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## The Croft Nursing Home, 2 Goldenbridge Walk, Inchicore, Dublin 8.

Item Type	report
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Citation	Nuala Rafferty, Sheila McKevitt, 'The Croft Nursing Home, 2 Goldenbridge Walk, Inchicore, Dublin 8.', [report], Health Information and Quality Authority, Compliance monitoring inspection report (Ireland. Health Information and Quality Authority. Regulation Directorate). Designated centres under Health Act 2007, as amended., 2015-12
Publisher	Health Information and Quality Authority
Rights	Y
Download date	2026-03-11 03:40:31
Link to Item	<a href="https://hdl.handle.net/20.500.14765/75477">https://hdl.handle.net/20.500.14765/75477</a>

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	The Croft Nursing Home
<b>Centre ID:</b>	OSV-0000028
<b>Centre address:</b>	2 Goldenbridge Walk, Inchicore, Dublin 8.
<b>Telephone number:</b>	01 454 2374
<b>Email address:</b>	info@silverstream.ie
<b>Type of centre:</b>	A Nursing Home as per Health (Nursing Homes) Act 1990
<b>Registered provider:</b>	Croft Nursing Home Limited
<b>Provider Nominee:</b>	Joseph Kenny
<b>Lead inspector:</b>	Nuala Rafferty
<b>Support inspector(s):</b>	Sheila McKeivitt
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	37
<b>Number of vacancies on the date of inspection:</b>	1

## **About monitoring of compliance**

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

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

Regulation has two aspects:

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was following notification of a significant incident or event. This monitoring inspection was un-announced and took place over 1 day(s).

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

From: 18 August 2015 10:00 To: 18 August 2015 19:00

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

<b>Outcome</b>	<b>Our Judgment</b>
Outcome 01: Statement of Purpose	Substantially Compliant
Outcome 02: Governance and Management	Non Compliant - Major
Outcome 04: Suitable Person in Charge	Compliant
Outcome 06: Absence of the Person in charge	Compliant
Outcome 07: Safeguarding and Safety	Non Compliant - Moderate
Outcome 08: Health and Safety and Risk Management	Non Compliant - Major
Outcome 09: Medication Management	Non Compliant - Moderate
Outcome 10: Notification of Incidents	Non Compliant - Major
Outcome 11: Health and Social Care Needs	Non Compliant - Major
Outcome 12: Safe and Suitable Premises	Non Compliant - Major
Outcome 15: Food and Nutrition	Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Non Compliant - Major
Outcome 18: Suitable Staffing	Non Compliant - Moderate

**Summary of findings from this inspection**

This was an unannounced monitoring inspection by the Health Information and Quality Authority (the Authority). The purpose of the inspection was to follow up on matters arising from a registration inspection carried out on 20 August 2014 and to monitor progress on the actions required arising from that inspection. The inspection also considered information received by the Authority in the form of unsolicited receipt of information, notifications and other relevant information.

As part of the inspection, the inspectors met with residents and staff members observed practices and reviewed documentation such as policies and procedures, staff rosters, care plans, medical records and risk management processes.

It was found that some progress was made by the provider in implementing the required improvements identified by the registration inspection although significant

acceleration was required to progress the refurbishment of the centre's premises in order to meet the required standards. Improvements were required in relation to supervision of care, centre routines, care assessment and planning, staff training and the standard of hygiene in the centre.

Recent changes to the clinical management team within the centre were found on this inspection with the person in charge commencing in post within the last four months and the assistant director of nursing having commenced the previous week. The fitness of the person in charge was assessed through interview and interaction for registration purposes and was found to have satisfactory knowledge of their role and responsibilities and sufficient experience and knowledge as required by the legislation. The fitness of the assistant director of nursing to replace the person in charge in the event of her absence was determined throughout the inspection process and was also found to have sufficient experience and knowledge as required by the legislation. However, improvements to the level of clinical governance and standards of care being delivered to residents were found to be required. It was noted that both the person in charge and assistant director of nursing would benefit from increased supports and guidance to develop and implement professional self development plans, effective supervision and work systems and education and training plans for all staff.

The Action Plan at the end of this report identifies areas where improvements are required to comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

**Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.**

***Outcome 01: Statement of Purpose***

***There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.***

**Theme:**

Governance, Leadership and Management

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

No actions were required from the previous inspection.

**Findings:**

A statement of purpose was available in the centre.

The statement needed to be revised to reflect the change to the person in charge and other senior management personnel within the organisation.

**Judgment:**

Substantially Compliant

***Outcome 02: Governance and Management***

***The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.***

**Theme:**

Governance, Leadership and Management

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

No actions were required from the previous inspection.

**Findings:**

There was a clearly defined overarching management structure that identified the lines of authority and accountability at a senior level within the broader organisation of Silverstream, however, the inspector found that the management systems in place within this centre were not effective enough to ensure that an appropriate and safe level of care was being delivered.

Findings which also reflect this are detailed under outcomes 8, 11 and 18 of this report. The inspectors in making their judgement took into consideration the recent appointment of the internal management team in the centre. The person in charge was in post for four months and the assistant director of nursing and person who replaced the person in charge in her absence had commenced in post one week earlier. Improvements in the supervision of care practices to ensure care was delivered by nursing and healthcare staff in line with best practice, training and recommendations of allied health professionals was found to be required. This is referenced under Outcome 18.

There was a lack of appropriate basic equipment including worn and torn bedding and towels. There was only one full body hoist, which was in use for all residents, including one with a transmittable infection. The premises were not clean and bad odours lingered in and around toilet and bathroom areas. The centre was in need of a thorough deep clean.

Although a system was found to be in place to monitor quality and safety of care and the quality of life of residents on aspects of care such as care planning; medication management; monitoring of pressure ulcer prevalence and weight loss, the system in place was not effective in that it did not identify improvements required to raise standards of care as part of overall quality and safety improvements and did not provide for consultation with residents and/or their representatives.

These areas were discussed in depth with the person in charge and the recently appointed clinical governance and operations manager during and at close of inspection.

**Judgment:**

Non Compliant - Major

***Outcome 04: Suitable Person in Charge***

***The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.***

**Theme:**

Governance, Leadership and Management

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

**Findings:**

Recent changes to the clinical management team within the centre were found on this inspection with the person in charge commencing in post within the last four months and the assistant director of nursing having commenced the previous week.

The fitness of the person in charge was assessed through interview and during the inspection to determine fitness for registration purposes and was found to have satisfactory knowledge of their role and responsibilities and sufficient experience and

knowledge as required by the legislation. The fitness of the assistant director of nursing to replace the person in charge in the event of her absence was determined throughout the inspection process and was also found to have sufficient experience and knowledge as required by the legislation.

However, the inspectors were concerned at the inadequate level of clinical governance which contributed to the poor standard of care being delivered to residents and found that both the person in charge and assistant director of nursing require considerable supports and guidance from the clinical governance operations manager to develop and implement professional development plans, effective supervision and work systems, education and training plans for all staff, review of staffing roster, numbers and skill mix of staff.

**Judgment:**

Compliant

***Outcome 06: Absence of the Person in charge***  
***The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.***

**Theme:**

Governance, Leadership and Management

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

No actions were required from the previous inspection.

**Findings:**

Suitable arrangements were in place for periods of absence of the person in charge and the provider complied with his responsibilities to notify the Authority when a change occurred to both the person in charge and the nominated person to replace them. The fitness of the assistant director of nursing to replace the person in charge in the event of her absence was determined throughout the inspection process and was found to have sufficient experience and knowledge as required by the legislation

**Judgment:**

Compliant

***Outcome 07: Safeguarding and Safety***  
***Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.***

**Theme:**

Safe care and support

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

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

**Findings:**

All lines of enquiry were not reviewed for this outcome.

A review of the use of restraint found that there was a reduction in the use of bed rails throughout the centre however bed rails were still in place for some residents. It was found that appropriate assessments for this type of restraint were not being fully completed and there was no clear rationale for their use in several cases. The rails were variously described by staff as being needed to maintain safety or for use as enablers, however risk assessments or care plans were in place, did not state how they were enabling the resident. Consultation on the decision to use the rails included residents' families in the majority of records viewed although on some only staff were involved. None viewed showed that the resident was included. Inspectors were told that a number of residents' families had requested their use, however this was not in line with national policy on the use of restraint or with best practice. Although inspectors did note that there was a move towards changing the culture and promoting a restraint free environment with an increase in the use of alternative safety measures such as bed alarms, roll out mats and low low beds. There was no evidence that the use of prn (pro re nata) psychotropic medication was unreasonably restrictive or unnecessarily implemented.

Further efforts to reduce restrictive practices and put in place systems to promote a restraint-free environment were found to be needed. A policy on the use of restraint was in place in the centre, but evidence to show that all considerations were explored and found to be unsuitable before a decision was taken to use a form of physical restraint was not available in all cases.

Risk assessments in place on the use of bed rail restraints were not fully completed and did not accord with national policy as published on the Department of Health website, to show that;

- the use and positioning of the rails had been assessed for risk of entrapment.
- alternative measures prior to using the restraint had been tried, for how long, how recently or with what results
- all risks involved in using the restraint had been considered
- what were the benefits, if any, of using the restraint as opposed to other measures.

**Judgment:**

Non Compliant - Moderate

***Outcome 08: Health and Safety and Risk Management***  
***The health and safety of residents, visitors and staff is promoted and protected.***

**Theme:**

Safe care and support

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

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

**Findings:**

All lines of enquiry under this outcome were not reviewed on this inspection. Actions arising from the registration inspection were found to be partially addressed; actions related to providing improved guidance on the safe use of hoists were addressed. Information in the form of a concern was received by the Authority which identified alleged poor moving and handling practices in the centre. This was investigated internally by the provider and person in charge who initiated further staff training and specific instructions on the procedures to be followed by staff when using hoists to transfer residents. On observation of a number of moving and handling interventions by staff including transfers using assistive equipment such as full body hoists, sit to stand hoists and slide sheets, inspectors found good practices which followed the principles of current safe moving and handling best practice training.

It was also noted that specific guidelines on the safe use of hoists were displayed in a number of areas for staff reference. These guidelines informed staff of a number of key principles which must be followed to ensure a safe transfer using this equipment.

Key directions within the guidance included;

- checks to be made to slings, battery, emergency button, spreader bar and boom to ensure all are in working order prior to use
- all transfers to be supervised by a nurse
- prior to using hoist agree which one person to take 'charge' or 'lead' the transfer.

It was observed that some although not all of the guidance was followed. Staff were not observed to check the hoist or slings prior to use, although it is accepted that the centre's guidance advises the checks are only required as a daily event and may have occurred earlier in the morning. However, a safety alert issued by the Authority to providers in 2012 advised providers to ensure staff check hoists prior to each use. A senior nurse was present and assisted with the transfer, but did not ensure that one person was agreed as the lead person before the transfer took place as stated in the centre's own guidance. However, it was noted that the transfer was safe and the healthcare staff took their time to make sure that the sling was correctly positioned prior to lifting the resident to ensure safety.

Actions which were not addressed included;

An updated risk management policy was not available in the centre.

The risk management policy was to be updated following the inspection in August 2014 to include improved guidance on areas such as, the management of absconsion and

security of the exit doors. Inspectors determined that this action was not addressed as the risk management policy relating to management of absconson available in the centre was last reviewed in 2013. A full updated copy of the risk management policy was not available in the centre and the person in charge had to contact the organisation head office to forward an updated copy to the centre. This raised concerns for the implementation of the policy and the familiarity of all staff but particularly recently appointed staff with the policy given the proximity of the centre to the canal right outside the gates of the centre. It was also noted that several residents were assessed as at high risk of absconson.

A risk register was found to have been established since the registration inspection but it did not include all of the risks found in the centre such as; trailing electric cables, poor hygiene in some areas, use of bait traps, lack of appropriate equipment such as adequate number of hoists or slide sheets, inadequate toilet facilities and communal bedrooms.

Measures in place to prevent and reduce the spread of infection were not being implemented in practice.

Inspectors found that there was a poor level of hygiene throughout the centre. An acceptable level of hygiene was not found in several areas throughout the centre which was in need of a thorough deep clean. Equipment throughout the centre also required to be thoroughly cleaned including the monitors for pressure relieving mattress systems. Many were found to be left on the floor underneath beds and were covered in dust and cobwebs. Several commode covers were dirty although the internal bowls were clean. The soft coverings of some chairs were also found to be stained. A strong odour of urine was found in all communal toilet areas including assisted shower rooms with toilets. Although there were mechanical extraction systems in all shower/toilet areas, the vents were found to be clogged with dirt and not effective enough to dispel the odour.

Staff implementation of best practice to ensure good infection control and prevention was not consistent or to a safe level. The placement of personal protective equipment to manage and control the spread of transmissible disease was not appropriate. Current best practice guidance advise staff to place this equipment outside the rooms of affected persons so that staff can access and wear it prior to entering the room. Inspectors were told that the equipment could not be left outside the rooms currently due to behaviours of identified residents who take the equipment and dispose of it down the toilet. Instead the equipment would be placed immediately inside the door of the room. But inspectors found the trolley containing the protective equipment was actually located on the far side of the room and so negated the reason for its use to a large extent.

Appropriate hand hygiene practices were also not consistently implemented. Staff were observed to enter and leave the room prior to and after delivering care to the resident for whom the infection control measures were in place, without washing their hands, or using any disinfectant gel to sanitize their hands.

**Judgment:**

Non Compliant - Major

***Outcome 09: Medication Management***

***Each resident is protected by the designated centre's policies and procedures for medication management.***

**Theme:**

Safe care and support

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

No actions were required from the previous inspection.

**Findings:**

All lines of enquiry under this outcome were not reviewed on this inspection.

Written operational policies relating to the ordering, prescribing, storing and administration of medicines were in place although some were not fully implemented in practice.

Inspectors found that the administration of medication was not in line with professional guidance. It was found that a prescribed oral nutritional supplement was not being signed as administered by nurses in the medication administration sheet, this replicated practices previously found on a recent audit of medication management two weeks prior to the inspection.

**Judgment:**

Non Compliant - Moderate

***Outcome 10: Notification of Incidents***

***A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.***

**Theme:**

Safe care and support

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

**Findings:**

A record of incidents occurring in the centre was maintained but all incidents were not being notified to the Chief Inspector as required by the regulations. The provider had failed to report to the Chief Inspector at quarterly intervals of incidences or events such as, use of restraints, adverse incidents or deaths.

It was also found that all incidences involving injury to residents which requires immediate medical or hospital treatment were not notified. Two residents had developed grade 2 pressure ulcers which were not notified. This was brought to the attention of the person in charge and notifications were subsequently submitted. The person in charge was also reminded that where the deaths of residents are notified this must

include cause of death. Where a post mortem to establish cause of death is awaited, the Chief Inspector should be subsequently notified of the cause once received.

**Judgment:**

Non Compliant - Major

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

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

**Theme:**

Effective care and support

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

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

**Findings:**

A safe and suitable standard of care was not being delivered to all residents. The clinical care needs of all residents were not being fully met.

Access to medical and allied health professionals was available with documented visits, assessments and recommendations by speech and language therapists; tissue viability nurse specialists and dietician reviews. However, an up to date record of medical condition on admission was not available for all residents.

The arrangements to meet residents' assessed needs were set out in individual care plans and each resident had a care plan completed. A number of recognised assessment tools to check for risk of deterioration were used including; risk of falls, nutritional status, levels of cognitive impairment, skin integrity, pain, continence and communication.

Although a healthcare plan for every identified health or social care problem is required to be put in place by the nursing team to maintain residents' health and well being and monitor improvements or deterioration this was not found. It was also noted that where plans were in place, they were not always linked to the assessments or implemented.

Inspectors found there were negative impacts on some residents' health and well being as a consequence of inadequate assessment planning and evaluation of care including;

- care plans not in place for every identified need such as, nutrition, oral care, prevention of pressure ulcers, weight loss monitoring, care of scotch plaster casts and wound care
- documentation of care delivery was not recorded in a manner to ensure completeness so that anyone reading it would be sure that each resident was provided with care to a high enough standard to fully implement the care plan and/or to meet their needs.
- evidence was not found, that where residents identified as at risk of pressure ulcer

development and who required assistance to reposition were always receiving this care, as records to show where residents were repositioned on a regular basis were not maintained. All pressure relieving mattress systems were not set at the correct setting linked to the current weight of the resident as appropriate and one mattress was found to be fully deflated

- food diaries to monitor intake of residents with significant weight loss were not in place although the nursing team were aware that three residents had recent weight loss of 15.8%, 13.5% and 7% within a four to seven month period. Evidence that each resident was reviewed by a dietician and had a nutritional care plan was not available. Where plans were in place they did not reference dietetic recommendations.

An effective system to make sure healthcare plans reflected the care delivered and were amended in response to changes in residents' health was not in place. These plans were not being checked regularly to make sure they were detailed enough to maintain or improve a resident's health, these included care plans to maintain skin integrity and prevent, treat or otherwise manage pressure ulcer development. The daily nursing progress notes did not always refer to changes in health care plans or changes to treatments or recommendations made by clinicians to give a clear and accurate picture of residents' overall health. It was also found that most although not all care plans were generic in nature and were not person centred.

A high standard of nursing care was not found to be delivered to all residents. Care practices which did not reflect good nursing practice in accordance with current evidence based nursing practice and professional guidance from the Irish Nursing and Midwifery Board were found.

Inspectors found that wound charts with measurements and visual records of the actual wounds to identify the type, size, depth, grade and granulation status of wound were not in place for all residents' wounds and a plan to identify changes in care, reflect recommendations of specialists further to reviews were not always in place. It was also found that incontinence sheets were in use in conjunction with pressure relieving mattress systems, a practice which research has shown limits the effectiveness of the mattress.

**Judgment:**

Non Compliant - Major

**Outcome 12: Safe and Suitable Premises**

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

**Theme:**

Effective care and support

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

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

**Findings:**

The Croft Nursing Home is a single storey detached building situated on a quiet walkway alongside Dublin's Grand Canal. The centre was not purpose built and is currently registered to provide care for 38 residents.

Facilities included;

10 single, 11 twin and two multi occupancy rooms of three residents. Six of the single rooms had en suite shower and toilet facilities. One of the multi occupancy rooms contained a small toilet en suite. None of the en suite toilet facilities were wheelchair and hoist accessible and were only suitable for independently mobile residents or those using walking frames with staff assistance.

There were three other assisted shower rooms, two with toilets, which were wheelchair and hoist accessible. However, it was noted that consideration needed to be given to the number of wheelchair accessible toilets having regard to the number of persons using wheelchairs being accommodated in the centre.

There was an enclosed garden to the rear of the centre with grassy areas and safe walkways. There was also a sunny patio area with garden furniture, enclosed by old stone walls and surrounded by flower beds and a herb garden. There was some evidence of ongoing maintenance and refurbishment. Some bedroom doors had already been painted in bright distinguishable colours to enable residents with cognitive impairment recognise their bedroom. Some equipment and furnishings had been replaced and all equipment was in good working order with regular servicing noted.

However, internally, the building required further maintenance and redecoration work to be completed including;

- paint was visibly peeling on doors, counter tops and corridors
- improvements to the overall fabric of the building was found to be required with badly chipped, torn and exposed surfaces on all woodwork such as hand rails on corridors, internal doors throughout the building, skirting and architraves and radiator covers
- an acceptable level of hygiene was not found in many areas throughout the centre which was in need of a thorough deep clean. Equipment throughout the centre also required to be thoroughly cleaned as stated under outcome 8 of this report. There was a

lack of suitable and sufficient equipment needed to fully and appropriately meet residents' needs. A process to review and replace old and worn equipment, furnishings, linen and bedding was required.

- inspectors observed that towels and bed linen were old, worn, discoloured and frayed and needed to be completely and immediately replaced.
- the number of disinfectant hand gel dispensers needed to be reviewed to ensure there were sufficient available in order to implement safe infection prevention control measures.
- although there were two sit to stand hoists, there was only one full body hoist available for 38 residents despite approximately 20% of residents requiring its use on a regular basis. The availability of only one full body hoist raises concerns for cross infection where isolation of residents is required for prevention of infection purposes and during possible outbreaks of transmissible disease.

Actions arising from the last inspection were reviewed on this visit, actions which were addressed included;

- provision of an additional assisted shower facility
- improved storage facilities for large items of equipment such as hoists and large chairs.

Actions which were not addressed include;

- implementation of the plan submitted by the provider to ensure full compliance with the regulations and standards by 2015
- reduction of one three bedded room to a twin room
- renovation of second three bedded room to provide one single and one twin room.

The premises were not found to meet the requirements of Regulation 17 and Standard 25.

Two three bedded rooms were not suitable to meet residents' needs in terms of privacy and dignity and in ensuring the delivery of safe and suitable care. Sufficient space is required to allow safe access to residents who require use of assistive moving and handling equipment or allowing staff to provide safe assistance to residents with varying levels of dependency needs.

Only one bed in each room was accessible from both sides to enable staff deliver care safely. There was limited space available for storage of personal possessions for three people and no space to enable residents bring any familiar objects of furniture from home should they wish to do so. Space and privacy would be further compromised where residents needed to use commode chairs or preferred to remain in their rooms and sit by their bedside. There was limited circulation space within the room for three persons. This space would be further compromised where residents using the rooms may require additional mobility aids such as walking frames, rollators, transit or powered wheelchairs

This issue was raised during the registration inspection in 2014. The provider submitted a plan to bring the centre into compliance by July 2015 by reducing one three bedded room to twin and reconfiguring the second three bedded room to a single and twin room. However, this plan in relation to communal bedrooms was not implemented. This was discussed with the provider nominee in a telephone conversation during the inspection. The provider was advised that a plan would be required to be submitted to the Authority detailing how the provider intends to come into compliance with these

conditions and such a plan would then be considered by the Authority.

**Judgment:**

Non Compliant - Major

**Outcome 15: Food and Nutrition**

***Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.***

**Theme:**

Person-centred care and support

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

No actions were required from the previous inspection.

**Findings:**

The inspectors found that residents were provided with food and drink at times and in quantities adequate for their needs. The inspectors observed that assistance was offered to residents in a discreet and sensitive manner in most cases.

The dining experience was conducive to conversation with round tables to facilitate conversation. Those residents on modified diets were offered the same choices as people receiving normal diets.

Most residents had their meals in one of two dining rooms located in the centre and the inspectors noted that the dining tables were appropriately set with cutlery condiments and napkins. Residents spoken with all agreed that the food provided was always tasty, hot and appetising. Food was served from a hot plate by a team of staff and was well presented. Modified consistency diets were served appropriately with each element of the meal presented in separate portions on the plate. Snacks and hot and cold drinks including juice, milk and fresh drinking water were readily available throughout the day.

The menu was displayed on a large board in the dining room, however it was not situated where all of the residents could view it and one inspector had to tell some residents what was on the menu for lunch as there were no individual table menus available. This was brought to the attention of the person in charge.

**Judgment:**

Compliant

***Outcome 16: Residents' Rights, Dignity and Consultation***  
***Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.***

**Theme:**

Person-centred care and support

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

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

**Findings:**

All lines of enquiry were not reviewed on this inspection.

There were no restrictions to visiting in the centre and many residents were observed spending time with family or friends, watching TV or chatting in the sitting rooms throughout the day.

Two activity co-ordinators were observed engaging with a large group of residents pre lunch in a variety of activities including singing, memory games and skittles. Later the team took a group of eight residents out to Bray for the afternoon.

In conversation with staff, inspectors learned there was a varied activities programme with arts and crafts, exercise and drama included, however activities specific to residents with cognitive impairments and/or with limited or no mobility were limited to occasional Sonas sessions and one to one activities did not form part of the activities programme.

Despite the significant number of residents with cognitive impairment, this aspect of the care programme has not yet been developed. This was identified on the registration inspection but had not been addressed. Consideration should be given to group and individual activities that are meaningful and reflect residents past interests or lifestyles. These could be incorporated into the programme which requires further development to ensure all residents are supported to participate in accordance with their capacities as required by the Regulations.

Although interactions between staff and residents were observed to be warm, personable and respectful, person centred routines and practices were not always observed including occasions where;

- residents privacy was not always protected by locking bathroom doors when providing assistance with intimate care
- practices need to be reviewed to improve the residents dining experience. Most although not all staff provided assistance in a respectful and dignified manner. Some were observed to stand over the resident whilst assisting them to eat their meal and others were observed to scrape leftover food from plates at the tables where residents were still eating.

- all residents were not appropriately dressed during the day and some remained in their nightwear throughout the day.  
- the weekly allocation work sheet identified those residents whom night staff were to assist with personal care for washing and dressing. Inspectors learned these residents were 'early risers' and could be up showered and fully dressed from 04:00. These practices as confirmed by staff were not person centred and did not respect residents rights to choice privacy or dignity

**Judgment:**

Non Compliant - Major

***Outcome 18: Suitable Staffing***

***There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.***

**Theme:**

Workforce

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

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

**Findings:**

The number of and skill mix of staff was not found to be suitable to meet the needs of residents during the day on the previous inspection. The provider was asked to review the number and skill mix on night duty and it was found that an additional healthcare assistant which increased the numbers of staff from three to four was actioned by the recently appointed person in charge.

Mandatory training was in place and staff had received up to date training in fire safety, moving and handling and safeguarding vulnerable persons. Training in other areas specific to the current residents' profile was also delivered including management of constipation, medication management and cardio-pulmonary resuscitation.

However, findings related to poor standards of care and previously referenced under outcome 11 and outcome 2 of this report found that training was required to improve standards of care in areas such as; nutrition, wound care, pressure ulcer care, assessment planning, evaluation and documentation of care, person centred care, hand hygiene and infection prevention and control.

The person in charge told inspectors that training in food fortification, nutritional risk assessment and wound care was planned but inspectors learned this training were only of one hour duration and did not assure them that this training would be sufficient to improve staff knowledge and improve care standards. Training in other areas identified

as required were not as yet planned.

It was found that there was insufficient supervision of care practices to ensure care was delivered by nursing and healthcare staff in line with best practice, training and recommendations of allied health professionals. Examples include healthcare assistants delivering wound care, pressure relieving mattress systems in use for residents at high risk of developing pressure ulcers deflated, care plans not updated when there were considerable changes to residents' conditions, care delivery such as repositioning charts and intake or output not being recorded in a timely manner to ensure accuracy. Assistance was not always observed to be delivered to residents in a person centred and dignified manner. Good basic care practices such as appropriate hand hygiene and use of personal protective equipment and person centred care were not consistently found.

**Judgment:**

Non Compliant - Moderate

## Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

### **Acknowledgements**

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

### ***Report Compiled by:***

Nuala Rafferty  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority

## Health Information and Quality Authority Regulation Directorate

### Action Plan



### Provider's response to inspection report<sup>1</sup>

<b>Centre name:</b>	The Croft Nursing Home
<b>Centre ID:</b>	OSV-0000028
<b>Date of inspection:</b>	18/08/2015
<b>Date of response:</b>	02/11/2015

### Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non-compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

#### Outcome 01: Statement of Purpose

**Theme:**

Governance, Leadership and Management

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

The statement needed to be revised to reflect the change to the person in charge and other senior management personnel within the organisation.

**1. Action Required:**

Under Regulation 03(2) you are required to: Review and revise the statement of purpose at intervals of not less than one year.

<sup>1</sup> 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:**

The Statement of Purpose has been revised to reflect the change to the PIC and other senior PPIM management personnel within the organisation.

**Proposed Timescale:** 01/10/2015

**Outcome 02: Governance and Management**

**Theme:**

Governance, Leadership and Management

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

Operational management systems in place did not effectively monitor care practices to ensure the delivery of safe consistent care to all residents.

**2. Action Required:**

Under Regulation 23(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

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

The current system in place for the monitoring of care practices includes: ongoing and regular monitoring and auditing of care practices, these are based on best evidence based practice. The findings from these audits are reviewed monthly by the PIC and PPIM Clinical Governance and Operations Manager. Learning outcomes and improvements of practice are identified at this review. The learning outcomes and required changes to care practices and residents care plans are then communicated to staff at the following meetings: Twice Daily Handover review, Weekly review with PIC/ADON, Monthly In house Clinical Reviews.

In improving our operational management system we have introduced additional staff "handover" meetings for nursing and care staff. This provides an opportunity for nursing staff to provide updates and instructions as to residents' care needs and provides carers with an opportunity to give the nurse information updates. At the initial morning handovers staff are allocated to teams of residents but within the team there are also more specific roles and responsibilities for example; maintaining fluid charts, position/turn charts etc. The staff member allocated to these duties/roles will present the documentation at the handover meeting so that the nurse can ensure that the documentation has been completed accurately and contemporaneously.

The PIC and ADON have increased the monitoring process, to assess standards of environmental hygiene (Weekly Home Review), completion of documentation, resident welfare and to assess if there are any new areas of concern and this will include monitoring of residents who require pressure area care, diet and fluid intake.

In improving the internal governance the PIC and ADON will meet formally on a weekly

basis. They will completed a Weekly Care Quality Indicator report, it will review the Nutritional needs and changes of residents, Infection Control issues, Continence Needs, Skin Integrity needs, Risk management needs (including the use of restraint),End of Life Care, Dependency Needs, Incidents and Accidents in previous 7 days and Complaints. This will be reviewed by the Clinical Governance and Operations Manager to ensure the delivery of safe consistent care to all our residents.

The Provider recognises that the PIC and ADON are new to their positions, and has developed a PIC professional and development programme which will guide and support both of these managers in their roles and provides a more formal process of development and evaluation.

**Proposed Timescale:** 04/01/2016

**Theme:**

Governance, Leadership and Management

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

Systems established to review the quality and care delivered to residents was not effective in that it did not identify improvements required to raise standards of care as part of overall quality and safety improvements and did not provide for consultation with residents and/or their representatives.

**3. Action Required:**

Under Regulation 23(d) you are required to: Ensure there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.

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

A more concise system has been established to review the quality and the care that is delivered to the residents. This review will identify improvements that will be required to the residents care plans to better meet the daily care needs identified. As each care plan is reviewed and amended it will be discussed with the residents and /or their representatives.

The system will include : a Weekly Care Quality Indicator report, it will review the Nutritional needs and changes of residents, Infection Control issues, Continence Needs, Skin Integrity needs, Risk management needs (including the use of restraint),End of Life Care, Dependency Needs, Incidents and Accidents in previous 7 days and Complaints. This will be reviewed by the Clinical Governance and Operations Manager to ensure the delivery of safe consistent care to all our residents.

A detailed Care plan Auditing and review programme to be established for the PIC and ADON. This will guide and support them to ensure that each of their residents care plans are reviewed in a timely manner and reflect the care needs identified by the residents/NOK and care staff. These include a review and set of corrective actions and

learning required in the following areas : Skin Integrity, Dependency, Falls, Clinical Care plan review, Restraint review, Nutritional Needs review, Wound Assessment, Medication Kardex review, Medication Drug Round Audit, Weekly Home Review, Weekly Care plan Quality Indicator report.

Monthly the Clinical Governance and Operations Manager will complete an Audit review in the home. The review will include the following: a sample of care plans will be reviewed, a sample of Medications Kardex will be reviewed, Review of the "Weekly Home Reviews). A review of the Incidents/Accidents and changes that may be required to the Safety Statement. A review of all active Policies and SOP's, review of complaints. This review will identify improvements required and the establish learning outcomes for staff and improvements for residents.

**Proposed Timescale:** 04/01/2016

### **Outcome 07: Safeguarding and Safety**

**Theme:**

Safe care and support

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

Evidence to show that all considerations were explored, in line with national policy as published on the Department of Health website, and found to be unsuitable before a decision was taken to use a form of physical restraint was not available.

**4. Action Required:**

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

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

We have reviewed the national guidelines to ensure that we are fully aware and will be compliant with same. Our policy and practice within the home will be guided and supported by the guidelines.

Each resident will have a completed restraint risk assessment which will guide staff as to the exact procedures to follow when considering the use of restraint and ensure that all alternatives have been trailed with the residents and with input from them and their representatives. The risk assessment which takes into consideration, for example the risk of entrapment, strangulation etc.

Currently, the centre only uses bed rails and also considers exit doors as a form of physical restraint.

We have considered the increased risk of falls from beds when using overlay or replacement mattresses and we do not wish to use bed rails to prevent such falls, therefore, we have purchased new compatible mattresses that may be used with pressure relieving mattresses without increasing the risk of accidental falls. Low Low beds have also been purchased.

We will discuss the use of devices which may be considered as physical restraint with all residents. Where a relative makes a request for the use of restraint and this is not considered as an appropriate measure, we are content to discuss the rationale for this, and will document accordingly. This was discussed at the last "relatives committee meeting", which took place on the 23rd September 2015. We will plan to discuss the use of equipment/restraint at the formal care plan review meetings.

**Proposed Timescale:** 04/01/2016

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

### **Theme:**

Safe care and support

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

A policy and procedure was not available in the centre which identified the measures and controls in place to manage the risks associated with unexplained absence of any resident.

### **5. Action Required:**

Under Regulation 26(1)(c)(ii) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the unexplained absence of any resident.

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

The Policy is available at the front desk of the home to be accessible to all staff in the case of an unexplained absence of any resident. The Policy and Missing persons' folder is reviewed as each resident is admitted and discharged to ensure it is up to date. This review is completed by the PIC and home Administrator. The policy identifies the measures and controls in place to manage the risks associated with an unexplained absence of any resident.

The Missing Persons Folder provides details of all residents such as photograph, description, distinguishing marks, next of kin details etc. which is used to provide information in the event that a resident should be absent without explanation.

The PIC has commenced a monthly "missing persons drill" , and as an indication of our commitment to the safety and welfare of our residents, we currently and will continue to: (i) carry out 30-min safety checks on those residents who are considered to be at risk of wandering/absconion; (ii) in-house "all resident" checks at regular intervals; (iii) hourly checks from 2000-0800; (iv) exit point checks six hourly over the 24-hr period and (v) we have identified the associated risks with being located so close to the canal and have always closed the main gates at 1900 in summer months and 1600 in the winter months (as daylight hours are reduced). This in no way impedes on visitors ability to come and go freely.

A more structured approach to how policies are managed has been introduced and this

will include the Clinical Administrator formally visiting the centre to ensure that the Schedule 5 and Appendix B policies are in place, up to date, and that the current version is available. The PIC has, since the inspection, made herself and the ADON familiar with the policies and have both hard and soft copies.

**Proposed Timescale:** 02/11/2015

**Theme:**

Safe care and support

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

An up to date revised risk management policy which included the identification, assessment, recording investigation and learning from serious incidents involving residents was not available.

**6. Action Required:**

Under Regulation 26(1)(d) you are required to: Ensure that the risk management policy set out in Schedule 5 includes arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.

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

The risk management policy as per 26(1)(d) is accessible and available to all staff and Inspectors, as required.

The policy guides staff as to the correct use of risk, risk register and the safety statement. We will ensure that the risks identified by the Inspectors are addressed and included in the risk register and where necessary we will amend the policy as necessary. A more structured approach to how policies are managed has been introduced and this will include the Clinical Administrator formally visiting the centre to ensure that the Schedule 5 and Appendix B policies are in place, up to date, and that the current version is available. The PIC has, since the inspection, made herself and the ADON familiar with the policies and have both hard and soft copies.

All serious incidents are reviewed by the PIC and the Corporate Clinical Governance Team, This review involves reflecting on the incident, reviewing the residents care plan, completing a risk assessment, and an evaluation including setting learning outcomes for staff and improvements for the resident care.

**Proposed Timescale:** 20/11/2015

**Theme:**

Safe care and support

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

The risk register in place did not include the identification and assessment of all risks throughout the centre.

**7. Action Required:**

Under Regulation 26(1)(a) you are required to: Ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.

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

A full risk assessment walk-through has been completed by the PIC and Company Maintenance Manager to address the risks identified by the Inspectors and to identify if there are other issues currently not addressed within the centre. Weekly the PIC and the in-house maintenance personnel will carry out a "Weekly Home Review", which will focus on any health & safety issues, Potential risks. Following this, the risk register will be updated and amended. The risk register will be reviewed, any actions "closed" will be added to the risk register on a three monthly basis and "live" risks will be reviewed as risk dictates.

**Proposed Timescale:** 20/11/2015

**Theme:**

Safe care and support

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

Appropriate and safe infection control and prevention practices in line with current research based evidence were not consistently implemented by staff.

**8. Action Required:**

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

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

All staff had been provided with personal, discreet, hand gel dispensers, we accept that that not all staff were able to produce them on the day of the inspections . The PIC/Nurse in charge will ensure they are with staff at the Handover of each shift. To assure ourselves of good practices, the PIC will be carrying our regular hand-hygiene audits and will monitor the usage daily of wall mounted gel dispensers.

In order to address the issues of the storage of gloves and aprons in the event that we cannot keep these outside of a residents bedroom, we will be purchasing a portable glove/apron dispenser unit that will be door/wall mounted in the residents room if there is an infection risk. This will prevent it being moved, and while, we accept that this is not in line with guidelines, in order to reduce other risks, it is an unavoidable alternative.

The PIC had booked staff training in infection control which was completed on the 22nd & 23rd September 2015

**Proposed Timescale:** 02/11/2015

## Outcome 09: Medication Management

### Theme:

Safe care and support

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

Evidence that all medication such as oral nutritional supplements were being administered according to the instructions of the prescriber was not available.

### **9. Action Required:**

Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.

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

The Inspector is correct that this issue had been identified by the Clinical Governance & Operations Manager and it was being addressed and: (i) the identified staff member had been spoken to immediately and; (ii) this issue had been added to the agenda for the nurses meeting planned for 25th August 2015 (planned prior to inspection). We are satisfied that all other medications have been signed for as per ABA guidelines and practices are safe, but, to ensure that there are no further non-compliances with regards to oral nutritional supplements, we have arranged for on-site training to be provided by Pharmacist on 4th November 2015.

The PIC/ADON will be completing a full review Audit on Each residents Kardex on a monthly basis. The PIC/ADON will complete a Medication Drug Round Audit on a fortnightly basis to ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.

These review Audits will be assessed and evaluated by the Clinical Governance & Operations Manager, who then completes an External monthly Audit of the Medication Kardex for a sample of Residents. Any non- conformances noted will be actioned and Learning outcomes set for the PIC/ADON and Staff Nurses. This ensures that medications have been signed for as per ABA guidelines and practices are safe, but, to ensure that there are no further non-compliances with regards to oral nutritional supplements, we have arranged for on-site training (to be provided by Pharmacist).

The PIC/ADON will be completing medication competency assessments with all current staff, within the next two months (from then on annually). In future, this will form part of the induction process with newly recruited nurses. We will also re-do medication competency assessments following any medication/incidents and we will of course continue to carry our regular medication audits and continue to learn and improve from these. All nursing staff to undertake medication management online training, HSELAND. This will be completed annually and post any medication incidents.

**Proposed Timescale:** 20/11/2015

**Outcome 10: Notification of Incidents**

**Theme:**

Safe care and support

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

The provider failed to notify the Chief Inspector of incidents as set out in Schedule 4 of the regulations.

**10. Action Required:**

Under Regulation 31(1) you are required to: Give notice to the chief inspector in writing of the occurrence of any incident set out in paragraphs 7(1)(a) to (j) of Schedule 4 within 3 working days of its occurrence.

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

With regards to the NF03 submissions, an incident was noted on 15th August 2015 (Saturday) and the paperwork duly submitted on 19th August 2015, this is in keeping with the regulations which require submission to be made within three working days.

All notifications will be submitted by the PIC/Provider within 3 working days of its occurrence. The Provider has requested that all incidents are reported within 24hrs to the Corporate Clinical Governance Team and this Team will ensure that all notifications timeframes are adhered to.

Daily the PIC/ADON attends and reviews the handover report. Any incidents that occur are reviewed at this stage and if Incident/Accident report not completed same is actioned.

**Proposed Timescale:** 02/11/2015

**Theme:**

Safe care and support

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

The provider failed to return a written report on a quarterly basis of all incidents and events as detailed under schedule 4 of the regulations

**11. Action Required:**

Under Regulation 31(3) you are required to: Provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of any incident set out in paragraphs 7(2) (k) to (n) of Schedule 4.

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

The Corporate Clinical Governance Team will support and guide the PIC to ensure that Quarterly Report to the Chief Inspector at the end of each quarter in relation to the

occurrence of any incident set out in paragraphs 7(2) (k) to (n) of Schedule 4 is submitted with the required timeframes.

**Proposed Timescale:** 02/11/2015

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

**Theme:**

Effective care and support

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

All the care needs of all residents were not being met and suitable safe and sufficient care was not being provided.

**12. Action Required:**

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

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

To meet all the care needs of our residents we have completed the following :  
A new handover nursing report sheet has been developed, this reporting structure accounts for the following, Dependency, Healthcare needs, Social needs, General medical needs, Skin assessment, falls assessment, Pain management, Infection control. This handover document is reviewed by PIC/ADON on a daily basis. Following this review the PICN/ADON will guide and support Nurses and care assistants in meeting the needs of our residents.

On a weekly basis the PIC and ADON will have a clinical review meeting, a "Weekly Care Quality Indicator report" will be completed and sent to the Clinical Governance and Operations Manager for review and evaluation. Learning outcomes and actions will be set as indicated by residents needs.

Monthly the PIC/ADON will discuss with the Clinical Governance and Operations Manager the reviews and actions and learning outcomes set and the amendments that have been put in place to meet the residents care needs. The review and audit will comprise of a review of the Weekly Care Quality Indicator and the handover sheets.

The PIC/ADON have commenced a full review of all care plans and are ensuring that they best reflect the care the residents require and guide and support staff in the delivery of the care. On a monthly basis the PIC/ADON will review and update 14 resident care plans, to ensure that they reflect the care required and being given. A monthly Audit by the Clinical Governance and Operations Manager takes place and this is to ensure that the care plan is compliant as per Standards and reflects the health and social needs and wellbeing of the residents.

To ensure that safe care is provided to all residents the following will be reviewed and audited monthly by the PIC and Corporate Clinical Governance Team : Skin Integrity, Dependency of Residents, Falls, Clinical Care plan review, Restraints, Nutritional Needs,

Wound care, Resident Medication Kardex, Medications Drug Rounds, Weekly Home Reviews, Review of weekly care quality indicator reports

**Proposed Timescale:** 02/11/2015

**Theme:**

Effective care and support

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

Assessment, care planning and clinical care did not accord with current evidence-based practice.

Complete comprehensive nursing assessments were not carried out for each resident in respect of every identified need.

**13. Action Required:**

Under Regulation 05(2) you are required to: 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 the designated centre.

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

Our pre admission assessment will form the basis and guide staff to implement a residents care plan on admission. It will use the a holistic model of care, (Roper Logan and Tierney, reviewed 1998), which is a well- recognised and widely used tool that does allow for a complete comprehensive assessment. In supporting clinical judgment we also use a wide range of clinical risk assessment tools (as directed by NICE guidelines, these are used to aide clinical judgment and not dictate practice).

To ensure that each care plan reflects the ongoing and changing needs of each resident further training will be given to support staff .This will be identified through auditing and review of the care plans and care plans.

The PIC/ADON are commencing a full review of all care plans and to ensure that they best reflect the care the residents require and guide and support staff in the delivery of the care. This will involve a Complete comprehensive nursing assessments for each resident in respect of every identified need.

The care plans will then reflect best practice and be supported by the policies and Standard Operating Procedures that will ensure delivery of care that is needs based..

On a monthly basis the PIC/ADON will review and update 14 resident care plans, to ensure that they reflect the care required and being given. A monthly Audit by the Clinical Governance and Operations Manager takes place and this is to ensure that the care plan is compliant as per Standards and reflects the health and social needs and wellbeing of the residents.

**Proposed Timescale:** 04/01/2016

**Theme:**

Effective care and support

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

Assessment and care planning were not specific enough to direct the care to be delivered in an holistic manner as evidenced by examples such as residents experiencing significant weight loss, wound and pressure ulcer care

**14. Action Required:**

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

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

Following the completion of the Full review of all residents care plans as outlined under ACTION 13, the PIC will be able to support and oversee the nurses, to ensure that the care plans are specific enough to direct care and under Regulation 05(3), as above, we will continue to ensure that the care plan is commenced on admission and this will be supported by the comprehensive pre admission assessment that will accompany each resident on admission.

To ensure that care is provided and delivered in an holistic manner as evidenced by examples such as residents experiencing significant weight loss, wound and pressure ulcer care, all residents care needs will be reviewed and audited monthly by the PIC and Corporate Clinical Governance Team under the followings identified needs : Skin Integrity, Dependency of Residents, Falls, Clinical Care plan review, Restraints, Nutritional Needs, Wound Care, Resident Medication Kardex, Medications Drug Rounds, Weekly Home Reviews, Review of weekly care quality indicator reports.

**Proposed Timescale:** 04/01/2016

**Theme:**

Effective care and support

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

Evidence that all care plans were fully reviewed for effectiveness as residents needs changed and records of residents current overall condition as required by the regulations were not available

**15. Action Required:**

Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.

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

As indicated in above in Action 12, 13 and 14, we fully intend to address the concerns of the Inspectors and will have reviewed all of the current resident care plans.

**Proposed Timescale:** 04/01/2016

**Theme:**

Effective care and support

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

The documentation of care was not sufficiently accurate or complete to determine that a high standard of evidence based nursing care was being delivered to all residents to fully meet their personal social and healthcare care needs.

**16. Action Required:**

Under Regulation 06(1) you are required to: Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

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

As per actions set out under 12, 13, 14 the full review and Audit and evaluations programme will ensure that all residents documentation of care will be sufficient, accurate and complete to determine that a high standard of evidence based nursing care is being delivered to all our residents to fully meet their personal social and healthcare care needs as identified.

**Proposed Timescale:** 04/01/2016

**Outcome 12: Safe and Suitable Premises**

**Theme:**

Effective care and support

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

The design and layout of the centre is not currently suitable for the purpose of achieving the aims and objectives set out in the statement of purpose. Services and facilities available do not meet the assessed needs of all of the current resident profile.

**17. Action Required:**

Under Regulation 17(1) you are required to: Ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.

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

The Statement of purpose amended to reflect the design and layout of the nursing home. The home meets the needs of all our current residents and a new admission policy introduced to ensure that all future residents can be accommodated. On the day of inspection one, three bedded room converted to double room  
Plans to be submitted to DCC re refurbishment of last three bedded room. Please see attached plans that will remove the triple bedroom.

**Proposed Timescale:** 18/11/2016**Theme:**

Effective care and support

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

The centre currently does not meet the requirements of Regulation 17 or Standard 25 (Physical Environment) of the National Quality Standards for Residential Care Settings for Older People in that; the physical design and layout of the premises does not meet the full needs of the current resident profile and all aspects of the premises are not accessible, hygienic, spacious or well maintained. The premises does not fully conform with all requirements of schedule 6 of the Regulations.

**18. Action Required:**

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

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

Plans to be submitted to DCC re refurbishment of last three bedded room. Please see attached. On the day of inspection one, three bedded room converted to double room to better meets the needs of the residents.

A full review of all household cleaning has taken place and any issues found are immediately addressed. A Full and comprehensive household rota in operation and supervised by PIC and Group Operations Manager

**Proposed Timescale:** 18/11/2016**Outcome 16: Residents' Rights, Dignity and Consultation****Theme:**

Person-centred care and support

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

All residents were not supported to participate in accordance with their capacities. Group and individual activities that are meaningful and reflect residents past interests or lifestyles and activities specific to residents with cognitive impairments and/or with

limited or no mobility were not evident.

**19. Action Required:**

Under Regulation 09(2)(b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests and capacities.

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

We are developing an activity programme that meets all the needs of our residents. The activity programme will be guided by the training workshops undertaken by the activity co-ordinator which was focused on Dementia activities and sensory stimulation.5. This was a three day course which was completed on the 24th, 25th and 31st August 2015. We have also commenced the "Choice Project " has been commenced which identifies each residents hobbies, likes, interests and will be used to develop activity programmes to best meet there needs.

**Proposed Timescale:** 04/01/2016

**Theme:**

Person-centred care and support

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

Resident's right to privacy was not always respected during personal care provision.

**20. Action Required:**

Under Regulation 09(3)(b) you are required to: Ensure that each resident may undertake personal activities in private.

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

The PIC has completed Information sessions with staff re respecting the privacy of residents during personal care. The importance of dignity during care giving is discussed at each handover of shift.

**Proposed Timescale:** 12/10/2015

**Theme:**

Person-centred care and support

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

Evidence that residents were consulted and choice respected in relation to daily life on an ongoing basis was not available.

**21. Action Required:**

Under Regulation 09(3)(a) you are required to: Ensure that each resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.

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

The PIC/ADON are reviewing all care plans and they will document that consultation and Residents choice is noted and followed as per their care needs. Any changes made by the resident will be documented and discussed with the resident and/or their representatives.

**Proposed Timescale:** 04/01/2016

**Outcome 18: Suitable Staffing**

**Theme:**

Workforce

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

Training relevant to the profile of residents was required to improve standards of care in areas such as nutrition, wound care, pressure ulcer care, assessment planning evaluation and documentation of care, person centred care, hand hygiene and infection prevention and control.

**22. Action Required:**

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

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

We have as a company always provided training and will continue to do so and have arranged for the following training:

Training on Nutrition took place on 25th and 27th August 2015.

Training on MUST to take place on 15th September 2015.

Training on Wound Care and Pressure Ulcer care to take place on 24th and 25th September 2015.

Training on Pressure Sore Prevention taking place on 15th September 2015

Hand Hygiene and Infection Control to take place 22nd 23rd September 2015

Assessment, planning, evaluation and documentation of care training taking place on 14th October 2015.

**Proposed Timescale:** 02/11/2015

**Theme:**

Workforce

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

There was inadequate supervision of care practices to ensure care was delivered by nursing and healthcare staff in line with best practice, training and recommendations of allied health professionals

**23. Action Required:**

Under Regulation 16(1)(b) you are required to: Ensure that staff are appropriately supervised.

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

In improving our operational management system and to ensure that adequate supervision is provided to care staff we have introduced additional staff "handover" meetings for nursing and care staff. This provides an opportunity for nursing staff to provide updates and instructions as to residents' care needs and provides carers with an opportunity to give the nurse information updates. At the initial morning handovers staff are allocated to teams of residents but within the team there are also more specific roles and responsibilities for example; maintaining fluid charts, position/turn charts etc. The staff member allocated to these duties/roles will present the documentation at the handover meeting so that the nurse can ensure that the documentation has been completed accurately and follows any recommendations made by allied health professionals.

Also, the PIC and ADON will now formalise the monitoring process by doing planned building walks, to assess standards of environmental hygiene, completion of documentation, resident welfare and to assess if there are any new areas of concern and this will include monitoring of residents who require pressure area care, diet and fluid intake.

In improving the internal governance the PIC and ADON will meet formally on a weekly basis. At this meeting the following will be discussed: residents considered to be at risk of, for example development of pressure ulcers, poor nutritional intake and will also plan the week ahead, as in areas to be concentrated on.

Based on the findings, outcomes of the above, a weekly report will be submitted to the Clinical Governance and Operations Manager. The Provider recognises that the PIC and ADON are new to their positions, and has developed a PIC professional and development programme which will guide and support both of these managers in their roles and provides a more formal process of development and evaluation.

**Proposed Timescale:** 02/11/2015