

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Gascoigne House
<b>Centre ID:</b>	OSV-0000038
<b>Centre address:</b>	37/39 Cowper Road, Rathmines, Dublin 6.
<b>Telephone number:</b>	01 496 9944
<b>Email address:</b>	sshields@cowpercare.ie
<b>Type of centre:</b>	A Nursing Home as per Health (Nursing Homes) Act 1990
<b>Registered provider:</b>	Cowper Care Centre Designated Activity Company
<b>Provider Nominee:</b>	Seamus Shields
<b>Lead inspector:</b>	Helen Lindsey
<b>Support inspector(s):</b>	Shane Walsh
<b>Type of inspection</b>	Announced
<b>Number of residents on the date of inspection:</b>	44
<b>Number of vacancies on the date of inspection:</b>	0

## 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.

Please note the definition of the following term used in reports: responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

**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 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 inform a registration renewal decision. This monitoring inspection was announced and took place over 1 day(s).

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

From: 25 July 2017 09:00 To: 25 July 2017 18:30

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

<b>Outcome</b>	<b>Our Judgment</b>
Outcome 02: Governance and Management	Non Compliant - Moderate
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Compliant
Outcome 07: Safeguarding and Safety	Compliant
Outcome 08: Health and Safety and Risk Management	Compliant
Outcome 09: Medication Management	Compliant
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 15: Food and Nutrition	Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Non Compliant - Moderate
Outcome 18: Suitable Staffing	Non Compliant - Moderate

**Summary of findings from this inspection**

The inspection was carried out in response to the provider's application to renew the certificate of registration.

Inspectors found the centre to be meeting six outcomes but improvements were required in four outcomes to ensure compliance the Health Act 2007 (Care and welfare for Residents in Designated Centres for Older People) Regulations 2013.

Inspectors met with residents and some of their relatives, observed practice in the centre, and spoke with staff and the management team. They also reviewed a range of documentation including residents' records, medication records, and the organisation's policies and procedures.

Residents and families provided positive feedback about the service they received especially praising the kind and caring staff team. Residents had good access to healthcare and were appropriately safeguarded by a staff team who were knowledgeable about protection of vulnerable adults and had received a range of

relevant training. Medication arrangements were also well managed.

The person in charge and the assistant care manager were available in the centre, and supported by the senior management team that included the provider. There were processes to monitor the quality of the service being provided in the centre, and external advice was also sought to provide assurance to the provider.

Overall improvements were required to ensure residents identified needs were being met. Specifically improvements were required in the governance and management arrangement, care planning standards, provision of meaningful activity and staffing arrangements. This is discussed further in the report and in the action plan at the end.

Of the eight actions made at the previous inspection, six had been addressed fully. Two actions remained outstanding relating to care planning records and activities being provided in line with peoples interests.

**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 Standards for Residential Care Settings for Older People in Ireland.**

***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 inspector found the quality of care and experience of the residents was monitored by the provider to ensure residents' needs were being met. However findings on inspection found that improvement was required in relation to resourcing and the system in place to review and monitor the safety and quality of the service.

There was a clearly defined management structure in the centre. The senior team consisted of the registered provider, a clinical director, facilities manager, HR manager and financial controller. In the centre there was the person in charge, assistance care manager, nursing staff, health care assistants, and kitchen and housekeeping staff. The lines of accountability were clear and all staff spoken with during the inspection were clear of their role in the centre. All staff were aware of management arrangements in the centre, including on call arrangements.

While the resources were found to be appropriate in relation to the premises, staff training, and equipment, their findings set out in outcome 16 and 18 indicate there were shortcomings in relation to staffing levels that were having a direct impact on residents. The lack of staff in certain areas lead to residents' identified needs not being met.

The impact of the staffing levels also resulted in the statement of purpose was not being fully implemented in practice. A commitment made in the statement of purpose was not being met. It stated that the registered provider will 'provide staff in the numbers and with the competencies and skills necessary to deliver care to residents with their varied needs as displayed in their assessments and detailed in their care plans. These numbers will vary from time to time according to the numbers in residence and their assessed needs for direct care provision including physical and psychological stimulation and support.

There were management arrangements in place to ensure the service provided was

safe, appropriate to residents needs and effectively monitored. A number of internal audits were carried out in the centre to ensure day to day practice followed the policies and procedures put in place by the provider. The audits covered topics such as physical environment, staff files, and clinical needs. There had also been an audit by an external group on corrective and preventative actions in relation to incident management. The person in charge and clinical director checked on key performance indicators linked to the quality of care provided in the centre. There were regular management meetings where the person in charge met with the operations officer to discuss a range of topics including accidents, incidents, residents' care needs, training and staffing levels. Records of these meetings showed good practice and areas for improvement were identified. Actions required for improvement were identified and clearly allocated to a staff member to action. However while there were systems in place to oversee the quality of care in the centre they had not picked up a number of areas of non compliance identified during the inspection and changes had not been made in relation to the findings, for example a recent meal summary survey. To ensure areas of non compliance are identified the system required review.

An annual report was available for 2016 that covered a summary of the main areas of practice for the centre including the findings from internal and external audits, incident reporting, and resources such as staff training. Staff provided input to the report via their staff meetings, and the residents via their committee meetings.

**Judgment:**  
Non Compliant - Moderate

***Outcome 04: Suitable Person in Charge***  
***The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.***

**Theme:**  
Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**  
No actions were required from the previous inspection.

**Findings:**  
The person in charge was experienced, suitably qualified and demonstrated good knowledge of the regulations and standards. She was actively engaged with the governance, operational management and administration of the designated centre on a day to day basis.

There were arrangements in place to cover when they were absent from the centre.

**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:**

This outcome was not inspected in full. The outstanding action from the last inspection was found to be implemented.

The system for archiving residents' medical and nursing notes was now on the centres IT systems. Staff could access archived material.

**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):**

No actions were required from the previous inspection.

**Findings:**

There were measures in place to safeguard and protect residents from abuse.

There was a detailed policy in place that set out the procedures for the prevention, detection and response to abuse. Inspectors spoke with staff and found they knew the procedure to follow in the event of an allegation, suspicion or disclosure of abuse, including who to report it to. They confirmed their training covered signs of abuse and

what steps to take to protect the resident if necessary. Training records confirmed all staff had up to date training in protection from elder abuse.

There was a separate guidance document that set out how to carry out an investigation into any allegations made in the centre. The document set out a clear step by step approach and provided relevant templates to support the manager in following the process fully. This document followed the HSE guidance document 'safeguarding vulnerable persons at risk of abuse'.

There was a policy setting out the approach to restrictive practice in the centre, that included a commitment to work towards a restraint free environment, and followed the national guidance for nursing homes.

Restrictive approaches in the centre were limited to the use of bedrails, and key pad access for one door in the centre and the main exit from the centre. There were clear assessments in place for each resident that identified the most appropriate and least restrictive intervention. Where bedrails were being used there were risk assessments in place. Practice in the centre included regular checks on the resident when the bed rails were in use. Any restrictions in place were reviewed at least four monthly to confirm they continued to be appropriate for the resident.

Where psychotropic medications were being used to support residents as an 'as required' (PRN) medication the procedures followed national best practice. There was a clear protocol to follow. For example care plans set out the types of behaviours to manage, approaches to de-escalation, and sign off from two staff was required before medication was administered.

The inspector reviewed the policy on 'meeting the needs of residents with challenging behaviour' and found it to provide clear guidance and directions to staff as to how they should respond and strategies for dealing with responsive behaviour. Staff supporting residents were seen to know them well. Some care plans were in place for residents relating to responsive behaviors but improvements were required as described in outcome 11. As discussed in outcome 18 the staffing levels impacted on the plans being put in to practice effectively.

There was transparent system in place in place for the management and safeguarding of residents' finances and valuables. The provider was not a pension agent for any of the residents. Where there was a charge for a resident in relation to an additional service, for example hairdressing or newspapers, then this was invoiced at the end of the month either directly to the resident or the person nominated on their behalf. There was a clear record of invoices for any additional charges.

Residents who spoke with inspectors said they felt safe in the centre. Questionnaires sent to HIQA completed by residents and relatives confirmed the same, giving examples such as access to the centre being monitored, having staff on call at all times, and staff being well trained.

**Judgment:**  
Compliant



***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:**  
The centre had policies and procedures to promote the health and safety of residents. There were appropriate measures in place in relation to fire safety. The two outstanding actions from the last inspection were found to be implemented.

The centre had policies in place relating to health and safety, and risk management that were being implemented in practice. This addressed an outstanding action from the previous inspection. There was a signed health and safety statement that outlined the health and safety of residents, staff and visitors in the centre. There was a system in place to identify and respond to risk. A risk register was in place which was comprehensive and had been reviewed within the last year. The register outlined risk under three categories, corporate, health and safety, and resident welfare. All identified risks had initial mitigating controls and any additional controls documented. Some risks identified included infection control, security, burns from cooking utensils, self-harm, restraints, elder abuse and poor privacy and dignity. Risk was discussed at quality and safety meetings. The risk register was reflective of the service and evidenced that the risk management policy was being implemented in practice. This was a required action from the last inspection.

Infection control procedures were found to be suitable in the centre. There were regular hand wash basins and hand sanitising dispensers available throughout the centre. The inspectors observed good infection control practices throughout the day. The inspectors visited the laundry room. Household staff working in the laundry room knew what infection control procedures to take when soiled laundry or linen required washing. There was also a communication board in the laundry room that informed household staff if a resident had an infectious disease to ensure additional precautions were taken. This was also a required action from the last inspection.

The centre had suitable systems in place relating to fire safety. Servicing records confirmed the emergency lighting and fire alarm had been serviced four times within the last year. There were a sufficient number of fire extinguishers and fire blankets throughout the centre, records also confirmed that they had been serviced in April 2017. Fire exits were clearly signposted throughout the centre and visual check of the exits and fire panel were carried out daily. The centre was divided into compartments through fire doors. The fire doors were on self closing mechanisms that would close on the sounding of a fire alarm.

The centre had a fire safety management policy in place. There were fire procedures displayed in the centre that represented what was documented in the policy. All staff were trained in fire safety and staff had a good awareness of the procedure to be followed on the sounding of a fire alarm. Fire drills were taking place on a regular basis. Records were kept of drills which detailed the content of the drill, however some were noted to have less detail recorded. This was discussed with the person in charge and the maintenance manager and they agreed to review the recording process.

There was an emergency plan in place. This outlined the steps to be taken following an emergency such as loss of power, loss of water, a storm, a gas leak or a fire.

**Judgment:**  
Compliant

***Outcome 09: Medication Management***  
***Each resident is protected by the designated centre's policies and procedures for medication management.***

**Theme:**  
Safe care and support

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

**Findings:**  
The residents were protected by the centres policies and procedures for medication management.

There was a medication policy in place that provided guidance and information on all areas relating to medication receipt, storage, administration and disposal of medication. The policy was seen to be followed in practice. There were also supporting policies and guidance on a range of nursing interventions and treatments, for example 'sound alike-look alike medication', enteral nutrition, and end of life care.

Prescription and administration records were seen to be clear and fully completed. The medication administration sheets viewed were signed by the nurse following administration of medication to the resident and recorded the name of the drug and time of administration. The drugs were administered within the prescribed timeframes. There was space to record when a medication was refused on the administration sheet.

Where drugs had been recommended to be crushed, they were signed by the general practitioner as appropriate for crushing. Alternative liquid or soluble forms of the drugs were sought where possible through consultation with the pharmacy. The maximum amount for (PRN) medication (a medicine only taken as the need arises) was indicated on the prescription sheets examined.

Medication was stored securely in the nurses' room. When nurses were carrying out administration they took a trolley to the relevant part of the centre, which was seen to be locked at all times for safety. There was a fridge to store medication that required refrigeration, the temperature of the fridge was monitored daily and a deep clean was carried out weekly.

Medications that required strict control measures (MDA's) were kept in a secure cabinet which was double locked. Nurses kept a register of controlled drugs. It was signed following a check completed by two nurses at the end of each shift. The inspector checked a selection of the medication balances and found them to be correct.

Audits were carried out of medication practice in the centre, and there was ongoing monitoring of trends in the centre such as antibiotic use, psychotropic medications, and residents who are diabetic.

The general practitioner (GP) confirmed they review medication every 3 months, and records confirmed changes were made to support residents' ongoing health.

The action from the previous inspection was fully addressed.

**Judgment:**  
Compliant

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

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

**Theme:**  
Effective care and support

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

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

**Findings:**

Resident's wellbeing and welfare was maintained by an acceptable standard of nursing care, appropriate medical care and allied health care. However improvement was required in relation to the consistency in developing and reviewing care plans when residents' needs changed, and ensuring they were implemented in practice. This action remains outstanding from the previous inspection.

There was a clear system in place for assessing and reviewing residents needs, supported by guidance and templates. It was noted that all the policies and guidance

promoted a person centred and individual approach to resident care and support.

Residents' needs were being assessed prior to admission to ensure the centre was able to meet their identified needs in line with the admission policy. On admission a detailed assessment was completed and then care plans were put in place to set out how the residents' needs were going to be met. Reviews were carried out every four months, or more frequently if required. The residents and their families were involved in the review if they chose to do so, and were made aware of any changes. Inspectors heard nursing staff giving updates to relatives through the day, and relatives spoken with confirmed they were informed of any changes to the resident, with their permission.

Inspectors reviewed a range of care plans, for example those relating to catheter care, diabetes, epilepsy, risk of falls and pressure care. Overall where residents had an identified need, they had a care plan in place. Contact was made with relevant healthcare professionals, and any recommendations were updated in their care plans and risk assessments. However, this was not consistent. A number of examples were seen where information was out of date, had gaps, or did not include changes to care and treatment recommended by allied healthcare professionals. This created a risk of resident's current health and social care needs not being met. The following examples set out some of the issues identified:

- A falls diary did not include all falls detailed in the physiotherapy records.
- One care plan did not reflect a physiotherapist's recommendations.
- Two examples where residents had responsive behaviour but no care plan in place.
- A recommendation from a speech and language therapist had not been progressed and had to be re-stated.
- Several care plans did not include advice from dieticians.
- A gap in guidance about what to do if a residents equipment was not functioning correctly

While most care plans were person centred and gave information on individual routines and preferences, examples were seen where the language used was not person centred, did not promote independence, and would not guide staff practice. For example general statements such as 'provide support' were made without explaining what that support would be for different residents.

Examples were also seen where the care plans were not being followed by staff. For example where residents required support and supervision when mobilising due to risk of falls but it was not provided. Examples were also seen where actions agreed in risk assessments were not implemented in practice, for example having alarm mats in place to alert staff to a resident getting up. This links to the findings on staffing levels set out in outcome 18.

A positive approach used in the centre was to ensure staff knew about residents' life and experiences by asking the resident and their families to complete a life history. Staff were seen to know the residents well and were engaging effectively with them when communicating directly.

A range of nursing tools were used to assess residents and identify if there were any

changes in their presentation, for example risk of falls, pressure areas, and depression. There were also risk assessments in place to ensure care was delivered safely but without limiting residents' independence.

Key indicators relating to resident care were monitored by the person in charge weekly and discussed at management meetings. The low incident of conditions such as pressure areas and low incidents of residents being at risk of malnutrition showed that the nursing approach was resulting in good outcomes for residents.

Records showed that where medical treatment was needed it was provided. They showed that residents had timely access to general practitioner (GP) services, and referrals had been made to other services as required, for example a physiotherapist, speech and language therapist or gerontology services.

Where residents were temporarily absent from the centre, records showed that relevant information was sent with them. Also when residents returned to the centre, for example from hospital, there was a clear summary of the residents needs and guidance on any interventions needed.

**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):**

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

**Findings:**

This outcome was not inspected in full. The outstanding action from the last inspection was found to be implemented.

At mealtimes a system of table rotation was in place to ensure the same residents were not always served first. Food was observed to be served directly from the kitchen to the residents so it did not get cold.

**Judgment:**

Compliant

***Outcome 16: Residents' Rights, Dignity and Consultation***

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

**Theme:**

Person-centred care and support

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

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

**Findings:**

Residents were consulted with around the running of the centre and their religious and civil rights were respected. However not all residents had opportunities to engage in meaningful activities and there were some observed instances where resident's dignity was not respected. An action relating to activities remains outstanding from the last inspection.

Residents meetings were held in the nursing home on a quarterly basis. Fixed discussion items included discussing the minutes from the previous meeting and the person in charge communicating any updates in the centre to the residents. Other topics for discussion included any issues residents may have with the service and the activities plan in the centre. From the minutes it is evident that efforts were made to implement suggestions made by the residents. For example residents suggested that menus be removed from tables and only displayed at the kitchen window and in the dining area. This was observed to have occurred.

The residents guide held information about how residents can access an independent advocacy service. There were Roman Catholic and Church of Ireland services held weekly in the centre. The person in charge confirmed that there were no residents of other religion in the centre but stated that efforts would be made to meet the religious needs of any resident of any religious denomination.

Residents could be registered to vote in the nursing home if they wished. A polling booth was set up in the nursing home during any local and general election or during a referendum.

Residents had access to various forms of media including television, radio, newspapers and WiFi. There was a suitable amount of communal and private space in the centre, and residents could receive visitors in private in the small day rooms. It was noted however that the smaller communal rooms were not regularly used, and the main sitting area became very busy at times.

The inspectors reviewed the activities plan for the centre. The healthcare team leaders were responsible for planning the weekly activities and various healthcare staff were

assigned to supervise each activity. The inspectors found that many of the activities were not engaging. Some 'activities' listed on the plan included the evening news and nature sounds. These would not be engaging for many residents with cognitive impairment and it is unclear as how they can be classed as activities. Each Wednesday the only activity listed until 17.30 was religious services; no alternative was listed for residents who did not wish to attend the services.

The inspectors observed two activities in the centre. One was a ball tossing game that occurred in the dementia specific unit and seemed to engage the majority of residents in that unit. An exercise group of seven residents was also observed in the main dining/day area. All of these residents seemed to be interested and engaged in the activity, however 10 residents were observed sitting in a semi circle in silence in the day space connected to the dining area. No staff member was observed interacting with the 10 residents for the majority of the activity. Three of the 10 residents were asleep in their chairs, while the others did not interact with each other.

Residents and relatives advised inspectors that there had been a recent BBQ that was enjoyed by many of the residents. Relatives had been invited to join the party with music and refreshments. There were parties arranged throughout the year, and inspectors saw a celebration during the inspection of a resident's birthday.

While the inspectors observed the staff speaking to the residents in polite and caring ways and in many cases assisting them in a dignified way, the inspectors observed some instances when the dignity of residents with high needs was not maintained. Residents were observed to be asleep in chairs in day rooms for long periods of times with staff only seen to wake them for meal times before returning them to the chair and not asking if they wished to return to bed. Some residents in wheelchairs were moved by staff into areas in the day room that seemed to isolate them, limiting their ability to interact with other residents and in some cases restricting their view.

**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):**

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

**Findings:**

Recruitment and training procedures were found to be effective. Night staffing levels had been increased following an action made at the last inspection. However the staffing levels during the day was not sufficient to meet residents needs and resulted in task orientated care.

Recruitment procedures in the centre were found to be effective. The inspectors reviewed a total of six staff files and all had the requirements as per Schedule 2 of the regulations. Files for all volunteers in the centre were also reviewed and they outlined the roles of the volunteers. All volunteer and staff files reviewed had Garda Síochána (police) vetting in place. Management confirmed that all staff had Garda vetting and that no staff or volunteers could start in the centre without it. All nursing registration pins with the Nursing and Midwifery Board of Ireland were in place.

The inspectors reviewed the roster for the centre. Every day either the person in charge or the assistant care manager were rostered to work 08:00 to 16:30 and were supernumerary to the other staff. During the day there were 2 nurses working 08:00 to 20:00. There were also seven healthcare assistants working between 08:00 to 20:00 (one finished at 13:00 and one finished at 18:00).

At night there were two nurses and two healthcare assistants working 20:00 to 08:00. Staffing levels at night had been increased by one nurse since the last inspection.

While the staffing numbers and skill mix met the nursing needs of the residents, care was observed, on many occasions, to be task orientated and not person centred. While staff were noted to be busy throughout the day, at various times throughout the inspection some residents in day areas were observed to be unsupervised and to be sitting for long periods without any meaningful interaction from staff. Some residents were seen to be mobilising around the centre without support when it was assessed as being required. The inspectors heard residents calling out for assistance but no staff were available to assist them. Inspectors noted that a meal time survey identified that staffing was identified as an issue at meal times. Issues raised included staff being assigned to assist two or three residents with meals and there was insufficient staff to assist residents to the toilet. Some care plans were also noted not to have been implemented in practice as described in outcome 11. The staffing arrangements require review to ensure staff are available in sufficient numbers, having regard to residents assessed needs and the layout of the designated centre.

Mandatory training in fire safety, manual handling and safeguarding from elder abuse was in place for all staff. There was a training plan in place to ensure staff training was kept up to date. Staff had a good awareness of training and of the policies and procedures in the centre.

During the inspection residents and relatives provided positive feedback about the staff in the centre, and this was also reflected in the questionnaires returned to HIQA. A reoccurring comment was that 'staff are very kind and helpful'.



<b>Judgment:</b> Non Compliant - Moderate
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### **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:***

Helen Lindsey  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority

# Health Information and Quality Authority Regulation Directorate

## Action Plan



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

Centre name:	Gascoigne House
Centre ID:	OSV-0000038
Date of inspection:	25/07/2017
Date of response:	01/09/2017

### 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:

Management systems require improvement to ensure the centre is effectively monitored and non-compliance with regulations is identified and corrected.

#### 1. Action Required:

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

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

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

1. The PIC and her deputy have reviewed and updated the audit schedule to ensure that all Social and Health Care Professionals (SCHP) recommendations are followed up and implemented as appropriate and care plans are updated and communicated accordingly.
2. The PIC and her deputy shall audit a minimum of 4 care plans per week. The PIC shall validate the care plans audited by her deputy and vice versa, the deputy shall validate the care plans audited by the PIC to ensure that they are factual, complete accurate and person centred. This system shall ensure that all care plans are reviewed and validated in a planned manner.
3. Issues identified on these audits of the care plan shall be communicated to the keyworkers responsible for the development and updating of these care plans. They shall be met by the auditors to discuss the findings and ensure that they fully understand the actions required in developing a person centred care plan.
4. The care planning education sessions which were carried out at the second quarter of this year shall be progressed to care plan work shops where staff shall learn to develop care plans that are written in a manner that is reflective of person centred care, would promote residents' independence and guide staff practice
5. Required actions generated from analysis of the audits shall be allocated to the link staff, keyworkers and members of management accordingly and shall be completed within specified time frame.
6. Required changes following surveys shall be implemented accordingly by the PIC and her deputy within the specified time frame. A follow up review shall be conducted by the Clinical Director to ensure that the required changes are adequately implemented.
7. All identified non-compliances, improvement plans and follow up actions shall be documented in QIP section of Q-pulse, an electronic system utilised to log incidents, identified non compliances (from audits, surveys, inspections etc), complaints and policies and procedures. Monthly quality and safety reports shall be generated, reviewed and presented to the management team.
8. Training shall be arranged for the link staff who shall be responsible for specific clinical areas such as nutrition, falls prevention, pressure and wound care management, continence management, medication management, social care/activities etc.

**Proposed Timescale:** 30/09/2017

**Theme:**

Governance, Leadership and Management

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

There were not sufficient staffing resources in the centre to ensure the service set out in the statement of purpose was delivered.

**2. Action Required:**

Under Regulation 23(a) you are required to: Ensure the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.

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

1. The staffing resources were reviewed by the management team including the staffing levels, work allocations and skill mix to ensure safe, consistent and effective services are provided to the residents on a daily basis.
2. The team leaders and nursing staff for each area of the house, under the guidance of the PIC and her deputy, shall ensure that residents identified needs are met on daily basis including required supervision and social needs.
3. A staff member shall be identified on a daily basis who shall function as the activity staff. This shall ensure that all resident's social needs are met on a daily basis.
4. Work experience persons and volunteers who meet our requirements, including garda-vetting and satisfactory references, shall provide additional resources to ensure effective delivery of care. They shall be deployed to areas of the house where their identified skills and personal attributes match the identified needs of the residents.
5. The PIC and her deputy shall ensure that residents who, due to cognitive impairment, call out instead of using a call bell will be identified to all staff (including housekeeping) to ensure a more rapid response to such a call which is not always for assistance but sometimes just a presence in the room.
6. All identified changes in residents' needs shall be communicated at handovers and mid-shift catch-up meetings and formally at staff meetings to ensure that staff are aware of such changes. The staff are also encouraged to provide suggestions to continuously improve the work system and care provision. A modified handover report has been designed that should greatly improve the information communicated. This will be piloted for two weeks commencing 4th September.

**Proposed Timescale:** 30/09/2017

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

**Theme:**

Effective care and support

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

Examples were seen where residents identified needs were not being met.

**3. Action Required:**

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

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

1. All residents care plans including those with responsive behaviour shall be reviewed and updated to ensure that they are person centred, individualised and reflect assessed needs, risks identified and inclusive of residents preferences and abilities. Care plans shall be updated in accordance with the changing needs by the allocated keyworkers. These care plans shall be audited and validated by the PIC and her deputy as per audit schedule.
2. A SHCP communication book has been introduced to ensure that their recommendations are communicated to the GP and relevant staff for required actions in a timely manner.
3. Clinical staff meetings and individual meetings were conducted to highlight to the staff their duties and responsibilities in ensuring that the care plans are fully implemented in practice and that these care plans are utilised as a form of communication therefore they need to be current, individualised and reflective of identified needs.
4. The team leaders and nursing staff shall ensure that the care plans of the residents are fully implemented in practice. This shall be monitored by the PIC and her deputy on a daily basis and will form part of the monthly audits and staff performance reviews.
5. The modified handover report shall be include a section for SCHP and GP recommendations and shall be used at handovers and for updating care plans.
6. We have assigned Link Nurses whose role is to educate and update nurses and HCAs in their particular areas of responsibility as outlined earlier. This system, which has worked successfully in the past will be reinvigorated.

**Proposed Timescale:** 30/09/2017

**Theme:**

Effective care and support

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

Care plans did not consistently guide staff practice in relation to residents health and social care needs

**4. Action Required:**

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

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

1. Each resident shall be assessed on a timely manner and individual care plans shall be developed for each identified need.

2. We have developed, over the past three years, a comprehensive set of policies and procedures that address areas of best practice.

We have not, however, as highlighted during our inspection, reflected these in care plan actions as short simple guides, corrective action guides – as a short descriptive where appropriate.

We are now preparing a set of short action guides that will inform and guide practice as an aid memoir.

3. The care planning education sessions which were carried out at the second quarter of this year shall be progressed to care plan work shops where staff will learn to develop care plans that are written in a manner that is reflective of person centred care, promote residents' independence and guide staff practice.

**Proposed Timescale: 30/09/2017**

**Outcome 16: Residents' Rights, Dignity and Consultation**

**Theme:**

Person-centred care and support

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

The dignity of residents with high needs was not always promoted.

**5. Action Required:**

Under Regulation 09(1) you are required to: Carry on the business of the designated centre with regard for the sex, religious persuasion, racial origin, cultural and linguistic background and ability of each resident.

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

1. The PIC and her deputy discussed at staff meetings the importance of ensuring that emphasis is placed on residents with high care needs and these needs are met at all.

2. For residents who like to take a nap after lunch, they shall be encouraged to rest in their bedroom instead of falling asleep in the sitting room. Should they prefer to stay in the sitting room despite the encouragement to go to their bedroom, this shall also be respected and such wishes shall be documented in their care plan and communicated to all staff.

3. The staff shall ensure that residents are assisted to spend time in an area where they are not isolated or likely to limit their ability to interact with other residents or restrict

their views. The team leaders shall be responsible for monitoring this action.

4. The use of the sitting rooms is also being reviewed with a view to helping residents engage more with each other and provide a more social environment. The staff were also met and the PIC and her deputy discussed the importance of encouraging and facilitating conversations among residents and between residents and staff including during meal times.

5. The use of the small sitting rooms shall be promoted and can be used as a quiet area for residents who like to read, listen to calm music or as a sensory room.

**Proposed Timescale:** 01/09/2017

**Theme:**

Person-centred care and support

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

All residents were not provided with opportunities to engage in meaningful activities in the centre.

**6. 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:**

1. The monthly calendar of activities was reviewed and updated to ensure that planned activities are engaging and offer opportunities for residents to participate and cater to their interests and hobbies. These activities are also based on individual resident's activity assessment. The newly revised activity calendar shall be presented and discussed at residents and visitors committee meetings and staff meetings to encourage feedback and suggestions. The final programme shall be reviewed after 3 months or earlier and shall be updated as necessary.

2. Residents shall be consulted by the staff on the type of activity they want on a day to day basis. This shall ensure that an engaging activity is available for the residents and help ensure that the residents are assisted to structure their day according to their needs and preferences. They shall be encouraged to decide on their involvement in activities.

3. Residents who wish to participate in communal recreational activities shall be facilitated according to their abilities, likes and interests.

4. Individual activities shall also be provided to residents who do not wish to join communal activities.

5. The activities program will be allocated to a specific staff member who will facilitate the activities on a daily basis who will action the activities on a daily basis.

**Proposed Timescale: 30/09/2017**

### **Outcome 18: Suitable Staffing**

**Theme:**  
Workforce

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

Staffing arrangements did not ensure residents' identified needs were being met.

#### **7. 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:**

1. Staffing arrangements were reviewed to ensure that an appropriate skill mix is in place to meet the identified care needs of the residents. A shift for activity staff shall be implemented immediately to meet the social care needs of the residents.
2. The roster and allocation of staff were reviewed and changes were made to ensure a sufficient number and skill mix is in place at all times.
3. Supervision of the staff is provided by the PIC and her deputy who ensure that skill mix is appropriate at all times.
4. Team leaders are in place to supervise direct care needs of the residents. A new team leader was appointed to lead the second team of staff in the general care area .
5. The required assistance at meal times was reviewed and addressed by having 2 sittings for residents who were identified as requiring full assistance with their meals. Specific staff are allocated to assist these residents to ensure that their needs during their meals are fully met.
6. Staffing routines were also reviewed and specific staff are allocated to immediately assist residents who may require assistance with toileting before, during and after meal times. Care plans for continence promotion of the residents will also be implemented.

**Proposed Timescale: 01/09/2017**