Health Information and Quality Authority
Social Services Inspectorate

Inspection report
Designated centres for older people

Centre name:	Harvey Nursing and Convalescent Home
Centre ID:	0048
Centre Address:	25 Upper Glenageary Road Glenageary Co Dublin
Telephone number:	01-2800508
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Email address:	rosemary@harveyhealthcare.ie
Type of centre:	☒ **Private** ☐ **Voluntary** ☐ **Public**
Registered provider:	Ardeeshal Lodge Limited
Person in charge:	Rosemary McCann
Date of inspection:	23 and 24 November 2010
Time inspection took place:	**23 Nov Start:** 08:30 hrs **Completion:** 17:00 hrs **24 Nov Start:** 08:10 hrs **Completion:** 14:00 hrs
Lead inspector:	Angela Ring
Support inspectors:	Sheila Doyle (23 and 24 Nov); Linda Moore (23 Nov)
Type of inspection:	☒ **Registration** ☐ **Scheduled** ☒ **Announced** ☐ **Unannounced**

About inspection

The purpose of inspection is to gather evidence on which to make judgments about the fitness of the registered provider and to report on the quality of the service. This is to ensure that providers are complying with the requirements and conditions of their registration and meet the standards; that they have systems in place to both safeguard the welfare of service users and to provide information and evidence of good and poor practice.

In assessing the overall quality of the service provided, inspectors examine how well the provider has met the requirements of the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland* under the following topics:

1. Governance and leadership: how well the centre is organised.
2. The quality of the service.
3. How well the healthcare needs of residents are met.
4. Premises and equipment: appropriateness and adequacy.
5. Communication: information provided to residents, relatives and staff.
6. Staffing: the recruitment, supervision and competence of staff.

This report summarises the findings of the inspection under some or all of these topics, highlighting areas of good practice as well as areas where improvements were required as follows:

Evidence of good practice – this means that an acceptable standard was reached and the provider demonstrated a culture of review and improvement and aimed to drive forward best practice.

Some improvements required – this means that practice was generally satisfactory but there were areas that need attention.

Significant improvements required – this means that unacceptable practice was found.

The report also identifies minor issues, where applicable, to which the provider should give consideration to enhance the quality of the service.

Registration inspections are one element of a process to assess whether providers are fit and legally permitted to provide a service. The registration of a designated centre is for three years. After that the provider must make an application for registration renewal at least six months before the expiration date of the current registration. New providers must make an application for first time registration 6 months prior to the time the provider wishes to commence.

In controlling entry to service provision, the Chief Inspector of Social Services is fulfilling an important regulatory duty under section 40 of the Health Act 2007. Part of this duty is a statutory discretion to refuse registration if the Chief Inspector is not satisfied about a provider's fitness to provide services, or the fitness of any other person involved in the management of a centre.

The registration inspection is one element for the Chief Inspector to consider in making a proposal to the provider in respect of registration. Other elements of the process designed to assess the provider's fitness include the information provided in the application to register, the Fit Person self-assessment and the Fit Person interviews. Together these elements are used to assess the provider's understanding of, and capacity to, comply with the requirements of the Regulations and the Standards. Following assessment of these elements, a recommendation will be made to the Chief Inspector and the formal legal process for registration will proceed. As a result, this report does not outline a final decision in respect of registration.

The report is available to residents, relatives, providers of services and members of the public, and is published on our website www.hiqa.ie.

About the centre

Description of services and premises

Harvey Nursing and Convalescent Home has places for 32 residents, providing long-term residential care for older people, convalescent care and respite care. All of the residents were over 65 years on the days of inspection and the majority of residents had varying degrees of dementia.

Harvey Nursing and Convalescent Home is a two-storey building. On the ground floor are three single en suite bedrooms, six two-bedded rooms, three of which have en suite facilities and one three-bedded room with an en suite. There is a stair lift up to the first return of the stairs where there are two single bedrooms and a further stair lift up to the first floor. There are three single bedrooms on the first floor - one of these has an en suite, three two-bedded rooms with an en suite and a three-bedded room with an en suite. All ensuite facilities have showers, wash-hand basins and toilets.

There are four additional bathrooms, three of these are wheelchair accessible. There are two front facing sitting rooms, a dining room off the kitchen and a visitors' room. An enclosed courtyard is accessible from the dining room.

The centre is located on a main road with limited parking at the front.

Location

The centre is located on the main Glenageary road in Dun Laoghaire.

Date centre was first established:	2000
Number of residents on the date of inspection	29 (plus two in hospital)
Number of vacancies on the date of inspection	1

Dependency level of current residents	**Max**	**High**	**Medium**	**Low**
Number of residents	9	7	8	4

Management structure

The named providers are Seamus Brady and Derry Shaw. Noeline Kinnear is the Director of Care for the Harvey Healthcare Group of residential centres, Rosemary McCann the Person in Charge of the centre reports to the director of care. Maya Mathews is a senior nurse who deputises for the Person in Charge. The staff nurses, care assistants, catering staff and domestic staff report to the Person in Charge.

Staff designation	Person in Charge	Nurses	Care staff	Catering staff	Cleaning and laundry staff	Admin staff	Other staff
Number of staff on duty on day of inspection	1	2	6	2	1	0	1

Summary of findings from this inspection

This was an announced registration inspection and the third to be carried out by the Health Information and Quality Authority (the Authority). As part of the registration process, the providers and person in charge has to satisfy the Chief Inspector that they are fit persons and that they will comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended). Inspectors carried out fit-person interviews with the person in charge and the provider and received the fit-person self-assessment document which was completed in advance of this visit. All of this information was reviewed by inspectors, in addition to the information provided in the registration application form and supporting documents. Inspectors met with residents and relatives and reviewed documentation as part of the inspection process.

The centre was initially inspected in September 2009 and a follow-up inspection was carried out in March 2010. During this inspection, inspectors followed up on the actions required from the inspection in March 2010. These issues relation to improvements required in complaints management and ensuring that all necessary documentation was required for staff files. Inspectors found that the provider had completed the action on staff files and partially completed the action on complaints management. These are further discussed in this report.

Inspectors found that residents' health needs were well monitored and met. There were adequate staffing levels to meet residents' needs and the staff knew the residents very well. Inspectors found that residents were safe in the centre and risk was well managed.

There were some areas for improvement identified by the inspectors which are addressed in the Action Plan at the end of this report. These include developing the care planning process, improving complaints management, providing opportunities for meaningful engagement for dependent residents and updating the emergency plan.

Inspectors found that there was inadequate screening in shared rooms which compromised residents' privacy and dignity. This was brought to the immediate attention of the providers who put measures in place to address this issue. There were also some improvements required in the premises such as meeting the minimum requirements for bed space in the one of the three-bedded rooms and increasing storage facilities.

Comments by residents and relatives

Inspectors met with residents and relatives during the two days of inspection. All of the residents spoken to expressed satisfaction with the care they received.

Inspectors received thirteen completed questionnaires from residents and their relatives prior to this inspection. Overall, they were positive except for a small number of relatives saying that clothes were lost on occasion and there was very little private space for residents. These issues were addressed during the inspection.

Residents said they were very happy and said that there was plenty to do during the day and were satisfied their health needs were met. They described the staff as kind and friendly. One resident described the centre as “a home from home”. Residents said they felt safe and were happy living there.

Relatives said they were kept well informed of their family member’s condition, and were always made feel welcome. They all agreed that the centre was clean and well maintained and there was good quality of food served.

Both residents and their relatives knew the person in charge and the senior nurse and described them as being kind and approachable.

Overall findings

1. Governance: how well the centre is organised

Outcome: The centre is well organised and managed and complies with the requirements of the Health Act 2007, the Regulations and standards.

Good governance involves the effective and efficient deployment of resources in accordance with the stated purpose and function of the centre. Governance includes setting clear direction for the service, a commitment to continual improvement and having a system in place to effectively assess and manage risk.

Evidence of good practice

Inspectors reviewed the fit-person self-assessment prior to the inspection and found that it had been completed to a good standard by the person in charge, director of care and providers. It identified areas for improvement and there was evidence of some improvements made such as setting up an advocacy group, further development of care planning and auditing.

Inspectors carried out fit-person interviews with the providers and found that they were aware of their legal responsibilities. They demonstrated a commitment to continuous quality improvement and were seen interacting well with residents and relatives.

Inspectors found that the person in charge was supported in her role by the director of care and the two providers. There was a strong management structure and all grades of staff were aware of their reporting relationships. The nursing and care staff told inspectors that they felt well supported by the person in charge and the senior nurse and could approach them if they needed advice or assistance. There were satisfactory deputising arrangements for the person in charge with the senior nurse or director of care in charge in her absence.

Fire procedures were well managed. Inspectors reviewed the fire book and found that all staff had attended fire training in February and March 2010. There was also evidence of regular checks of fire fighting equipment, alarm testing, emergency lighting and fire doors. Staff were knowledgeable about fire and evacuation procedures. Inspectors reviewed a fire safety letter from a suitably qualified person which stated that the premises and fire procedures were in compliance with statutory requirements. The provider told inspectors that a fire expert visited the centre recently to ensure that all fire prevention precautions were put in place.

Inspectors looked at the directory of residents and found that it was updated to include all residents' details. The contract of care was reviewed by inspectors who found that it complied with the Regulations and contained details of additional fees to be paid by the resident. There was also an up-to-date insurance certificate.

Inspectors found that there was a policy on the prevention and detection of elder abuse, they spoke to staff who had received training and were aware of the procedures to follow in the prevention and detection and response to elder abuse.

Inspectors found that the senior nurse had a system for reviewing and improving the quality and safety of care provided to, and the quality of life of, residents in the centre. Inspectors found that the senior nurse carried out a weekly audit of some of the key quality indicators such as wounds, catheters, residents with pain and the number of residents on psychotropic drugs. The senior nurse explained that she used this information to closely monitor all issues in the centre and to identify patterns and areas for improvement. Inspectors saw evidence of this information being used to inform the pain management plan for a resident.

The person in charge told inspectors that she did not manage any residents' finances. Therefore inspectors did not review issue on inspection.

Inspectors reviewed the statement of purpose and Residents' Guide and although they contained most of the information required by the Regulations, including the services to be provided, it did not include details of the accommodation and room sizes. However, this was submitted to inspectors a short time after the inspection.

Inspectors carried out interviews with the director of care and the senior nurse. The senior nurse demonstrated an awareness of person-centred care and had recently completed a Level 6 course in Gerontology. During the interview, the senior nurse was asked what training is required for staff, she stated that additional training would be of benefit in caring for residents with dementia and caring for residents with behaviours that challenge. The director of care explained her role in supporting the person in charge on clinical issues and the sourcing of education and training programmes.

The complaints policy was read by inspectors and was found to be in compliance with the Regulations. There was an independent appeals process and the complaints policy was displayed in a prominent place for residents and relatives. Inspectors reviewed the complaints log and found that only verbal complaint was recorded and the person in charge told inspectors that they had never received a written complaint. Inspectors found that some improvements had been made in managing and responding to verbal complaints since the last inspection. The person in charge had started to record the interventions taken in response to the complaint and the outcome of the complaint. Staff told inspectors that complaints were discussed with them at report meetings and they were aware of the complaints procedure. Residents and relatives told inspectors that they knew who to speak to if they wished to make a complaint.

Some improvements required

Inspectors found that there was a copy of the Standards and the Regulations. However, the person in charge told inspectors that she does not regularly refer to these documents for guidance.

Inspectors found that although there was an emergency plan in place, it was not detailed enough to provide adequate guidance to staff on the procedures to follow in the event of an emergency such as an identified place for evacuation.

Inspectors reviewed the records of incidents and accidents and found that falls were recorded. However, inspectors found that there were inadequate arrangements in place for the identification, recording, investigation and staff learning from incidents involving residents, including falls. There was no formal process in place to analyse incidents to determine potential contributory factors or potential actions to be taken to reduce the incidence of falls.

The risk management policy complied with the Regulations as it addressed risks associated with self harm, residents absconding and assault. However, the policy stated that staff should meet on a three-monthly basis to discuss incidents and inspectors found that this did not happen in practice. Inspectors reviewed the safety statement and found that it identified environmental and clinical risks in the centre and the named person responsible for different issues.

2. Quality of the service

Outcome: Residents receive a good standard of service, appropriate treatment and are treated with courtesy and respect.

A quality service is one where residents are protected from harm or abuse, where practice is person-centred, where rights are protected, where residents are enabled to play an active part in the centre and where management, staff and residents work together towards continuous improvement.

Evidence of good practice

Inspectors observed staff speaking to residents in a kind and friendly manner. Residents' personal care needs were met and residents were well dressed, some of the female residents wore jewellery and make-up.

Inspectors found that there were some links with the community such as students visiting from local schools and a small number of residents went out for coffee on two occasions in the summer. Inspectors saw a poster inviting residents and their relatives to go to the National Concert Hall for a Christmas concert. Inspectors found that there were a small number of volunteer groups visiting the centre to carry out activities with residents. Inspectors met with one of these activity coordinators and she explained all of the activities that she encourages residents to partake in. These activities include music, singing, crosswords, cards, art, aromatherapy and SONAS (a therapeutic activity that is focused on communication). Inspectors reviewed documentation completed by the senior nurse which recorded the activities that residents engaged in each week.

Inspectors found that there were open visiting hours and relatives told inspectors that their relatives and friends were always welcomed.

Inspectors found that there was some flexibility in the residents' daily routine, mealtimes were flexible and residents were given breakfast when they wished during the morning.

Inspectors sat with residents during lunch and found that the food was hot and well presented, in adequate amounts and this included soft diets. Residents told inspectors that they enjoyed their meals.

Staff told inspectors that they had access to the kitchen at all times to make snacks for residents if required. There were plenty of drinks available to residents throughout the day.

Some improvements required

There were a significant number of residents with dementia and some of these highly dependent residents were seen sitting for long periods of time with little opportunity for meaningful occupation or engagement. Inspectors found that there were a small number of activities available to these residents such as SONAS and aromatherapy. Inspectors found that the staff did not have the necessary specialist skills and training to provide opportunities for meaningful engagement to highly dependent residents and to observe their response to different activities to determine what the residents enjoyed and found stimulating.

Inspectors found that a social and personal profile was completed on residents to record their past life history and to identify their hobbies and interests. While this was identified as good practice, the information was not used to develop an individual plan of activity and meaningful engagement for each individual resident.

There were limited opportunities for residents to take an active part in running the centre. There was a comment box placed in the entrance hall for relatives and visitors to make suggestions on how the centre could be improved, however this was not accessible to residents. The providers and person in charge informed inspectors about an advocacy group that was set up in January 2010 with one resident representative and two relative representatives. Inspectors reviewed the minutes and found that this group was in its initial phase and there was room for further development and improvement. The small number of residents on the group resulted in a lack of inclusivity and there was a risk that not all residents' views and opinions would not be represented.

Improvements were required in the dining experience for residents. The main dining room could not accommodate all residents, therefore some residents who required assistance had their meals on tables placed in front of them on trays in the day rooms and other residents decided to have their meals in the day rooms. Inspectors spent time in the dining room and in the day room. In the day room, inspectors found that some staff did not provide assistance in a dignified manner and there was no sense of a social dining occasion as residents ate separately in their chairs with a bed table placed in front and did not have an opportunity to engage with others during their meal. Inspectors found that the dining room was dark and cold on the first day of inspection but was warm on the second day of inspection.

3. Healthcare needs

Outcome: Residents' healthcare needs are met.

Healthcare is integral to meeting individual's needs. It requires that residents' health, personal and social care needs are assessed and reviewed on an ongoing basis, within a care planning process, that is person centred. Emphasis is firmly placed on health promotion, independence and meaningful activity.

Evidence of good practice

Staff promoted residents' health by encouraging them to stay active. Residents had weekly exercise classes and residents were seen walking about during the day.

A comprehensive pre-admission assessment was carried out by two senior members of the nursing staff on each prospective resident. This included assessments of care requirements. The resident and relatives were also invited to visit the centre prior to admission. Inspectors read the file of a resident recently admitted. This confirmed that assessment had been undertaken. In addition the centre had developed an admission checklist which reminded the admitting nurse of the necessary information to be given to the resident and the assessments to be undertaken.

Weight records were examined which showed that residents' weights were checked on a monthly basis or more regularly if required. Nutrition assessments were used to identify residents at risk of fluctuations in weight. Inspectors reviewed residents' records and saw where residents were reassessed if they had lost weight. There were records to indicate that there were assessments of pain and wound management was good. Records also showed that some residents had been referred for dietetic review and inspectors read where the outcome of this was recorded in the residents' care plan. Medication records showed that nutritional supplements were prescribed by a doctor and administered appropriately. Inspectors reviewed risk assessment tools being used by staff to identify residents at risk with swallowing difficulties and the action to be taken if the resident was identified as being a high risk.

Residents had regular access to medical services and out-of-hours medical cover was available. Residents and relatives told inspectors that they were satisfied with medical care provided. Inspectors reviewed medical notes which confirmed that general practitioners (GPs) attended residents both for routine review and sooner if the resident was unwell.

Residents had access to a range of peripatetic services. Physiotherapy, occupational therapy, speech and language therapy and dietetic services were available on a referral basis as were audiology services. Dental and optical services were provided locally or in house if required. Close working relationships had been established with the department of psychiatry of old age in a nearby acute hospital which provided on going support and advice on the management of behaviours that challenged. While reviewing residents' files, inspectors noted the referral requests, the reviews and treatment plans from these services.

There were audits completed on care planning and medication practices and records to identify potential errors and areas for improvement.

Some improvements required

Inspectors found evidence of good medication management processes. There were comprehensive medication management policies which provided guidance to staff. Inspectors joined nurses on part of their medication rounds and found that medication was administered in accordance with An Bord Altranais guidelines. There were no residents prescribed medications that required special control measures. Medication audits were completed on a monthly basis and all nursing staff were assessed for their competency in medication administration. However, inspectors reviewed the prescription sheets of residents who required their medication to be crushed and found that the medication was not prescribed as requiring crushing. A generic 'medication may be crushed' was written on the front of the medication sheet. Inspectors were concerned that this practice could increase the risk of medication errors. Inspectors spoke to staff who were unclear of the potential dangers of crushing medication that should not be crushed prior to administration. Inspectors also noted that all medications did not have an individual prescribing signature.

Inspectors read residents' care plans and found that comprehensive care plans were in place for all residents. Nurses also used risk assessments to prevent pressure ulcers, malnutrition and falls. Inspectors read the care plan of residents who had fallen and noted that the strategies to prevent reoccurrence had been implemented. Reviews were completed every three months and dated and signed by staff. However there was limited evidence of resident or relative involvement in the care plan development or review. Any resident spoken with was not aware of their care plan or its content. In addition, although a social assessment was undertaken, this was not reflected in the plan of care for each resident.

Inspectors found that some of the staff with FETAC (Further Education and Training Awards Council) Level 5 had received training on caring for residents requiring end-of-life-care, the majority of staff did not receive training. There was a policy on end-of-life care to guide staff.

Significant improvements required

Inspectors observed staff transferring residents from a wheelchair to an armchair in the sitting room using poor manual handling techniques on several occasions. The issue of staff using poor manual handling techniques was identified at the first inspection in September 2009 and was still not properly addressed by the person in charge.

Inspectors were concerned that the use of bed rails could result in injury to residents. There was a policy providing direction to staff on the use of restraint and it included a direction to consider all other options. However inspectors found that this policy was not used to inform practice. Inspectors reviewed the care plans of residents who were using bedrails and found that in each case reviewed, the reason for use was written as 'residents choice'. Inspectors were concerned that a full assessment had not been

undertaken or alternatives fully explored. In addition the use of bed rails was only routinely reviewed on a three-monthly basis.

Inspectors found that some residents were lying on pressure relieving mattresses and nursing staff were unaware of the procedures to use to calculate the setting on the mattress. This poses an increased risk for residents developing pressure ulcers.

4. Premises and equipment: appropriateness and adequacy

Outcome: The residential care setting provides premises and equipment that are safe, secure and suitable.

A good physical environment is one that enhances the quality of life for residents and is a pleasant place to live. It meets residents' individual and collective needs in a comfortable and homely way, and is accessible, safe, clean and well-maintained. Equipment is provided in response to the assessed needs of each of the residents and maintained appropriately.

Evidence of good practice

The building was clean throughout and nicely decorated. The day rooms were bright and well furnished, including paintings done by a resident.

Residents and their relatives said that clothes were laundered and returned promptly. Inspectors found that residents' clothes were labelled and a washing line was used to dry clothes outside which gave a domestic feel to the centre. Inspectors observed that a resident had written the menu and activity schedule for the week. Inspectors visited the laundry which is in an outdoor room on the grounds of the centre and found that there an industrial sized washer and dryer, a wash-hand basin and a sink. The care staff told inspectors that they are responsible for laundering residents' clothes during the day as part of their duties. The person in charge had introduced a new system of labelling clothes to prevent problems associated with clothes getting lost.

The kitchen was clean and well managed with adequate supplies of fresh food and vegetables and temperature recordings of food maintained. The chef demonstrated a good knowledge of residents' likes, dislikes and preferences and had completed training in food hygiene.

There was an outdoor secure paved courtyard at the rear of the centre with seating and raised beds. One of the residents was responsible for maintaining the garden and showed great pride in this task.

There were sufficient gloves and aprons available and hand gels were appropriately placed at several points throughout the centre to ensure that infection control precautions were adhered to by staff. Waste was well managed with procedures for clinical waste being stored in a locked bin outside.

There was a recently refurbished private space for residents to spend time alone, to meet with their friends and relatives and to make or receive a phone call. This issue had been identified at the previous inspection and was satisfactorily addressed by the providers.

Equipment was well maintained. The provider told inspectors that the staff carried out a weekly check of residents' call bells and light bulbs to ensure they are in good working order. The providers told inspectors that they have a maintenance team employed for all their centres and a robust reporting structure in place for reporting items requiring attention with a code system to indicate the risk associated with each item that required maintenance.

There were adequate changing facilities for staff and lockers provided for their belongings. There was a treatment room used to store clinical equipment.

Some improvements required

Inspectors found that there was a strict protocol on cleaning commode basins which staff were aware of and adhered to as there were no mechanical sluicing facilities. However, inspectors noticed that commodes were left beside some residents' beds throughout the day and night. This reduced the amount of space in residents' rooms, causing unnecessary clutter, and did not support the resident's right to privacy and dignity. This issue was also highlighted at the initial inspection in September 2009.

Inspectors found that the signage for residents with dementia was confusing. The building had a complex layout with several unmarked doors, which made it difficult for residents with dementia to navigate their way around. Most of the residents spent long periods of the day sitting in the day room, where their chairs were lined up against the wall giving an institutional appearance. This did not allow them to converse with each other and to socialise. There was no orientation board used to provide information on the day, date, staff on duty and the weather which would have helped to orientate residents with dementia.

Even though there was a separate toilet for kitchen staff, inspectors found that there were no specific toilet facilities for visitors or staff, therefore staff used a toilet in a bathroom where the shower was also used by residents which presented a risk of cross infection.

Inspectors visited some residents' bedrooms with their permission and found that some of them were personalised with their possessions. However, inspectors found that one of the two three bedded rooms did not meet the minimum space requirements in terms of space as identified in the Standards. The providers assured inspectors that there were plans in place to address this issue over the coming years.

Inspectors found that a small number of residents did not have access to a locked space in their bedrooms. This was also identified at a previous inspection and had only been partially addressed.

Inspectors found that there was inadequate storage space for equipment such as commodes, walking frames and wheelchairs. This could result in potential risk of falls for residents.

Even though there was a locked room for cleaning materials, some gardening chemicals were left outside which could have caused a risk to residents. This was brought to the attention of the providers who rectified it immediately.

Significant improvements required

Inspectors found that there was inadequate screening in place in some residents' rooms to ensure that residents' privacy and dignity was maintained. There were no screens between some beds and some of the screens were not long enough to provide adequate privacy. This was brought to the immediate attention of the providers and arrangements were put in place to address this issue the following day with new screens being fitted.

5. Communication: information provided to residents, relatives and staff

Outcome: Information is relevant, clear and up to date for residents.

Information is accessible, accurate, and appropriate to residents' and staff needs. Feedback is actively sought from residents and relatives and this informs future planning and service provision. Information is recorded and maintained in accordance with legal requirements and best practice and is communicated to staff on a need to know basis to ensure residents' privacy is respected.

Evidence of good practice

Inspectors found that there were good communication systems in place and staff said they were kept informed about issues arising in the centre. Staff told inspectors that they attended a daily report where each resident was discussed and they also attended regular staff meetings. Inspectors reviewed the minutes of these meetings and found that staff were kept informed of the importance of being up-to-date with the infection control guidelines, complaints procedure and of the upcoming inspection.

Inspectors observed staff communicating well with residents with dementia and responding to their individual needs.

Residents told inspectors that they had access to newspapers which were delivered on a daily basis. There was a sign-in book at reception which kept a record of all visitors to the centre for evacuation purposes. Inspectors found that residents' records were stored in the office which ensured confidentiality.

Inspectors found that most of the policies and procedures were centre-specific. The director of care explained that she was responsible for the development, approval, implementation and review of policies and procedures. The person in charge told inspectors that staff were encouraged to read and understand policies and a policy was regularly discussed with staff to determine their level of understanding and to clarify issues.

6. Staff: the recruitment, supervision and competence of staff

Outcome: Staff are competent and recruited in sufficient numbers to meet residents' needs

Staff numbers and skill-mix are determined by the size and complexity of the service and there should be sufficient competent staff on duty, both day and night, to meet the needs of residents. Robust recruitment and selection procedures ensure the appointment of suitably qualified and experienced staff. Staff are supported in their work by ongoing training and supervision.

Evidence of good practice

Inspectors found that there were adequate numbers of staff on duty and the skill-mix met the needs of residents. Dependency levels were calculated using an evidenced based standardised assessment tool. The person in charge told inspectors that the providers supported her decisions to increase staff if residents' needs increase.

Inspectors found that four of the care staff had completed Further Education and Training Awards Council (FETAC) training and another care assistant was in the process of completing the course. One of the care assistants told inspectors that she really enjoyed the course as it gave a new perspective to caring for older people.

Inspectors reviewed four staff files and found that they contained three references, curriculum vitae, proof of Garda Síochána vetting, medical declaration and proof of identity. There were copies of nurses' registration with their regulatory body An Bord Altranais for 2010. The person in charge told inspectors that she completed yearly appraisals for all staff. Inspectors saw evidence of this and the identification of training needs for staff.

There was a list of all training completed by each member of staff in 2009 and 2010. This included training on manual handling, fire prevention, CPR (cardio pulmonary resuscitation), health and safety and infection control.

Inspectors reviewed the recruitment policy and found that it complied with the requirements in the Regulations as it identified the procedures for selecting and vetting staff.

Significant improvements required

Inspectors found that staff required further training on caring for residents with dementia as there were a high number of residents with varying degrees of dementia which required specialist care and skills to meet their needs. Inspectors also found that staff required training on end-of-life care as they had not received any recent training and training on responding to behaviours that challenge to meet residents' needs in order to keep abreast of best practice.

Closing the visit

At the close of the inspection visit a feedback meeting was held with the providers, the person in charge, the director of care and the senior staff nurse to report on the inspectors' findings, which highlighted both good practice and where improvements were needed.

Acknowledgements

The inspectors wish to acknowledge the cooperation and assistance of the residents, relatives, provider and staff during the inspection.

Report compiled by

Angela Ring

Inspector of Social Services
Social Services Inspectorate
Health Information and Quality Authority

29 November 2010

Chronology of previous HIQA inspections	
Date of previous inspection	**Type of inspection:**
30 September and 1 October 2009	☐ Registration ☒ Scheduled ☐ Follow up inspection ☐ Announced ☒ Unannounced
18 March 2010	 ☐ Registration ☐ Scheduled ☒ Follow up inspection ☐ Announced ☒ Unannounced

Health Information and Quality Authority
Social Services Inspectorate

Action Plan

Provider's response to inspection report*

Centre:	Harvey Nursing and Convalescent Home
Centre ID:	0048
Date of inspection:	23 and 24 November 2010
Date of response:	11 January 2011

Requirements

These requirements set out what the registered provider must do to meet the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

1. The provider has failed to comply with a regulatory requirement in the following respect:

There was inadequate screening between residents' beds in shared rooms to ensure residents privacy and dignity was maintained.

Action required:

Carry out plans to provide adequate screening for residents to ensure privacy and dignity is respected.

Reference:

Health Act, 2007
Regulation 19: Premises
Standard 25: Physical Environment

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

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: Completed	 Completed

2. The person in charge has failed to comply with a regulatory requirement in the following respect:
Staff did not have the necessary training to adequately meet the needs of residents with dementia and residents with behaviours that challenge and residents requiring end of life care. Staff were unaware of the procedures to follow in regulating the setting on pressure relieving mattresses. Staff displayed evidence of poor manual handling techniques.
Action required: Ensure that staff have access to education and training to enable staff to provide care in accordance with contemporary evidenced based practice.
Reference: Health Act, 2007 Regulation 17: Training and Staff Development Standard 24: Training and Supervision

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: We are disappointed by the inspector's remarks regarding our staff training in Dementia Care. As well as the mandatory training that staff receive and internal training, two members of staff attended a training course in Dementia Care in St James' Hospital in 2010 and another member of staff is enrolled for 2011. Another staff member attended a similar course that was held in Dementia and end-of-life care in Mercer House, Dun Laoghaire (awaiting the schedule for 2011). As acknowledged in the report we have four carers who have either completed or studying for FETEC Level 5 which includes a module in dementia care and another three staff members are scheduled to commence the course in 2011.	 Ongoing

Staff training will continue to have a very important role in our nursing home. Both formal training, but more importantly informal training, in caring for residents with dementia will continue to the fore. Whilst we appreciate inspectors require written evidence of almost every interaction between our staff and residents, things such as a spontaneous sing songs, card games, nail painting, help with knitting, playing board games as well as many other interactions, some even as simple as hand holding, are not always recorded in resident care notes but are very much part of an average day in caring for a residents with Dementia. Most of care staff have been with us for several years and come to know our residents and their personalities very well and we welcome the comments from residents that 'there was plenty to do during the day' and we will continue to focus on improving the services we offer to all our residents and record more of these interactions.	Ongoing
We appreciate that the developments of dementia care are changing all the time but many parts of the formal approaches to these studies, such as Dementia Care Mapping, Social Psychologies and Butterfly Moments are already practised in the everyday care that our residents receive. That said we will, of course, ensure that our staff receive formal training in this area.	January 2011
The pressure relieving mattresses are set, monitored and adjusted by the nursing staff. We will ensure that care staff are also aware of the correct settings going forward. All our staff are trained in manual handling and these practices are monitored. The resident in this example has issues with the use of hoists but we have ordered a sit stand hoist which we will trial to see if this provides a more useful means of transfer.	February 2011

3. The provider has failed to comply with a regulatory requirement in the following respect: Each medication prescribed did not have an individual prescribing signature. Crushed medications were not prescribed as crushed by the GP.
Action required: Put in place a system where each medication is prescribed in accordance with professional guidelines.
Action required: Put in place appropriate and suitable procedures for crushing of medication.

Reference: Health Act, 2007 Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines Standard 14: Medication Management	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: This is a common practice by doctors when prescribing a number of medications for an individual resident. Rather than sign each line the doctor signs the top and bottom of the prescription sheet and brackets in between. The two doctors engaging in this practice have been spoken to and signed each line in the prescription sheet. The resident who required to have her drugs crushed has this officially marked by the doctor in her prescription sheet.	Complete Complete

4. The provider has failed to comply with a regulatory requirement in the following respect: Restraint measures were used with some residents but inspectors found that best practice was not adhered to in the use of restraint. The restraint policy in place was not used to inform practice.
Action required: Put in place a system to ensure that best practice is adhered to in the use of restraint.
Action required: Put in place a system to ensure that practice reflects the restraint policy.
Reference: Health Act, 2007 Regulation 22: Maintenance of Records Standard 21: Responding to Behaviour that is Challenging

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: We are pleased to note that it was acknowledged that none of our residents have any form of restraint used during the day and those that are in danger of falling are monitored closely whilst maintaining their independence.	

In the report there was the suggestion that residents are at risk of injury from the use of bed rails. Firstly the only residents who use bed rails are residents who request them either for security and comfort reasons as they may have been used to sleeping in a double bed, or as an enabling tool to assist a resident turning in the bed. This is the 'residents' choice' and, where bed rails are used, it is signed by the resident or relative, GP and Director of Nursing and this is reviewed regularly. If there is any sign of a resident (who has requested bed rails) hurting themselves we have looked at alternatives which range from certain residents having posey alarms attached to their bed, (which informs staff when a resident leaves the bed to help prevent falls) to having more suitable, profiled beds used or simply attaching buffers to be bedrails that still gives the resident the security and comfort of the rail whilst ensuring that there is no injury caused through sudden movement during the night.	Will be reviewed on ongoing basis and as part of the three-monthly care plans reviews

5. The person in charge is failing to comply with a regulatory requirement in the following respect: Care plans did not adequately reflect the residents' social care and recreational needs. Residents were not aware of the contents of their care plan or involved in their development.	
Action required: Ensure that residents' care plans are completed, reflect the assessment findings and set out in detail the action to be taken by staff, to ensure that all aspects of the health, personal and social care needs of the residents are met.	
Action required: Ensure residents are involved in the development and ongoing review of their care plan.	
Reference: Health Act, 2007 Regulation 8: Assessment and Care Plan Standard 11: The Resident's Care Plan	
Please state the actions you have taken or are planning to take following the inspection with timescales:	**Timescale:**

Provider's response: All our residents or their advocates are invited to contribute to individual care plans. As part of the aspects of daily living residents and relatives are invited to contribute and are shown their care plans. Many residents choose not to formally contribute as they feel that they do so already to care staff on an ongoing and daily basis. Many relatives are happy to just become involved if there are changes in medical conditions. We will continue to encourage this involvement and monitor the input. We conduct detailed social and personal assessments as part of our resident care plans. These will be reviewed and we will formally record the actions that have been taken as a result of this.	Will be formally recorded as part of our care plans reviews which will be completed within the next three months

6. The provider has failed to comply with a regulatory requirement in the following respect:

There were inadequate procedures in place for staff learning from incidents and complaints.

Action required:

Put in place adequate procedures for staff learning from serious or untoward incidents or adverse events involving residents.

Reference:

Health Act, 2007
Regulation 31: Risk Management Procedures
Regulation 39: Complaints Procedures
Standard 26: Health and Safety
Standard 6: Complaints

Please state the actions you have taken or are planning to take following the inspection with timescales:	**Timescale:**
Provider's response: Any incidents and accidents are discussed each morning at the staff meeting for all staff to input and this has resulted in considerable improvements for resident care. The outcome and actions taken from these discussions has not always been entered in the accidents book for the inspectors to review but this will be rectified. Regarding complaints our policy is to deal with any issues as soon as possible. As stated in the report the only complaints received have been verbal and were dealt with promptly as acknowledged by the inspectors. This was borne out by the positive comments from the resident and relative survey that was conducted as part of this inspection.	January 2011

7. The provider has failed to comply with a regulatory requirement in the following respect:

There were limited opportunities for residents to partake in the running of the centre.

Action required:

Further develop the arrangements to ensure residents are consulted with and facilitated to participate in the organisation of the centre.

Reference:

Health Act, 2007
Regulation 10: Residents' Rights, Dignity and Consultation
Standard 2: Consultation and Participation

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: All residents were invited to join our Advocacy group and, although only one resident is represented currently, there are two relatives who represent the interests of the other residents and there have been good suggestions from these meetings, which are included in the minutes of these meetings. At mealtimes there is as much flexibility in the residents daily routines as possible with breakfasts served during most of the morning and for residents who prefer to have lunch or dinner in the sitting rooms their wishes are accommodated. Residents are regularly consulted over food preferences by our catering team. Much of our Nursing Home activities have been shaped by residents and their preferences with particular emphasis on music, singing, cards and aromatherapy because of comments from residents. The report does state that our suggestions box is located in the entrance corridor but it is mainly aimed at suggestions from visitors as most residents would be unable to use it and make suggestions verbally – although this will be moved.	January 2011

8. The provider has failed to comply with a regulatory requirement in the following respect:

Some of the shared bedrooms did not meet the minimum requirements identified in the standards.

Some of the residents did not have access to lockable storage space.

There was inadequate storage space for commodes, wheelchairs and walking aids.

Action required:

Put a plan in place to ensure that bedrooms meet the minimum requirements in terms of space.

Action required:

Provide lockable storage space for all residents.

Action required:

Provide adequate storage facilities.

Reference:

Health Act, 2007
Regulation 19: Premises
Standard 25: Physical Environment

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: There were three bedside lockers that require a lockable drawer and this will be done by end January. As stated to inspectors some residents prefer to have their commodes kept in their room and this will be noted in their care plans. Changes to the three-bedded room will be made within the timeframe guidelines within the Regulations and Standards.	January 2011

9. The provider has failed to comply with a regulatory requirement in the following respect:

The emergency plan did not provide adequate guidance to staff on the procedures to follow in an emergency.

Action required:

Update the emergency plan to ensure it provides detailed guidance to staff.

Reference: Health Act, 2007 Regulation 31: Risk Management Procedures Standard 26: Health and Safety	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: We would like the readers to be clear about this point as we take fire safety very seriously. The inspectors found that we had a detailed emergency plan with precise procedures to be followed in the event of an emergency. We have employed the services of an structural building Fire Officer as well as highly experienced Fire Officer who conducts unannounced inspections of the building at regular intervals as well as training our staff in fire prevention and fire training. The inspector refers to a member of staff not being aware of precisely how many taxis and ambulances would be required in the event of a fire to transfer residents – this will of course be rectified. In the event of an emergency, however, the person in charge would contact one member of the management team and the management would liaise with emergency services and deal with transportation issues.	January 2011

10. The provider has failed to comply with a regulatory requirement in the following respect: The person in charge was not very familiar with the Regulations and Standards.	
Action required: Put procedures in place to ensure that all staff have a good knowledge of the Standards and Regulations.	
Reference: Health Act, 2007 Regulation 17: Training and Staff Development	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**

Provider's response: There may have been a misunderstanding of the comments by our director of nursing at this meeting. Our director of nursing has read the Regulations and Standards and indeed these have shaped the policies and practices that are in place in our nursing home currently. During the meeting with the inspectors the director of nursing stated that she does not refer to the Regulations and Standards on a day-by-day basis - since they are already part of the structure of the nursing home practices. Moreover, policies and practices are agreed, discussed and updated at our regular director of nurses meeting which are chaired by our director of care. We will ensure that the Regulations and Standards are reviewed on an ongoing basis at these meetings and in our nursing home.	Ongoing

11. The provider has failed to comply with a regulatory requirement in the following respect: There were no individualised assessments on residents' manual handling needs. Staff did not adhere to best practice in manual handling.	
Action required: Carry out individualised manual handling assessments for all residents.	
Action required: Put a system in place to monitor staff using manual handling techniques and provide increased training if necessary.	
Reference: Health Act, 2007 Regulation 6: General Welfare and Protection Standard 8: Protection	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: This was in place and copies scanned and emailed and manual handling was commented on action point 2.	

Recommendations

These recommendations are taken from the best practice described in *the National Quality Standards for Residential Care Settings for Older People in Ireland* and the registered provider should consider them as a way of improving the service.

Standard	Best practice recommendations
Standard 19: Meals and Mealtimes	Review the dining experience for all residents.

Any comments the provider may wish to make:

Provider's response:

We would like to thank the inspectors for their positive comments on our nursing home. The inspection was carried out in a professional manner and we welcome all suggestions on how we can continue to tailor our service and further develop our staff training program to the needs of our residents.

Provider's name: Seamus Brady
Date: 14 January 2010