Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Hillcrest House Nursing Home
Name of provider:	Hillcrest Nursing Home Limited
Address of centre:	Long Lane, Letterkenny, Donegal
Type of inspection:	Unannounced
Date of inspection:	05 September 2024
Centre ID:	OSV-0000346
Fieldwork ID:	MON-0044559

About the designated centre

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

Hillcrest House Nursing Home is a designated centre registered to provide 24 hour health and social care to 58 male and female residents. It provides long term, respite and end of life care including care to people with dementia. The philosophy of care as described in the statement of purpose ensures that residents can enhance their quality of life in a safe comfortable environment, with support and stimulation to help them maximise their potential physical, intellectual, social and emotional capacity. The centre is located in a residential area of Letterkenny, a short drive from the shops and Letterkenny University Hospital. Accommodation for residents is provided in single and double rooms. There is a range of communal areas where residents can spend the day and there is an outdoor courtyard garden that is easily accessible and safe for residents to use independently.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	52

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 5 September 2024	20:00hrs to 21:50hrs	Ann Wallace	Lead
Friday 6 September 2024	08:50hrs to 17:45hrs	Ann Wallace	Lead
Thursday 5 September 2024	20:00hrs to 21:50hrs	Manuela Cristea	Support
Friday 6 September 2024	08:50hrs to 17:45hrs	Manuela Cristea	Support

What residents told us and what inspectors observed

On the first day of inspection, the inspectors arrived late in the evening after the nursing handover had been completed. One inspector was based in the unit called The House and the other one in the unit called The Lodge. Staffing levels in both units were observed to be in line with the scheduled roster.

The atmosphere in both units was calm and relaxed. Some residents were up and about, while others were being assisted to bed by the night staff. In the House two residents were observed in the small lounge listening to the radio in front of the cozy fireplace and enjoying a cup of tea. The atmosphere was comfortable and warm. When one resident left, they wished each other good night and it was clear that they were very comfortable and familiar with each other. In the day room in The House two gentlemen were observed watching sport on TV, one drinking a non-alcoholic beer and the other one a cup of tea. The fire place was on and it was a very relaxed evening. One resident who spoke with the inspector said that life in the centre was good, 'everything was great, staff are lovely, food is good'. Another man arrived in the day room and sat down watching tv. Staff offered him a cup of tea and biscuits. In the House most residents had retired to their bedrooms. One gentleman was watching sport on the large screen television in the lounge on the first floor and a second resident was playing video games on his personal computer. Both residents appeared comfortable and staff confirmed that this was the resident's 'preferred nightly routines. Hot drinks and snacks were being served to those residents who wanted them.

The majority of residents in the House had dementia or cognitive impairment. Inspectors spoke with more than 10 residents who were all unanimous in their appreciation for the care and support they received in the House. One resident said: 'This is not really my home but it is the nearest thing I am going to get'. Inspectors spoke with a number of residents in The Lodge many of whom praised the staff and the care and services that they received. However some residents expressed dissatisfaction with the number of changes in staff working in the unit and said that it had impacted on their care as new staff were not familiar with their care needs. One resident told the inspectors that they did not have a good quality of life in the centre and that they wanted to go home.

Inspectors returned in the morning of the second day of inspection and again observed what life was like for the residents and the care they received in both units of the designated centre. Inspectors observed that there were no restrictions to accessing outdoor spaces and throughout the day residents were observed going out freely and enjoying the sun. Some were reading newspapers while enjoying a glass of orange, others informed inspectors that they were going for a walk. Staff were aware of residents' whereabouts and where assistance was required it was provided in a discreet manner. Inspectors observed that there were no activities in the House in the morning of the second day of inspection, and that there was not much to do after the breakfast finished. Residents were observed sitting in one of

the day rooms with little stimulation going on. However, the afternoon became more lively as a musician came in playing guitar, which was greatly received by residents. Staff and residents were observed singing and dancing together and there was a joyous atmosphere. In The Lodge activities commenced late morning and residents were engaged with a variety of sessions including reading the newspaper and discussions about national and local events, games and live music which was enjoyed by most residents.Those residents who preferred to spend time in their rooms were visited regularly by staff and appeared content reading their newspapers or listening to the radio. All residents had access to a television in their rooms but most residents came to the lounge to watch television.It was a sunny day and ice-creams were served to residents in both units after lunch, which residents greatly enjoyed. The inspectors observed that two residents accommodated in The Lodge who had additional needs for companionship and support did not have appropriate supports in place to provide this care. Both residents spent long periods of time by themselves with little to do or stimulate them and neither resident appeared to participate significantly in the activities that were provided in the social programme on the day.

Inspectors observed the breakfast and lunch time. Feedback from the residents was that the quality of food was good and that they had choices, if the food on the day was not to their liking. However, inspectors also observed that the serving of the food required improvement. For example, in the House inspectors observed some task-oriented practices such as applying clothes protectors at mealtimes without asking permission in advance. There were numerous examples of person-centred practices too, and it was evident that staff knew the residents really well, including their likes and dislikes. The majority of the residents were served food in the dining room, where the tables were nicely set with tablecloths, condiments and flowers. However, there were other residents who received their food in the day room and in the lobby. The serving of food for these residents could be further improved. Tables were not set, there were no napkins available and inspectors observed that toast and boiled eggs were served from a trolley and makeshift arrangements on a nearby table. This arrangement required improvement. In the Lodge most residents took their lunch in th dining room. There was a choice of two options and alternatives were also available if residents did not want what was on the menu. Meals were served hot, however the fish option of the day was a fish pied which did not have a pie topping and was not nicely presented. As a result some residents told the inspectors that they did not enjoy their meal. Notwithstanding, inspectors observed positive and kind interactions between staff and residents. One resident woke up late at 11 o'clock and was observed to enjoy their breakfast in the sunshine. They said, their choice of when to get up was respected.

Inspectors observed medication administration practices, and found that improvements were required, as further detailed in the report.

Visitors were observed coming and going throughout the day, and spending as much time as they wished with their loved one. One visitor said that they were very happy with the care their relative received, communication with management and staff, but said that the management of personal possessions was not as good. They said that numerous items of clothing they brought in for their loved one had gone

missing, which was frustrating. They said they had not reported this to the management as overall they were very happy with the care, however this was something they wished could be improved on.

The next two sections of the report will set out the findings of the inspection under the relevant regulations in the Governance and Management and the Quality and Safety pillars

Capacity and capability

Whilst it was clear that the provider was working hard to implement effective management and oversight structures and processes this inspection found that there was a need to ensure that a stable management team was in place that could support and develop staff to take responsibility for their roles so that that the provider's policies and procedures were implemented in full and standards of care were maintained. The provider had recognised this and was in the process of appointing a director of nursing in addition to the assistant director of nursing and the person in charge.

The provider is Hillcrest Nursing Home Limited. Directorship of the company had changed in quarter four 2023 and two of the current directors were present in the centre on this inspection. One of the directors works full time in the designated centre and is responsible for ancillary staff and the facilities. The person in charge was absent on the two days of this inspection. The inspection was facilitated by the directors, the recently appointed director of nursing and the assistant director of nursing. They were present over the two days and attended the feedback meeting at the end of the inspection.

This inspection was carried out over one evening and one day. Solicited and unsolicited information submitted to the office of the Chief Inspector since the previous inspection in March 2024 was followed up. Inspectors found that the unsolicited information was partially substantiated. These findings are set out in the Quality and Safety section of this report.

The person in charge led a team of nursing and health care staff. In addition there was a housekeeping team and a separate laundry staff, a catering team, two activities staff and an administrator. Day to day maintenance of the building was the responsibility of a part time maintenance person. Although there was a core staff team who had worked in the centre for many years there had been a lot of staff changes in 2024 and a significant number of the staff on the roster had worked in the centre for less than six months. The turnover of staff in the previous months served to increase the workload of both managers and longer term staff in the centre as they trained and supported new team members to settle into their roles. Not withstanding these changes the inspectors observed that staff worked well

together and demonstrated co-operation and flexibility in how they worked which helped to create a positive and friendly environment for the residents.

The provision of additional staff resources to meet the needs of those residents with additional requirements for companionship and support was still not in place on this inspection. This was evident in a review of the rosters which showed that no additional staff were in place for these residents. This finding was validated by staff and managers working in the centre and by one of the residents. However records showed that the provider had engaged with the agencies responsible for funding the care and support of these residents and the family of one of the residents in an effort to secure appropriate supports for both residents. The lack of appropriate supports was found to be negatively impacting on the quality of life for both residents which left them more isolated and was reflected in one of the resident's feedback to inspectors that their needs were not being met and that they were not happy with their quality of life in the centre. Furthermore these findings demonstrated that the provider remained in breach of Condition 5 of registration which required them to have additional staffing in place for those residents.

Although some improvements had been made following the previous inspection not all of the actions committed to in the provider's compliance plan following that inspection had been implemented. More effort and focus was now required to ensure that resources were made available and were used to bring about planned improvements.

The provider had implemented a number of new quality assurance processes including updating their oversight of housekeeping services and their clinical audit system. The inspectors found that housekeeping services had improved and the general environment was clean and fresh. However the oversight of key areas of clinical care such as medication practices and the management of nutritional risk was not robust and did not ensure that residents received safe and appropriate care in line with their needs.These findings are set out under Regulations 6 and 29.

Staff had good access to training and were up to date with their mandatory training requirements in safeguarding, fire safety and moving and handling.Training used a blend of on line and interactive sessions and was focused on the policies and procedures which guided staff in their work. Overall staff were clear about their roles and responsibilities and the standards that were expected of them in their work, however inspectors found that significant improvements were required in the oversight of staff practices to ensure that the provider's policies and procedures were consistently implemented.

Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration

The provider had submitted an application to vary Condition 1 of the designated centres conditions of registration to reflect the appointment of an assistant director

of nursing. The application, the prescribed information and the required fee had been submitted to the office of the Chief Inspector.

Judgment: Compliant

Regulation 14: Persons in charge

There was a person in charge (PIC) who met the criteria of the regulations however they were on long term absence and had been away form the designated centre for more than 28 days. The provider had notified the Chief Inspector of the absence of the PIC as required under the regulations. The provider had deputising arrangements in place to cover when the PIC was absent form the centre and the recent appointment of a director of nursing helped to ensure that these were at the level set out in the provider's conditions of registration.

Judgment: Compliant

Regulation 15: Staffing

The provider had failed to ensure there were sufficient staff available to provide companionship and support in line with the assessed needs of two residents aged under 65 years. There were no additional staff identified on the roster to provide this support and the inspectors observed that all care provided for these residents on the day of the inspection was provided by the baseline staff team as identified on the roster. This meant that the two residents spent their day in the centre sitting in the communal areas with little engagement except when staff were providing care. This was confirmed by staff who spoke with the inspector on the day and by feedback from one of the residents.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff supervision processes required significant improvements to ensure staff were consistently implementing the provider's own policies and procedures in key areas such as medication management, assessment and care planning and the management of clinical risks such as malnutrition.

Furthermore laundry staff were not clear about who was responsible and the procedure that should be followed to ensure resident's clothing was returned to

them after being laundered. This was reflected in the feedback from some families who said that items of clothing had gone missing during the laundering process.

Judgment: Not compliant

Regulation 21: Records

Inspectors were not assured that all Schedules 3 records were kept in a safe and accessible manner. For example inspectors found a number of resident's personal details contained in a handover sheet and a medication summary sheet had been misfiled in one resident's personal records.

Judgment: Substantially compliant

Regulation 23: Governance and management

The provider had failed to ensure the resources were provided to ensure that the additional companionship and supports for which two residents had been assessed were met and the lack of support and companionship for these residents was negatively impacting on their quality of life.

There was a management structure in place which identified clear lines of accountability and responsibility, however the effectiveness of the management team had been impacted by a series of long term absences. Whilst the provider had recently appointed a Director of Nursing to strengthen the team it was evident on this inspection that these prolonged absences had impacted on the oversight ad management processes in the centre which is reflected in the findings of this inspection.

There were a number of quality audits in place however these were not effective in driving improvements in staff practices and in care and support for residents. For example the medication audits reviewed by the inspectors had not identified a number of the non compliant findings set out under Regulations 6 and 29. In addition it was not clear how audit information and responsibility for improvement actions were communicated to the relevant staff. Staff meetings were not held regularly and management meeting records did not include information about audit results and improvement actions.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

The inspectors reviewed a sample of residents' contracts. Contracts included the terms on which the resident would reside in the centre including the fees to be paid and the services to be provided for the resident. A representative of the provider Hillcrest Nursing Home Limited and the resident or their representative had signed the contracts.

Judgment: Compliant

Regulation 3: Statement of purpose

There was a statement of purpose in place Revision number 7 dated 17 August 2023. In addition the provider had submitted an application to vary the centre's statement of purpose to Revision number 10 dated 14 August 2024. Both documents included the information set out under Schedule 1 of the regulations.

Judgment: Compliant

Quality and safety

Overall, the vast majority of residents were supported to live a good quality of life and were cared for by staff who knew their needs well. However the provider had failed to ensure that the needs of two residents assessed for enhanced support and companionship had services in place to met those needs. This required further action as it was a repeat finding from previous inspections and the lack of appropriate supports was negatively impacting on the quality of life for these residents. In addition significant improvements were required in the management and oversight of key aspects of quality and safety to ensure the care that residents received was of a high standard and evidence-based. Action was required in respect of residents' individual assessment and care plans, healthcare, medication management as well as end of life care, food and nutrition and residents' rights. The areas where improvements are needed are outlined under each regulation.

The inspectors observed medication management practices both in the House and the Lodge. The provider had recently introduced a new electronic prescribing and administration system and the nurses were familiar with it. There were good prescribing and dispensing arrangements in place with the most recent pharmacy audit completed in June, and the management of controlled drugs was in line with best practice. However, significant improvements were required in the area of medicine administration, storage and return to pharmacy practices as further described under Regulation 29: Medicines and pharmaceutical services.

Inspectors spoke with a number of staff both in the evening and the day of the inspection. Staff were knowledgeable in respect of residents' dietary needs, preferences and requirements. The inspectors also observed staff practices in respect of transferring residents from one chair to another and found that they were not in line with the principles of manual handling training. While all communication with the resident was courteous and kind, it was evident that the transfer technique was not appropriate and it created high levels of anxiety for this resident. Furthermore, the inspectors reviewed this resident's assessments and plan of care and found numerous inconsistencies between the assessed needs, care plan and implementation. Despite staff reporting a marked physical decline in mobility needs, there had been no referral to a physiotherapist.

Inspectors reviewed the care plan arrangements for more than 10 residents and found that further action was required to ensure a high standard of evidence-based nursing care was consistently provided to the residents. While some care plans were very person-centred and fully described that identified care needs and the supporting interventions required, there were many care plans that were generic, did not inform care and did not provide any guidance to staff in respect of how to meet residents' assessed needs. In addition, not all care plans were informed by risk assessments and initiated within 48 hours from admission.

Inspectors were informed that there were no residents at the end of life during this inspection. A review of end-of-life care that residents received in the centre, found inconsistent practices. There were positive examples of very good care provided, including the involvement of families, general practitioner (GP) and palliative care team, multidisciplinary approaches, advanced decision-making, anticipatory prescribing and good nursing care. However, inspectors also found gaps in care that could significantly impact the care a resident received at the end of their life and that clinical deterioration was not always promptly identified and responded to.

Residents had access to water and a variety of drinks throughout the day and night. Inspectors observed a choice of milk, cranberry juice, orange juice, water, tea and coffee provided to the residents. The menus displayed showed choices available for residents at lunch at teatime, but did not include any information in respect of breakfast. Overall, residents were satisfied with the quality and quantity of food provided and available to them, however further improvements were required in respect of choices and serving arrangements.

There was good evidence to show that residents had access to a general practitioner (GP) of their choice and other health professionals including dietitians, speech and language therapists (SALT), tissue viability nurse (TVN), occupational therapists (OT), chiropody, physiotherapy as well as psychiatry and palliative services. However, further action was required to ensure that a high standard of evidence-based nursing was consistently provided to all residents and that appropriate referrals were made in a timely manner and were informed by accurate assessments. This is further outlined under Regulation 6: Healthcare.

Residents had access to advocacy services and information about these services was included in the resident's guide and displayed on information boards in both units.

Regulation 13: End of life

Residents' end of life care plans were not always person centred as some care plans did not give information in respect of their specific end of life preferences to inform decisions of care and effectively address the person's individual physical, emotional, social, psychological and spiritual needs. For example;

- One care plan gave conflicting information in relation to the resident's preferences for medical interventions in the event of an emergency.
- One care plan did not provide clear information in respect of the resident's preferences for their spiritual care at end of life.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Improvements were required in the way food was served to the residents and the choices available to them. For example

- One of the meal options on the day of the inspection was a fish pie however this dish was not presented in an appetising manner. Inspectors observed that one resident declined eating it as the top layer had been removed and the consistency of the pie filling did not look appetising.
- Staff did not always offer choice at meal time. For example, staff knew the residents' preferences well, however, they were seen to provide tea with milk and sugar without asking the resident in advance how they would like their tea.
- The serving of breakfast in the day room in The House could be further improved to ensure a dignified mealtime experience for all residents. Inspectors observed that food was being dished out from a trolley, and pre-made butter toast was left on a nearby residents' table. There were no napkins or condiments offered or available on these tables.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

Further action was required to ensure residents were protected by safe practices in respect of storing, medication administration practices as follows;

- Medication was not always administered in line with prescriber's directions and as dispensed from the pharmacy. For example, inspectors observed that at least three residents in the House were provided with medication in a crushed format, despite the fact that the prescription explicitly instructed that medication was not to be crushed. This posed a risk that residents received medication in a format that was not appropriate and could cause harm.
- Medication storage practices in the Lodge were poor. Insulin pens that were in use by residents were found to be stored in the fridge, which is not in line with the direction of use for this medicine.
- Out of date medication was found in the medication fridge in the Lodge. Inspectors requested that an immediate review was carried out to ensure all medications were in date including a retrospective review whether any resident had been administered medication that was out of date.
- Medication belonging to deceased residents was not timely returned to pharmacy in line with best practice and local policy. The systems in place for returning of medications were not consistent. While controlled drugs belonging to deceased residents had been returned, this process was not applied with the remaining medications and required review.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Significant action was required in respect of care planning arrangements for residents, and ensure that they were sufficiently detailed to guide practice, initiated within 48 hours of admission and reviewed and updated when residents' condition changed. For example:

- There was a disconnect between assessments and care plans. Care plans were put in place without risk assessments being completed, which meant that they were not informed by evidence. When assessments were completed, care plans were not updated with the revised information, which meant that in numerous instances there were discrepancies between the information contained in the assessments, the care plans and the nursing notes. This could cause confusion and a risk to the residents, as the inspector observed in one instance conflicting information in respect of residents' needs with Level 0, level 1 and level 2 fluids listed in the care records.
- Care plans also contained redundant historical information that was no longer relevant to the current care of the resident, and which could cause confusion as to what the needs of the resident were.
- Overall care plans were initiated within 48 hours from admission, however the inspector saw that in one instance care plans were only put in place 6 days after a residents' admission to the designated centre.

- Care plans did not meaningfully inform practice and in many cases were generic. For example, in one care plan it was stated 'Utilise Solar model when speaking with'. Staff were not aware of what that meant.
- Mobility care plans were not sufficiently specific to inform the assistance level required and did not inform the care observed to be delivered. For example, as per the risk assessment completed, the resident required to mobilise with aid of Zimmer frame, yet the care plan stated that the resident was immobile. Inspectors observed this resident and saw that staff transferred the resident without any aid.
- Wound care plans did not contain sufficient information to guide care and inform the management of wounds. This information was available in the narrative of the nursing notes, however it was difficult to track and trace who had made the decision and informed the plan of care.

Judgment: Not compliant

Regulation 6: Health care

The registered provider did not ensure that a high standard of evidence-based nursing care in accordance with professional guidelines and having regard to residents' needs was consistently provided to all residents. For example;

- Oversight of residents' weight loss and risk of malnutrition was not sufficient to ensure a proactive approach to meeting residents' healthcare needs. Comprehensive assessments were not completed on admission, for example weight was not taken as a baseline and to inform clinical oversight. This could delay early identification and prompt response to clinical deterioration.
- There was a lack of assurance that staff were familiar with the protocol for unwitnessed falls. While nursing notes stated that neurological observations were completed, the records shows that only vital observations were in fact carried out post fall. This posed a significant risk of delayed intervention as key clinical indicators of deterioration will be missed.
- Nursing staff did not ensure full adherence to the 10 rights of medication administration to ensure residents' safety; for example checking that medication was administered in the format prescribed.
- Where a risk assessment identified a healthcare need, it was not always appropriately followed up with a referral to the appropriate healthcare professional for review. For example, staff were observed using inappropriate manual handling procedures for a resident whose mobility had declined. There had been no referral made to a physiotherapy to ensure appropriate assessment and equipment for the transferring of this resident.

Judgment: Not compliant

Regulation 9: Residents' rights

Not all residents were provided with opportunities to participate in meaningful activities and entertainments in line with their capacities and preferences. For example;

- This was a particular concern for two residents aged under 65 years who had assessments in place identifying their needs for additional support and companionship on a one to one basis and who were not in receipt of these services. Although the provider was engaging with a range of agencies to put these supports into place these efforts had not been effective at the time of the inspection.
- Furthermore one of the residents who had expressed a clear preference to go out into the community to access local amenities and services was not supported to do this on a regular basis. As a result the resident spent almost all of their their days in the centre with limited opportunity to engage in outside activities and personal interests which was negatively impacting on their well being and quality of life.

The inspectors were not assured that residents views and expressed wishes were being listened to and adequately followed up. For example;

- There had only been one resident meeting held since the inspection in March 2024. The records of the meeting did not provide any evidence of issues raised by the attendees and there was no evidence that issues raised by residents had been followed up.
- The location of the one television in the one twin bedroom in The Lodge did not ensure that both residents accommodated in this room were able to see the television if they were in bed. Furthermore the residents were not able to choose what they wanted to watch themselves if the other resident was watching their preferred programmes.
- Staff did not always promote residents' dignity and independence at meal times. For example, on more than five occasions inspectors observed staff applying clothes protectors to the residents without asking the resident's for permission.

Inspectors were not assured that the rights of one resident were being upheld in relation to the resident's expressed preference to return to live in the community with adequate support.The discharge plan for the resident had not been progressed since the previous inspection. Furthermore there was no evidence that the resident had been involved in the decision making processes about their discharge. As a result the resident did not know what was happening in relation to their discharge arrangements or when they might be going home.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Compliant
Quality and safety	
Regulation 13: End of life	Substantially compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Hillcrest House Nursing Home OSV-0000346

Inspection ID: MON-0044559

Date of inspection: 05/09/2024

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: There is currently one resident in the centre assessed as requiring companionship. This is now clearly reflected in a separate, updated roster and daily staff allocations. A daily log of activities provided by the companion will be maintained to ensure all interactions and engagement are properly documented and monitored. Status: Completed, Ongoing	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Supervision: To improve staff supervision processes, a structured supervision framework will be established to ensure consistent implementation of the provider's policies and procedures. This will include regular on the floor scheduled supervision sessions and spot checks by Clinical Managers to monitor adherence in critical areas, such as medication management, assessment and care planning, and the management of clinical risks like malnutrition, wounds and falls. Audits: A monthly audit schedule will be introduced to review specific areas, including: Medication Management, meal time experience, nutrition, wounds management and falls prevention. The ADON reviews assessments and care plans on a weekly basis. If any issues are identified, a meeting will be held with the responsible nurse, who will be required to amend the assessments and care plans within a specified time frame. Training: Additional training will be provided to address any identified gaps and reinforce high standards of practice. Specific training will focus on areas like Falls prevention,	

Nutrition and Wound care.
Medication management training: all nurses are attending management and risk management of medication in community setting by the CNME. This training is scheduled to be completed by December 20th, 2024.
Additionally, the pharmacist will provide medication management training to all nurses in December 2024.

Laundry Management: It is the responsibility of the laundry staff, not housekeeping, to ensure residents' clothes are put away correctly. All staff have been made aware of this process and have received training on their specific roles and responsibilities.
Spot checks will be conducted at the end of each day to ensure that all clothing is returned to the correct bedrooms.
Follow-up checks will be conducted with residents and/or their families to ensure satisfaction with the laundry system.
Status: Commenced, Ongoing

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
A comprehensive review of all resident files will be conducted to ensure they contain only resident-specific documents and that Schedule 3 documents are correctly filed.
The Retention of Records policy will be updated to clearly set out the procedures for properly filing and maintaining Schedule 3 documents.
The updated policy will be communicated to all nursing staff to ensure they follow the correct procedures for documenting and storing records in a safe and accessible manner.
Status: Commenced, Ongoing

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Management Meetings: Weekly management meetings will be held, including the Provider Representative, PIC, DON, and ADON, to discuss events from the previous week, including monitoring reports and audit findings.
The responsibility for addressing specific findings from audits will be assigned to the DON and ADON, who will ensure that appropriate actions are taken in response to identified issues.
Audit Plan: An audit schedule for the remainder of 2024 and for 2025 will be

implemented. This schedule will include regular audits of key areas such as medication management, resident care, and quality assurance processes.
Data collected from audits and monitoring reports will be analysed to identify trends, address recurring issues, and implement evidence-based improvements.
Quality Improvement Plan: A comprehensive Quality Improvement Plan will be developed based on audit findings to guide continuous improvement in care practices and staff performance.
Daily Safety Pauses: Daily Safety Pauses will be introduced to allow staff to report issues, share concerns, and suggest ideas for improvements. This will encourage open communication and active participation from the staff team in addressing challenges.
The PIC will review the documentation from these safety pauses weekly to ensure issues are being addressed promptly.
Staff and Management Communication: Regular staff meetings will be scheduled to ensure that all staff are informed of audit findings, the progress of improvement actions, and any changes to care processes.
Management meeting records will include audit results and improvement actions, and these will be communicated to relevant staff to ensure accountability and transparency.
Status: Commenced, Ongoing

Regulation 13: End of life	Substantially Compliant

Outline how you are going to come into compliance with Regulation 13: End of life:
End-of-Life Care Assessment: On admission, a comprehensive assessment will be conducted to capture each resident's religious beliefs, spiritual practices, and specific end-of-life preferences. This assessment will inform the development of an individualized End of Life Care Plan.
Details of significant religious events, such as receiving sacraments or other important spiritual practices, will be specifically included in the End of Life Care Plan to ensure that the resident's spiritual needs are fully met.
Review of Existing End-of-Life Care Plans: End of Life Care Plans for all current residents will be reviewed and updated as necessary to ensure they accurately reflect each resident's religious and spiritual preferences, as well as any specific end-of-life wishes.
End-of-Life Care Policy: The End of Life Care Policy will be followed to ensure that specific practices relevant to the different faiths represented by our residents are observed and respected. This policy will guide staff in addressing the spiritual and religious needs of residents at the end of life, ensuring that these practices are included in the End of Life Care Plan.
CARU Training Programme for staff: We will implement the CARU Training Programme, to nursing and care staff to improve their knowledge and skills in delivering compassionate, person-centred care at the end of life. The CARU programme will focus on both practical and emotional aspects of end-of-life care, equipping staff to meet the needs of residents and families in a holistic and sensitive manner.
CARU Committee: A CARU Committee will be established within the nursing home to oversee the implementation of the CARU programme and ensure ongoing quality

improvements in end-of-life care.
This committee will include staff from nursing, care assistants, and other relevant departments to support the delivery of high-quality end-of-life care. It will provide guidance and support to both residents' families and staff, ensuring that care practices are in line with the principles of the CARU programme. The committee will also monitor and evaluate the effectiveness of the programme, ensuring continuous improvement in care delivery.
Status: Commenced, ongoing

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
Improving Meal Presentation: To enhance the presentation of meals, we will ensure that all dishes are visually appealing and appetizing. This will include incorporating garnishes and using improved plating techniques.
A meeting with kitchen staff will be held to review meal preparation and presentation standards. Staff will be trained on how to present meals in an appealing way to encourage residents' enjoyment of their food.
Menu Planning and Resident Preferences: A new menu is currently being planned, with input from residents and care staff to ensure that it reflects residents' preferences and dietary needs. Once completed, the menu will be forwarded to a dietitian for review to ensure it meets the nutritional requirements of all residents.
We will offer a wider variety of meal choices tailored to meet the dietary and individual preferences of residents. This will give residents more options to choose from at mealtimes.
Audit and Mealtime Experience Improvements: An audit of Resident Experience at mealtimes has been conducted. As a result we have introduced new procedures:- napkins and condiments such as butter and jam are on the tables for residents to use as they prefer. Staff now ask residents what they would like for breakfast and how they would like specific elements, such as tea or condiments, to cater to individual preferences and increase meal satisfaction. Residents are asked if they would like a clothes protector. Staff ensure residents clothes, hands and mouths are cleaned before leaving the dining room.
Status: Commenced, ongoing

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
Medication management training: All nurses will attend Medication Management and Risk Management training in a community setting, facilitated by the CNME. This training will be completed by November 20th, 2024.
In addition, a pharmacist is scheduled to provide further medication management training to all nurses in December 2024 to reinforce safe practices in medication administration and storage.
Medication Competency Assessment: A Medication Competency Assessment will be carried out by the ADON on all nursing staff to assess their knowledge and competency in medication management, including the correct administration and storage practices.
Review and Update of Medication Policy: The Medication Policy will be reviewed and updated to provide clear guidelines and procedures for medication storage, administration, and the return of medications after a resident's death.
The policy will specifically address the return of medications for all residents, not just controlled drugs, ensuring timely return to the pharmacy in line with best practices and local policy.
The updated policy will be communicated to all nursing staff to ensure consistent adherence to the guidelines.
Monthly Medication Audits: A monthly medication audit will be conducted to review:
MDA (Medication and Drug Administration) records and processes
Medication orders, delivery, and storage practices
The use of PRN psychotropic medications, ensuring that appropriate documentation and usage protocols are followed.
These audits will help identify any non-compliance with medication management practices and ensure timely corrective actions are taken.
Status: Commenced, Ongoing

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
Timeliness and Consistency: All care plans will be initiated within 48 hours of a resident's admission, in line with regulatory requirements. In cases where there are delays, these will be promptly addressed, and corrective actions will be taken to ensure timely implementation.
The ADON will conduct regular reviews of all nursing documentation, particularly following incidents, new admissions, returns from hospital, or changes in a resident's condition. Any discrepancies between assessments, care plans, and nursing notes will be addressed immediately, and shortfalls will be communicated to the responsible nurse both verbally and in writing to ensure updates are made promptly.
Relevance and Clarity: Historical or irrelevant information will be removed from care plans to avoid confusion. Only relevant, current, and specific details will be included,

ensuring that care plans accurately reflect the needs of the resident at the time of care.
Care plans will be tailored to each resident's individual needs, with clear and specific guidance, particularly in critical areas such as mobility, nutrition, and wound care.
Meaningful Care Plans: Care plans will be developed with meaningful, actionable details that inform practice and guide care delivery. Generic statements will be clarified or replaced with practical instructions that staff can easily understand and apply in their interactions with residents.
Wound care plans will be updated to ensure they contain sufficient information to effectively guide wound management and monitor healing progress. Information available in nursing notes will be incorporated into the care plan, making it easier to track decisions, actions, and outcomes.
Training and Ongoing Review: Comprehensive training has been provided to all nurses on the importance of thorough assessment and care planning. Ongoing training will continue to be provided for nursing staff on best practices in care planning and documentation, with a focus on ensuring that care plans are individualized, accurate, and actionable.
The effectiveness of the care plans will be continuously monitored through audits and staff feedback, ensuring that all documentation remains relevant, meaningful, and up-to-date, reflecting the evolving needs of the residents.
Status: Commenced, Ongoing

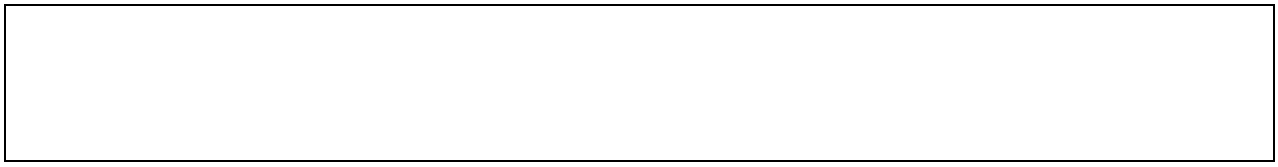
Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
Audits and Corrective Actions: Audits on nutrition, falls management, medication administration, and MDT (multidisciplinary team) have been initiated. The findings from these audits will be used to identify gaps and implement corrective actions promptly.
The ADON will lead the implementation of corrective actions based on audit results, with follow-up audits to assess the effectiveness of improvements.
Staff Meetings and Communication: Weekly management meetings will be held to review the outcomes of audits, discuss corrective actions, and ensure all staff are informed about updated care protocols and clinical guidelines.
Action points from management meetings will be documented and assigned to relevant staff members to ensure clear responsibility and accountability for improvements.
Training: Targeted training programs will be organized for nursing and care staff in key areas, including Medication management, Must assessments, Falls management, and Wound management
Training will ensure that all staff are equipped with the necessary knowledge and skills to mitigate risks and provide safe, evidence-based care.
Audit Plan for Increased Oversight: A detailed audit plan for 2024-2025 has been established to increase oversight across areas including nutrition, falls, medication administration, wound management etc.
The audits will be used to identify risks, ensure timely interventions, and improve care

standards to enhance the quality of care for residents.
Status: Commenced, Ongoing

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Resident Participation and Engagement: A dedicated activities plan will be implemented to ensure that all residents, including those requiring additional support and companionship, have access to meaningful activities. Currently, only one resident is identified as needing companionship and one-to-one support. This resident's needs are reflected in a separate rota and individualized plan to ensure they receive the required level of support and engagement.
For residents wishing to engage with the community, community access plans will be developed and closely monitored to ensure these residents are supported in accessing external activities and services regularly.
Resident Feedback and Communication: Resident meetings will be scheduled every two months in 2025, with a meeting template to ensure consistency and detailed minutes of all discussions. These records will document the specific issues raised by residents and outline the actions taken to address them. This will provide transparency and accountability.
A follow-up system will be implemented to track and ensure that concerns raised by residents are addressed promptly. This system will allow for ongoing review and follow-up during subsequent meetings or sooner if needed.
Promoting Dignity and Independence at Mealtimes: Based on the findings from the audit of resident experience at mealtimes, the following actions will be taken to improve mealtime practices and ensure residents' dignity and independence are upheld:
Napkins and condiments such as butter and jam will be available on all tables for residents to use as they prefer.
Staff will now ask residents about their preferences for breakfast, tea, and condiments to cater to individual tastes and promote choice.
Clothes protectors will be applied only with resident consent, ensuring that residents are treated with respect and dignity.
Staff will ensure that residents' clothes, hands, and mouths are cleaned before leaving the dining area, further promoting dignity during mealtimes.
Resident Involvement in Care Planning: Residents will be actively involved in the planning of their care, and updated on any changes to their care plan. Care plans will be regularly reviewed and discussed with residents to ensure their preferences, needs, and wishes are reflected in their care.
Encouraging resident feedback: Residents will be encouraged to speak about their care needs and plans during regular care plan reviews and meetings with staff. This will ensure they are fully engaged in the decision-making process regarding their care.
Status: Commenced, Ongoing



Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 13(1)(a)	Where a resident is approaching the end of his or her life, the person in charge shall ensure that appropriate care and comfort, which addresses the physical, emotional, social, psychological and spiritual needs of the resident concerned are provided.	Substantially Compliant	Yellow	30/01/2024
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	30/01/2025
Regulation 16(1)(b)	The person in charge shall	Not Compliant	Orange	30/01/2025

	ensure that staff are appropriately supervised.			
Regulation 18(1)(b)	The person in charge shall ensure that each resident is offered choice at mealtimes.	Substantially Compliant	Yellow	28/02/2025
Regulation 18(1)(c)(i)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are properly and safely prepared, cooked and served.	Substantially Compliant	Yellow	30/01/2025
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Substantially Compliant	Yellow	30/01/2025
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	30/01/2025
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and	Not Compliant	Orange	31/03/2025

	effectively monitored.			
Regulation 29(4)	The person in charge shall ensure that all medicinal products dispensed or supplied to a resident are stored securely at the centre.	Not Compliant	Orange	30/11/2024
Regulation 29(5)	The person in charge shall 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.	Not Compliant	Orange	30/11/2024
Regulation 29(6)	The person in charge shall ensure that a medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident shall be stored in a secure manner, segregated from other medicinal products and disposed of in accordance with national legislation or guidance in a manner that will	Not Compliant	Orange	30/11/2024

	not cause danger to public health or risk to the environment and will ensure that the product concerned can no longer be used as a medicinal product.			
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Not Compliant	Orange	30/01/2025
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.	Not Compliant	Orange	30/01/2025
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the	Not Compliant	Orange	30/11/2024

	designated centre concerned.			
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Not Compliant	Orange	30/01/2025
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.	Not Compliant	Orange	30/01/2025
Regulation 6(2)(c)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the care referred to in paragraph (1) or other health care	Substantially Compliant	Yellow	30/01/2025

	service requires additional professional expertise, access to such treatment.			
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Not Compliant	Orange	30/01/2025
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Substantially Compliant	Yellow	30/01/2025
Regulation 9(3)(c)(iv)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may communicate freely and in particular have access to voluntary groups, community resources and events.	Substantially Compliant	Yellow	30/01/2025
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the	Substantially Compliant	Yellow	30/01/2025

	organisation of the designated centre concerned.			
Regulation 9(3)(e)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise their civil, political and religious rights.	Substantially Compliant	Yellow	30/01/2025