in August 2015. The policy did not adequately the proactive and reactive strategies in place to support residents and the measures to be taken in order to identify and alleviate the underlying causes of behaviours that challenge. Records indicated and the person in charge confirmed that staff had not completed training in challenging behaviour.

An inspector reviewed a sample of care plans and saw that care plans had been developed to support residents with behaviours that challenge. Some of the care plans seen did identify specific triggers and guided staff in the use of reassurance and distraction techniques. However, some residents who required support with behaviours that challenge did not have a comprehensive care plan in place even though staff with whom the inspector spoke were knowledgeable in relation to the residents' needs and possible underlying causes for behaviour that challenges. Behaviour mapping was in place to ascertain possible triggers. However, the inspector noted some instances where the behaviours to be recorded had not been tailored to the individual resident and therefore triggers may not be accurately identified. The inspector also noted that, where a possible underlying cause for behaviour (pain) had been noted by the resident's doctor, evidence based pain assessment and monitoring tools were not implemented. Multi-disciplinary input was sought when appropriate.

There was a centre-specific policy on the use of resident restraint, but this did not reflect the national policy as published by the Department of Health. The policy had been reviewed in August 2015. Inspectors observed that bedrails and periodic chemical

restraint were in use.

In relation to the use of bedrails, the policy suitably detailed the ongoing monitoring and observation of a resident while a bedrail was in place and this was evidenced in practice. A risk-balance tool was completed for residents prior to the use of a bedrail, a care plan was developed and both were reviewed at least every four months. Inspectors noted that signed consent from residents was secured where possible and the use of bedrails was discussed with residents' representatives as appropriate. However, where a resident was unable to express their views in relation to restraint, it was not clear that a multi-disciplinary assessment had been completed and a decision had been made in the best interests of the resident.

In relation to the use of chemical restraint, strategies were in place to review prescriptions of PRN ('as required') diazepam every two weeks. However, some residents were prescribed other PRN psychotropic medicines and these were not reviewed in the same manner. Care plans reviewed by inspectors did not provide sufficient guidance to staff to ensure that PRN psychotropic medicines were only administered as a last resort. Alternative strategies to be trialled were not adequately outlined.

Judgment:
Non Compliant - Major

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

Findings:
The previous inspection focussed on the prevention and control of healthcare associated infections. Inspectors found that overall, significant improvement had been made to address the failings identified at the previous inspection. Some areas required further development or improvement and are discussed below where applicable. Where residents had a healthcare associated infection, arrangements were in place to communicate this information to staff. Since the previous inspection, changes to the layout of the premises now ensured that clean laundry was segregated from potentially contaminated laundry. Inspectors observed that hand hygiene opportunities were taken, staff were observed to use the correct technique. Inspectors also noted that audits had been carried out to inform good practice.

The policy on infection control policy had been developed and now included information

about specific healthcare associated infections and additional guidance for staff. However, policies required further development to ensure that they were specific to this centre.

Since the previous inspection, a review of the general cleaning arrangements had been completed by an infection control nurse, which had been implemented. Household staff had received training since the previous inspection in relation to environmental cleaning and hand hygiene.

An inspector observed that isolation procedures had been modified appropriate to this setting and practices in place were sensitive to the need to maintain a good quality of life for all residents living in the centre. However, the specific practices to be followed were not clearly outlined either in a policy or residents' care plans. In addition, the provider and person in charge did not demonstrate a clear understanding that the practices in place did constitute isolation. This was discussed with the provider and person in charge at the close of inspection in order to ensure that staff clearly understood why such procedures were being followed and how they might differ from isolation of residents for other healthcare associated infections such as influenza or norovirus (the flu or the 'winter vomiting bug').

Urinary catheter care bundles had been introduced and were being used. For example, the indication for its use, when a catheter was due to be changed, checks of the urinary catheter and when a catheter was removed were now clearly recorded and being monitored.

At the previous inspection, monitoring and oversight of healthcare associated infections was not adequate. At this inspection, inspectors found that this failing had not been adequately addressed. The person in charge told inspectors that advice from a Consultant Microbiologist had been sought but this was not documented anywhere. The quality improvement plan did not contain up-to-date objectives or goals. Risk assessments did not outline the measures and actions in place to control the risk from healthcare associated infections meaning that the effectiveness of controls in place was not being reviewed or monitored. In addition, inspectors observed unsafe practices around the management of sharps (needles, syringes). The container for safe disposal of sharps in the nursing station was above eye-level, making it difficult to tell when it was full. Inspectors observed that the lid of the sharps container was open and a syringe could be observed protruding from the bin. This is not in line with the centre's own policy or best practice for the safe use and disposal of sharps.

Other aspects of health and safety, including fire safety were inspected on this inspection. Inspectors found significant deficits in relation to fire safety practices, which were at the level of major non-compliance.

Staff had received training in relation to fire safety. According to the fire register, drills were meant to be practiced monthly, although no drill had taken place for the previous two months. The fire register specified that daily visual checks were to be completed, although these were being completed monthly and the fire risk assessment for the centre did not specify that it was adequate to only complete such checks monthly. The monthly checks required in the centre were being completed as required on a monthly

basis. The servicing of fire equipment and the fire alarm panel was up to date.

An inspector reviewed records of practice fire drills. The most recent practice fire drill had taken place on 24 June 2015. Practice fire drills involved staff sounding the alarm, assembling and checking the fire panel. Some practice fire drills were completed with a fire training consultant and involved a demonstration of how to discharge a fire extinguisher. However, records of practice fire drills for 2014 and 2015 indicated that no drill had simulated night-time conditions or night-time staffing levels. Fire drill records did not demonstrate that staff would know how to evacuate the centre in the event of a fire as evacuation (or simulation of same) did not form part of practice fire drills. In addition, personal evacuation plans were not prominently displayed or available for inspection.

Finally, the arrangements in place for containing fires were not adequate. Inspectors observed that fire doors in bedrooms and living rooms were propped open with door wedges throughout the centre at night.

Judgment:
Non Compliant - Major

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):
No actions were required from the previous inspection.

Findings:
The centre-specific policies relating to medication management was made available to inspectors and had been reviewed in August 2015. Staff with whom inspectors spoke demonstrated adequate knowledge of this document. However, the policy was not comprehensive and this is covered in Outcome 5: Documentation.

Medicines for residents were supplied by a local community pharmacy. There was evidence that the pharmacist was facilitated to meet his/her obligations to residents.

Inspectors noted that medicines were stored in a locked cupboard or medication trolley. The temperature of the refrigerator used to store medicines was noted to be within an acceptable range. The temperature of the refrigerator was to be monitored and recorded daily but gaps were noted in the recording sheets viewed by inspectors. The refrigerator was unlocked and located in the nurses' office and this room was observed to accessible to non-nursing staff.

Storage of controlled drugs was safe and in accordance with current guidelines and

legislation. The balance of controlled drugs was checked at the handover of shift at 08:00 and 20:00.

Compliance aids were used by nursing staff to administer medications to residents. An inspector examined a number of compliance aids and noted practices to be unsafe. The inspector saw and nursing staff confirmed that the compliance aids were modified following receipt from the pharmacy. Medicines were added and removed from the compliance aid by nursing staff. Therefore, the sheet supplied by the pharmacy outlining the medicines contained within the compliance aid was invalidated and identifiable information for the medicines added to the compliance aids was not present to allow nursing staff to identify individual medicines. A tamper proof seal was not present on the compliance aids which would prevent against medicines loss.

An inspector observed medication administration practices and found that the nursing staff did adhere to professional guidance issued by An Bord Altranais agus Cnáimhseachais. Staff reported and inspectors saw that no residents were self-administering medication at the time of inspection. The practice of transcription was not in accordance with professional guidance issued by An Bord Altranais agus Cnáimhseachais; this is further outlined in Outcome 11: Health and social care needs.

A sample of medication prescription sheets and administration records were examined by an inspector. Where medicines were to be crushed, this was individually prescribed. It was noted that oxygen prescriptions were not available for all residents receiving long term oxygen therapy (LTOT) to ensure that the correct concentration/volume of oxygen was being administered for the required time.

Medication administration sheets examined identified the medications on the prescription sheet, contained the signature of the nurse administering the medication and allowed space to record comments on withholding or refusing medications. However, medication administration records were not always accurate; this is covered in Outcome 5: Documentation. The inspector observed occasions where the times of administration did not match the prescription sheet. The inspector observed an incident where a medicine was prescribed to be administered every second day but had been not been recorded as administered for six days.

Where medicines were withheld and not administered, the prescriber was not appropriately informed. For example, a number of medicines which cause drowsiness were withheld for a resident on three consecutive nights. There was no record that the prescriber was contacted even though the prescriber had reduced the dose of one of the medicines due to possible side-effects and excessive drowsiness.

Nursing staff outlined the manner in which medications which are out of date or dispensed to a resident but are no longer needed are stored in a secure manner, segregated from other medicinal products and are returned to the pharmacy for disposal. An itemised verifiable audit trail was in place for these medicines.

A system was in place for reviewing and monitoring safe medicines management practices. Results of weekly medication management audits were made available to inspectors; this is covered in Outcome 2: Governance and management.

Inspectors saw that processes were in place for the identification, recording, investigating and learning from medication incidents.

Judgment:
Non Compliant - Major

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):
No actions were required from the previous inspection.

Findings:
There was evidence that residents' healthcare needs were met through timely access to medical treatment. Emergency treatment and out-of-hours medical services were also accessed as necessary.

Overall, inspectors found that each resident had a comprehensive nursing assessment completed on admission and every three to four months thereafter. Where needs were identified, care plans had been developed. Inspectors reviewed a number of care plans and found that overall they were comprehensive and specific to the individual. Some care plans however required further development to reflect the care to be given to an individual resident. The identified care need was not always clear, for example, a care plan indicated that a resident was receiving oxygen therapy but it was not clear why. Care plans for healthcare acquired infections required improvement and this was previously discussed under Outcome 8. The interventions outlined to meet the social care needs of residents who may have an intellectual disability were not accurate and the terminology used was inappropriate.

Residents' right to refuse treatment was respected and documented.

Residents' social care needs were met through a varied and meaningful activity programme. An activities co-ordinator visited the centre each day and for a half day at weekends. Activities offered included exercise classes, reading from the newspaper or book reading, gardening, completing quizzes and crosswords, bingo and art.

As outlined in Outcome 9: Medication management, the practice of transcription was not in accordance with professional guidance issued by An Bord Altranais agus

Cnáimhseachais as records were not dated by the transcribing nurse.

Judgment:
Substantially 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):
No actions were required from the previous inspection.

Findings:

A review of the rota demonstrated that staffing levels took into account the statement of purpose and the size and layout of the building. There was an actual and planned staff rota. According to the staff rota, there was a staff nurse on duty at all times. Inspectors observed on this unannounced inspection at 07:00 that there was one staff nurse and three carers at night-time, which was in accordance with the rota.

Staff training in relation to fire safety and the protection of vulnerable adults was up to date. All staff had received training in relation to hand hygiene. Eight staff required refresher training in people moving and handling and this was scheduled for the day following the inspection (12 November 2015). However, staff had not received mandatory training in relation to the management of behaviour that challenges. No date was scheduled for this training.

Other training had been delivered relevant to residents' needs. For example, individual staff members had attended training relevant to end of life care, food and nutrition, falls prevention and activities for older persons.

Judgment:
Non Compliant - Moderate

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:

Julie Hennessy
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

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|----------------------------|------------------------|
| Centre name: | Rivervale Nursing Home |
| Centre ID: | OSV-0000425 |
| Date of inspection: | 11/11/2015 |
| Date of response: | 09/12/2015 |

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:

It was not demonstrated that there were clear lines of accountability, specific roles and responsibilities for all areas of care provision:

The person in charge was included in the daily rota and it was not demonstrated that this arrangement facilitated the effective operation, management and administration of the designated centre.

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

In addition, there were gaps in the knowledge of both the provider and person in charge of their responsibilities under the Regulations.

1. Action Required:

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

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

The PIC is rostered to cover overall management of the Nursing Home including some Nursing duties when required. The Nursing staff, Care Staff, Catering Staff, Laundry Staff and cleaning staff all report to the PIC. The PIC then reports to the Provider and in the absence of the PIC the provider is also the deputy PIC.

Both the Provider and PIC will refresh their knowledge of their responsibilities under the regulations.

Proposed Timescale: 30/01/2016

Theme:

Governance, Leadership and Management

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

Overall, it was not demonstrated that audits contributed to the monitoring and review of the quality and safety of care being delivered to residents. In addition, it was also not clear how audits assessed the standards of care being delivered as audits were not carried out using an accredited tool or against a specific policy, standard, national or best practice guidance.

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:

To assist Rivervale Nursing home to deliver accredited tools for the monitoring and review of the quality of care being delivered to Residents an external audit consultant will be commissioned. This external audit consultant in association with the PIC will also assess how the audits assess the standards of care being delivered.

Proposed Timescale: 15/03/2016

Theme:

Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in

the following respect:

The annual review did not assess whether care was delivered in accordance with relevant standards set by the Authority,

3. 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:

We will ensure that the annual review (due 30th January 2016) assesses whether care is being delivered in accordance with the relevant standards

Proposed Timescale: 15/02/2015

Theme:

Governance, Leadership and Management

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

The annual review had not been prepared in consultation with residents and their families.

4. Action Required:

Under Regulation 23(e) you are required to: Prepare the review referred to in regulation 23(1)(d) in consultation with residents and their families.

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

We will prepare all future reviews in consultation with the Residents and their Families who wish to participate & who will be given the opportunity & facilitated to participate in the review.

The review report will be distributed & available.

Proposed Timescale: 15/01/2016

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:

Inspectors observed that a number of policies were out of date (dated 2010), including policies related to fire prevention and risk management. In addition, the fire prevention policy did not outline the procedures to be followed in this centre in sufficient detail.

5. Action Required:

Under Regulation 04(3) you are required to: Review the policies and procedures referred to in regulation 4(1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.

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

We are currently updating our Fire Prevention and Risk Management Policies which were created in 2010 but will record all updates to these & other policies going forward. We are updating our Fire Prevention policy in conjunction with Fire Prevention officer to ensure that it contains precise details on procedures to follow.

Proposed Timescale: 15/01/2016

Theme:

Governance, Leadership and Management

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

The policy in relation to medicines management did not outline the ordering, receipt and storage of medicines as required by Schedule 5. The policy did not include administration of medicines via non-oral routes.

6. 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:

The policy in relation to medication management is currently being updated to include the ordering, receipt and storage of medicines as required in schedule 5. The policy now includes other methods on the administration of medicines via non-oral routes.

Proposed Timescale: 30/01/2016

Theme:

Governance, Leadership and Management

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

The information required under Schedule 2 of the Regulations had not been obtained for all staff.

7. Action Required:

Under Regulation 21(2) you are required to: Retain the records set out in Schedule 2 for a period of not less than 7 years after the staff member has ceased to be employed in the designated centre.

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

Files for all Staff members are being reviewed to ensure all information under schedule 2 has been obtained and in date and will be retained for 7 years once employment has ceased.

Proposed Timescale: 09/12/2015

Theme:

Governance, Leadership and Management

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

Records and documentation were disjointed and difficult to retrieve.

8. Action Required:

Under Regulation 21(6) you are required to: Maintain the records specified in paragraph (1) in such manner as to be safe and accessible.

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

Will undertake a review of all records and documentation to ensure they are continuously stored in a safe, systematic, methodical manner and are readily accessible for retrieval purposes.

Proposed Timescale: 28/02/2016

Theme:

Governance, Leadership and Management

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

Medication administration records were not always accurate.

9. Action Required:

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

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

All medications administered will be recorded accurately as per prescriber's instructions and records will be routinely reviewed to ensure that accuracy is maintained.

Proposed Timescale: on-going

Proposed Timescale: 09/12/2015

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:

Records indicated and the person in charge confirmed that staff had not completed training in challenging behaviour.

10. 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:

Training in challenging behaviour has been sought and is scheduled to take place on January 8th & 12th 2016 and will be renewed every two years thereafter by an external trainer with ongoing In house training taking place regularly.

Proposed Timescale: 12/01/2016

Theme:

Safe care and support

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

The policy in relation to challenging behaviour did not adequately the proactive and reactive strategies in place to support residents and the measures to be taken in order to identify and alleviate the underlying causes of behaviours that challenge.

A comprehensive care plan in place was not in place for all residents with challenging behaviour.

Behaviour mapping was not always tailored to the individual resident and therefore triggers may not be accurately identified.

Where a possible underlying cause for behaviour had been noted, evidence based assessment and monitoring tools were not implemented.

11. Action Required:

Under Regulation 07(2) you are required to: Manage and respond to behaviour that is challenging or poses a risk to the resident concerned or to other persons, in so far as possible, in a manner that is not restrictive.

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

We will review the policy to ensure it adequately covers the proactive and reactive strategies in place to support residents and identify the triggers that result in the challenging behaviour

We have rechecked all care plans in place for residents with challenging behaviour to ensure that a comprehensive care plan is in place

We have revised the behaviour mapping in place for Residents to ensure that resident specific triggers are accurately identified using evidence based assessment and monitoring tools.

Proposed Timescale: 27/01/2016

Theme:

Safe care and support

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

The centre-specific policy on the use of resident restraint did not reflect the national policy as published by the Department of Health.

Where a resident was unable to express their views in relation to restraint, it was not clear that a multi-disciplinary assessment had been completed and a decision had been made in the best interests of the resident.

Care plans did not provide sufficient guidance to staff to ensure that PRN psychotropic medicines were only administered as a last resort. Measures in place to review PRN psychotropic medicines were not consistent.

12. 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 website of the Department of Health from time to time.

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

We will update our Restraint Policy to reflect National policy as published by the department of health.

We promote a Restraint free environment but in the event of a Resident unable to express their own opinion a multi-disciplinary assessment will be completed and decisions made in the best interest of the Resident.

The Care plans will be reviewed and updated to ensure that Nursing Staff have clear guidance on the use of PRN psychotropic medicines and that these are only administered as a last resort. All PRN psychotropic medicines will be reviewed by their GP on a two weekly basis.

Proposed Timescale: 30/03/2016

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:

Inspectors observed unsafe practices around the management of sharps (needles, syringes) that were not in line with the centre's own policy or best practice for the safe use and disposal of sharps.

13. Action Required:

Under Regulation 26(1)(b) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the risks identified.

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

The centre will ensure that we adhere to our own policy regarding sharps and will follow National best practice for the safe use & disposal of sharps.

Proposed Timescale: 09/12/2015

Theme:

Safe care and support

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

Further improvement was required by the provider to ensure that procedures, consistent with the National Standards for the Prevention and Control of Healthcare Associated Infections were implemented by staff:

Isolation procedures and practices to be followed by staff were not clearly documented;

Isolation procedures were not outlined in residents' care plans;

A clear understanding that the practices in place did constitute isolation was not demonstrated;

As detailed in the findings, monitoring and oversight of healthcare associated infections was not adequate.

14. 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:

We have reviewed the isolation policy to ensure that procedures and practices to be followed by staff are clearly documented.

The care plans are being reviewed and isolation procedures outlined as appropriate. We will ensure that correct isolation practices are in place and followed. We will ensure there is robust monitoring and oversight of healthcare associated infections.

Proposed Timescale: 20/02/2016

Theme:

Safe care and support

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

The arrangements in place for containing fires were inadequate. Fire doors that served as bedroom doors and TV/living room doors were propped open with door wedges throughout the centre at night.

15. Action Required:

Under Regulation 28(2)(i) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

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

We are in the process of fitting all fire doors with Dorgard which will close the door once the fire alarm sounds as the majority of our Residents wish to have their door in the open position rather than closed.

Proposed Timescale: 20/01/2016

Theme:

Safe care and support

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

As detailed within the findings, the fire drill records examined did not contain sufficient detail to adequately review the fire precautions in place for an evacuation of the centre.

16. Action Required:

Under Regulation 28(1)(c)(ii) you are required to: Make adequate arrangements for reviewing fire precautions.

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

We have arranged our Bi-annual fire training and evacuation procedure with our external Fire prevention officer. Training will take place on the 11th & 18th of December 2015.

Proposed Timescale: 15/01/2016

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:

Compliance aids were modified following receipt from the pharmacy. Medicines were added and removed from the compliance aid by nursing staff.

There were occasions where the times of administration did not match the prescription sheet and medicines were not administered as prescribed.

Prescriptions were not always available for residents receiving LTOT.

Where medicines were withheld and not administered, the prescriber was not appropriately informed.

17. 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:

Compliance aids will no longer be modified following receipt of them from the pharmacy. Any additional short term medicines prescribed will be stored in their original container and dispensed accordingly.

Prescriptions are now available for all residents receiving long term oxygen therapy. Following verbal confirmation from the prescribing doctor recommending the withholding of a prescribed medication it will be recorded in the narrative notes and in the Residents medication administration cardex.

Proposed Timescale: 09/12/2015

Theme:

Safe care and support

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

The refrigerator was unlocked and located in the nurses' office and this room was observed to be accessible to non-nursing staff. Gaps were noted in the daily recording of the refrigerator temperature.

18. 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:

As it is not possible to provide a lock for the existing pharmacy fridge we intend to purchase a new pharmacy fridge complete with locking system to replace the existing one

Proposed Timescale: 31/01/2016

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:

Some care plans however required further development to reflect the care to be given to an individual resident. The identified care need was not always clear, for example, a care plan indicated that a resident was receiving oxygen therapy but it was not clear why. Care plans for healthcare acquired infections required improvement. The interventions outlined to meet the social care needs of residents who may have an intellectual disability were not accurate and the terminology used was inappropriate.

19. Action Required:

Under Regulation 05(1) you are required to: Arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2).

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

We will review the care plan to ensure all care needs are accurately recorded and documented.

Where care needs are assessed the reason for the care need, the intervention for the care need and the goals for the care need will be documented

Proposed Timescale: 30/01/2016

Theme:

Effective care and support

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

The practice of transcription was not in accordance with professional guidance issued by An Bord Altranais agus Cnáimhseachais as records were not dated by the transcribing nurse.

20. 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:

In accordance with professional guidance issued by An Bord Altranais agus Cnáimhseachais transcriptions will be dated & signed by the transcribing Nurse.

Proposed Timescale: 09/12/2015

Outcome 18: Suitable Staffing

Theme:

Workforce

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

Staff had not received mandatory training in relation to the management of behaviour that challenges.

21. Action Required:

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

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

Training has been scheduled for January 8th & 12th 2016 for all Staff which will mandatorily updated every two years.

Proposed Timescale: 12/01/2016