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:	Hillview Convalescence & Nursing Home
Name of provider:	Hillview Convalescence & Nursing Home Limited
Address of centre:	Tullow Road, Carlow
Type of inspection:	Unannounced
Date of inspection:	05 July 2023
Centre ID:	OSV-0000238
Fieldwork ID:	MON-0039977

About the designated centre

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

Hillview Nursing Home is a family owned centre which opened in 2003. The registered provider is Hillview Convalescence and Nursing Home Limited. It is a purpose-built centre located on the outskirts of Carlow town, within walking distance of many amenities such as shops and churches. The centre is surrounded by spacious landscaped gardens with access to a secure garden for residents. There is ample parking available to the front and side of the centre. The centre can accommodate up to 54 residents, both male and female over the age of 18 in its 32 single and 11 twin bedrooms. Bedroom and communal spaces are divided over two floors with access to the first floor via a passenger lift and stairs. Communal space includes a dining room, day room, sun room, activity room, quiet room, reminiscence room and seating areas in the reception and landings on the first floor. Services provided include 24 hour nursing care, visiting general practitioners (GPs), pharmacy, chiropody, occupational therapy, physiotherapy, dietetics, speech and language, optician, dental and audiology. A range of social activities are offered to meet the needs of all residents over six days each week. Religious and advocacy services are also available. The centre caters for residents with varying levels of dependency for long term, convalescence and respite care.

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
Wednesday 5 July 2023	08:30hrs to 16:30hrs	Sinead Lynch	Lead

What residents told us and what inspectors observed

The inspector walked around the centre with the person in charge. The inspector observed the centre to be clean and mostly well-maintained. Bedrooms were found to be well organised and many with personal effects making them feel homely. Residents spoken with told the inspector that their rooms were cleaned daily and they were happy with the cleanliness of the centre.

One twin bedroom required further review, as the inspector observed that the design and layout of the room did not afford each resident sufficient private space. Following the last inspection the provider had made some improvements to this room, however further consideration was needed. Some areas required further maintenance, such as skirting boards and hand rails required painting or upgrading.

There was clear signage around the centre to guide residents and visitors. The front door had a key code to access but visitors were seen to be promptly responded to when they pressed the bell.

There was an enclosed courtyard and garden for residents and their relatives to use. At the time of inspection, the provider was applying a thumb lock to this door for residents to have more freedom to 'come and go' as they pleased. There was another outdoor which was not secured but had an arrangement of shrubbery and flowers. One resident was out in this area watering the flowers on the day of the inspection. They said they 'loved gardening and could maintain their favourite hobby while living in the centre'.

There were two dining rooms in the centre, one on each floor. Residents had an array of choice with two meat dishes, one fish and one vegetarian option available. Residents were very positive about the meals available and the choice offered each day. The inspector observed that there was adequate staff available to assist residents when required. Assistance was seen to be offered discreetly.

There was a quarterly newsletter available in the centre. This included results of residents surveys, changes made and improvements planned for the premises and any celebrations that had occurred in the centre.

The registered provider had just introduced a 'magic table' (a device which projects onto a table with a serious of interactive light games specially designed to help those with dementia to be more active socially, cognitively and physically) and the feedback was overwhelmingly positive. This was in use in the centre on the day of the inspection and residents were observed to be stimulated by this. One relative said this has been a 'godsend' as this magic table had a 'calming effect' for their relative.

Staff were observed to be very interactive with the residents and there appeared to be a trusting relationship between the residents and the staff. The staff turnover

was low and the residents told the inspector that they had built a 'bond' with some staff.

The next two sections of the report will present the findings of this inspection in relation to the governance and management arrangements in place, and how these arrangements impact on the quality and safety of the service being provided.

Capacity and capability

Overall, this was a good, well resourced centre with effective governance and management arrangements which ensured residents were supported to enjoy a good quality of life and receive safe quality care and supports.

The registered provider is Hillview Convalescence and Nursing Home Limited. The person in charge had been in place for two years and was available on the day of the inspection. They were supported in their role by an assistant director of nursing (ADON) and a clinical nurse manager (CNM). There was a clearly defined management structure in place and accountability for the delivery of the service was clearly defined. The person in charge was supported by the general manager who was also the owner of the centre.

There were regular management team meetings and minutes of these meetings were available to the inspector. The management team had documented many key improvements they wanted to implement following audits in the centre. Some of these were the outings over the summer and how they were going to increase the capacity for outings in 2023. Action plans from other audits were made available such as an increase to the seating area in the outdoor space for residents.

There was a comprehensive annual review available to view. This included feedback from residents and relatives about their lived experience in the centre. It showed what improvements the registered provider had planned for 2023 such as the garden improvements and increased outings for the residents. There was a suite of audits in the centre. These showed where the centre had done well and also where improvements were required. Where improvements were required there was an action plan in place with specific dates of completion.

There was one volunteer in the centre. This person was also the nominated advocate for residents. This person had a staff file in place with a Garda Siochana vetting (police clearance) report available. Their roles and responsibilities were clearly set out. There was another external advocacy service if residents wished to avail of this service.

There was a directory of residents made available to the inspector. This included all the necessary information required such as their next of kin or any person authorised to act on the residents behalf.

The provider had the appropriate insurance in place against injury to residents, including loss or damage to resident's property.

The registered provider was aware of their responsibility in relation to notifying the Chief Inspector of Social Service should the person in charge be absent. They had a person available that met the requirements of the regulations should the need arise.

The person in charge had notified the Chief Inspector of any accident that had occurred in the centre. However they had not notified about an incident of physical abuse between two residents which is a requirement under the regulations. The person in charge submitted this retrospectively.

Regulation 19: Directory of residents

The directory of residents was reviewed and it was found to contain all of the required information outlined in part 3 of Schedule 3.

Judgment: Compliant

Regulation 22: Insurance

There was an appropriate contract of insurance in place that protected residents against injury and against other risks, including loss or damage to their property.

Judgment: Compliant

Regulation 23: Governance and management

The designated centre had sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose. An annual review, which included consultation with the residents was in place. There were effective management systems in place to ensure the service was safe, appropriate, consistent and effectively monitored, as demonstrated by sustained levels of compliance across the regulations.

Judgment: Compliant

Regulation 30: Volunteers

There was one volunteer in the centre at the time of inspection. The management team had their roles and responsibilities set out in writing and a vetting disclosure. There was evidence that this volunteer was receiving supervision and support.

Judgment: Compliant

Regulation 33: Notification of procedures and arrangements for periods when person in charge is absent from the designated centre

The inspector was assured on the day of the inspection that the provider was aware of the notice to be given to the Office of the Chief Inspector should the person in charge be absent from the centre.

Judgment: Compliant

Regulation 31: Notification of incidents

The person in charge had notified the Chief Inspector of Social Services in relation to any accident within the required time-frame. However, they had not reported a confirmed episode of peer-to-peer physical abuse. The registered provider and person in charge had taken appropriate action at the time of the incident to safeguard the residents involved.

Judgment: Substantially compliant

Quality and safety

Overall, this was a good service and a well-managed centre, where a high quality of care was provided. Residents appeared well cared for with their personal care needs being met.

Where a resident had been transferred to hospital, a copy of the general practitioner (GP) referral and nursing transfer documentation was available. The discharge documents and the resident's prescription were in the resident's file and any changes to medication was communicated to the GP and pharmacist.

Residents were provided with a varied and nutritious diet. Minutes from a residents' meeting were seen by the inspector which showed residents had discussed changes to the menu. Residents had put their preferences forward and these changes were

made. Each day residents had a varied choice to suits all dietary requirements.

The minutes of residents' meetings and the residents who spoke with the inspector showed that they were consulted in the running of the service. Residents were provided with access to independent advocacy service and contact details were made available in the centre's newsletter and on the notice boards around the centre.

The premises were found to be well-maintained. However, further improvements were required in relation to the painting and upgrading of handrails and skirting boards throughout the centre. The provider showed the inspector that this was already in their quality improvement plan for the premises. There was a twin room that required further review. On the last inspection this was highlighted and the provider had made changes, but this required further review in relation to ensuring each resident had the required personal space. This bedroom did not provide each resident with adequate personal space. Each resident had adequate storage space in their bedrooms. There was a lockable space for each resident.

Residents were provided with an in-house laundry facility. Residents informed the inspector that their laundry was always well-maintained and returned promptly.

End-of-life care plans were viewed by the inspector. These had details of the residents' preferences at the end of life phase. Their religious requests were clearly documented and records showed that family members were sometimes involved when the residents requested this.

There was a comprehensive residents guide made available. This indicated the services and facilities available in the centre and how residents could access them. It detailed how a resident or visitor could make a complaint and the time frames for responses in relation to responding to the complainant. The up-to-date visiting arrangements were also available.

Medicines and pharmaceutical services were well-managed in the centre. Each resident had a choice of the pharmacy they wished to use. Medicines that were no longer required for a specific resident were returned to the pharmacy in a traceable format.

Residents with communication difficulties had a care plan in place to guide staff on their needs. Staff were observed to be following these care plans. Staff were seen to be calm in their approach and those residents with communication difficulties were given the time required to express themselves.

Regulation 10: Communication difficulties

The registered provider ensured that each resident who had communication difficulties could communicate freely.

Judgment: Compliant

Regulation 12: Personal possessions

Each resident had access to and retained control over his or her personal property and finances. Residents' clothes were laundered and returned to that resident promptly.

Judgment: Compliant

Regulation 13: End of life

The person in charge had ensured that where a resident was approaching the end-of-life, appropriate care and comfort, which addressed the physical, emotional, social, psychological and spiritual needs of the resident concerns were provided.

Judgment: Compliant

Regulation 17: Premises

Some aspects of the premises did not conform to the requirements set out in Schedule 6 of the regulations. For example;

- One twin bedroom required further review to ensure each resident had adequate private space
- The hand rails and skirting boards throughout the centre required painting or upgrading.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

The person in charge ensured that residents received wholesome and nutritious meals that met the dietary needs of the residents. There was access to a safe supply of fresh drinking water at all times.

Judgment: Compliant

Regulation 20: Information for residents

The residents' guide was made available to the inspector and contained all the information as required under the regulations.

Judgment: Compliant

Regulation 25: Temporary absence or discharge of residents

The documentation completed for the temporary discharge of a resident to hospital was available to the inspector. All relevant information about the resident was sent to the receiving hospital. On return from the hospital, a discharge letter and relevant documentation was received and filed in the resident's individual record.

Judgment: Compliant

Regulation 26: Risk management

The registered provider had a risk management policy in place as set out in Schedule 5. This included the hazard identification and assessment of risks throughout the designated centre.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

Medication was stored and dispensed in line with the regulations. Residents were given a choice in relation to what pharmacist they preferred to use.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Staff required further training in relation to their role in responding to and managing responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment). For example, care plans in relation to responsive behaviours did not identify triggers or an appropriate de-escalation method.
Judgment: Substantially 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	
Regulation 19: Directory of residents	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Compliant
Regulation 30: Volunteers	Compliant
Regulation 33: Notification of procedures and arrangements for periods when person in charge is absent from the designated centre	Compliant
Regulation 31: Notification of incidents	Substantially compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 13: End of life	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 20: Information for residents	Compliant
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 26: Risk management	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant

Compliance Plan for Hillview Convalescence & Nursing Home OSV-0000238

Inspection ID: MON-0039977

Date of inspection: 05/07/2023

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 31: Notification of incidents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: Going forward the PIC will submit an NF06 notification on any further episodes of any peer to peer physical abuse that may occur in the future. A section has been added to our behaviour incident reports to ensure that notifications are submitted where necessary. Responsive behaviour audits will be updated to identify if notifications have been submitted where peer to peer abuse occurs.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: The upgrading of handrails was already listed on the maintenance audit action plan and all handrails have been painted / upgraded since inspection. Skirting boards are currently being painted / upgraded. Skirting board maintenance will be added to the maintenance audit going forward. The twin room will be reviewed and adjustments made to ensure each resident has adequate personal space.	

Regulation 7: Managing behaviour that is challenging	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging: Mostly all staff have completed Responsive behavior training in April and June this year, the final training session is booked for this September. All responsive behaviour care plans have been reviewed by management since inspection and going forward nursing staff will ensure that identified triggers and appropriate de-escalation methods are documented on all responsive behaviour care plans. A review of care plan information will be added to the current responsive behaviour audit.	

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 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	30/09/2023
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.	Substantially Compliant	Yellow	02/08/2023
Regulation 7(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour	Substantially Compliant	Yellow	30/09/2023

	that is challenging.			