

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Clontarf Private Nursing Home
Centre ID:	OSV-0000127
Centre address:	5 - 7 Clontarf Road, Clontarf, Dublin 3.
Telephone number:	01 833 5455
Email address:	clontarf@silverstream.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Clontarf Private Nursing Home Limited
Provider Nominee:	Joseph Kenny
Lead inspector:	Nuala Rafferty
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	38
Number of vacancies on the date of inspection:	2

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 to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
12 August 2015 10:30	12 August 2015 19:00
13 August 2015 09:00	13 August 2015 15:00

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

Outcome	Our Judgment
Outcome 01: Statement of Purpose	Non Compliant - Major
Outcome 02: Governance and Management	Compliant
Outcome 03: Information for residents	Non Compliant - Major
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Compliant
Outcome 06: Absence of the Person in charge	Non Compliant - Moderate
Outcome 09: Medication Management	Substantially Compliant
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 12: Safe and Suitable Premises	Non Compliant - Major
Outcome 14: End of Life Care	Compliant
Outcome 15: Food and Nutrition	Non Compliant - Moderate
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 11 November 2014 and to monitor progress on the actions required arising from that inspection.

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

It was found that limited progress was made in many areas by the provider in implementing the required improvements identified by the registration inspection and further action is required in all areas. In particular, significant acceleration is required to progress the refurbishment of the centre's premises in order to meet conditions of registration and considerable improvements are required to care planning, staffing and the management of nutrition.

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:

No actions were required following the registration inspection in November 2014.

However the statement of purpose needs to be revised to reflect a change to the person in charge of the centre.

Additionally it was found that the statement of purpose was not being fully implemented in practice in that;

- the criteria for admission and the admission policy referenced was not being adhered too. it was also found that the admission policy referenced was not the most up to date version (version 3) notified to the Authority and identified as the version to be implemented.

- the conditions for use of facilities relating to the triple bedrooms to enable safe and suitable care be delivered to residents availing of these rooms were not being implemented.

Judgment:

Non Compliant - Major

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:

As no actions were required arising from the last inspection all lines of enquiry for this outcome were not covered on this inspection

A defined management structure was in place. This included an overarching management structure that identifies the lines of authority at a senior level and included; director of operations and clinical governance; compliance risk and quality manager; human resource manager; estates manager and nominated provider. This management team provides support to several centres operating within the Silverstream group and are not specific to Clontarf staff or residents.

Within Clontarf Nursing Home, there is a full time person in charge and a part time assistant director of nursing. The person in charge told the inspector that sanction had only recently been given to improve the internal management structure within Clontarf to include two clinical nurse managers. Two senior nurses have been identified to take up these positions and will be supernumerary for one 12 hour shift per week to undertake duties associated with the role.

Systems previously identified as being in place during the registration inspection in 2014 to monitor and review the quality and safety of care being delivered to residents were found to have lapsed and findings under Outcomes 11 and 15 of this report reflect that there was a lack of clinical governance over a nine month period which negatively impacted on the standard of care being provided to residents.

However, a clinical governance team within the overarching management structure has recently been established and have commenced a clinical review process. A full audit of the standard of care planning and delivery was conducted in Clontarf on July 1st 2015. This audit included assessment of the effectiveness of care plans and risk assessments such as nutrition; pressure area care and use of bed rails. Evidence of this clinical review was provided and learning derived verbalised by the operations and clinical governance manager. The inspector was told that actions arising from the review were in the process of being collated and would now also include actions arising from the findings of this monitoring inspection.

Given the establishment of this clinical governance team and the evidence available of recent clinical audits, the inspector was assured that improvements to clinical governance will be made, however the learning and actions arising from these audits must be rigorously implemented to drive improvements in the standard of care delivery.

Judgment:

Compliant

Outcome 03: Information for residents

A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

Theme:

Governance, Leadership and Management
<p>Outstanding requirement(s) from previous inspection(s): No actions were required from the previous inspection.</p> <p>Findings: A change of provider had just concluded at the time of the registration inspection and the inspector was assured that all residents would be issued with a new contract of care which reflected the change in provider. However, it was found that only those residents admitted since the change in provider took place had up to date contracts and all other residents did not have a written signed contract with the current provider.</p>
<p>Judgment: Non Compliant - Major</p>

<p><i>Outcome 04: Suitable Person in Charge</i> <i>The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.</i></p>
<p>Theme: Governance, Leadership and Management</p>
<p>Outstanding requirement(s) from previous inspection(s): No actions were required from the previous inspection.</p> <p>Findings: The centre was managed by a suitably qualified and experienced nurse who was recently appointed to the role. The fitness of the person in charge was assessed through interview and throughout the inspection process to determine fitness for registration purposes and was found to have satisfactory knowledge of the roles and responsibilities under the legislation and sufficient experience and knowledge to provide safe and appropriate care to residents.</p>
<p>Judgment: Compliant</p>

<p><i>Outcome 05: Documentation to be kept at a designated centre</i> <i>The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has</i></p>
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all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:

Governance, Leadership and Management

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

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

Findings:

This action was fully addressed.

On review of a sample number of personnel records they were all found to meet the requirements of schedule 2 of the regulations.

All other records were noted to be maintained in line with best practice and relevant legislation in that they were retained securely, up to date and easily retrievable.

Some improvements to documentation and policies were found to be required but are referenced under other outcomes including outcome 11 and 15 further in this report.

An action in respect of the use of restrictive practices is included under this outcome and findings are detailed under Outcome 11 in this report.

An action in relation to nutrition is also included under this outcome and findings are detailed under Outcome 15 in this report.

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:

The inspector found that the former person in charge had left to take up a new role on 23 April and was told that the assistant director of nursing acted as replacement until the commencement of the new appointee in June 2015.

The provider had not notified the Authority of a change to the person in charge as required under Regulation 32. The provider also failed to notify the Authority of the procedures and arrangements that would be in place for duration of the absence of a person in charge as required under regulation 33.

Judgment:

Non Compliant - Moderate

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):

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

Findings:

This action was partially addressed.

Actions addressed included;

- an original prescribers' signature was in place for every prescribed drug
- the route of administration was identified for every drug
- where medications were being crushed a prescribers' signature for each drug being crushed was available.

Actions not addressed included;

- maximum dosage for as required or pro re nata drugs were not identified
- the system to ensure the safe return of unused or out of date medications had been revised to include the signature of the nurse returning the medication but a signature of the pharmacist to evidence receipt of the returned drugs was not available.

Judgment:

Substantially Compliant

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):

No actions were required from the previous inspection.

Findings:

Residents had access to GP services. There was evidence of access to specialist and allied health care services to meet the care needs of residents such as opticians, dentists and chiropody services. Access to palliative care specialists and speech and language were available through the primary care and acute hospital services. A dietician consultancy service was provided by a private nutrition products company. The provider had also sourced private physiotherapy services and a physiotherapist visited the centre weekly to review residents needs. It was noted that timely referral to allied health specialist were made where relevant by the nursing team.

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 core risk assessment tools to check for risk of deterioration were also completed.

Although there was a system in place to make sure healthcare plans reflected the care delivered and were amended in response to changes in residents' health, it was not implemented for all residents. The checks in place did not ensure all plans were effective enough to maintain or improve a resident's health.

All care plans were not detailed enough to direct or manage care needs, were not always updated as needs or circumstances changed, were not linked to risk assessments or progress notes and were not always implemented.

Examples related to the management of nutrition such as; weights and MUST (risk assessments) scores or recommendations by dietician such as special diet not referenced in care plans. Where food preferences, nutritional supplements or food fortification was included in plans, there was no evidence this was being implemented.

Although in general, most residents nutritional care needs were met, there was evidence that some residents had experienced significant weight loss of between 4 and 6 kgs in three months. Evidence was available that staff were aware that these residents were at risk and had commenced a process to review care needs associated with it including; review by dietician and general practitioner and monitoring intake. However, there was limited evidence that the additional interventions included in the care plans were being implemented fully in practice. This aspect is also referenced under outcome 15

A strong 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. 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.

The inspector found that staff delivered care to residents in a warm and respectful manner. As the profile of residents included a significant number of persons with a diagnosis of dementia, the inspector incorporated some elements of the dementia specific thematic process. The inspector used this process to observe the interactions between staff and residents during the lunch period. At this time three staff were observed to assist residents enjoy their lunch in a busy dining room environment. All

staff sat beside the resident to whom they were giving assistance and were noted to patiently and gently encourage the resident throughout their meal. Conversation was limited however and centred predominantly on the meal, exchanging names and the weather. It was noted that the staff were not very familiar with the residents they were assisting, although it is acknowledged that some staff were from an agency and not regularly working in the centre. For those staff who worked full time in the centre it was a missed opportunity to chat to residents about their families, interests or discover how they were feeling.

During the course of the lunch period the inspector also observed the interactions of other staff who were working in the dining room or bringing residents into the room for lunch. Several moments of spontaneous care and affection such as hugs, singing, joking and banter were noted and choices of meals were taken by a person on work experience who showed a considerate and thoughtful manner by giving time, identifying the meal choices on offer and showing them each one.

It was further noted that improvements were required to develop and promote a restraint free environment within the centre.

A high level of bed rails was noted to be in use for almost half of residents. However the rationale for their use was not clear and findings include;

- risk assessments in place were not fully completed.
- evidence of alternatives trialled was not always available
- rails were in use for some residents in direct contravention of known wishes of the resident.

The inspector noted that bed rails were primarily in use at night and appeared to form part of a risk averse culture.

An action in respect of this finding is included under outcome 5

Judgment:

Non Compliant - Moderate

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:

Actions addressed included;

- additional assisted shower with w.c. installed in close proximity to Bedrooms 1 & 2 on the lower ground floor
- upgrade of non assisted bathroom to an assisted shower without w.c. and with a sink suitable for use by hairdresser on the middle floor
- racking in place in both sluice rooms
- key code pad on exit door to front of house on lower ground floor
- nurse call system upgraded

The estates manager informed the inspector that other repair and maintenance works to the fabric of the building primarily externally was carried out including; painting of external fire escape; insulation of roof space; repointing masonry; replacement of guttering.

Actions not addressed;

- reduction of all three bedded rooms to two beds
- all communal bedrooms require to be refurbished and/or renovated with the layout of each room to be carefully considered in relation to the space available. The design and layout of each room must take account of the space required to meet the dependency needs of each resident while also maintaining their privacy and dignity. 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. A review of the space available for personal possessions is also required particularly wardrobe space in communal rooms. Currently in some twin rooms residents share one wardrobe and access is limited by the placement of the locker between the bed and wardrobe
- provision of additional assisted shower room on the top floor
- provision of additional bed pan washer in sluice room on lower ground floor
- full refurbishment of all residents bedrooms furniture and décor; repairs to paintwork, skirting, architrave, doorways, windows and window frames, radiators, flooring and wall tiles or paintwork in all rooms, corridors sluice areas ,showers and toilets
- full review and where necessary replacement of all equipment such as; bed tables lockers wardrobes beds commodes shower chairs and wheelchairs. Additional grab rails were also noted to be required in some shower/toilet areas.

There was evidence that some replacement of equipment such as shower chairs/ commodes/ crockery and hoists however an equipment survey which was to include full replacement of lighting, flooring, fixtures and fittings such as lockers beds wardrobes and provision of soft furnishings such as curtains mirrors pictures etc was not available

However, the inspector observed and was informed that main refurbishment of the interior had not yet commenced.

Although there were multiple reasons for the delay in commencing the refurbishment including staff changes, the inspector learned that the main reason was due to the difficulties being encountered to secure planning permission for the new build proposed to replace the closure of beds in the existing building.

The Estates manager told the inspector that a decision would be made on 23 August by the provider on whether to pursue the grant of planning permission any further as the management team were aware that there was a high probability that the planning permission would be refused.

As previously stated under outcome 1, the inspector found that admissions to the three

bedded rooms was not in line with the centre's statement of purpose or with the admissions policy submitted to the Authority.

The estates manager clinical governance manager and person in charge were reminded that registration was conditional on plans submitted to the Authority for full refurbishment of the existing centre and all beds in the three bedded rooms being reduced to 2 when works were completed by June 2016

It was found that there was limited progress made in the nine months since the registration inspection on the refurbishment of the centre and there was a high probability that the plans submitted to the Authority on which conditional registration was based would not now be implemented.

Judgment:

Non Compliant - Major

Outcome 14: End of Life Care

Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.

Theme:

Person-centred care and support

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

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

Findings:

The actions arising from the last inspection were satisfactorily addressed as follows; On review of clinical documentation it was noted that preferences for funeral arrangements and family inclusion in the end of life care plans were in place.

Judgment:

Compliant

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 inspector found that food was properly prepared cooked and presented and residents were observed to enjoy their meals at both breakfast and lunch. A two week rolling menu was in place and included a variety of choices for main courses and desserts but did not include all of the options available for each meal time. The menu gave the options for the main lunch with dessert and tea time options. A breakfast or supper meal was not identified.

Snacks in the form of tea coffee milk and biscuits were provided in between main meals healthy options for mid meal snacks such as fresh fruit portions, smoothies, cheese, nuts, fresh or dried fruits were not available and could be considered.

Although systems were in place for assessing, reviewing and monitoring residents nutritional intake, they were not implemented in practice and significant improvements required to be made. In a sample of clinical documentation reviewed the inspector found that several residents had experienced weight loss over the five month period prior to this inspection. It was found that the levels of weight loss experienced by these residents which were between 5 -10% of overall body weight constituted an early indicator of the risk of malnutrition.

Although there was evidence that staff were aware of the risk and had commenced daily food diaries to document intake over a period of days, it was noted that these were not being fully or accurately completed This included;

- a consistent system to determine portion sizes in order to accurately record intake was not in place. Entries on intake variously referred to; spoonfuls or 'half/ quarter/ full' meal taken and there was no reference to the size of the meal initially served to allow an accurate determination of how much of the meal was actually ingested.
- food fortification was not identified such as cream eggs cheese added to elements in the meal
- amount of nutritional supplements taken not always recorded

It was also found that although policies and processes were in place they were not sufficiently comprehensive to guide staff on the monitoring, documentation recording and overall management of residents nutritional intake specifically for residents experiencing gradual although significant weight loss over a period of time. It was found that the policy in place was not being implemented in that;

- individualised meal plans to encourage small frequent eating were not being prepared.
- provision of snacks to prevent extended fast periods especially was not found especially at night
- high energy or high protein snacks such as cheese and crackers pate or rice puddings were not available

An action in relation to these findings is included under outcome 5 of this report.

Improved communication systems were needed to ensure residents received the correct diet as recommended by the dietician. An up to date diet list was not being provided to the kitchen staff. Although the kitchen staff were familiar with diets such as diabetic/ puree or mince moist requirements they were not informed of the high number of residents who were supposed to be receiving high calorie high protein diets.

Judgment:

Non Compliant - Moderate

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:

All lines of enquiry were not reviewed on this inspection.

Recruitment processes with induction systems were in place and on review of a sample of personnel files were found to meet the requirements of schedule 2 as required.

A staff rota was checked and found to be maintained with all staff that worked in the centre identified. But it was noted that due to a recent high turnover of staff and other forms of leave, a number of vacancies for health care assistants, relief chef and activity co ordinator existed.

It was found that at the time of this inspection, the levels and skill mix of staff were not sufficient to meet the needs of residents. Specifically this related to lack of appropriately qualified relief catering staff and activity co ordinator.

Although the person who was currently covering the chef role was observed to be skilled, organised and was preparing cooking and providing hot tasty meals to residents, they did not have the relevant qualifications for the role. It is acknowledged that training in basic food hygiene and HACCP had been undertaken and principles observed to be implemented

It was also noted that the number of health care assistants had reduced by one since the registration inspection yet the numbers and dependency of residents had not changed and it the inspector heard one lady calling for assistance and waiting 15 minutes before being attended too.

The inspector was told that the activity co ordinator up to the week of inspection had been replaced but due to staff shortages this had ceased in recent days. As a result although staff tried to provide some activities such as films, nail care the activity programme was not being delivered in full and meaningful activities were not provided. Due to the recent staff turnover there was a heavy reliance on agency staff use and it was found that a system to provide cover in the event of emergency or when staff were

unable to attend work at short notice was not in place.
Additionally it was noted that a level of succession planning for key areas such as catering was required.

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 report¹

Centre name:	Clontarf Private Nursing Home
Centre ID:	OSV-0000127
Date of inspection:	12/08/2015 & 13/08/2015
Date of response:	22/09/2015

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 facilities and services outlined in the statement of purpose does not accurately reflect the service being provided

The statement of purpose was not being fully implemented in practice.

1. Action Required:

Under Regulation 03(1) you are required to: Prepare a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Welfare of

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

Residents in Designated Centres for Older People) Regulations 2013.

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

The statement of purpose will to be updated to reflect the new PIC. The updated statement of purpose will clearly outline the admissions process for the nursing home and the criteria for each of the triple bedrooms. The admission policy will be reviewed and updated. This will be updated by the 1st of October 2015 due to the appointment of an additional PPIM to the Management team. This post of Admissions Liaison Nurse comes into effect on 21st September, and to allow time to review our processes with this post in mind both our Statement of Purpose and Admissions Policy will be completed and sent to HIQA on 1st October 2015.

Proposed Timescale: 01/10/2015

Outcome 03: Information for residents

Theme:

Governance, Leadership and Management

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

All residents did not have a written signed contract of care with the current provider of the centre.

2. Action Required:

Under Regulation 24(1) you are required to: Agree in writing with each resident, on the admission of that resident to the designated centre, the terms on which that resident shall reside in the centre.

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

Contracts of Care to be issued to all families indicating the current Provider of the Nursing Home.

Proposed Timescale: 01/10/2015

Outcome 05: Documentation to be kept at a designated centre

Theme:

Governance, Leadership and Management

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

The inspector found that the policies and processes in place were not sufficiently comprehensive to guide staff on the monitoring, documentation recording and overall management of residents nutritional intake.

The policy in place was not being fully implemented

Where residents intake was being recorded a review of the system in place to ensure it

is sufficiently detailed to allow for meaningful analysis is required.

3. 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:

All nutritional policies reviewed and SOP's to be introduced to better guide staff in implementing our policies on nutritional intake. PIC and ADON have developed controls to ensure that staff are adhering to the policies. These include, Referral systems to all relevant Health Care Professionals, comprehensive details of recommendations from Dietician, details of individual preferences, lists of Residents requiring Food Fortification, Lists of Supplements in use, comprehensive details of Special Diets, Individual Food Plans, Staff Allocations, Handover Documents. A Kitchen and Nutritional Audit to commence in October 2015.

All policies and procedures will be reviewed on a 3 yearly basis of when a change is required to reflect best practice. The Silverstream Corporate Clinical Governance team will commence this process in October 2015

Proposed Timescale: 01/10/2015

Theme:

Governance, Leadership and Management

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

Risk management policy was not being fully implemented in respect of the use of restrictive practices.

A restraint free environment was not found to be promoted.

There was a lack of full and appropriate assessment in relation to the use of bed rails and in some instances these were in use in direct contravention of residents wishes.

4. Action Required:

Under Regulation 04(1) you are required to: Prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.

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

Following the inspection our Risk Management Policy will be reviewed to better guide and support staff and residents in promoting an environment in respect of the use of restrictive practices. These will include a detailed Restraint Risk assessment completed with the resident/NOK and staff Nurse on admission. The Assessment will include a detailed history of all alternatives put in place to avoid a restrictive practice such as Posy floor, bed, chair alarms, Low beds, crash mats that Residents will be offered and trailed.

A restraint free environment will be promoted at admission and Residents and Families

will be provided with information on the alternative arrangements in place as above. A Restraint Free environment will be discussed at the next Relatives and Residents meeting at the end of October 2015. Staff Training will be delivered by the PIC/ADON on "Promoting a Restraint Free Environment". This training will include respecting and honouring residents wishes in regard to the use of Restraints.

Proposed Timescale: 30/11/2015

Outcome 06: Absence of the Person in charge

Theme:

Governance, Leadership and Management

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

The provider failed to notify the Authority of the expected absence of the person in charge

5. Action Required:

Under Regulation 32(1) you are required to: Provide notice in writing to the Chief Inspector where the person in charge proposes to be absent from the designated centre for a continuous period of 28 days or more.

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

NF 20 submitted to Authority.

Proposed Timescale: 10/09/2015

Theme:

Governance, Leadership and Management

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

The provider failed to notify the Authority of the arrangements made for the running of the designated centre during the absence of the person in charge.

6. Action Required:

Under Regulation 33(2)(a) you are required to: Give notice in writing to the Chief Inspector of the arrangements which have been or were made for the running of the designated centre during the absence of the person in charge.

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

NF 20 Submitted detailing the arrangements that were made for the running of the designated centre during the absence of the PIC.

Proposed Timescale: 10/09/2015

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:

Medication practices to ensure safe administration were not clear in respect of the maximum dosage for all pro re nata medications in line with relevant legislation and professional guidance.

7. 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 resident's GP will be requested when completing the prescription to indicate the maximum dosage for all pro nata medications. In the absence of this the pharmacist will provide nursing staff with guidance to the maximum dosage for all pro nata medications.

Proposed Timescale: 01/10/2015

Theme:

Safe care and support

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

Records to evidence the safe receipt of returned drugs to external pharmacists were not fully maintained.

8. Action Required:

Under Regulation 29(6) you are required to: Store any medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident in a secure manner, segregated from other medicinal products and dispose of in accordance with national legislation or guidance in a manner that will not cause danger to public health or risk to the environment and will ensure that the product concerned can no longer be used as a medicinal product.

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

A returns book to evidence the safe receipt of returned drugs to the pharmacy is now in place. This book is reviewed by DON/ADON to ensure that it is correctly maintained by nursing staff

Proposed Timescale: 10/09/2015

Outcome 11: Health and Social Care Needs

Theme:

Effective care and support

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

Complete comprehensive nursing assessments were not carried out for each resident.

9. 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 comprehensive pre admission assessment will be completed on each prospective resident and within 48hrs the nursing staff in the home with support and guidance from the DON/ADON will ensure the care plan reflects the health, personal and social care needs of the residents. Clear Timeframes will be set for nursing staff to maintain each care plan and evaluate and audit every 3 months thereafter. The Corporate Clinical Governance team will audit each new residents care plan on a monthly basis.

Proposed Timescale: 01/10/2015

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 residents experiencing weight loss.

10. 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:

All nutritional policies to be reviewed and SOP's to be introduced to better guide staff in implementing our policies on nutritional intake. PIC and ADON have developed controls to ensure that staff are adhering to the policies. These include, Referral systems to all relevant Health Care Professionals, Individual food plans, staff allocations, Handover documents. A Kitchen and Nutritional Audit to commence in October 2015.

A full and comprehensive care assessment will be completed on each prospective resident and within 48hrs the nursing staff in the home with support and guidance from the DON/ADON. The residents weight and MUST assessment will be taken on the day of admission and then monthly thereafter. The effectiveness of the care plan will be assessed at each weighing of the resident and at each review of the MUST assessment. The Following is the proposed care plan for all residents in relation to meeting their Nutritional. General Care Planning guidelines for Nutritional Status :

- 1: Record MUST Score on the admission of a new resident. The need and frequency to re assess the MUST score is indicated by ongoing continuous nursing assessment including monthly weight findings.
- 2 : Irrespective of the MUST tool score the care plan should reflect the individual health status of the resident.
- 3 : A Food plan for each resident is drawn up by the Director of Nursing and Chef in consultation with the Resident/Advocate/Care Staff incorporating likes, dislikes, food/drink choices and portion size.

Sample Care Plan Action for MUST Score.

0 = Low Risk
 Weight Monthly and review findings
 Initially no care plan action is necessary unless the residents weight findings indicate that action is required.
 Refer to Dietician and/or SLT as required

1 = Medium Risk
 Inform Kitchen and Care Staff and ask for their co-operation in observing dietary intake.
 Discuss with GP and Action findings in care plan.
 Refer to Dietician/SLT as required
 Record intake for 3 days.
 Weighing weekly for one month and review again with GP.

2 or higher = High Risk
 Inform Kitchen and Care Staff and ask for their co-operation in observing dietary intake.
 Discuss with GP and Action findings in care plan.
 weighing weekly for one month and review again with GP
 food supplements
 Refer to Dietician and/or SLT as required
 Food Intake diary for 3 days every month.
 Timeframes will be set for nursing staff to maintain each care plan and evaluate and audit every 3 months thereafter.

The Corporate Clinical Governance team will continue to audit care plans on a monthly basis to ensure that each care plan is compliant and is effective in meeting the care needs of the residents. Learning outcomes are identified at the time of Audit with the DON and care staff. These Learning outcomes are reviewed on a monthly basis by the Corporate Clinical Governance team. The DON/ADON are issued a monitoring/compliance report indicating corrective action required with timeframes.

Proposed Timescale: 31/10/2015

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 was not available

11. 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:

The DON/ADON to fully review and audit 14 care plans per month to ensure they are effective in reflecting the health, personal and social care needs of the resident. The corporate Clinical Governance team will review and Audit a sample of these on a monthly basis and set corrective action if required. All care plan needs to be discussed with resident and/or their families.

Proposed Timescale: 31/10/2015

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 and healthcare care needs.

12. 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 comprehensive care assessment will be completed on each prospective resident and within 48hrs the nursing staff in the home with support and guidance from the DON/ADON will ensure the care plan reflects the health, personal and social care needs of the residents. Clear Timeframes will be set for nursing staff to maintain each care plan and evaluate and audit every 3 months thereafter.

The Corporate Clinical Governance team will continue to audit care plans on a monthly basis and issue the DON/ADON a monitoring/compliance report indicating corrective action required with timeframes.

The DON/ADON to fully review/audit 14 care plans per month to ensure they are effective in reflecting the health, personal and social care needs of the resident. The

corporate Clinical Governance team will review and Audit a sample of these on a monthly basis and set corrective action if required.

Timeframes will be set for nursing staff to maintain each care plan and evaluate and audit every 3 months thereafter. The time-fames will be detailed re all assessments and care plan codes that each resident requires.

Proposed Timescale: 01/10/2015

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.

13. 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 following works are planned to ensure compliance with regulations.

Refurbishment of the 3 bedded and 2 bedded rooms in the Home:

Aim of this refurbishment is

- to improve the quality of lighting in the rooms;
- to provide more personalised space for individual residents and to provide adequate space for the residents' clothing and personal belongings.

These works will include:

- Replacement of all wardrobes and lockers in these rooms;
- reconfiguration of the layout of the rooms;
- increasing the number and quality of light fittings;
- repair/replacement of flooring;
- installation of TV's;
- installation of sundry items (dressing tables, mirrors etc).

Please see appendix 1.

Admissions are on hold in the nursing home until all triple rooms meet the criteria set out in the Statement of purpose. The holding of admissions will be in place until at least 30th November to allow for all refurbishment to take place and be completed. On the 30th November the Dependency levels will be reviewed and if the multi occupancy

rooms reflect 2 low/medium residents and 1 High/Max admissions will recommence if not, holding of admissions will continue.

Proposed Timescale: 30/11/2015

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 do not fully conform with all requirements of schedule 6 of the regulations

14. 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:

Admissions are on hold in the nursing until all triple rooms meet the criteria set out in the Statement of purpose. The holding of admissions will be in place until at least 30th November to allow for all refurbishment to take place and be completed. On the 30th November the Dependency levels will be reviewed and if the multi occupancy rooms reflect 2 low/medium residents and 1 High/Max admissions will recommence if not, holding of admissions will continue.

As evidenced by the most recent attached correspondence to Dublin City Council Planning Department dated 4th September 2015, we are at an advanced stage in our Planning Application for the 6 additional single rooms and 2 additional Assisted Bathrooms/WCs.

To allow for preparation for construction drawings, following the tender process, securing funding and carrying out the construction to fit out for registration we envisage that this can be completed by June 2016 at the latest. This will almost double the number of single rooms available to residents at Clontarf Private Nursing Home and bring us closer to the proposed 80:20 ratio of single to multi-occupancy rooms.

Proposed Timescale: 30/06/2016

Outcome 15: Food and Nutrition

Theme:

Person-centred care and support

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

An up to date diet sheet which identified all of the special diets recommended by dieticians was not in place

15. Action Required:

Under Regulation 18(1)(c)(iii) you are required to: Provide each resident with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional assessment in accordance with the individual care plan of the resident concerned.

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

All nutritional policies reviewed and SOP's to be introduced to better guide staff in implementing our policies on nutritional intake. PIC and ADON have developed controls to ensure that staff are adhering to the policies. These include, referral systems to all relevant Health Care Professionals, Individual food plans, staff allocations, Handover documents. Kitchen/ Nutritional Audit to commence in October 2015.

An updated Diet sheet is available for each resident and each staff member. This sheet outlines the diet and nutritional needs of each resident.

Proposed Timescale: 01/10/2015

Theme:

Person-centred care and support

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

Healthy options for mid meal snacks such as fresh fruit portions, smoothies, cheese, nuts, fresh or dried fruits were not available and provision of snacks to prevent extended fast periods was not found.

16. Action Required:

Under Regulation 18(1)(c)(ii) you are required to: Provide each resident with adequate quantities of food and drink which are wholesome and nutritious.

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

Meal choices and snack choices are available to each resident and displayed in the dining room. Snacks are available to all residents 24hrs per day. The times of meals are displayed in the home and a variety of snacks are available and given to residents at their request or as indicated by their needs. The Snack menu was formalised following the inspection and is now displayed in the dinning room Snacks such as soup, sandwiches, fruit cups, smoothies, biscuits, crackers with a variety of sweet and savoury toppings, scones, muffins, cup cakes, apple sponge and a range of other items are baked freshly daily. There is also a range of foods available for residents who require a soft diet, these include pureed fruit, soup, yogurts, rice pudding and custard.

Proposed Timescale: 10/09/2015

Outcome 18: Suitable Staffing

Theme:

Workforce

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

Evidence that the the levels and skill mix of staff were not sufficient to meet the needs of residents was found.

17. Action Required:

Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

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

Staff have been recruited, some are already in place, others will commence work by 1st October 2015. Staffing levels based on the dependency of the residents have been increased. This will be reviewed and amended every 2 weeks by Clinical Governance Manager and DON.

The additional staff that have been hired are 4 full time permanent care staff, Full quota of nursing staff in place, Laundry supervisor in place on 1st October .Care staff increased to 7 with 2 nurses in the am.. Additional Qualified Chef to be in place by 1st October.

Proposed Timescale: 01/10/2015