

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Oakfield Nursing Home
Centre ID:	OSV-0000259
Centre address:	Courtown, Gorey, Wexford.
Telephone number:	053 942 5679
Email address:	info@oakfieldnursinghome.com
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Patrick Shanahan
Provider Nominee:	Patrick Shanahan
Lead inspector:	Ide Cronin
Support inspector(s):	Leanne Crowe
Type of inspection	Unannounced Dementia Care Thematic Inspections
Number of residents on the date of inspection:	70
Number of vacancies on the date of inspection:	3

About Dementia Care Thematic Inspections

The purpose of regulation in relation to residential care of dependent Older Persons is to safeguard and ensure that the health, wellbeing and quality of life of residents is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer and more fulfilling lives. This provides assurances to the public, relatives and residents that a service meets the requirements of quality standards which are underpinned by regulations.

Thematic inspections were developed to drive quality improvement and focus on a specific aspect of care. The dementia care thematic inspection focuses on the quality of life of people with dementia and monitors the level of compliance with the regulations and standards in relation to residents with dementia. The aim of these inspections is to understand the lived experiences of people with dementia in designated centres and to promote best practice in relation to residents receiving meaningful, individualised, person centred care.

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor compliance with specific outcomes as part of a thematic inspection. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 05 July 2016 09:20 To: 05 July 2016 18:30

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

Outcome	Provider's self assessment	Our Judgment
Outcome 01: Health and Social Care Needs	Substantially Compliant	Non Compliant - Moderate
Outcome 02: Safeguarding and Safety	Compliance demonstrated	Non Compliant - Moderate
Outcome 03: Residents' Rights, Dignity and Consultation	Substantially Compliant	Non Compliant - Major
Outcome 04: Complaints procedures	Not applicable	Compliant
Outcome 05: Suitable Staffing	Compliance demonstrated	Non Compliant - Moderate
Outcome 06: Safe and Suitable Premises	Compliance demonstrated	Substantially Compliant
Outcome 08: Governance and Management		Non Compliant - Moderate

Summary of findings from this inspection

This inspection report sets out the findings of a thematic inspection which focused on six specific outcomes relevant to dementia care. The purpose of this inspection was to determine what life was like for residents with dementia living in the centre. The Health Information and Quality Authority (HIQA) had received a concern in relation to potential issues of safeguarding vulnerable adults in the centre. Inspectors explored practice areas in relation to the information received and were satisfied that reasonable measures were being taken to protect residents from abuse. However, improvement was required in relation to training in safeguarding vulnerable persons and managing behaviours that challenge.

Improvement was also required in relation to the assessment and management of behavioural and psychological symptoms of dementia (BPSD). The inspection also

considered progress on some findings following the last inspection carried out on 3 December 2015 and to monitor progress on the actions required arising from that inspection.

Inspectors met with residents, relatives and staff members on this unannounced inspection. Inspectors reviewed the assessed care needs of residents and tracked the journey of a sample of residents with dementia within the service. They observed care practices and interactions between staff and residents who had dementia using a formal recording observational tool. Inspectors also reviewed documentation such as care plans, policies relating to dementia care, medical records and staff files.

The provider had submitted a completed self-assessment tool on dementia care to HIQA with relevant policies and procedures prior to the inspection. The provider had assessed the compliance level of the centre through the self-assessment tool but the findings of inspectors did not equal with the provider's judgements. However, inspectors observed that the management team and staff working in the centre were committed to providing a quality service for residents with dementia.

Although some progress had been made by the provider in implementing the required improvements identified on the inspection in December 2015, some non-compliances found at that time were again evident on this inspection. Risks associated with standards of clinical care which included management of behaviours that challenge, supervision of practice, care planning documentation and mandatory staff training were found. Due to the level of non-compliances identified on this inspection, inspectors also reviewed the outcome of governance and management on this inspection; this was found to be at a level of moderate non-compliance.

Matters requiring review are discussed throughout the report and the action plan at the end of the report contains actions that are required to be completed 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.

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: Health and Social Care Needs

Theme:

Safe care and support

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

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

Findings:

Pre-admission telephone assessment information was obtained from residents' families or hospital staff. However, the inspectors found that pre-admission documentation was scant in some case records and not recorded in others. This finding supported a requirement for improvement in pre-admission assessment procedures to ensure the service could meet the needs of residents, including those with dementia. The person in charge told inspectors that the process of pre-admission assessments had commenced a year ago.

A paper-based care planning and resident information management system was in place. Nursing staff completed daily progress entries. However, there were gaps in the records and some were not completed on a daily basis as required by legislation. Recognised assessment tools were used to evaluate residents' progress and to assess levels of risk for deterioration, for example vulnerability to falls, dependency levels, nutritional care, the risk of developing pressure sores and moving and handling assessments. Staff demonstrated good knowledge and understanding of each resident's background in conversation with the inspector. While staff told the inspector that residents and relatives were involved in the care planning process, there was inconsistent documentary evidence that residents or their representative were involved in the development and review of their care plan.

There were assessment and care procedures in place to ensure residents' nutritional needs were met and that they did not experience dietary or hydration deficits. Residents' weights were checked on a monthly basis. Diet and fluid intake records were used as appropriate. Menus were available and all residents were offered choice at each meal. There was evidence of efforts being made to ensure residents with dementia had their individual food tastes and choices met. An inspector observed that wound assessment and care planning was in accordance with best practice.

The inspectors observed residents having their lunch in two different dining rooms. A choice of meal was offered to residents and snacks and refreshments were provided between mealtimes. There was adequate staff available to assist residents with eating where required. However, an inspector observed that a resident was not discreetly

assisted with eating by staff during lunch as the staff member stood over the resident while assisting them. Observation at mealtimes was also indicative of some elements of task orientated care and there were limited opportunities for social engagement with residents as observed by inspectors.

There were no residents in the centre in receipt of end-of-life care on the day of inspection. Palliative care services were available to support residents and staff with symptom control, including pain management. However, inspectors found there was no evidence of a pain assessment being completed for a resident with dementia even though the narrative records indicated that the resident experienced pain. There was inconsistent evidence that the end-of-life needs and wishes of all residents with dementia were discussed with them and or with their next of kin as appropriate and this was documented in a care plan. Some care plans addressed the residents' physical, emotional, social and spiritual needs. Some care plans did not reflect each resident's wishes and preferred pathway as part of their end-of-life care. It was not evident in the documentation reviewed that the resident was involved in the decision making process relating to end-of-life care.

There were written operation policies relating to the ordering, prescribing, storing and administration of medicines to residents and disposal of unused or out-of-date medicines. The inspector reviewed a sample of residents' individual medicine prescription charts and there was evidence that residents' prescriptions were reviewed at least every three months by a medical practitioner. The medication administration sheets viewed were signed by the nurse following administration of medication to the resident and recorded the name of the drug and the time of administration.

Photographic identification was available on the drugs chart for each resident to ensure the correct identity of the resident receiving the medication and reduce the risk of medication error. The prescription sheets reviewed were clear and the signature of the GP was in place for each drug prescribed in the sample of drug charts examined. However, the inspector found that medication administration did not meet professional standards and prescribing requirements in one area:

-medications administered in a crushed format were not individually prescribed.

The pharmacist was facilitated to meet all necessary obligations to residents in accordance with guidance issued by the Pharmaceutical Society of Ireland, and visited the centre on a regular basis conducting audits of medicines management practice in the centre. The supply, distribution and control of scheduled controlled drugs was in line with legislation.

Judgment:

Non Compliant - Moderate

Outcome 02: Safeguarding and Safety

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:

HIQA had received a number of notifications from the centre relating to alleged allegations of abuse since the beginning of this year. Investigation reports concerning these allegations were made available to inspectors on the day of the inspection. While almost all of these investigations had been closed out and actions recorded, some of these actions had not been completed. For example, ensuring that all staff received training in the prevention, detection and management of abuse was listed as an action in reports from February and April 2016, yet training records indicated that this was still outstanding on the day of the inspection. Inspectors were furnished with training records on the day of the inspection. These records indicated that in response to the action from the last inspection, 63 staff members had received training in the prevention, detection and management of abuse in 2016. Twenty-seven staff members were recorded as still requiring up-to-date training in this area and three members of staff had no training date recorded in the matrix.

There was a safeguarding policy in place which had been reviewed however, it did not fully reference the Health Service Executive Safeguarding Vulnerable Persons at Risk of Abuse, National Policy and Procedures (2014). Improvement was required in the management of behaviours that challenge. There were policies in place on behaviours that challenge and the use of restrictive practices. However, supporting assessment tools were not available therefore indicating to inspectors that the policies were not implemented in practice.

The policy of the centre in relation to behaviours that challenge outlined that all residents with behaviours that challenge would have a standardised assessment completed. There was no standardised assessment tool to assess behaviours. Clear strategies were not outlined to support a consistent approach to the management of behaviours that challenge or that focussed on a proactive and positive approach. None of the staff had completed any recent training in the management of behaviours that challenge or dementia care.

Care plans for residents with dementia or behaviours that challenge required review to ensure they are more person-centred. Inspectors observed that the plans were not specific enough to guide staff and manage the needs identified. Inspectors observed that where a small number of residents exhibited aspects of behaviours that challenge, their care plans required improvement. The care plan did not fully guide staff on the signs to look for as potential triggers to responsive behaviour. The care plans did not describe effective positive behavioural strategies for use by staff to manage these behaviours.

For example, in a file reviewed by inspectors the plan did not guide staff on the type of distraction techniques which could be employed to reduce escalation or of all measures which were known to manage the behaviour and prevent recurrence. Although it was

found that long-term regular staff were familiar with residents' needs and could recognise changes to their demeanour, for new, inexperienced or replacement staff care assessment and planning documentation was not sufficiently explicit to direct care.

The use of restraint in the centre had reduced considerably since the last inspection. There were six residents who used bed rails in the centre. The inspector observed application of a good standard of assessment and care planning in this area. There were clear assessments in place to reflect their use and alternatives tried prior to their use were clearly recorded. For example, the use of low-low beds, crash mats and other methods were observed by an inspector to prevent the use of bed rails in some instances. Checks were in place for the use of restraint and inspectors saw that these were recorded.

Inspectors saw that expert advice from the relevant professionals was sought where necessary before commencing any psychotropic medication or any use of physical restraint. There was no chemical restraint used on a p.r.n basis. (a medicine taken only as the need arises). Some residents had seating assessments and were provided with specialist wheelchairs. There was a written policy on restraint. However, the policy on restraint did not include reference to the Department of Health document "Towards a Restraint Free Environment".

The centre maintained day-to-day expenses for some residents and there was a policy on residents' accounts and personal property. All transactions were appropriately documented with lodgements and withdrawals co-signed by two staff members as observed by an inspector. Checks completed by an inspector on a random sample of an account were correct.

Judgment:

Non Compliant - Moderate

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

Residents' privacy and dignity were respected, including receiving visitors in private. There were systems in place to support residents to exercise their religious, civil and political rights. There were notice boards available in the centre providing information to residents and visitors. Staff informed inspectors that every effort was made to provide each resident with the freedom to exercise choice in relation to their daily activities. There was no residents' committee in operation. Instead, external independent advocates were available to residents or relatives should they wish to obtain help to make a complaint or require assistance to express their views. This service was provided

through the patient advocacy services and meetings were held in the centre once a month. Inspectors reviewed records of an advocate visits and the issues that had been raised and rectified with advocates during their visit.

However, the inspector observed that residents paid for this service, as it was included as part of a daily charge to residents under the heading of additional services. While inspectors acknowledge that residents could access advocacy services, the Registered Provider should facilitate the establishment of an in-house residents' committee at no extra charge to residents. This would facilitate feedback, consultation and improvement in all matters affecting residents in their home.

Residents were facilitated to exercise their political and religious rights. Residents told the inspector that religious services were held regularly and there was an oratory on-site. Inspectors were told that residents were enabled to vote in national referenda and elections with the centre registered to enable polling.

Inspectors' observations and review of residents' documentation did not support findings that residents with dementia were provided with adequate and appropriate activation to meet their needs. Inspectors observed and reviewed the activation service provided to residents. Findings did not confirm that residents with dementia were given opportunities for participation in meaningful, purposeful and age-appropriate activities to suit their assessed and documented activation needs, preferences and capacities.

There was not a dedicated activities coordinator in the centre. Healthcare staff were given protected time each day to conduct an activity. Inspectors found that the activity programme was limited to Monday to Friday. Dementia relevant activities were limited to Sonas and reminiscence weekly as per the activity programme furnished to inspectors. On the day of inspection a reminiscence session was taking place which was observed to be very interactive for residents who did not have cognitive impairment. Inspectors observed that there was limited use of other techniques such as reality orientation or sensory equipment for residents with dementia. Inspectors formed the judgement that meaningful self-expression was not facilitated by occupational, recreational physical or sensory stimulation.

Inspectors used a validated observational tool to rate and record at five minute intervals the quality of interactions between staff and residents in the centre. The observation tool used was the Quality of Interaction Schedule or QUIS. These observations took place in the lounge areas and in the dining areas of the centre. Each observation lasted a period of 30 minutes and inspectors evaluated the quality of interactions between staff and residents with dementia.

Some positive interactions between staff and residents were observed during the inspection. However, inspectors observed that staff did not avail of opportunities to socially engage with residents. It was also observed that many staff did not engage residents in conversation except when engaging in tasks. There were periods during the observation when the communal room was left unsupervised. Some staff were observed to be busy and rushed and did not engage with some residents who sought their attention. An inspector observed that a resident dropped their cup of tea on the floor but could not pick it up as there was no staff member present to assist them for the 30

minute period that the inspector was in the room. A relative told an inspector that often there would be no supervision of communal areas by staff. A resident told an inspector that there was not much to do during the day. Although staff seemed familiar with residents' basic physical care needs and their family backgrounds, opportunities to chat with them about their family, previous interests or working life were limited.

Overall, observations of the quality of interactions between residents and staff in the communal area for a selected period of time indicated that the majority of interactions were of a neutral nature. Inspectors observed that for the majority of the residents in the communal area, there were no meaningful interactions with staff. Most residents were not engaged, or were asleep in their chairs with no stimulation for periods of time. During the lunch time period staff were observed for the most part to offer assistance in a respectful and dignified manner. Inspectors observed that when interactions did take place they were task orientated, such as encouraging the residents to eat their meal or take a drink. Inspectors found that during the observation periods that practices were led by routine and resources. Inspectors discussed these findings in detail with the person in charge and care manager at the feedback meeting post inspection.

There was a communication policy in place which had been due for review in December 2015 but had not been reviewed. Inspectors found that the policy did not reflect practices in the centre. The policy indicated that life stories were used as a basis for planning care for residents with dementia. The care manager told inspectors that there were possibly three life stories completed out of 16 residents with a definitive diagnosis of dementia.

There were issues of capacity to make decisions that staff had to consider, as some residents were highly dependent or had dementia or a combination of complex conditions. There was a policy on consent however; staff could not clearly demonstrate that the process used to obtain valid consent was in accordance with legislation and current best practice guidelines. All residents did not have an advanced end-of-life care plan in place documenting discussions in relation to life sustaining treatments. Each resident was not consulted regarding their future healthcare interventions, personal choices and wishes in the event that they became seriously ill and were unable to speak for themselves.

Based on the findings during inspection of this outcome inspectors judged it to be at a level of major non-compliance due to:

routines and practices did not maximise each resident's independence or choice, and residents with dementia were not enabled to make informed decisions about the management of their care.

Judgment:
Non Compliant - Major

Outcome 04: Complaints procedures

<p>Theme: Person-centred care and support</p>
<p>Outstanding requirement(s) from previous inspection(s): No actions were required from the previous inspection.</p> <p>Findings: There was a policy and procedure in place for managing complaints, which was found to support practice within the centre. A simplified copy of the complaints procedure was displayed prominently in the reception area of the centre. A large print version of the procedure was also available in order to be more accessible to residents.</p> <p>There was a nominated complaints officer to deal with complaints, an independent person to manage appeals and an independent person to ensure complaints are appropriately managed and recorded. Further information about the appeals process, including the Ombudsman, was included in the complaints procedure. However, not all residents spoken with on the day of the inspection could identify who they would direct complaints to.</p> <p>The centre maintained a complaints log, which was reviewed by inspectors. Records contained details of complaints, investigations undertaken, outcomes of complaints and whether the complainants were satisfied with these outcomes. There was evidence that verbal complaints were also being recorded.</p> <p>Inspectors spoke with staff who were knowledgeable about the complaints process. Staff could describe how they would assist residents, particularly residents with dementia, in making a complaint. Staff could also describe what action to take if a complaint was made to them.</p>
<p>Judgment: Compliant</p>

Outcome 05: Suitable Staffing

<p>Theme: Workforce</p>
<p>Outstanding requirement(s) from previous inspection(s): Some action(s) required from the previous inspection were not satisfactorily implemented.</p> <p>Findings: While there was appropriate staff numbers to meet the needs of the residents, including those with dementia, a number of improvements were required in relation to staff training and supervision. Insufficient levels of up-to-date mandatory training had also been identified in the previous inspection in 2015.</p>

There was limited evidence of any current relevant training available to staff to support them in advancing their skills, particularly in relation to dementia care. The care manager delivered training in the prevention and protection of residents from abuse while the health and safety manager was certified to offer training in fire safety. However, training records indicated that a substantial number of staff were not up-to-date with mandatory training in fire safety, moving and handling practices and the prevention and detection of residents from abuse. This had been identified in the previous inspection in 2015, and had been proposed in the centre's action plan to be addressed by January 2016. While approximately 60-70% of staff had received mandatory training as of July 2016, a large number of staff were still outstanding, with some staff last receiving training mandatory training in 2013. Inspectors spoke with staff on the day of the inspection regarding their knowledge of the various types of training they undertook. While the majority of staff spoken with could describe elements of the training they had received, some staff had conflicting knowledge regarding infection control precautions and the use of personal protective equipment (PPE).

Some policies in the centre had been signed as being read by only a small number of staff. In addition, staff members spoken with by inspectors were not aware that an updated version of the National Quality Standards for Residential Care Settings for Older People in Ireland had recently come into effect. While staff could identify where they would locate a copy of the regulations in the centre, they could not state where they would locate a copy of the aforementioned Standards. It is the responsibility of the person in charge to ensure that copies of any relevant standards published by HIQA are available to staff.

Inspectors viewed rosters for staffing levels, which reflected actual staff provision on the day of the inspection. Staff recruitment procedures were in place and included vetting of staff. A sample of staff files were examined by inspectors and were found to contain all of the necessary information required by Schedule 2 of the Regulations.

Staff meetings were held twice a year, but the person in charge advised inspectors that they communicated with staff more frequently through text messages and notices. While staff supervision was occurring in the centre, observations from inspectors as well as feedback received from a resident's relative indicated that improvements could be made. This is outlined under Outcome 3. In addition, appraisals of staff were not on going and had not been carried out in the centre in at least one year.

Volunteers had Garda Síochána vetting, and their roles and responsibilities had been set out in writing.

Judgment:
Non Compliant - Moderate

Outcome 06: Safe and Suitable Premises

Theme:

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

No actions were required from the previous inspection.

Findings:

The design and layout of the centre met the needs of the residents and was suitable for its purpose. While objects and colour were used to support residents with dementia to find their way around, contrasting colour could be used in bathrooms and toilets. In addition, equipment such as a cleaning trolley and a fan were being incorrectly stored in a sluice room, where soiled or contaminated equipment is cleaned. The storage of these items in such a room does not promote good hygiene or infection control practices.

The premises and grounds were well-maintained with suitable heating, lighting and ventilation. The centre provided adequate areas of personal spaces and common areas for residents, including a sun room, a library, a beauty therapy room, an art room, a large sitting room and a smaller sitting room in the Darac Suite. The layout of the centre supported movement of residents to these common areas and to their personal spaces, with clear signage indicating where various rooms were located and hand rails installed throughout corridors. However, some equipment such as a laundry trolley were seen to be stored in a corridor.

Residents' bedroom accommodation consisted of 35 single rooms and 19 twin rooms and were of an adequate size to accommodate specialised or assistive equipment that residents might require. All bedrooms contained en-suite bathrooms and there was also an assisted bathroom on each of the two floors where residents resided. Common areas and residents' bedrooms were suitably decorated, with clocks and calendars in some rooms to orientate residents to time and place. Some residents had personalised their rooms with pictures and ornaments. All rooms contained sufficient storage for residents' personal belongings.

Dining room facilities were located on two floors of the centre and were configured to meet the needs of residents. While there were various outdoor spaces at the centre, not all of these were immediately accessible to residents. For example, an enclosed garden adjoining the Darac Suite was not accessible to residents due to uneven surfaces of pathways. The person in charge told inspectors that there were plans to renovate this garden and make improvements to another enclosed area adjoining one of the dining rooms. However, there was another enclosed garden on the ground floor which was accessible to all residents.

There was appropriate equipment for residents that was well maintained. A health and safety and estates manager worked full-time in the centre, and addressed any maintenance requirements. There was a functioning call bell system in place for residents, and a lift was available to support movement between floors.

Judgment:

Substantially Compliant

Outcome 08: Governance and Management

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

Inspectors found that the system in place to monitor the quality and safety of care and the quality of life for residents required improvement. There were governance meetings which were held on a monthly basis which dealt with complaints, finance, accidents and incidents, advocacy, policies and any other business. Inspectors found that the management systems were ineffective in monitoring the delivery of safe and quality care services to residents as evidenced through the deficits outlined in the report.

The inspectors observed that clinical and non clinical audit had not been carried out. Therefore the quality of care and experience of residents was not monitored effectively as deficits in practice were not identified and could not positively inform improvements in the safety and quality of care or the quality of life of residents. Satisfaction surveys had not been completed for a couple of years. An annual review of the quality and safety of the service as required by legislation for 2015 was not available to inspectors or residents on this inspection.

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:

Ide Cronin
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	Oakfield Nursing Home
Centre ID:	OSV-0000259
Date of inspection:	05/07/2016
Date of response:	25/07/2016

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: Health and Social Care Needs

Theme:

Safe care and support

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

There was limited documentary evidence that residents or their representative were involved in the development and review of their care plan.

1. Action Required:

Under Regulation 05(5) you are required to: Make the care plan, or revised care plan, prepared under Regulation 5 available to the resident concerned and, with the consent

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

of that resident or where the person-in-charge considers it appropriate, to his or her family.

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

- 1)The nursing staff will be scheduled with dedicated time to develop and review residents' care plans in conjunction with the resident and/or their representatives
- 2)Case meetings with the resident, representatives and care team have been implemented on a rolling programme of two residents per week. Care plan formulation and review will be included in these meetings.
- 3)A steering group of nursing staff has been established to review all nursing documentation to promote person centred care.
- 4)Regular audits of the nursing documentation will be carried out to ensure compliance with this action.

Proposed Timescale: 30/04/2017

Theme:

Safe 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 or guide staff on the appropriate use of interventions to consistently manage the identified need.

2. 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:

A steering group of nursing staff has been established to review all nursing documentation to ensure assessments and care plans specifically direct care and include the appropriate use of interventions to consistently manage identified needs. Regular audits of the nursing documentation will be carried out to ensure compliance with this action.

Proposed Timescale: 30/09/2016

Theme:

Safe care and support

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

The inspectors found that pre-admission documentation was scant in some case records and not recorded in others.

3. 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:

A pre-admission document has been developed and implemented. This is in use for all new admissions from 12 July 2016.

Proposed Timescale: 12/07/2016

Theme:

Safe care and support

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

There was no evidence of a pain assessment being completed for a resident with dementia even though the narrative records indicated that the resident experienced pain.

4. 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:

A steering group of nursing staff has been established to review all nursing documentation. This will include an check list for the nurses when completing and reviewing care plans to ensure all indicated assessments including pain assessments are implemented and documented.

Proposed Timescale: 30/09/2016

Theme:

Safe care and support

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

Some care plans did not reflect each resident's wishes and preferred pathway as part of their end of life care.

5. Action Required:

Under Regulation 13(1)(a) you are required to: Provide appropriate care and comfort to a resident approaching end of life, which addresses the physical, emotional, social, psychological and spiritual needs of the resident concerned.

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

The Let Me Decide Advanced Care Directive will be implemented to allow residents and/or their representative where appropriate to communicate their end of life wishes to the care team. An end of life care plan will be in place for each resident that reflects their wishes.

Proposed Timescale: 30/09/2016

Theme:

Safe care and support

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

An inspector observed that a resident was not discreetly assisted with eating by staff during lunch as the staff member stood over the resident whilst assisting him.

6. Action Required:

Under Regulation 18(3) you are required to: Ensure that an adequate number of staff are available to assist residents at meals and when other refreshments are served.

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

- 1) Adequate staffing will be available to assist residents.
- 2) 30% of direct care staff will receive dementia care training including, person centred care and behaviours that challenge by 31 December 2016
- 3) 90% direct care staff will receive dementia care training including, person centred care and behaviours that challenge by 31 December 2017
- 4) Rostering changes that will minimise the rotation of staff thus fostering more person centred approach to care.

Proposed Timescale: 31/12/2017

Theme:

Safe care and support

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

There were gaps in the nursing records and some were not completed on a daily basis as required by legislation.

7. Action Required:

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

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

- 1) There will be a minimum of one nursing entry in every 24 hour period

2)Nursing record sheets have redesigned to ensure clear recording of the date and time of each entry
3)Regular audits of the nursing documentation will be carried out to ensure compliance with this action.

Proposed Timescale: 30/09/2016

Theme:

Safe care and support

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

The inspector found that medication administration did not meet professional standards and prescribing requirements in one area:

-medications administered in a crushed format were not individually prescribed.

8. 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:

Medication prescription sheets will be redesigned to ensure that where crushed medications are administered they are prescribed individually.

Proposed Timescale: 31/07/2016

Outcome 02: Safeguarding and Safety

Theme:

Safe care and support

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

None of the staff had completed any recent training in the management of behaviours that challenging or dementia care.

9. Action Required:

Under Regulation 07(1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.

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

1)30% of direct care staff will receive dementia care training, including person centred care and behaviours that challenge by 31 December 2016

2)90% direct care staff will receive dementia care training, including person centred care and behaviours that challenge by 31 December 2017.

Proposed Timescale: 31/12/2017

Theme:

Safe care and support

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

There was no standardised assessment tool to assess behaviours. Clear strategies were not outlined to support a consistent approach to the management of behaviours that challenge or that focussed on a proactive and positive approach.

10. Action Required:

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

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

- 1)A standardised assessment tool will be implemented to assess behaviours
- 2)Our challenging behaviour policy will be reviewed and communicated to all staff.
- 3)Training as identified above will be given to staff.

Proposed Timescale: 31/12/2017

Theme:

Safe care and support

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

The policy on restraint did not include reference to the Department of Health document "Towards a Restraint Free Environment".

11. 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:

The restraint policy will be reviewed and update to meet current standards.

Proposed Timescale: 31/07/2016

Theme:

Safe care and support

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

The care plans did not always describe effective positive behavioural strategies for use by staff to manage behaviours. The care plans in place to manage these needs did not fully guide staff on the signs to look for as potential triggers to responsive behaviour.

12. Action Required:

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

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

The care plans will be reviewed and updated to ensure that they describe effective positive behavioural strategies for use by staff to manage behaviours.

Proposed Timescale: 30/08/2016

Theme:

Safe care and support

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

All staff had not received training in the prevention, detection and management of abuse.

13. Action Required:

Under Regulation 08(2) you are required to: Ensure staff are trained in the detection and prevention of and responses to abuse.

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

Further training dates have been scheduled to ensure the remaining 33% of the staff are fully trained in safeguarding procedures.

Proposed Timescale: 30/09/2016

Outcome 03: 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:

There was a communication policy in place which had been due for review in December 2015 but had not been reviewed.

14. Action Required:

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

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

The communication policy will be reviewed and updated in accordance with required standards and best practice.

Proposed Timescale: 31/07/2016

Theme:

Person-centred care and support

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

Findings did not confirm that residents were given opportunities for participation in meaningful, purposeful and age-appropriate activities to suit their assessed and documented activation needs, preferences and capacities.

15. 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:

A activities co-ordinator post has been agreed and is currently being advertised. The focus of this new role will be to increase opportunities for participation in meaningful and appropriate activities for all residents.

Proposed Timescale: 30/09/2016

Theme:

Person-centred care and support

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

There was a policy on consent however; staff could not clearly demonstrate that the process used to obtain a valid consent was in accordance with legislation and current best practice guidelines.

16. 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 consent policy will be reviewed and updated in accordance with regulations and best practice and communicated to staff.

Proposed Timescale: 30/09/2016

Theme:

Person-centred care and support

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

Facilitate the establishment of an in-house residents' committee.

17. Action Required:

Under Regulation 09(3)(d) you are required to: Ensure that each resident is consulted about and participates in the organisation of the designated centre concerned.

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

A residents meeting has been planned for 31 August 2016. The establishment of a residents' committee will be discussed at this meeting and volunteers sought.

Proposed Timescale: 31/10/2016

Theme:

Person-centred care and support

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

The communication policy indicated that life stories were used as a basis for planning care for residents with dementia. Inspectors saw that there were possibly three life stories completed out of 16 residents with a definitive diagnosis of dementia.

18. Action Required:

Under Regulation 10(1) you are required to: Ensure that each resident, who has communication difficulties may communicate freely, having regard to his or her wellbeing, safety and health and that of other residents in the designated centre.

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

- 1) My life story booklets have been developed and circulated to all residents' and/or their representatives where appropriate.
- 2) These booklets once returned will be made accessible in the residents' rooms.

Proposed Timescale: 30/09/2016

Outcome 05: Suitable Staffing

Theme:

Workforce

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

Staff appraisals had not been carried out in the centre.

19. 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:

Staff appraisals will be undertaken on an annual basis

Proposed Timescale: 31/12/2016

Theme:

Workforce

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

There was limited evidence of any current relevant training available to staff to support them in advancing their skills particularly in relation to dementia care.

20. 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:

- 1)30% of direct care staff will receive dementia care training, including person centred care and behaviours that challenge by 31 December 2016
- 2)90% direct care staff will receive dementia care training, including person centred care and behaviours that challenge by 31 December 2017.

Proposed Timescale: 31/12/2017

Theme:

Workforce

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

Training records indicated that a number of staff were not up-to-date with mandatory training. This had also been identified in the previous inspection in 2015.

21. Action Required:

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

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

Further training dates have been scheduled to ensure the remaining 33% of the staff

have received up-to-date mandatory training.

Proposed Timescale: 30/09/2016

Theme:
Workforce

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

Under Regulation 16(2)(b) the person in charge is required to ensure that copies of standards set and published by the Authority are made available to staff.

22. Action Required:

Under Regulation 16(2)(b) you are required to: Make copies available to staff of any relevant standards set and published 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:

Copies of the standards have been made available to all staff in each department. The location of these has been communicated to staff.

Proposed Timescale: 20/07/2016

Outcome 06: Safe and Suitable Premises

Theme:
Effective care and support

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

Under Part 1(3)(l), suitable adaptations as may be required shall be provided to residents.

23. 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:

The use of contrasting colours in bathrooms will be implemented on a person centred basis where it is assessed that it will benefit the resident.

Proposed Timescale: 31/12/2016

Outcome 08: Governance and Management

Theme:

Governance, Leadership and Management

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

An annual review of the quality and safety of the service as required by legislation for 2015 was not available to inspectors or residents on this inspection.

24. 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:

An annual review of the quality and safety of the service will be completed.

Proposed Timescale: 30/08/2016

Theme:

Governance, Leadership and Management

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

The inspectors observed that clinical and non clinical audit had not been carried out. Therefore the quality of care and experience of residents was not monitored effectively as deficits in practice were not identified.

25. 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:

Clinical and non-clinical audits will be implemented and used to inform service provision

Proposed Timescale: 31/12/2016

