

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Central Park Nursing Home
Centre ID:	OSV-0000328
Centre address:	Clonberne, Ballinasloe, Galway.
Telephone number:	093 45 231
Email address:	maguire667@hotmail.com
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	AllanBay Limited
Provider Nominee:	Caroline Maguire
Lead inspector:	Marie Matthews
Support inspector(s):	Mary McCann
Type of inspection	Unannounced Dementia Care Thematic Inspections
Number of residents on the date of inspection:	52
Number of vacancies on the date of inspection:	12

About Dementia Care Thematic Inspections

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor compliance with specific outcomes as part of a thematic inspection. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
25 February 2016 15:00	25 February 2016 22:00
26 February 2016 09:30	26 February 2016 18:30
03 March 2016 10:30	03 March 2016 20:00

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

Outcome	Provider's self assessment	Our Judgment
Outcome 01: Health and Social Care Needs		Non Compliant - Major
Outcome 02: Safeguarding and Safety		Non Compliant - Moderate
Outcome 03: Residents' Rights, Dignity and Consultation		Non Compliant - Moderate
Outcome 04: Complaints procedures		Non Compliant - Moderate
Outcome 05: Suitable Staffing		Non Compliant - Moderate
Outcome 06: Safe and Suitable Premises		Non Compliant - Moderate

Summary of findings from this inspection

This inspection report sets out the findings of a thematic inspection which focused on six specific outcomes relevant to dementia care. The purpose of this inspection was to determine what life was like for residents with dementia living in the centre. The inspection also considered findings from the last inspection carried out on in August 2014, notifications submitted and information submitted by the provider in reply to a provider led investigation issued by the Health Information and Quality Authority (the Authority).

As part of the thematic inspection process, providers were invited to attend information seminars given by the Authority. In addition, evidence-based guidance was developed to guide the providers on best practice in dementia care and the inspection process. At the request of the Authority, the provider had submitted a

completed self assessment tool on dementia care to the Authority comparing the services provided with the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland. The provider had assessed the centre as compliant in all areas. The findings of the inspectors did not accord with the provider's judgements.

The centre is registered to accommodate 64 residents. There were 52 residents accommodated on the day of the inspection (three in hospital). The centre has a dementia specific unit known as Memory lane and at the time of inspection there were 15 residents with a formal diagnosis of dementia accommodated in this unit. A further 34 residents were accommodated in the main nursing unit including. Five residents who were identified as having some level of cognitive impairment. Some immobile residents with advanced dementia were accommodated in the main unit.

Inspectors met with residents and staff members during the inspection. The Director of Nursing who is the Person in charge (PIC) was responsible for the day to day management of the centre and was based in the main nursing unit. She was supported by an Assistant Director of Nursing (ADON) who manages the dementia unit. The provider had recently completed a Masters Degree in Dementia care and had recently returned to nursing care in addition to her provider responsibilities.

Inspectors tracked the journey of four residents with dementia within the service. They observed care practices and interactions between staff and residents with dementia using a validated observation tool. Inspectors also reviewed documentation such as care plans, medical records and staff files. They also reviewed the care plans of residents in the main nursing area. Inspectors examined relevant policies including those submitted prior to inspection. The building was well maintained and comfortably warm although all communal areas were not utilised. Staff demonstrated good knowledge of each resident's likes and dislikes. There was a choice of a nutritious variety of food at mealtimes.

Significant issues were identified in relation to the overall governance of the centre. Management systems in place were inadequate to ensure the service provided was safe, appropriate, consistent and effectively monitored to deliver a good quality of care. This was evident in relation to falls prevention and also in relation to the management response to an incident where staff on night duty had failed to check on residents. Immediate action plans were issued by the Authority requiring the provider to respond to these areas. A third day of inspection was completed to ensure that the immediate action notices issued had been appropriately addressed which confirmed that the provider had taken action to address the risks identified.

Inspectors also identified that improvements were required in the deployment of staff to ensure adequate supervision of residents in communal areas. During periods of observations completed by inspectors there was poor evidence that the staff deployed to these areas interacted in a positive and connected manner by staff.

Improvements were also identified as required in care planning and there was limited ongoing assessment of residents to track the progress of their dementia and guide

staff as to the level of cognitive function retained by the resident. Privacy was observed to be respected but there were inadequate systems in place to ensure residents were consulted with and involved in the organization of the centre. The design and layout of the building was suitable for the needs of residents but there was poor use of available space and facilities.

The areas of non compliance were discussed in detail with the provider, the person in Charge, and the Assistant Director of Nursing at the end of the inspection. The action plan at the end of this report identifies in full all improvements required to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.

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

Outcome 01: Health and Social Care Needs

Theme:

Safe care and support

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

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

Findings:

The self assessment tool (SAT) completed by the provider for this outcome was rated compliant.

There were 51 residents in the centre on the day of this inspection and a further 2 residents were in hospital. 15 residents had a formal diagnosis of dementia and were accommodated in a dementia specific unit. A further five residents were identified as having some degree of cognitive impairment. While comprehensive assessments were carried out, care plans were not always developed based on the assessments of need and in line with residents changing needs. The assessment process involved the use of validated tools to assess each resident's risk of malnutrition, falls, level of cognitive impairment and their skin integrity.

There was evidence in some care plans that residents and their families, where appropriate were involved in the care planning process but this was not consistently found in all care plans reviewed. The nutritional and hydration needs of residents with dementia were found to be met and some systems were in place to prevent unnecessary hospital admissions. For example, staff were trained to administer subcutaneous fluids to reduce the risk of dehydration. Residents were able to retain the services of the own General Practitioner (GP). Inspectors saw that while some residents were regularly reviewed by their GP, others whose GP was located further from the centre were reviewed less frequently.

Some new residents had visited the centre prior to admission and the person in charge said she had visited other residents at home or in hospital to complete an assessment to ensure that the centre could adequately meet their needs. A copy of the hospital discharge letter was available on files reviewed. A copy and the Common Summary Assessments (CSARS), which includes assessments by a geriatrician, a medical social worker and a comprehensive nursing assessment completed prior to admission, was only available on one file reviewed. In discussion with the PIC she advised that a version of this would be retained for all future admissions. An admission policy was available to

guide practice.

Inspectors examined the files of residents who had been transferred to hospital from the centre and found that a copy of a transfer letter with information about the resident's health, medications and their specific communication needs was not available. In discussions with the PIC she advised that this information was generated electronically and sent with the resident to the acute services. However, as a copy was not retained, it was not possible to confirm this. In the sample of files reviewed, a care plan was developed within 48 hours of admission based on the assessments completed. There was evidence that residents and their families were involved in the care planning process

Inspectors identified that some care plans were generic and didn't contain sufficient information to direct care. This was particularly evident in relation to residents identified as being at risk of sustaining a fall. Inspectors found that the management of falls was inadequate. An immediate action plan was issued requiring the provider to take action to improve the management of falls. The inspector returned to the centre on the 3rd of March 2016 and found that the provider had reviewed the management of falls. Some residents who had sustained a fall and were identified as been at high risk of sustaining another fall did not have a falls prevention plan in place to minimise the risk of a further fall. Where a falls prevention care plan was in place, it was not updated following a fall to include interventions to reduce the risk of further falls.

There were 30 falls in the last year and more than half of these were unwitnessed. An incident form was completed when a resident sustained a fall. Inspectors observed that there were two systems in use to record incidents that occurred. Some staff used the electronic system that linked to the residents care plans while others completing a paper record. In both systems the forms were found to be incomplete and the management section where learning from the incident was recorded was blank on several records. The PIC stated that she reviewed all incidents, however; this review was not always recorded on the forms.

A falls prevention policy was available but practice did not fully reflect the policy. For example, the policy stated that a falls prevention care plan should be developed to address the risk of falls. Several residents who were identified as a having a high risk of falling had no falls prevention care plan to guide staff. Where care plans were available, inspectors found that they had not always been reviewed to reflect recent falls. An immediate action requiring the provider to address the management of falls was issued and when an inspector returned on the third day of the inspection the provider had taken action to improve falls management. A falls risk assessment was carried out for residents identified as high risk had a care plan put in place and those at risk of sustaining falls had their charts and their beds labelled with a red sticker to alert staff in a private and dignified way that the resident is a high risk of falls. Residents identified as a high risk of falls had hip protectors put in place and bed alarms fitted to their beds. The use of crash mats was risk assessed for the residents who had them.

The policy also stated that residents should be checked hourly at night-time however management systems to ensure that these checks were completed were not robust and inspectors found that these did not always happen in practice. A more robust system

was put in place when this was brought to the attention of management.

Inspectors were told that a physiotherapist was available where required however there was no evidence that residents who had sustained a fall were reviewed by the physiotherapist following the fall. Inspectors also saw that there was no regular input by a physiotherapist for a resident with a neurological disorder. A number of falls prevention strategies were in use, for example, some residents wore hip protectors and others had low entry beds. Crash mats were also in use to minimise the risk of injury. Risk assessments were not routinely completed to ensure that the use of the crash mat was safe for the resident to use and did not increase the risk of a fall.

Residents' individual food preferences were recorded on admission and this information was recorded in the nutritional care plan. A policy on nutritional intake was available to guide staff. Staff had completed training to enable them to administer subcutaneous fluids to prevent dehydration and in percutaneous endoscopic gastrostomy (PEG) tube replacement in order to avoid unnecessary hospital admissions.

All residents were screened for nutritional risk on admission using a recognised assessment tool. Inspectors saw that residents' weights were checked monthly or more frequently where indicated. Where residents were identified as been at risk nutritionally they were referred to a dietician. Food and Fluid intake charts were available for residents assessed as being at risk of weight loss, however on review inspectors found that these were not completed in sufficient detail to provide a reliable therapeutic record of the residents' nutritional intake over a 24 hour period. Inspectors saw that those residents who had an impaired swallow were reviewed by a speech and language therapist. Inspectors saw that special dietary requirements were communicated to the catering staff. An inspector met with the chef who had a list with names of each resident who required a modified diet and those on weigh reducing or diabetic diets. Inspectors observed the residents during their lunch and during their evening meal in both units. There was a choice of meals provided and residents on modified diets were given the same choice as other residents. Inspectors observed that residents with an impaired swallow were seated in an upright position in accordance with the advice of the Speech and Language therapist to prevent aspiration. All tables were appropriately set. There was good interaction between staff and residents in the main unit however inspectors observed that some staff assisting residents in the dementia unit demonstrated a task based approach to care and did not engage with the residents at all throughout their meal.

There was evidence that residents were referred to appropriate support services where required including dietician, speech and language therapy, dental, ophthalmology and podiatry services. Psychiatry of old age team also visited residents in the centre and reviewed residents. Occupational therapy services were not provided in the centre however the PIC said that the service was available privately where necessary.

Staff provided end of life care to residents with the support of their medical practitioner and palliative care services. The inspectors reviewed a number of 'End of life' care plans. Improvements had been completed in this area in response to the action plan from the last inspection. A booklet called 'priorities of Care' had been provided to residents and to their families and the information obtained informed care plans. This work had not been

completed for all residents at the time of inspection and inspectors found that some end of life care plans were generic and had not been adapted to reflect the residents' wishes. For example the names of the family members the resident would like to have with them had not been indicated. Special bags had been obtained for the storage of the deceased residents belongings which was in response to an action from the previous inspection.

Residents at risk of developing pressure ulcers had care plans in place and pressure relieving mattresses and cushions to prevent ulcers developing.

A cognitive impairment assessment was completed for all residents on admission however a care plan was not developed to map where the resident was on their dementia journey, their level of independence, what they could do for themselves who they still recognised or the activities they could participate in. There were written operational policies relating to the ordering, prescribing, storing and administration of medicines. Staff were observed to follow appropriate administration practices. Residents had access to a pharmacist of their choice and the pharmacist participated in medication reviews. Inspectors found that some practices in relation to prescribing and medication required review to meet with regulatory requirements. For example the route of administration was not always indicated on the prescriptions and there was no separate administration sheet for 'as required' (PRN) medication.

Judgment:

Non Compliant - Major

Outcome 02: Safeguarding and Safety

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

The self assessment tool (SAT) completed by the provider for this outcome was rated compliant. However, inspectors identified significant areas for improvement and an immediate action notice was issued requiring the provider to take appropriate action to ensure residents were appropriately safeguarded. The centres' safeguarding policy included 'failure to provide appropriate care to residents' in the definition of abuse. Inspectors reviewed an incident where staff on night duty had failed to check on residents for a significant period. While the provider completed a review of this incident, it was not robust or comprehensive in nature. For example, although staff had been interviewed regarding the incident, none of the staff involved had been retrained in adult protection. The provider had increased the frequency of the unannounced visits she completed to the centre but there was no record of what aspects of the service she reviewed on these visits.

A visitors' record was available in the reception area to monitor the movement of

persons in and out of the building to ensure the safety and security of residents. Staff interviewed regarding safeguarding residents were aware of the procedure to follow in the event of a suspected incident of abuse. The PIC had completed training to enable her to deliver this training and training records reviewed indicated that all staff had completed training however some staff had not had recent training. Smaller sums of pocket money were stored on behalf of some residents. Each resident's money was kept in a separate wallet. A sample of these was reviewed by the inspector. A record of each transaction was maintained and signed when transactions took place. The balance recorded was found to be accurate.

Five residents were identified as having behaviours and psychological symptoms of dementia (BPSD). The ADON said that most residents admitted to the dementia unit had BPSD and that staff worked with the residents' GP to get help the resident to settle into the new environment. As a result there was a reduction in the number of residents presenting with BPSD. Residents were also appropriately referred to the mental health team of later life for specialist input which was evidenced in the files reviewed.

Most staff had completed training in the management of BPSD and in dementia care to assist them to respond to the needs of residents. There was a policy and procedures in place to assist staff to care for residents with of the BPSD. It was not evident however that the policy was fully implemented. For example some of the behavioural support plans reviewed were found to be inadequate. While they described the behaviours of concern, the proactive and reactive strategies described lacked sufficient detail to adequately direct care in a consistent manner. Staff were knowledgeable regarding the underlying triggers that could cause of the behaviour and the distraction techniques that helped them to relay the residents' anxiety and prevent an escalation of the behaviours.

The use of bed rail restraint in the centre was reviewed. The centre had adapted the national policy on a restraint free environment. Restraints in use included bed rails. Risk assessments were completed to determine if the restraint was safe to use. Some of these were documented as enablers. There was evidence that other less restrictive options were considered before a bed rail was used such as the use of low entry beds.

Judgment:

Non Compliant - Moderate

Outcome 03: Residents' Rights, Dignity and Consultation

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 self assessment tool (SAT) completed by the provider for this outcome was rated compliant. Inspectors identified areas for improvement. Overall residents' privacy and

dignity was respected and residents were supported to make choices about their day to day lives however; there was little evidence that residents were consulted regarding the day to day running of the centre.

Inspectors reviewed how residents particularly those with dementia were involved and included in decisions about the life of the centre. The residents guide referred to monthly residents meetings but there was no evidence that any recent meetings had taken place. When the minutes available were reviewed, inspectors saw that the last meeting was held in October 2014. Minutes of this meeting were reviewed and included discussions about staffing levels and concerns raised by residents about staff response times for assisting residents to the bathroom. The minutes did not contain an action plan so it wasn't possible to determine what action was taken to resolve the issue for residents. A staff member acted as an advocate for residents and facilitated residents meetings. From the minutes available it was not apparent that residents with dementia were adequately represented at the meetings. The PIC stated that meetings were reconvening in the near future and the inspector verified that a meeting was scheduled on the third day of inspection.

Life histories were collated by staff and included a good level of detail about the residents. Most residents were from the locality and staff spoken with had a good knowledge of some aspects of their life before they became residents. However there was little evidence that the information collected in the life stories was used to plan a meaningful activity programme which reflected the residents' specific interests.

A room was available for residents to meet with visitors in private and there were no restrictions on visits. Newspapers, televisions, radios and internet access were available. A phone was available for residents to make or receive phone calls in private. Residents were facilitated to vote in the centre or in the local village voting centre and access to an independent advocate was available here were clocks and calendars displayed in communal areas to help orientate residents. Large screen televisions were provided however on several occasions both were on at the same time which was confusing especially for the residents with dementia.

An activities co-ordinator was employed full time and had protected time specifically for the delivery of an activities programme for residents. There was an activities programme in place which included an arts class, passive exercises, bingo, crafts, music and card playing. There were also individual activities such as hand massage on the schedule. There were events organised each month to mark seasonal events such as Valentine's Day and Saint Patricks day. Mass was celebrated monthly and residents were facilitated to pray the rosary once a week. Pet therapy was also part of the activities programme and an Irish therapy dog visited the centre regularly. Staff told the inspectors that during the summer residents spent time outside in the garden and took part in gardening activities and helped feed the centres chickens. Children from the local school come in regularly and entertain residents by singing and dancing.

The activities coordinator had completed Sonas training as well as a diploma in dementia awareness. She informed inspectors that one to one time was scheduled for residents with dementia or cognitive impairment who could not participate in the group activities, and that this time was used for sensory stimulation such as providing hand massages.

There were dementia relevant activities included in the activity programme such as Sonas which was held twice a week and reminiscence therapy which was held weekly.

Arrangements were in place for residents to vote and those who were able were taken by bus to the polling centre. However; there was no postal vote organised for those residents who were not well enough to leave the centre. Staff worked to ensure that each resident with dementia received care in a dignified way that respected their privacy. All residents in Memory Lane had their own bedroom with en suite facilities. Screening was provided in the twin bedrooms. Staff were observed knocking on bedroom and bathroom doors, and privacy locks were in place on all bedroom, bathroom and toilet doors. Closed Circuit Television Cameras (CCTV) was in use in corridors and at the entrance to the centre but had been removed from the sitting rooms, day rooms and dining rooms in response to the action plan from the last inspection

Judgment:

Non Compliant - Moderate

Outcome 04: Complaints procedures

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 self assessment tool (SAT) completed by the provider for this outcome was rated compliant. Inspectors identified that improvements were required with the management of complaints. On the previous inspection, the complaints procedure displayed in the centre was not accessible to residents as it was displayed in an elevated position and the writing was in a small font size. This had been modified and the policy was displayed at eye level in larger print.

The complaints policy and procedure had been updated in response to the last inspection and contained guidance in the event that a complaint was in relation to the person in charge. A log of all complaints was maintained. The inspectors reviewed a sample of the complaints records on file which included details of the investigation completed however; there was no indication of whether the complainant was satisfied with the outcome of the complaint or if they had been given information about the centres independent appeals process referenced in the policy.

In discussion with the provider some expressions of dissatisfaction with the service made verbally were not recorded in the complaints log so it was not possible to determine what investigations had taken place or if the matter was resolved. Residents spoken with said they would speak to any of the staff if they were unhappy or wanted to make a complaint. The Assistant Director of Nursing was the nominated person within

the centre to review complaints and to ensure they were appropriately managed in line with the policy.

Details of a number of advocacy services were included in the policy. A staff member acted as an advocate for residents and facilitated residents meetings. This is discussed further under outcome 3.

Judgment:

Non Compliant - Moderate

Outcome 05: Suitable Staffing

Theme:

Workforce

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

No actions were required from the previous inspection.

Findings:

The self assessment tool (SAT) completed by the provider for this outcome was rated compliant. However, inspectors found that the deployment of staff was not adequate to ensure appropriate supervision of residents and to ensure a high standard of evidence based nursing care. The provider told inspectors that difficulties had been encountered recruiting staff to replace staff who had resigned their positions. Inspectors reviewed the staff roster which covered arrangement for the main unit and for Memory Lane. The roster was unclear and working times were not recorded using a 24 hour clock. Codes were used to denote work shifts, for example N denoted the night shift however no key to the codes was present.

The provider had recently completed a master's degree in dementia care and had returned to a nursing role in addition to her management role. The PIC supervised care in the main unit and the Assistant Director of nursing (ADON) supervised care in the dementia unit. In addition to the PIC and ADON, there were two staff nurses and 8 care staff on duty during the day. This reduced to two nurses and six care staff in the evening and to one nurse and three care assistants at night.

As part of the inspection, inspectors spent a period of time observing staff interactions with residents. Inspectors used a validated observational tool (the quality of interactions schedule, or QUIS to rate and record at five minute intervals the quality of interactions between staff and residents in communal areas. The scores for the quality of interactions are +2 (positive connective care), +1 (task orientated care, 0 (neutral care), -1 (protective and controlling), -2 (institutional, controlling care). The observations took place in the communal areas and dining area over four 15 minute periods. Inspectors observed that staff delivered care in a respectful manner however, there were a high number of neutral interactions observed where staff walked past residents without any interactions or social engagement. There were also several task orientated interactions where staff provided appropriate care but without any meaningful dialogue with the

resident. Inspectors also observed several periods where residents were left unsupervised in communal areas. Staff who spoke with inspectors evidenced knowledge of all the residents and residents were generally positive about the staff. However, some told inspectors that they sometimes had to wait to be brought to the bathroom and perceived the staff as good but very busy.

In the staff files reviewed all the requirements of Schedule 2 of the Regulations were available including Garda Vetting and appropriate references. The registration numbers for nursing staff with an Bord Altranais agus Cnáimhseachais na hÉireann were available on staff files. A training plan for 2016 was being drafted although not yet scheduled. Staff had completed mandatory training in fire safety, manual handling and protection and some staff had also completed training in dementia care and managing behaviour associated with dementia.

Judgment:

Non Compliant - Moderate

Outcome 06: Safe and Suitable Premises

Theme:

Effective care and support

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

No actions were required from the previous inspection.

Findings:

The self assessment tool (SAT) completed by the provider for this outcome was rated compliant. Some areas for improvement were identified.

The centre was found to be well maintained, warm, comfortably and tastefully furnished and visually clean. All corridors were kept clear and uncluttered to ensure resident could mobilise safely. There were a number of dementia friendly design features throughout in the building that included space for residents to walk around freely, good lighting, contrast in colours used for floors and walls but there was not good use of the space available in the centre to provide care in small groupings and in a quiet low arousal environment for residents with dementia.

There was a choice of communal spaces available however; inspectors saw that some rooms were not in use. The design and layout of memory lane was conducive to dementia care with smaller dining and communal areas but there were too many residents for the area to be a therapeutic environment for the residents residing there. The space available in the largest communal areas was not used to facilitate seating groups of residents together and seating was arranged around the perimeter of the room. While, there was a smaller quiet sitting room available, this room was not used by residents at any stage on the day of inspection.

Residents in the dementia unit had a front door entrance to their bedroom painted in

different colours to aid recognition. Bedrooms contained an ensuite bathroom which was within view of the residents' bed and chair. Inspectors saw that bedrooms were personalised to reflect residents' individual wishes with pictures photograph's and mementos. The premises and grounds were clean and well maintained. Wall/floor junctions were differentiated by visible contrasting colours throughout the building. There was good use of pictorial signage in the dementia unit to identify bedrooms and bathrooms. Clocks and calendars were located in a position on the wall where residents could see them time and notice boards displayed the date to help orientate residents.

The dementia unit was decorated and fitted with domestic style furnishings and memorabilia to support the comfort of residents. All parts of the premises were suitable lit and adequately ventilated. Handrails were provided along the corridor to assist residents mobilise safely. Residents in the dementia had access to a secure external garden area however the gravel surface provided meant that residents could not use this area independently.

There was a functioning call bell system in place within the centre, and hoists and pressure relieving mattresses were in working order, with records available to indicate servicing at appropriate intervals. For example, a sensory room with a water bed was provided which was suitable for individual one to one activities for residents with dementia but inspectors found it full of assistive equipment and not accessible to residents.

Signage in the main building was observed to be inadequate and there was not good use of signs to identify specific areas or visual cuing to prompt recognition.

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:

Marie Matthews
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:	Central Park Nursing Home
Centre ID:	OSV-0000328
Date of inspection:	25/02/2016
Date of response:	17/06/2016

Requirements

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

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

Outcome 01: Health and Social Care Needs

Theme:

Safe care and support

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

Families were not always involved in the care planning process and care plans were not revised to reflect residents changed needs.

1. 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

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

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:

Communication was made to all family members in January 2016 requesting them to come in and discuss the resident's care plan and encourage involvement. While several families did come in, nurses were waiting to hear back from other family members to do same. Going forward, the Person In Charge allocated named nurses to each resident to ensure families are always involved in the care planning process. The registered provider is now auditing that this action is completed by all nurses on a monthly basis.

The registered provider, the person in charge and the assistant director of nursing proactively have addressed all care plans to reflect all residents changed needs. All named nurses have been trained on revising care plans to reflect their residents changed needs. Nurses attended a Care Planning Training Webinar on 25/05/2016.

Proposed Timescale: 31/07/2016

Theme:

Safe care and support

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

A copy and the Common Summary Assessments (CSARS), which includes assessments by a geriatrician, a medical social worker and a comprehensive nursing assessment completed prior to admission, was only available on one file reviewed.

2. 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:

Post inspection, the management found that a comprehensive assessment was completed on every resident on admission and updated every four months. Going forward all admissions will be assessed by using the CSARS form prior to admission.

Proposed Timescale: 17/06/2016

Theme:

Safe care and support

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

Some care plans were generic and didn't contain sufficient information to direct care.

3. 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:

An emergency nurses meeting was held post inspection on 29/02/2016 at 9am to address that some care plans were generic and didn't contain sufficient information to direct care and that care plans didn't reflect the assessments carried out. Named nurses were allocated to residents to carry out assessments and care plans for their residents. Training of care plans and assessments has been completed with nurses and auditing is ongoing on a monthly basis by the registered provider and the assistant director of nursing. Champions have also been allocated to specific areas, e.g. Falls, Nutrition, End of Life, Behaviours that are Challenging, Skin Integrity and Wound Care.

Proposed Timescale: 30/06/2016

Theme:

Safe care and support

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

The management of falls was inadequate.

4. Action Required:

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

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

The management of falls was inadequate on the first inspection on 25/02/2016 and 26/02/2016. We received an immediate action to address this issue by the 03/03/2016. By that date, management put in place the following: A Cannard Falls Risk Assessment was carried out on all residents and those deemed as high risk had a care plan put in place. Residents who were of high risk of falls had their charts labelled with a red sticker as well as their beds to alert staff in a private and dignified way that the resident is a high risk of falls. Residents identified as a high risk of falls had hip protectors put in place and bed alarms fitted to their beds. The use of crash mats were risk assessed for the residents who had them. The electronic version of recording incident reports was removed and only a paper Incident Report took its place. If a fall was to occur in future, the nurse on duty was to fully complete the Incident Report and the attached post fall investigation report both in full detail. These documents are then to be filed away in the allocated Falls Diary folder. A falls map was also designed and displayed in the main nurses station so that when a fall occurs the area where it occurred could be marked with an 'X' in order to identify if an environmental issue can be addressed or if there are any trends with falls in a particular area. The Garden Room was then utilised for supervision of residents with high risk of falls. The touch screen was relocated from the

hallway to this day room to encourage extra supervision. A staff member was then allocated to stay in the Garden Room at all times for supervision and for positive interaction and activities. After reviewing the previous year's falls record, it was found that majority of falls occurred in the dementia unit. Post inspection all staff read the supervision of residents and falls policy and management implemented the supervision levels to alert staff on falls risks. Residents from the dementia unit are also included in Garden Day room activities to increase their supervision simultaneously as well as in the living room in the dementia unit. These actions are being continued. It has been found from the 03/03/2016 to 09/06/2016 there has been 2 falls (with no injuries sustained), compared to 10 falls in the same time period in 2015. Staff are constantly reminded of a zero falls tolerance. All care plans are now updated immediately to include interventions to reduce the risk of further falls. The assistant director of nursing was also appointed the Falls Champion who audits the incident reports, keeps the falls diary up-to-date and audits that care plans are updated as well as ensuring that all incident reports are completed fully. Should a serious incident or fall occur a Root Cause Analysis is completed in conjunction with the safety committee. A more robust system was put in place to ensure that hourly night checks were being done with the use of a night check list. The assistant manager conducts random spot checks using the CCTV on a monthly basis to ensure night checks are being done and the registered provider makes random unannounced night visits.

Going forward a physiotherapist will review a resident post falls.

Proposed Timescale: 30/03/2016

Theme:

Safe care and support

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

There were no care plan for residents with dementia to map where the resident was on their dementia journey, their level of independence, what they could do for themselves who they still recognised or the activities they could participate in.

5. 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:

Currently, we have individual care plans for each resident which maps out their level of independence and their level of social participation and dementia care, however, going forward in review of your inspection, we will now put in place a specific and comprehensive dementia care plan which will map where the resident is on their dementia journey, their level of independence, what they can do for themselves, who they still recognise and the activities they can participate in and that this care plan also reflects their MMSE score.

Proposed Timescale: 31/07/2016

Theme:

Safe care and support

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

Some end of life care plans were generic and had not been adapted to reflect the residents' the physical, emotional, social, psychological and spiritual wishes.

6. Action Required:

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

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

Since the inspection, all residents DNR status have been documented and more comprehensive end of life care plans are being completed. Having attended the seminar for providers of residents services for older people on 15/06/2016, we have decided to implement the "Think Ahead" form which will be provided to the new resident and families on admission and complete it with our current residents should they wish to do so.

Proposed Timescale: 31/08/2016

Theme:

Safe care and support

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

Food and fluid balance records were not completed in sufficient detail to provide a reliable therapeutic record of the residents' nutritional intake over a 24 hour period

7. 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:

During our inspection, we realised that care assistants were using a calculator icon on the touch screen instead of inputting the fluid intake in intervals after each time it is provided. Epic Care removed the calculator icon so that care assistants can only use a specific breakdown of fluids showing the exact amount of fluid given at that time. Staff were told at the staff meeting post inspection to only input food and fluid record after it occurred in a timely fashion and not at the end of their shift. The assistant manager is

now to conduct spot checks that the proper procedure for recording fluid and food intake is done.

Proposed Timescale: 17/06/2016

Theme:

Safe care and support

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

The route of administration was not always indicated on the prescriptions and there was no separate administration sheet for 'as required' (PRN) medication.

8. Action Required:

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

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

Post inspection, the pharmacy was contacted immediately to address that there was no separate Kardex for PRN medications. New Kardex was issued for all residents in April. A meeting is being held on Tuesday, 21st June with our pharmacist in regards to the Kardex of medications to ensure this practice is continuous.

Proposed Timescale: 30/06/2016

Outcome 02: Safeguarding and Safety

Theme:

Safe care and support

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

Behavioural support plans reviewed were found to be inadequate and lacked sufficient detail to adequately direct care in a consistent manner.

9. Action Required:

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

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

All residents with dementia currently have a behavioural/challenging behaviour care plan in place. The ADON will personalise these care plans further by describing the behaviours of concern, the proactive and reactive strategies will be included to adequately direct staff in a consistent manner.

Proposed Timescale: 31/07/2016

Theme:

Safe care and support

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

Training records reviewed indicated that some staff had not completed training in the management of BPSD or recent training in dementia care to respond to the needs of residents.

10. Action Required:

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

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

The registered provider, having completed her Masters in Dementia, is now conducting training sessions with staff. At present, 22 staff have completed training in 'Communication in Dementia' and a further two more sessions over a two day period have been scheduled for this month and will continue training on a monthly basis covering different topics under BPSD. All new employees complete training in Behaviours that are Challenging as well as other topics on induction. Our policy for Behaviours that are Challenging and Dementia Care is available to all staff at all times and they will be requested to reread them immediately.

Proposed Timescale: 10/07/2016

Theme:

Safe care and support

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

An incident where staff on night duty failed to check on residents for a significant period did not have full and robust review by the provider

11. Action Required:

Under Regulation 08(3) you are required to: Investigate any incident or allegation of abuse.

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

After the inspection, we completed a further more robust review in regards to this incident on 02/03/2016. This involved an analysis of the incident report, progress notes, observations, medications, rota, statements from staff on duty, internet history, CCTV footage, Peninsula Consultations and minutes of meetings with staff regarding the incident. Detailed outcomes were reached following this review and are currently being

rolled out. Should an incident occur in the future a Root Cause Analysis will be completed within 48 hours of the incident as per our Risk Management Policy.

Proposed Timescale: 02/03/2016

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

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

There was little evidence that the information collected in the life stories was used to plan a meaningful activity programme which reflected the residents' specific interests.

12. Action Required:

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

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

While we do have a very eventful and therapeutic activities programme in place including rummage boxes that were developed to address resident's specific interests as well as scrapbooking, we are now going to make better use of resident's life stories in order to plan a meaningful activity programme which will reflect the residents' specific interests.

Contact has been made with a Dementia Training Specialist to come to our centre and provide more training with our staff. A meeting was held with the two recreation therapists to develop a programme detailing all the meaningful activities that are done. A specific care plan on meaningful activities is to be made for all our residents detailing the activities that are meaningful to them and the programme integrated into their social care needs.

Proposed Timescale: 31/07/2016

Theme:

Person-centred care and support

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

Residents meetings were held infrequently and the minutes did not contain an action plan so it wasn't possible to determine what action was taken to resolve the issue for residents.

13. Action Required:

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

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

A residents council meeting was held on 02/03/2016 and again on 11/05/2016. Meetings will now be held every 2 months in the front green room. Management sat down and discussed the minutes and carried out an action plan and addressed any issues. The PIC will now commence the residents council meeting for a few minutes to communicate the outcome of the management meeting to residents. The receptionist has been appointed as the person responsible of scheduling and coordinating the resident council meetings as well as communicating when it is to occur, via clear, big posters throughout the home and friendly reminders.

Proposed Timescale: 11/06/2016

Theme:

Person-centred care and support

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

There was no postal vote organised for those residents who were not well enough to leave the centre.

14. Action Required:

Under Regulation 09(3)(e) you are required to: Ensure that each resident can exercise their civil, political and religious rights.

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

All residents received a voting cards and each resident was asked would they like to attend the local school to vote. Those who wished to vote were accommodated. With regards to the postal vote, the register was updated by the PIC and the Register of Voters and deceased residents were removed and new residents were added in the weeks prior to the vote. Unfortunately, a postal vote was not received. Going forward, a postal vote is to be fully organised to ensure residents receive the postal vote.

Proposed Timescale: 17/06/2016

Outcome 04: Complaints procedures

Theme:

Person-centred care and support

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

There was no indication of whether the complainant was satisfied with the outcome of the complaint or if they had been given information about the centres independent appeals process referenced in the policy.

15. 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:

Management appointed post inspection the ADON to be the new the nominated person within the centre and to ensure they are appropriately managed in line with the policy. The PIC and the ADON will audit any complaints on a monthly basis ensuring there is a record of all complaints including the details of any investigation, the outcome of the complaint and whether or not the resident was satisfied.

Proposed Timescale: 06/07/2016

Outcome 05: Suitable Staffing

Theme:

Workforce

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

The deployment of staff was not adequate to ensure appropriate supervision of residents and to ensure a high standard of evidence based nursing care.

16. 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:

The registered provider told inspectors of a shortage of nurses due to HSE recruitment and recruitment including overseas is ongoing. A new nurse is due to join the team in July. The staff roster is now being completed using software and all employees have access to it and it is displayed in a locked display board in the staff room. The shift hours are clearly printed with am and pm beside them. During the day, there were two nurses and 8 care assistants and this reduced to two nurses and 7 care assistants in the evening and then to one nurse and 4 care assistants at night.

Management were satisfied with the number of staff on the floor and their levels. However, they were not being utilised and delegated to ensure appropriate supervision of the residents and to ensure a high standard of nursing care. Therefore, a meeting was held post inspection on 29/02/2016 with nurses and on 02/03/2016 with care assistants to instruct staff that there must be supervision at all times in the Garden Day room and in Memory Lane. In the evening, our high risk residents in Memory Lane are supervised and any residents who wish to join the Garden Day room are free to do so.

Proposed Timescale: 11/06/2016

Outcome 06: Safe and Suitable Premises

Theme:

Effective care and support

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

Some rooms were not in use and there were too many residents in the dementia area to provide a therapeutic environment for the residents.

A sensory room was used to store assistive equipment and was not accessible to residents for therapeutic purposes.

A gravel surface provided external garden area meant that residents could not use this area independently.

Signage in the main building was observed to be inadequate and there was not good use of signs to identify specific areas or visual cuing to prompt recognition.

17. 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:

Our dementia unit, Memory Lane, has 15 residents. Within this unit there is a kitchen, three sitting rooms, dining area and a private visitor's area. Residents from Memory Lane are able to join the Garden Day room also.

The sensory room is now going to receive a refurbishment and all wheelchairs are now never to be stored in this room. This room will be accessible to all residents when complete.

The gravel surface outside will be removed and a safer surface put in its place.

New signage to be designed for throughout the building and new signs to identify specific areas or visual cuing to prompt recognition.

Proposed Timescale: 31/08/2016