

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	St Pappin's Nursing Home
Centre ID:	OSV-0000178
Centre address:	Ballymun Road, Ballymun, Dublin 9.
Telephone number:	01 842 3474
Email address:	jkenny@silverstream.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	St Pappins Partnership
Provider Nominee:	Joseph Kenny
Lead inspector:	Jim Kee
Support inspector(s):	Leone Ewings
Type of inspection	Unannounced
Number of residents on the date of inspection:	50
Number of vacancies on the date of inspection:	4

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 1 day(s).

The inspection took place over the following dates and times

From: 19 February 2016 09:40 To: 19 February 2016 19:05

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

Outcome	Our Judgment
Outcome 01: Statement of Purpose	Compliant
Outcome 02: Governance and Management	Substantially Compliant
Outcome 03: Information for residents	Compliant
Outcome 05: Documentation to be kept at a designated centre	Substantially Compliant
Outcome 06: Absence of the Person in charge	Compliant
Outcome 07: Safeguarding and Safety	Non Compliant - Moderate
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 12: Safe and Suitable Premises	Non Compliant - Major
Outcome 13: Complaints procedures	Non Compliant - Moderate
Outcome 15: Food and Nutrition	Non Compliant - Moderate
Outcome 18: Suitable Staffing	Compliant

Summary of findings from this inspection

This report sets out the findings of an unannounced inspection of this centre, which took place over one day. The purpose of this inspection was to follow up on non-compliances identified during the last inspection of the centre in April 2015 and to monitor on-going compliance with the Health Act 2007 (Care and Welfare of Residents in Designated centres for Older People) Regulations 2013. The Health Information and Quality Authority (the authority) had also received information relating to this centre, primarily regarding staffing and the supervision of residents. On the day of the inspection inspectors found that the levels and skill mix of staff were sufficient to meet the needs of the residents and that the supervision arrangements in place were also sufficient. As part of the inspection, the two inspectors met with residents and staff members. The inspectors observed practices and reviewed documentation such as care plans, accidents and incident forms, medical records, policies and procedures, and staff files.

There were 48 residents residing in the centre at the time of inspection. A further two residents were in hospital during the course of the inspection, and there were four vacancies. The person in charge had recently resigned, and the authority had been appropriately notified. The inspectors briefly met with the provider nominee during the inspection. Overall inspectors were satisfied with the governance and management of the centre, and that there were sufficient resources to ensure the effective delivery of care.

Evidence of good practice was found across all outcomes with 4 out of 12 outcomes deemed to be in compliance with the regulations. Outcomes judged to be fully compliant were the statement of purpose, information for residents, absence of the person in charge, and staffing. The outcomes on governance and management and documentation were found to be in substantial compliance with the regulations.

The outcomes on safeguarding and safety, health and social care needs, food and nutrition, the complaints procedure and health and safety were found to be moderately non-compliant.

The outcome on safe and suitable premises was found to be in major non compliance with the regulations, as a number of the multi occupancy rooms within this centre did not facilitate residents' privacy and dignity, and did not provide sufficient physical space to meet their needs.

The action plan at the end of the report identifies those areas where improvements were required in order to comply with the regulations and the authority's standards.

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):

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

Findings:

The inspectors were provided with the most recently updated statement of purpose for the centre. The statement of purpose contained the information set out in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013.

Judgment:

Compliant

Outcome 02: Governance and Management

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The management structure in the centre had changed as the person in charge (director of nursing) had recently resigned. The assistant director of nursing was now the acting director of nursing. There was a clearly defined management structure that identified the lines of authority and accountability, and all staff with whom inspectors spoke knew

the reporting structure within the centre. Residents had also been informed of the recent changes to the management structure at the most recent residents' meeting. The acting director of nursing was supported by two clinical nurse managers. The clinical governance and operations manager was also based in the centre for a number of days each week to support the acting director of nursing, and was present in the centre on the day of the inspection. The senior management team had also arranged for another senior clinical nurse manager to work in the centre on a part time basis to strengthen the management structures in place.

Inspectors found that there was a system in place to monitor the quality of care and the experience of the residents on an ongoing basis, and that there were sufficient resources to ensure the effective delivery of care. Inspectors reviewed the monthly operational compliance reporting and care quality indicators for the centre. This included the monitoring of a number of different areas including compliance with care planning, dependency levels, monitoring of restraint, monitoring of residents' weights, and the number of residents with wounds or pressure sores. Monthly clinical audits of a sample of resident care plans were also conducted.

The annual report for the centre for 2015 was made available to the inspectors. The report contained the business and development plan for the centre, details of incident and accident reporting and care quality indicators and also the training and development plan. The report did not contain reference to consultation with residents and their families as required by the regulations.

Judgment:
Substantially 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

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

Findings:
The non-compliances identified in this outcome during the last inspection of the centre in April 2015 were found to have been addressed. The inspectors reviewed a sample of the 'contracts for the provision of care services' in place in the centre and found that the agreed monthly fee was specified and that the fees payable by residents for services not included in the agreed monthly fee were also outlined.

Judgment:
Compliant

Outcome 05: Documentation to be kept at a designated centre
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 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:

The aspects of this outcome reviewed during the inspection related to the non-compliances identified during the last inspection. The policy on staff training and development had been developed and was available in the centre. Inspectors did not identify inconsistencies in the clinical documentation relating to end of life care or the risk of absconsion.

Staff rosters were reviewed and found to reflect the nursing and care staff on duty during the inspection. However the roster did not include the hours being worked by members of the group management team who were working in the centre on a regular basis to support the acting director of nursing. The clinical governance and operations manager amended the rosters on the day of the inspection to ensure this information was included on the current rosters and all future rosters.

Judgment:

Substantially 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 authority had been appropriately informed that the person in charge (director of nursing) had resigned. Information had been provided to the authority regarding the arrangements in place for management of the designated centre. The assistant director of nursing was acting as the director of nursing, with support provided by the clinical governance and operations manager and also by another senior nurse manager.

Judgment:
Compliant

Outcome 07: Safeguarding and Safety

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

Theme:
Safe care and support

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

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

Findings:

Inspectors found that measures were in place with regard to the safeguarding of residents. However inspectors did observe that the bed rail in place for one resident required review to ensure there was no risk of entrapment.

Measures were in place to protect residents from being harmed or suffering any form of abuse, including a policy outlining measures to prevent, detect and respond to any allegation of abuse. Staff with whom inspectors spoke were knowledgeable with regard to their responsibilities in this area, and had attended training on elder abuse. Residents spoken to by the inspectors stated that they had no concerns regarding their safety in this centre.

The use of bed rails was monitored within the centre, and details recorded in the restraint log. Inspectors reviewed a sample of the assessments for bed rails and found that there was not always documented evidence of the trial/consideration of alternatives to ensure the use of bed rails was in accordance with national policy. Low low beds, crash mats and alarm mats were available and were observed to be in use in the centre. Inspectors were informed that there was a plan to purchase further low low beds. Inspectors observed that for one resident the one bed rail in place at night required review to ensure that measures were put in place to mitigate the risk of entrapment due to the space between the mattress and the bed rail.

There was a policy in place for managing behaviour that is challenging/responsive behaviours. Care plans were in place for mood and behaviour that included information on managing such behaviours for residents reviewed by the inspectors. The authority had received information of concern relating to staffing and the supervision of residents

who could at times exhibit responsive/challenging behaviours. Inspectors did not observe any evidence of poor supervision of residents on the day of the inspection.

Judgment:

Non Compliant - Moderate

Outcome 08: Health and Safety and Risk Management

The health and safety of residents, visitors and staff is promoted and protected.

Theme:

Safe care and support

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

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

Findings:

Inspectors found that there were policies and procedures in place for risk management, emergency planning and health and safety within the centre. However on the day of the inspection inspectors found that escape routes were not kept clear at all times, and that the signage in one area of the centre directing residents, staff and visitors to exits required review to ensure it directed people to appropriate final exits.

The centre had a health and safety statement in place and records of completed risk assessments were available. Fire drills were completed and any issues identified were addressed. Fire evacuation instructions were clearly displayed within the centre, although the floor plans on display indicating emergency exits required review to ensure the information displayed reflected the current layout of the centre. Inspectors also found that the signage in one area of the centre directing occupants of the building to fire exits in the event of evacuation required review to ensure it directed evacuation through an appropriate final exit. Inspectors received confirmation from the provider after the inspection to confirm that the signage had been reviewed and rectified where necessary. There was an emergency plan in place detailing procedures to be followed in the event of fire, flood, a gas leak, a bomb threat and if a resident was missing.

Staff spoken with were all knowledgeable regarding fire safety and evacuation procedures, and had completed fire safety training. The records showed that there was regular servicing of the fire detection and alarm system, the fire equipment, and the emergency lighting system by an external company. A documented system of in-house checks relating to fire safety was also in place. However on the day of the inspection the corridor outside the kitchen leading to one of the emergency exits was obstructed with trolleys and other equipment which would have impeded evacuation of the centre via this exit. The stairwell at this exit was also being used to store further catering trolleys. Staff in the centre cleared all equipment from these areas to ensure exit routes were clear from obstruction and the inspectors received confirmation from the provider that measures would be put in place to ensure all exits were kept free from obstruction.

Inspectors reviewed a sample of the accident and incident reports and it was evident that accidents and incidents were appropriately reviewed and measures put in place to prevent recurrence were possible. There was a health and safety committee in place in the centre and the last meeting had taken place at the end of January.

Inspectors found that there was insufficient storage space available in the centre, and storage of equipment such as hoists, wheelchairs, catering trolleys and other equipment required review to ensure all such equipment could be stored in an appropriate manner. This is included under outcome 12 on premises.

Judgment:

Non Compliant - Moderate

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 good access to general practitioner (GP) services, and GP's attended the centre on a regular basis. The community geriatrician was also available to residents, and the centre had access to services from the psychiatry of older age community care team. Residents had access to a wide range of allied health professional services including, physiotherapy, speech and language therapy, chiropody, dental and dietetics. Inspectors observed that the seating arrangements in place for two residents required review. There was no documentation in the residents' files regarding referral to an occupational therapist.

Inspectors reviewed a number of admission assessment forms and care plans. The care planning process involved the use of validated tools to assess residents' risk of falls, nutritional status, level of cognitive impairment, skin integrity and dependency levels. However care plans were not consistently updated to reflect recommendations made by allied health care professionals including recommendations from dieticians. There was no evidence of residents' and/or their family members being involved in the development and review of care plans in the resident files reviewed by the inspectors. Inspectors also found that the recommendations from a dietician for one resident had not been included in the diet list for the floor to ensure the resident received a fortified diet with snacks before bedtime to prevent hypoglycaemic episodes. This is included

under outcome 15. Inspectors reviewed records maintained by staff of records of activities of daily living which included details of assistance with personal hygiene and repositioning records. These records were not being maintained contemporaneously to provide assurance as to the actual care and assistance provided.

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:

A number of the multi occupancy bed rooms (three and four bedded rooms) within this centre did not meet the requirements of Regulation 17 or Standard 25 of the National Quality Standards for Residential Care settings for Older People. These three and four bedded rooms did not facilitate residents' privacy and dignity, and did not provide sufficient physical space to meet their needs. This outcome was found to be in major non-compliance with the regulations during the previous inspection and the action plan submitted by the provider did not satisfactorily address the identified failings. Inspectors did find that some improvements had been made to a number of the multi occupancy rooms, including the removal of the second doorway into a number of these rooms. This space had been used to provide extra storage space and now included built in wardrobe space in a number of the rooms. A new toilet/shower room had also been provided next to one of the four bedded rooms on the ground floor. On the day of the inspection a number of the rooms were in the process of being painted.

The centre's resident accommodation and communal areas were split over the ground and first floor of this purpose built nursing home that incorporates much of the original church building. There were 19 bedrooms located on the ground floor, 16 of which were single en-suite rooms. There were also two four bedded rooms and one three bedded room on the ground floor. On the first floor there were 17 bedrooms including 13 single en-suite rooms, and two four bedded rooms, and two three bedded rooms. The en-suite bedrooms visited by inspectors were found to be comfortable, well maintained and with adequate storage facilities.

However inspectors identified a number of issues in a number of the multi occupancy

bed rooms including:

- limited space between some of the beds (including space to safely place crash mats)
- no room for chairs beside the beds for residents or visitors to sit on. Inspectors found that in some rooms accommodating up to four residents there was only one armchair and one smaller chair available in the room.
- the distance from some of these bedrooms to the nearest bathroom was substantial, and involved residents having to pass the nurses' station, and the entrance to the stairs and lift.
- The availability of toilets on the same corridor as these multi occupancy rooms. On the ground floor there was one accessible toilet on the corridor on which two of the multi occupancy rooms were located with seven beds available to accommodate residents in these rooms. On the first floor there was one accessible toilet on the corridor on which three of the multi occupancy rooms were located with ten beds available in these rooms to accommodate residents.
- the distance from some of these bedrooms to the nearest sluice room was substantial posing a potential infection control risk.
- when entering a number of the multi occupancy rooms there was limited space between the doorway and the nearest bed, and when the privacy curtains were in place around this bed access to the whole bedroom was restricted.

Inspectors found that the majority of the communal toilets/bathrooms in the centre had no operating privacy locks on the doors. The lack of privacy locks on communal toilets and bathrooms had been identified during the previous inspection and the action plan submitted following this inspection stated that privacy locks would be in working order from 3rd April 2015.

Inspectors observed that storage facilities in the centre were inadequate to appropriately store equipment such as hoists, catering trolleys, chairs awaiting repair, and transit wheelchairs. On the day of the inspection there were catering trolleys obstructing emergency escape routes as outlined under outcome 8. Hoists, transit wheelchairs and rollators were found to be stored in one of the multi occupancy bedrooms as staff had no alternative space available to store this equipment. A chair awaiting repair was stored at the top of one of the stairwells. There was also insufficient storage available in communal bathrooms for storing toiletries and other necessary items.

The centre itself was homely, with sufficient communal areas that were comfortably furnished. The centre was clean, suitably decorated and had suitable heating, lighting and ventilation. There was a functioning call bell system in place but inspectors found that at meal times the call bell could not be heard by staff in the dining area on the first floor. Residents had access to a large enclosed landscaped garden area, which now contained the designated smoking area for the centre.

Judgment:

Non Compliant - Major

Outcome 13: Complaints procedures

The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals

procedure.

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 inspectors reviewed the complaints records maintained in the centre. One complaint had been documented since the last inspection of the centre in April 2015. This complaint had been made in February 2016. The complaint had been appropriately documented, investigated and the satisfaction of the complainant had been recorded. However the Authority had received information of concern relating to staffing, supervision, information provided to families after incidents involving residents and the overall management of the centre. In two instances the Authority was informed that the concerns had been raised with management in the centre but that the response was unsatisfactory. These concerns were not appropriately documented as complaints and managed through the complaints process. Inspectors were informed that it had come to the attention of the senior management team at the beginning of the year that complaints were not being managed according to the complaints policy. Inspectors were assured that complaints raised by residents' relatives had now been documented and a process of investigation of these complaints was now underway. Meetings had been organised with the family members who had made complaints to discuss the issues raised and to resolve the complaints where possible. A new complaints process had been implemented to ensure that complaints could now be forwarded to senior management directly, and the centre's website had a facility to enable concerns to be submitted online. This revised complaints policy also outlines that all complaints are reviewed on a monthly basis, by the Registered Provider, Clinical Governance and Operations Manager, Compliance Manager and Resident Advocate, to ensure that complaints management procedures have been followed and that actions have been completed. The revised complaints process was discussed at the centre information and support group meeting to ensure residents and their family members were aware of the process. The complaints procedure was on display in the centre.

Judgment:

Non Compliant - Moderate

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:

Inspectors were present in the main dining areas of the centre while lunch was being served to residents. The food provided was hot, and attractively presented. Residents were offered a choice of main courses, cold drinks, desserts, and tea or coffee. Nursing and care staff monitored and provided assistance to residents in a discreet and appropriate manner when required.

Residents' weights were checked monthly or more frequently if required. The centre used a screening tool to identify residents at risk of malnutrition, and referrals were made to the dietician if necessary. Staff spoken to by the inspectors were knowledgeable with regard to residents' special dietary requirements, and those residents who had been assessed as requiring a modified consistency diet. A record of these requirements was maintained in the centre on each floor but inspectors found that this diet list was not always updated to ensure it reflected the recommendations of allied healthcare professionals such as dieticians and speech and language therapists. One resident had been reviewed by the dietician and had recommended that the resident received a fortified diet, with a snack to be provided before going to bed to prevent the occurrence of hypoglycaemic episodes. However the diet list in place had not been updated to ensure all staff were aware of these recommendations. The care plan in place on nutrition and hydration had not been updated to reflect these recommendations as outlined in outcome 11.

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):

No actions were required from the previous inspection.

Findings:

Inspectors found that the levels and skill mix of staff were sufficient to meet the needs of residents at the time of this inspection. The authority had received information of concern relating to staffing, and had requested that the centre complete a provider led

investigation. The provider had submitted a detailed response to the authority.

Inspectors observed that staff on duty during the inspection were familiar with the needs of the residents, and provided care in a considerate and respectful manner. A number of the residents with whom inspectors spoke were complimentary of the care provided by staff working in the centre.

Staff rosters were reviewed and found to reflect the nursing and care staff on duty during the inspection. However the roster did not include the hours being worked by members of the group management team who were working in the centre on a regular basis to support the acting director of nursing. This is included under outcome 5.

Resident dependency levels were assessed using a recognised dependency scale and the staffing requirements were calculated using a staffing needs assessment model to ensure appropriate staff levels and skill mix. There was a staff training matrix in place to identify staff members requiring refresher mandatory training and training was scheduled to be provided as per the training calendar for 2016. Staff spoken to by inspectors reported that training and education was provided on an on-going basis. Inspectors reviewed a sample of the nursing staff registrations to ensure up to date registration information from the professional registration body was available.

Judgment:

Compliant

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:

Jim Kee
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:	St Pappin's Nursing Home
Centre ID:	OSV-0000178
Date of inspection:	19/02/2016
Date of response:	29/04/2016

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 02: Governance and Management

Theme:

Governance, Leadership and Management

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

The annual report for the centre for 2015 made available to the inspectors did not contain reference to consultation with residents and their families as required by the regulations.

1. Action Required:

Under Regulation 23(e) you are required to: Prepare the review referred to in regulation

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

23(1)(d) in consultation with residents and their families.

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

The home adopts a multifaceted proactive and robust approach to addressing complaints and ascertaining the views of residents and visitors regarding service matters. Key forums include the Residents Committee which meets each month where issues/complaints/suggestions are formally documented and progressed for resolution through the Director of Nursing initially, the outcome of which is reported to the next meeting. The Relatives Information and Support Group meets on a quarterly basis with the Director and the company's Chief Executive to address any issues or suggestions which relatives may wish to raise. Both these forums are facilitated by our advocate who also provides 1-2-1 visitation to residents who may have individual service issues. Also a complaints/suggestion box is located in the main reception area. All matters raised through these various channels are progressed in accordance with the home's formal complaints policy. This is widely published throughout the home on notice boards, residents guides etc).

In addition to these procedures, the company's clinical governance committee meets on a monthly basis to review: a) all complaints/ issues received by the home, b) the minutes of the above forums, c) advocacy visits and issues which residents/relatives may have raised with the advocacy services or staff. This committee serves as an additional checking mechanism to ensure compliance and full oversight and also helps with learning outcomes. The members of the senior management team also receive the aforementioned documentation for review at management meetings. The home also works with external advocates (SAGE etc) as required and their inputs are progressed through the mechanisms outlined above.

Going forward we will ensure the Annual Report clearly sets out the improvements made to the home as a result of the feedback from the resident and relative forums and the work of the inhouse advocate, and also ensure that any outstanding actions are included in the quality improvement plan for the year going forward. This will be included as a separate section within the Annual Report.

Furthermore, a Resident Satisfaction Survey will be carried out in 30th September 2016 and the outcomes of this will be reflected/included in the Annual report for 2016

Proposed Timescale: 30/09/2016

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:

Rosters made available to the inspectors did not include the hours being worked by members of the group management team or the senior nurse manager who were working in the centre on a regular basis to support the acting director of nursing.

2. 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:

Silver Stream Group does provide ad hoc management support to the existing management team in the home per the statement of purpose. This is provided by head office when needed and in response particularly to feedback from the various forums such as the "Residents Committee" and "The Relatives Information and Support Group", and our complaints process.

The Roster was updated on the day of the inspection to reflect the extra management support to include hours worked and to be worked by the Group Senior Nurse Manager and the Group Clinical Governance & Operations Manager in the home.

Rosters since the inspection include hours provided by the Group Senior Nurse Manager and the Clinical Governance Manager & Operations Manager. Such hours worked by these staff members in the home will be included on all rosters going forward

Proposed Timescale: 19/02/2016

Outcome 07: Safeguarding and Safety**Theme:**

Safe care and support

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

There was not always documented evidence of the trial/consideration of alternatives to ensure the use of bed rails was in accordance with national policy. Inspectors observed that for one resident the one bed rail in place at night required review to ensure that measures were put in place to mitigate the risk of entrapment due to the space between the mattress and the bed rail.

3. 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:

A team meeting will take place with the staff nurses in the home led by the PIC and the ADON to highlight the issue re documenting in a residents care plan the trial/consideration of alternatives to ensure bed rail use is in accordance with national policy.

Going forward care plans will be audited by the PIC and the results of these audits discussed with staff at team meetings to improve compliance in this area and to

reinforce the homes policy on restraint and the national guidelines on the promotion of a restraint free environment in the home.

Within our Policy & Procedure there is guidance on the safe fitting of a bed rail for staff to follow. An audit of existing beds, mattresses and bedrails will be carried out to ensure that such equipment used within the home are of compatible size and design, and do not create entrapment gaps for residents. Where an entrapment risk is identified action will be taken immediately to correct the problem.

All such equipment is maintained under a service contract with an external provider, and they carry out an annual audit/review of all beds/bedrails and mattresses to ensure that they are all in good working order.

Carers will carry out hourly checks on bed rails in use to assure themselves the bed rail is safe and will document these checks. The nursing staff will oversee the carers to ensure carers are carrying out these checks and that the documentation is complete

Proposed Timescale: 31/05/2016

Outcome 08: Health and Safety and Risk Management

Theme:

Safe care and support

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

Emergency escape routes were not kept clear from obstruction at all times.

4. Action Required:

Under Regulation 28(1)(b) you are required to: Provide adequate means of escape, including emergency lighting.

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

On the day of the inspection all emergency exits that were not clear of obstruction were cleared.

A new designated area in the home has been identified for keeping catering trollies when not in use. Furthermore, a room on the first floor that had been ear marked for alternate use by the previous person in charge, and was not used as storage on the day of the inspection, has been reinstated as storage for assistive equipment.

Proposed Timescale: 19/02/2016

Theme:

Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in

the following respect:

Signage in one area of the centre directing occupants of the building to fire exits in the event of evacuation required review to ensure it directed evacuation through an appropriate final exit.

5. Action Required:

Under Regulation 28(2)(iv) you are required to: Make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and safe placement of residents.

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

The emergency exit signage has been reviewed within the home, and the necessary changes made to ensure that it directs occupants to appropriate final exits has been carried out

Proposed Timescale: 19/02/2016

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:

Review of the residents' documentation did not indicate that residents and where appropriate their family members were consistently consulted when revising and preparing care plans.

6. 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 PIC will implement a timetable with the staff nurses responsible for a residents care plan so that every 4 months the care plan review and or revisions will be discussed with the resident and or their next of kin. This process will commence from 01/05/2016 as the PIC has just commenced her role.

Proposed Timescale: 31/08/2016

Theme:

Effective care and support

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

Inspectors found that care plans were not consistently updated with recommendations from allied healthcare professionals.

7. 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:

There is access to a multi disciplinary team and there is evidence of this within the care plans. However, these interventions are noted in the residents "care plan re-evaluation" and not in the section "care interventions for implementation". This will be reinforced with nursing staff that any required interventions as recommended by any member of the multi disciplinary team that these are written up/documentated within the "care interventions for implementation" section of the care plan. We have introduced a "SOP" to guide staff through this process.

Continued audit and review of care plan documentation by the Person in Charge and Group Clinical Governance team will highlight this issue and the results of these audits relayed onto staff nurses at team meetings until there is improvement in this area.

Proposed Timescale: 30/04/2016

Theme:

Effective care and support

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

Records of repositioning and activities of daily living including assistance and provision of personal hygiene were not being recorded contemporaneously to provide assurance that the appropriate care was being provided.

8. 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:

At handover the staff nurses are identifying the residents that require a record of their repositioning throughout the shift. The repositioning records are provided to the care assistants who complete them throughout the shift. These are reviewed at the end of the shift by the staff nurse on duty to ensure the residents identified need is met.

ADL's including assistance with residents personal hygiene needs are recorded daily by the staff nurse on duty in the residents individualised care plan

Carers are allocated to manage the Daily needs of residents, this includes personal hygiene provision and repositioning of residents throughout a shift. Personal Hygiene provision when carried out is documented on a "Daily flow" sheet of a resident and repositioning when carried out is documented on a "Repositioning chart" belonging to the resident. Completion of such documentation is the carers responsibility. The nurses responsibility is to oversee and carry out checks to ensure care staff are carrying out the tasks set per the allocation sheet (ie Personal hygiene needs/repositioning needs) and to ensure that the records documenting that these tasks are complete and are contemporaneous. These checks by nursing staff are carried out on an ad-hoc basis throughout shifts.

Nursing staff currently sign off on repositioning charts at the end of shift.

The PIC and the Assistant Director of Nursing have brought it to the attention of nursing staff that if they have identified that care staff are not documenting contemporaneously repositioning/ personal hygiene tasks carried out, they are to firstly to bring it to the attention of the carer, reinforcing with the carer that this is a vital part of their role and responsibilities. Furthermore, the nursing staff have been asked that where care staff are regularly failing to document that this is escalated to the management team in the home, so that proper action is taken so as to improve the record keeping carried out by carers.

The PIC will also carry out checks on this issue and where provision of personal hygiene and repositioning are not being recorded contemporaneously that this is followed up with nursing staff at team meetings.

Proposed Timescale: 15/05/2016

Theme:

Effective care and support

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

Residents who required seating assessments to ensure appropriate seating was available had not had access to an occupational therapist to complete the necessary assessments.

9. Action Required:

Under Regulation 06(2)(c) you are required to: Provide access to treatment for a resident where the care referred to in Regulation 6(1) or other health care service requires additional professional expertise.

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

Going forward where residents are observed/assessed as requiring access to an occupational therapist this will be discussed with the resident and their family. Contact details of an occupational therapist (private) will be provided for the family to facilitate them in getting the resident assessed by an occupational therapist. This discussion with and information provided to the resident and their family will all be documented in the

residents care plan.

Continued audit and review of care plan documentation by the Person in Charge and Group Clinical Governance team will ensure nurses are following up with families as regards getting the resident access to the occupational therapist.

Proposed Timescale: 31/05/2016

Outcome 12: Safe and Suitable Premises

Theme:

Effective care and support

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

- A number of the multi occupancy bed rooms (three and four bedded rooms) within this centre did not meet the requirements of Regulation 17 or Standard 25 of the National Quality Standards for Residential Care settings for Older People. These three and four bedded rooms did not facilitate residents' privacy and dignity, and did not provide sufficient physical space to meet their needs.
- a number of the communal toilets and bathrooms did not have functional privacy locks in place.
- the emergency call bell system could not be heard by staff in the dining area on the first floor.
- there was insufficient storage space to appropriately and safely store equipment such as hoists, catering trolleys, transit wheelchairs and other equipment.

10. 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:

In accordance with the Authority's Regulatory Notice on Premises & Physical Environment (RN001/2016) of January 2016 - where significant non-compliance has been identified, written, explicit, costed plans with defined timescales will be required.

As of 3rd March 2016 we can confirm that St. Pappins Nursing Home Limited's offer to purchase an adjoining site, has been accepted.

Our plan is to build additional bedroom space, communal space, storage and bathroom/toilet facilities. We have provide HIQA with Architect drawings for the proposed development, we have submitted to HIQA these with timelines, which will clearly demonstrate how and when we will reach effective compliance with the relevant Regulations and Standard 25, and when possible we will include proposed costed plans for the centre, with a timeframe.

In the interim period we have adjusted the rails and purchased new curtains. We are

currently sourcing a suitable armchair to ensure that each resident has an individual chair for their own personal use.

We are currently looking at the multi-occupancy rooms and will ensure that the residents accommodated in these rooms can have their needs met. To achieve this the PIC has begun a process of reviewing the dependencies and mobility of residents in the home particularly in the multiple occupancy rooms. Rooms 10 and 30, which are 4 bedded rooms, we will going forward seek more mobile, ie ambulatory residents, to be accommodated in these rooms.

All The multiple occupancy rooms in the home will be reviewed and reconfigured as part of the development outlined above so as to meet the regulations. This will all be achieved by January 2019.

Privacy locks will be fitted to all communal toilets and bathrooms on before 31/03/2016
An additional call bell panel has been fitted in the dining area on the first floor, to ensure that the call bell can be heard.

Proposed Timescale: 18/01/2019

Outcome 13: Complaints procedures

Theme:

Person-centred care and support

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

Complaints were not properly recorded, or investigated.

11. Action Required:

Under Regulation 34(1)(f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.

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

The management of complaints in the home has been inconsistent. The new Person in charge to be inducted with training on Silver Stream documentation and systems and a separate training to be provided on the handling of complaints and complaints management.

All complaints verbal/written within the home going forward to be reported by the PIC using the Silver Stream complaints form and scanning it to the Group Clinical Governance Team within 24hours of receipt of the complaint. This will ensure complaints are properly recorded and required investigations are carried out.

Proposed Timescale: 30/04/2016

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:

The diet list of residents with special dietary needs or specialised modified consistency diets was not always updated to reflect the recommendations of allied healthcare professionals such as dietitians and speech and language therapists to ensure all staff were aware of these requirements.

12. 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:

An SOP will be developed to guide staff nurses in relation to documenting allied health care professionals recommendations (in this case dietician and SLT) to ensure that these are communicated to the relevant staff in the home.

Proposed Timescale: 30/04/2016