Health Information and Quality Authority
Social Services Inspectorate

Inspection report
Designated centres for older people

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	St. Pappin's Nursing Home
Centre ID:	0178
Centre address:	Ballymun Road Ballymun Dublin 9
Telephone number:	01-8423474
Fax number:	01-8420026
Email address:	stpappins@silverstream.ie
Type of centre:	☒ **Private** ☐ **Voluntary** ☐ **Public**
Registered providers:	Silverstream Healthcare Group
Person in charge:	Erika Eris
Date of inspection:	27 April 2012
Time inspection took place:	**Start:** 07:45 hrs **Completion:** 17:45 hrs
Lead inspector:	Nuala Rafferty
Support inspector:	Ann Delaney
Type of inspection:	☐ Announced ☒ Unannounced
Purpose of this inspection visit:	☐ Application to vary registration conditions ☐ Notification of a significant incident or event ☐ Notification of a change in circumstance ☐ Information received in relation to a complaint or concern ☒ Follow-up inspection

About the inspection

The purpose of inspection is to gather evidence on which to make judgments about the fitness of the registered provider and to report on the quality of the service. This is to ensure that providers are complying with the requirements and conditions of their registration and meet the Standards, that they have systems in place to both safeguard the welfare of service users and to provide information and evidence of good and poor practice.

In assessing the overall quality of the service provided, inspectors examine how well the provider has met the requirements of the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

Additional inspections take place under the following circumstances:

- to follow up matters arising from a previous inspection to ensure that actions required of the provider have been taken
- following a notification to the Health Information and Quality Authority's Social Services Inspectorate of a change in circumstance for example, that a provider has appointed a new person in charge
- arising from a number of events including information received in relation to a concern/complaint or notification to the SSI of a significant event affecting the safety or wellbeing of residents
- to randomly "spot check" the service.

All inspections can be announced or unannounced, depending on the reason for the inspection and may take place at any time of day or night.

All inspection reports produced by the Health Information and Quality Authority will be published. However, in cases where legal or enforcement activity may arise from the findings of an inspection, the publication of a report will be delayed until that activity is resolved. The reason for this is that the publication of a report may prejudice any proceedings by putting evidence into the public domain.

About the centre

Description of services and premises

St. Pappin's Nursing Home is a three-storey, purpose-built residential centre with accommodation for up to 59 residents and provides continuing care for older persons with age related illnesses including those with dementia.

The ground floor consists of 16 single bedrooms with full en suite facilities and three four-bedded rooms without en suite. There are two assisted bathrooms, one assisted shower and two assisted toilets. Other facilities include one sitting room, one dining room with recreation area, conservatory, nurses' office, nurses' station, clinical room, main kitchen, sluice room, cleaning room, five store rooms and two offices.

The first floor consists of 13 single bedrooms with full en suite facilities three four-bedded rooms and one six-bedded room without en suite. There are four assisted bathrooms, one assisted shower and four assisted toilets. A large balcony which overlooks the main reception area is multi functional as dining room, recreation and sitting room. A second smaller sitting room, nurses' station, clinical room, kitchenette, sluice, cleaner's room and three store rooms are also available.

The second floor consists of laundry, staff toilets, lockers, store, offices, lift and stair access.

The grounds were secured by means of an electronic gate linked to the reception area. A well maintained hedgerow offers privacy to the front of the building which faces onto a busy main road in central Dublin. The building is surrounded by mature grounds and has an enclosed courtyard with seating for residents. The front facade of the centre is a converted church.

To the side and rear of the building there are enclosed gardens which are wheelchair accessible with seating and well maintained shrubberies for residents and visitors to enjoy.

Car parking is available for relatives and visitors.

Location

St. Pappin's Nursing Home is located on the Ballymun Road, within walking distance of all local amenities and a city centre bus service.

Date centre was first established:	12 January 2003
Number of residents on the date of inspection:	53
Number of vacancies on the date of inspection:	6

Dependency level of current residents	Max	High	Medium	Low
Number of residents	22	10	18	3

Management structure

Silverstream Healthcare Limited is the Provider. Joseph Kenny is the Director of Silverstream and is the nominated person on behalf of the provider. There is a Senior Management Team which consists of operations, finance and facilities managers. Erica Eris is the Person in Charge and she along with all managers' report to the Operations Manager, Gary Downey.

On the day of inspection a Senior Director of Nursing (DON), Ms Veronica Lacey, from another of the Silverstream Healthcare group of centres was directing care in the centre. An Assistant Director of Nursing (ADON) had started on the day previous to the inspection. The Person in Charge was on leave.

The DON was supported by a Clinical Nurse Manager (CNM) and senior nurse. All nursing staff report to the Person in Charge. Care assistants are supervised by a team of lead care assistants and all care assistants report to the nursing staff. All other administration and household staff report to the Person in Charge. Catering staff are provided through an external company and report to a supervisor who works across all of the centres under the remit of the Silverstream Company.

Staff designation	Person in Charge	Nurses	Care staff	Catering staff	Cleaning and laundry staff	Admin staff	Other staff
Number of staff on duty on day of inspection	1	2	10	3	3	1	*6

* ADON, CNM, maintenance person, operations manager, catering supervisor and activities person

Background

This was the seventh inspection of St. Pappin's Nursing Home by the Health Information and Quality Authority's (the Authority) Social Services Inspectorate and was a one day follow up inspection.

The centre was previously inspected on 1 December 2009, 19 April 2010 and on 23, 24 and 25 November 2010, which was a registration inspection. Follow-up inspections were also carried out on 14 and 21 July 2011, 27 and 31 January 2012 and 3 April 2012.

This inspection focused on the quality and safety of health care being delivered and to determine the welfare status of residents further to issues identified in January and 3 April 2012.

The inspection was also to establish the progress made by the provider in implementing the required improvements identified by the registration and subsequent follow up inspections.

The report following this inspection identified where improvements were necessary to comply with the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*. The provider was required to complete an action plan to address areas where significant improvements, some improvements and minor issues were required. All inspection reports can be found at www.higa.ie

Summary of findings from this inspection

The inspection was facilitated by the senior director of nursing in charge, staff and residents. All staff residents and visitors were helpful and engaged with the inspection process in a positive manner.

This inspection was a follow up inspection to review the areas of significant concern as identified to the provider following the inspection of 3 April 2012. Although some actions had been completed in full, progress was found on many of the actions. The identified timeframe for implementation of all the actions, contained within the provider's response has not yet expired and therefore are not included in this report.

There were 15 non compliances identified in the action plan from inspection dated 27 January 2012, the provider had actioned three and partially actioned 12 as required by the Authority.

There were 10 non compliances identified in the action plan from the inspection dated 3 April 2012 follow up inspection, the provider had actioned one, partially actioned eight and not actioned two.

Improvements in relation to referral and access to medical and allied health professionals review delivery and recording of personal care and infection prevention and control practices were found.

Actions reviewed on inspection:

1. Non Compliance:

Suitable and sufficient care to maintain each resident's welfare and wellbeing, having regard to the nature and extent of each resident's dependency and needs was not in place.

Action required from previous January and April 2012 inspection:

Put in place suitable and sufficient care to maintain each resident's welfare and wellbeing, having regard to the nature and extent of each resident's dependency and needs.

Provide a high standard of evidence-based nursing practice.

Provide appropriate medical care by a medical practitioner of the residents' choice or acceptable to the residents.

This was partially addressed. Inspectors observed improvements in the delivery and recording of personal care to residents with residents now being offered and provided with showers on a regular basis. The cleanliness and presentation of residents' hair nails and dentures was much improved. Staff were observed delivering care to residents in an appropriate and respectful manner. Residents' dignity was maintained through the appropriate use of screening, closing bedroom doors and ensuring residents were appropriately covered when transporting from bedrooms to shower room.

Further improvements in terms of attention to detail in the overall cleanliness, repair and presentation of clothing is required in that some clothing was noted to be creased and although staff were observed taking laundered clean clothing from wardrobes, some items were noted to have old staining.

2. Non Compliance:

Each resident was not provided with access to regular medical and allied health professional review to ensure facilitation of appropriate health care and promotion of best possible health.

Action required from previous January and April 2012 inspection:

Facilitate all appropriate health care and support each resident on an individual basis to achieve and enjoy the best possible health.

Facilitate the medical treatment that is recommended for each resident and agreed by him/her.

Facilitate each resident's access to physiotherapy, chiropody, occupational therapy, or any other services as required by each resident.

Respect and document each resident's right to refuse treatment and bring the matter to the attention of the resident's medical practitioner.

Maintain records of all health care referrals and follow-up appointments.

This was addressed. All residents continued to be reviewed on an as required basis by the general practitioner (GP) and where referrals were made residents were reviewed in a timely manner. Improved access to allied health professionals such as dieticians, physiotherapists, tissue viability nurse community medical teams and psychiatry of old age was noted on this inspection. All referrals or inputs were documented in the medical notes section of the residents' files.

3. Non Compliance:

The person in charge failed to ensure that each resident was provided with adequate quantities food and drink which took account of their special dietary requirements and was consistent with their individual needs.

The person in charge failed to ensure that the nutritional intake of those residents who required it was monitored and documented on an ongoing basis to ensure they received adequate quantities of food and drink.

Action required from previous January and April 2012 inspection:

Provide each resident with food and drink in quantities adequate for their needs, which is properly prepared, cooked and served; is wholesome and nutritious; offers choice at each mealtime; is varied and takes account of any special dietary requirements; and is consistent with each resident's individual needs.

Provide each resident with food and drink in quantities adequate for their needs, Implement a comprehensive policy and guidelines for the monitoring and documentation of residents' nutritional intake.

This was partially addressed. Improvements were noted in that daily food records labelled as 'diet sheet' were in place for those residents with identified weight loss. However, the information captured was not sufficiently specific to identify if the amount of food and fluid being ingested by those residents at risk of malnutrition was adequate and a system for reviewing what a resident had eaten over a 24 hour period and whether it was sufficient was not in place. Example of entries for lunch intake included "1 bowl of vegetables and mash and Spanish omelette". However, this does not reference whether the bowl of vegetables and mash was large, medium or small, whether there were one or two scoops of vegetables/mash or exactly how much was eaten in order that the nutritional status of resident could be monitored.

Recording of ingestion of nutritional supplements was found to be inconsistent. On review of the food records of two residents identified as being at risk of malnutrition with MUST scores of two and continuing weight loss, these supplements were only recorded once in a three-day period.

Food fortification was not being provided. In discussion with the catering supervisor, chef on duty, catering and care staff and on observation of food served at meal times, evidence of additional fortification of food as per dieticians instructions for those residents who required it was not found.

The meal menu has not changed since the inspection of 31 January 2012 or been reviewed by a dietician to establish its nutritional value.

The regular chef was replaced at short notice by a chef from another centre. This chef did not know the residents or their dietary requirements and had to rely on the diet list to ensure residents received the correct diet. On enquiry, the inspector learned that there were two out-of-date diet lists taped to the side of the refrigerator in the kitchen, one was not dated and the other dated March 2012. The chef was working from the undated diet list. In conversation with the catering supervisor and the director of nursing the inspector was told that an updated diet list was given to the regular chef by the person in charge and placed in a folder in the chef's office. This information was not given to the replacement chef.

4. Non Compliance:

Evidence that a review of staff levels and skill-mix to ensure numbers, skill-mix and sufficient governance were appropriate to provide a safe level of quality person-centred care given the current resident profile was not found.

Action required from previous January and April 2012 inspection:

Ensure that the numbers and skill-mix of staff are appropriate to the assessed needs of residents, and the size and layout of the designated centre.

Ensure that an appropriately qualified registered nurse is on duty and in charge of the designated centre at all times, and maintain a record to this effect.

Maintain a planned and actual staff rota, showing staff on duty at any time during the day and night.

This was partially addressed. An experienced director of nursing from another centre within the Silverstream Healthcare group has been allocated to direct care in the centre for a period of four months. An assistant director of nursing had also commenced working in the centre on the day before the inspection.

However, as was previously noted on 27 January and 3 April inspections, in conversation with staff and on observation, inspectors found that the care staff continued to work in teams of two or alone without direct supervision or guidance.

The nursing staff continued to spend the majority of the morning administrating medications. The morning medication 'round' finished at 10.40 am on the ground floor and the midday 'round' commenced at approximately 12.45 pm. This amount of time spent on medication administration was reflected on the first floor also. This meant that the staff nurse on each floor was engaged in an activity that required their full attention and were not available to supervise the care staff.

Given the layout of the centre and the profile of residents, the level and skill-mix of staff available could not meet residents assessed needs in a timely responsive manner.

5. Non Compliance:

Appropriate and complete records in respect of all of the information required to be retained in respect of each resident under Schedule 3 and Schedule 4 of the Regulations were not maintained in relation to, but not solely, record of condition, nursing care, specialist care, complaints, food records, restraint, communications, staff disciplinary action and meetings.

Action required from previous January and April 2012 inspection:

Maintain the records listed under Schedule 3 (records in relation to residents) and Schedule 4 (general records) in a manner so to ensure completeness, accuracy and ease of retrieval.

Keep the records listed under Schedule 3 and Schedule 4 up-to-date and in good order and in a safe and secure place.

Make the records listed under Schedule 3 and Schedule 4 available to the resident to whom the records refer and made available at all times for inspection and monitoring purposes under the Act.

Retain the records under Regulation 22 for a period of not less than seven years after the resident to whom they relate ceases to be resident in the home.

Maintain all documentation of inspections relating to food safety, health and safety and fire inspections in the designated centre.

This was partially addressed. As identified under Actions 1 to 4 above, evidence of improvements in documentation of care was found. Food 'diet sheets' were commenced to record the intake of those residents previously identified with weight loss. Repositioning charts were also commenced.

However, further improvement in relation to documentation is required. Inspectors noted that where prescribed, the actual amount of intake of nutritional supplements was not being regularly recorded, the actual amount of food residents are taking to ensure they receive adequate nutrition is also required to be recorded.

6. Non Compliance:

A comprehensive risk management policy was not in place in the centre.

Risk management policy and processes in place were not sufficiently robust or specific to ensure the health and safety of residents were promoted and protected at all times.

The policy and procedures in place were limited in terms of the categories of risks to be identified and assessed and did not cover all potential risks both clinical and non clinical to ensure effective minimisation and elimination of risks to residents, including, but not exclusively, reviews, referrals and communications with all persons involved in residents' care.

Action required from previous January 2012 inspection:

Put in place a comprehensive written centre-specific risk management policy and implement this throughout the designated centre.

Ensure that the risk management policy covers, but is not limited to, the identification and assessment of risks throughout the designated centre and the precautions in place to control the risks identified.

Ensure that the risk management policy covers the arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents.

Ensure that the risk management policy covers the precautions in place to control the following specified risks: the unexplained absence of a resident; assault; accidental injury to residents or staff; aggression and violence; and self-harm.

Take all reasonable measures to prevent accidents to any person in the designated centre in the grounds of the designated centre and when outside of the centre with staff knowledge.

This was partially addressed in that a revised centre-specific risk management policy was reviewed. A revised risk management process to identify and limit the potential for recurrence of risk throughout the centre has been developed. This includes the establishment of a clinical governance committee comprising of the senior management team with the general practitioner. However, meetings of this committee were not yet initiated. Other aspects of the revised risk management processes were not yet commenced at the time of inspection.

7. Non Compliance:

All care plans in place were not sufficiently specific to manage the needs of the residents appropriately.

All care plans were not revised as required by residents changing needs.

Care plans and risk assessments were not linked and were not consistent.

All residents and relatives were not involved in reviews of care plans.

Action required from previous January and April 2012 inspection:

Set out each resident's needs in an individual care plan developed and agreed with the resident.

Keep each resident's care plan under formal view as required by the resident's changing needs or circumstances and no less frequent than at three-monthly intervals.

Revise each resident's care plan, after consultation with him/her.

Notify each resident of any review of his/her care plan.

This was partially addressed. A review of care plans, identification of residents' needs and risk assessments had commenced.

During the inspection it was noted that some staff (additional to those rostered for duty) were attending training on assessment and care planning delivered by external consultant. Inspectors were told that a review of all care plans had commenced and would be fully completed when training was complete. Inspectors viewed the revised care plans of one resident and found that the care plans were improved in that they were linked to identified needs and risks.

8. Non Compliance:

Evidence of ongoing supervision of staff and assessment of staff knowledge or competence of policies and procedures in the centre in relation to their role and responsibilities was not available.

Action required from previous January & April 2012 inspection:

Provide staff members with access to education and training to enable them to provide care in accordance with contemporary-evidence based practice.
Supervise all staff members on an appropriate basis pertinent to their role.
Make staff members aware, commensurate with their role, of the provisions of the Regulations, the statement of purpose and any policies and procedures dealing with the general welfare and protection of residents.

This was partially addressed. Training was being delivered to staff on the day of inspection as mentioned previously. In conversation with staff and the director of nursing evidence of additional training was found such as team building, nutrition, documentation and prevention of elder abuse. Staff could discuss aspects of the training given and sign off sheets on training delivered were available.

The lack of clinical governance and clear communication processes were identified on the two most recent inspections as being cause for concern. Measures to address these issues were noted on this inspection particularly the leadership demonstrated by the director of nursing. In conversation with the director of nursing inspectors found she had identified a number of specific areas which require immediate action in order to minimise risk. These included, strong leadership for staff, improved communication, including language skills, improved gender balance in staffing and residents profile.

Some improvement in relation to the level and quality of supervision and direction being provided to staff was also noted.

The director of nursing was observed to maintain a presence on the floor throughout the day. In the morning, she rotated between the first and ground floor, talking to residents and staff and directing them in prioritising residents care needs.
She identified residents who were not eating and if other staff were not available assisted the residents herself. Where she observed details such as clothes protectors not in use, or towels being used instead of clothes protectors she spoke to care staff.

Improvement was required in relation to supervision and direction to staff. While it is acknowledged that improved governance systems have been put in place with the appointment of an assistant director of nursing the level of guidance and direction being provided to care staff in relation to documentation and delivery of care, safe use of manual handling aids and prioritisation of residents care needs was not adequate. Inspectors found that whilst observing care delivery they had to intervene on several occasions to ensure safe care was provided. For example, care staff were not using appropriate manual handling aids whilst providing assistance with personal care or re positioning residents.

One nurse was rostered on both the ground and first floor during the day. On the day of inspection there were 32 out of 53 residents assessed as being of high to maximum dependency. On the ground floor two residents required additional nursing inputs during the morning. Both nurses were noted to be extremely busy throughout the day mainly occupied with medication administration, referral of residents to other professionals, and documenting nursing care provided. Neither were observed at any time to offer guidance or direction to the care staff.

In addition communication processes within and between centre management and the external catering company are not robust and improved governance is urgently required. For example at 10.30 am, inspectors were told soup would not be available for residents although it was on the menu, because there was none in the stock room. Inspectors brought this to the attention of the director of nursing who was unaware of this. The director of nursing contacted the catering supervisor who had just left the centre, who returned and discussed this with the replacement chef who

immediately commenced preparing fresh tomato and basil soup, which inspectors viewed. However, up to that time neither the director of nursing nor the catering supervisor were aware of the decision not to provide soup, no one was checking to ensure the menu was being delivered as planned and no staff brought it to their manager's attention.

9. Non Compliance:

Findings of the inspection do not reflect the information contained in the statement of purpose dated September 2011. The range of residents needs being met, organisation structure has been revised, the number and layout of rooms in the centre is not fully correct and the complaints process contained in the statement of purpose is different to that in place in the centre.

Action required from previous January 2012 inspection:

Compile a statement of purpose that describes the facilities and services which are provided for residents.

Compile a statement of purpose that consists of all matters listed in Schedule 1 of the Regulations.

Notify the Chief Inspector in writing before changes are made to the statement of purpose which affect the purpose and function of the centre.

Keep the statement of purpose under review.

Make a copy of the statement of purpose available to the Chief Inspector.

This was partially addressed. A revised statement of purpose was provided in March 2012 and reflects the amended organisation structure. Range of resident's needs being met has also been revised without reference to dementia-specific care needs or respite care provision. The complaints process is clearly outlined. However, identification of the type of nursing care being provided and number of dining and lounge rooms requires further clarification, the size of rooms available is also omitted.

10. Non Compliance:

The systems in place to review the quality and safety of care were not sufficiently robust or comprehensive to identify poor care practices or implement improvements to ensure a culture of learning, quality assurance and continuous improvement.

The information from quality improvement initiatives were not formulated into a report in accordance with the Regulations.

Action required from previous January 2012 inspection:

Establish and maintain a system for improving the quality of care provided at, and the quality of life of residents in, the designated centre.

Consult with residents and their representatives in relation to the system for reviewing and improving the quality and safety of care, and the quality of life of residents.

Make a report in respect of any review conducted by the registered provider for the purposes of Regulation 35(1), and make a copy available to the Chief Inspector.

This was partially addressed. Improvements in relation to maintaining and monitoring systems for improving the quality of care provided were found. Inspectors reviewed documentation which showed residents were regularly offered showers and where they refused this was documented. Where residents continuously refused efforts were made to encourage compliance, inputs were sought from relatives and next of kin. Improved access to medical, and where required, relevant allied health professionals was also noted.

Further improvements were still required in relation to reviewing care practices on restraint, medication management, documentation and delivery of care and risk management. An analysis of the information gathered with reports on learning outcomes and recommendations to improve care practices was not found in accordance with the Regulations. Other quality assurance systems such as adequacy of staff supervision and assessment of competency further to training or induction was not yet in place.

11. Non Compliance:

The records of complaints did not meet the requirements of the Regulations in that they did not contain all details of investigation, interventions taken to resolve the complaint or review of satisfaction of the complainant.

All complaints were not recorded.

The complaints policy and procedure for managing complaints did not contain all information required the Regulations such as the appeals process available to complainants.

Action required from previous January 2012 inspection:

Provide written operational policies and procedures relating to the making, handling and investigation of complaints from any person about any aspects of service, care and treatment provided in, or on behalf of a designated centre.

Ensure the complaints procedure contains an independent appeals process, the operation of which is included in the designated centre's policies and procedures. Make available a nominated person in the designated centre to deal with all complaints.

Make a person available, independent to the person nominated in Regulation 39(5), to ensure that all complaints are appropriately responded to and that the person nominated under Regulation 39(5) maintains the records specified under Regulation 39(7).

Investigate all complaints promptly.

Maintain a record of all complaints detailing the investigation and outcome of the complaint and whether or not the resident was satisfied.

Inform complainants promptly of the outcome of their complaints and details of the appeals process.

Record all complaints and the results of any investigations into the matters complained about. Ensure these records are in addition to and distinct from a resident's individual care plan.

This was addressed. The process for dealing with the complaints was found to be in accordance with the centre policies. The complaints record was reviewed and two recent complaints were documented. It was noted that a more proactive approach to the management of complaints was being taken by the director of nursing in that staff were encouraged to report any instance where they were aware of relatives or residents negative experience or comment and to treat this seriously and promptly. This was the case in one of the complaints recorded. Evidence of improvements in the detailed recording of investigation, interventions, satisfaction of complainant, outcome and review was found.

12. Non Compliance:

The policy in place for end of life care was not reviewed and updated to reflect practice as required further to previous inspections.

Action required from previous January 2012 inspection:

Establish and implement suitable policies and procedures which underpin best practice in end of life care and review regularly.

This was partially addressed in that the policy and processes in the centre are under review in association with a community based pilot project through the hospice friendly project.

13. Non Compliance:

Appropriate and transparent processes to safeguard residents' finances were not in place as required further to previous inspections.

Action required from previous January 2012 inspection:

Put in place appropriate transparent accounting systems which meet best practice and safeguard residents' property, possessions and finances.

Ensure all accounting systems meet the requirements of all statutory legislation including Section 2 of the Health (Repayment Scheme) Act 2006, HSE guidelines on patients private property accounts, the Health Act, 2007 and all other relevant legislation.

Provide written evidence of authorisation of the provider to manage residents' accounts on residents' behalf.

Revise all policies and procedures on resident's personal possessions and property to ensure they meet evidence-based practice and reflect all relevant statutory legislation and guidelines.

Ensure by all means necessary that all staff are aware of the revised policies and procedures and knowledgeable in terms of their implementation.

Establish a system which audits and reviews such accounting systems on a regular basis and no less frequently than annually.

This was addressed. The findings of a recent audit on management of residents' finances is being forwarded to the Authority.

14. Non Compliance:

All policies and procedures available were not fully implemented or reviewed as required by the Regulations and agreed further to previous inspections.

Action required from previous January 2012 inspection:

Ensure staff are aware of the policies and procedures and knowledgeable in relation to their responsibilities towards their implementation.

Establish a system which audits and reviews implementation of policies and procedures and disseminates learning to all staff.

This was partially addressed. Improvements in staff knowledge of the centre policies and procedures were found in relation to care planning and documentation of care. Staff told inspectors they were being supported to become more familiar with their responsibilities under the centre policies and procedures. An audit system is due to be established by end of May 2012.

15. Non Compliance:

The physical design and layout of the centre and the level of equipment provided does not meet the needs of all residents.

Action required from previous January 2012 inspection:

Ensure the physical design and layout of the premises meets the needs of each resident, having regard to the number and needs of the residents.

Provide suitable and sufficient communal space which includes; sufficient separate dining room space and space for interest and diversion for residents.

Ensure the size and layout of rooms occupied or used by residents are suitable for their needs.

Provide ventilation, heating and lighting suitable for residents in all parts of the designated centre which are used by residents.

Keep all parts of the designated centre clean and suitably decorated.

Provide separate cleaning facilities and separate cleaning equipment for catering and non-catering areas.

Review the layout of the laundry.

Ensure communal bedrooms meet the minimum usable space and contain required number of wash-hand basin per residents and meet the requirements of the Standards.

This was partially addressed with some improvement noted in the overall standard of hygiene. The centre and equipment was visually clean. The physical design and layout of the centre complies with Regulations and have until 2015 to comply with the criteria contained in the Standards.

16. Non Compliance:

Medication administration practices were not in line with professional guidelines.

Action required from 3 April 2012 inspection:

Put in place appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents and ensure that staff are familiar with such policies and procedures.

This was not addressed. Evidence that medication was being administered according to An Bord Altranais guidelines was not found. Inspectors found one instance where medication was not signed following administration.

Nutritional supplements were left on residents' lockers or bed tables. In some instances the supplements were unopened, none of the supplements were dated or timed and where residents were in communal rooms not all contained the name of the resident to whom they were administered.

Reference guides were not available for nurses to refer to when administering medications.

17. Non Compliance:

All parts of the designated centre and all equipment contained within the centre were not clean, and measures to ensure good infection prevention and control were not in place in the centre.

Action required from 3 April inspection:

All parts of the designated centre are to be kept clean and suitably decorated.

All equipment provided at the designated centre for use by residents or persons who work at the designated centre to be maintained in good working order.

This was partially addressed. As mentioned earlier in this report, some improvements in the standard of hygiene of the centre and cleanliness of equipment were found. Alcohol gel dispensers were found to be in working order and the hygiene of residents' mattresses and chairs was much improved. However, there was no system in place detailing the responsibilities of all staff in the checking and cleaning of equipment and there was no documented process in place to ensure that all equipment was cleaned.

18. Non Compliance:

All notifications were not submitted by the provider as required by the Regulations.

Action required from 3 April inspection:

Give notice to the Chief Inspector without delay of the occurrence in the designated centre of any serious injury to a resident.

This was not addressed. In the course of the inspection inspectors identified two incidents which were required to be reported to the Chief Inspector. However, notification had not been received. One resulted in the transfer of a resident to an acute hospital service and the other where a resident was found outside the gates of the centre.

Report compiled by:

Nuala Rafferty

Inspector of Social Services
Social Services Inspectorate
Health Information and Quality Authority

1 May 2012

Chronology of previous HIQA inspections	
Date of previous inspection:	**Type of inspection:**
1 December 2009	☐ Registration ☒ Scheduled ☐ Follow-up inspection ☐ Announced ☐ Unannounced
19 April 2010	☐ Registration ☐ Scheduled ☒ Follow-up inspection ☐ Announced ☐ Unannounced
23, 24 and 25 November 2010	☒ Registration ☐ Scheduled ☐ Follow-up inspection ☐ Announced ☐ Unannounced
14 and 21 July 2011	☐ Registration ☐ Scheduled ☒ Follow-up inspection ☐ Announced ☐ Unannounced
27 and 31 January 2012	☐ Registration ☐ Scheduled ☒ Follow-up inspection ☐ Announced ☐ Unannounced
3 April 2012	☐ Registration ☐ Scheduled ☒ Follow-up inspection ☐ Announced ☐ Unannounced

Health Information and Quality Authority
Social Services Inspectorate

Action Plan

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Provider's response to inspection report *

Centre:	St. Pappin's Nursing Home
Centre ID:	0178
Date of inspection:	27 April 2012
Date of response:	17 May 2012

Requirements

These requirements set out what the registered provider must do to meet the Health Act, 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

1. The provider has failed to comply with a regulatory requirement in the following respect: Suitable and sufficient care to maintain each resident's welfare and wellbeing, having regard to the nature and extent of each resident's dependency and needs was not in place.
Action required: Put in place suitable and sufficient care to maintain each resident's welfare and wellbeing, having regard to the nature and extent of each resident's dependency and needs.
Action required: Provide a high standard of evidence-based nursing practice.

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

Reference: Health Act, 2007 Regulation 6: General Welfare and Protection Standard 13: Healthcare	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Since the previous inspection, the mentoring programme on assessment and care planning for staff nurses has been completed. Throughout this process, resident's care plans have been reviewed and updated. Staff nurses will continue to review resident assessments and care plans and will have a follow up session with the mentor to monitor their progress. A training plan has been submitted previously to the inspectorate and staff have and will continue to attend training as indicated in this plan. With regard to the laundry service, we have increased the laundry hours so that there is an additional seven hours per week to address the laundry needs of residents. We have also arranged for training for the laundry staff, which will be provided on 18 May 2012.	29/06/2012 Completed Completed 18/06/2012

2. The person in charge has failed to comply with a regulatory requirement in the following respect:
The person in charge failed to ensure that each resident was provided with adequate quantities food and drink which took account of their special dietary requirements and was consistent with their individual needs. The person in charge failed to ensure that the nutritional intake of those residents who required it was monitored and documented on an ongoing basis to ensure they received adequate quantities of food and drink.
Action required: Provide each resident with food and drink in quantities adequate for their needs, which is properly prepared, cooked and served; is wholesome and nutritious; offers choice at each mealtime; is varied and takes account of any special dietary requirements; and is consistent with each resident's individual needs.

Action required: Provide each resident with food and drink in quantities adequate for their needs.	
Action required: Implement a comprehensive policy and guidelines for the monitoring and documentation of residents' nutritional intake.	
Reference: Health Act, 2007 Regulation 20: Food and Nutrition Standard 19: Meals and Mealtimes	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: As outlined in our previous response, the recording and monitoring of residents' nutritional needs have been made more robust in the following ways: ▪ every resident's food intake is recorded using a daily care and handover sheet completed on each shift and used at handovers in the morning, nigh time and midday handover meetings ▪ for resident's at risk of malnutrition, a food diary sheet is in place ▪ an updated policy on nutrition and hydration identifies specific conditions whereby a resident must be referred to the dietician ▪ since the most recent inspection, a four-week menu plan has been submitted to the dietician for review of nutritional values and guidance where nutritional values in the menu plan need to be improved ▪ a new chef has taken over responsibility for provision of food and the person in charge continues to meet with the chef to ensure that diet sheets and menu planning are in accordance with residents' current nutritional needs. ▪ a meeting has taken place between the chef and the dietician to advise on menu planning to meet residents' needs.	Completed Completed Completed Completed Completed Completed

3. The person in charge is failing to comply with a regulatory requirement in the following respect:

Evidence that a review of staff levels and skill mix to ensure numbers, skill mix and sufficient governance was were appropriate to provide a safe level of quality person centred care given the current resident profile was not found.

Action required:

Ensure that the numbers and skill-mix of staff are appropriate to the assessed needs of residents, and the size and layout of the designated centre.

Reference:

Health Act, 2007
Regulation 16: Staffing
Standard 23: Staffing Levels and Qualifications

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: As mentioned in our previous response, we have undertaken a review of our staffing levels and skill-mix using two validated tools. A staffing plan was submitted to the inspectorate detailing plans for immediate, short term and long term staffing of the centre. The plan is based on addressing the following areas: ▪ adequate numbers of staff ▪ appropriate skill mix ▪ clinical supervision ▪ managerial supervision for staff ▪ continuing professional development to ensure staff develop and maintain competencies required to meet the needs of residents. Nursing and care staff now work in teams to ensure appropriate supervision of care staff. An additional CNM is in place since 8 May 2012, so that a nursing manager is available on all shifts to provide supervision and support to nursing and care staff and monitor the care of residents, especially those whose condition is unstable or deteriorating. An additional healthcare assistant is now on night duty and an extra whole time equivalent registered is rostered during the day. Rosters have been submitted to the inspectorate to illustrate the changes made to staffing to meet the needs of residents.	04/05/2012

4. The provider failed to comply with a regulatory requirement in the following respect:

Appropriate and complete records in respect of all of the information required to be retained in respect of each resident under Schedule 3 and Schedule 4 of the Regulations were not maintained in relation to, but not solely, record of condition, nursing care, specialist care, complaints, food records, restraint, communications, staff disciplinary action and meetings.

Action required:

Maintain the records listed under Schedule 3 (records in relation to residents) and Schedule 4 (general records) in a manner so to ensure completeness, accuracy and ease of retrieval.

Reference:

Health Act, 2007
Regulation 22: Maintenance of Records
Standard 32: Register and Residents' Records

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: All of the areas of concern identified by both this and the previous inspection have been actioned in the following ways:	
▪ as part of implementing the new system of care planning, each resident's healthcare record is currently being organised so that all information related to the resident's healthcare needs will be kept in this record	31/05/2012
▪ recording of the amount of nutritional supplements and any fortification in the new food diary sheets has commenced	Completed
▪ the residents' directory is maintained by the person in charge or her deputy so that the required information regarding admission, discharge and transfer dates are recorded	Completed
▪ Schedule 4 information will be updated as required in line with any changes to the centre. As there are changes being made to address inspection reports, and because we are currently not admitting residents to the centre, we will update all required documentation to reflect these changes and submit them once completed	29/06/2012

▪ a policy on the management of records will be developed, which will outline the requirements for the management of records for residents.	29/06/2012

5. The provider is failing to comply with a regulatory requirement in the following respect: Full implementation of the revised risk management policy and processes was not in place.	
Action required: Put in place a comprehensive written centre-specific risk management policy and implement this throughout the designated centre.	
Reference: Health Act, 2007 Regulation 31: Risk Management Procedures Standard 26: Health and Safety Standard 29: Management Systems	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: We have submitted an updated risk management policy, which has been reviewed by the inspector. The clinical governance committee will be responsible for risk management. The first meeting of the clinical governance committee is scheduled for 24 May 2012. The committee will receive mentoring on implementing clinical governance on 24 and 25 May 2012. On 11 May 2012, both the operations manager and person in charge received the first session on mentoring for risk management. This session included reviewing all aspects of the current medication management process; identifying 'failure modes' and redesigning processes to promote safe and effective medication management in the centre.	Completed

6. The person in charge is failing to comply with a regulatory requirement in the following respect:

All care plans in place were not sufficiently specific to manage the needs of the residents appropriately.

All care plans were not revised as required by residents changing needs.

Care plans and risk assessments were not linked and were not consistent.

All residents and relatives were not involved in reviews of care plans.

Action required:

Set out each resident's needs in an individual care plan developed and agreed with the resident.

Action required:

Keep each resident's care plan under formal view as required by the resident's changing needs or circumstances and no less frequent than at three-monthly intervals.

Reference:

Health Act, 2007
Regulation 8: Assessment and Care Plan
Standard 3: Consent
Standard 10: Assessment
Standard 11: The Resident's Care Plan
Standard 17: Autonomy and Independence

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response:	
As mentioned previously, nursing staff have completed mentoring in assessment and care planning using a new system.	Completed
Each nurse will now have responsibility for reviewing the assessments and care plans for residents in the centre.	29/06/2012
A follow up session will be held with staff nurses to monitor their progress.	13/06/2012

A meeting for family members of our residents has been arranged for 24 May 2012. At this meeting we will discuss with family members our approach to person centred care planning and ascertain their wishes on how they wish to be involved in the process of care planning in accordance with residents' known wishes.	24/05/2012

7. The person in charge has failed to comply with a regulatory requirement in the following respect: Evidence of ongoing supervision of staff and assessment of staff knowledge or competence of policies and procedures in the centre in relation to their role and responsibilities was not available.	
Action required: Provide staff members with access to education and training to enable them to provide care in accordance with contemporary evidence-based practice.	
Action required: Supervise all staff members on an appropriate basis pertinent to their role. Make staff members aware, commensurate with their role, of the provisions of the Regulations, the statement of purpose and any policies and procedures dealing with the general welfare and protection of residents.	
Reference: Health Act, 2007 Regulation 16: Staffing Regulation 17: Training and Staff Development Standard 23: Staffing Levels and Qualifications	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Supervision of staff is being addressed by the addition of an additional CNM, an additional staff nurse and introduction of team working as outlined previously in this report and detailed in the staffing plan submitted to the inspectorate. Staff knowledge and competency is being addressed through training, additional support at floor level and the mentoring programme completed.	Completed Completed

Additionally, staff knowledge and competency will be monitored through performance appraisals as outlined in the staffing plan and through monitoring of quality and safety indicators at clinical governance meetings. A policy on delegation and supervision in the centre has been submitted to the inspectorate.	Commencing 24/05/2012 Completed

8. The provider is failing to comply with a regulatory requirement in the following respect: Findings of the inspection do not reflect the information contained in the statement of purpose dated March 2012. The type of nursing care being provided was not included and number and layout of rooms in the centre is not fully correct.	
Action required: Compile a statement of purpose that describes the facilities and services which are provided for residents.	
Action required: Compile a statement of purpose that consists of all matters listed in Schedule 1 of the Regulations.	
Reference: Health Act, 2007 Regulation 5: Statement of Purpose Standard 28: Purpose and Function	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Between now and the end of June, there will be continuous changes made in the centre in accordance with the action plans submitted to the inspector. Because of this and the fact that no new residents will be admitted in that time, we felt that it would be more appropriate to update the statement of purpose and function at the end of this period and submit it to the inspectorate. If however, this is not satisfactory, we will submit an updated statement earlier at the request of the inspectorate.	29/06/2012

9. The provider is failing to comply with a regulatory requirement in the following respect:

The systems in place to review the quality and safety of care were not sufficiently robust or comprehensive to identify poor care practices or implement improvements to ensure a culture of learning, quality assurance and continuous improvement.

The information from quality improvement initiatives were not formulated into a report in accordance with the Regulations.

Action required:

Establish and maintain a system for improving the quality of care provided at, and the quality of life of residents in, the designated centre.

Action required:

Consult with residents and their representatives in relation to the system for reviewing and improving the quality and safety of care, and the quality of life of residents.

Reference:

Health Act, 2007
Regulation 35: Review of Quality and Safety of Care and Quality of Life
Standard 30: Quality Assurance and Continuous Improvement

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response:	
Our first clinical governance committee meeting will take place on 24 May 2012. In preparation for this, the assistant director of nursing has commenced collation of data of key quality and safety indicators, which will be reviewed at this meeting.	24/05/2012
Additionally, an audit of infection prevention and control will be undertaken on 22 May 2012 and the findings from this will also be reviewed at the meeting, with a view to developing an action plan to address any improvements required.	24/05/2012
A standard format for reviewing the quality and safety of care and services based on a continuous improvement approach, will be outlined in a clinical governance policy and framework for the centre.	18/05/2012

10. The provider has failed to comply with a regulatory requirement in the following respect: All policies and procedures available were not fully implemented or reviewed as required by the Regulations and agreed further to previous inspections.	
Action required: Ensure staffs are aware of the policies and procedures and knowledgeable in relation to their responsibilities towards their implementation.	
Reference: Health Act, 2007 Regulation 27: Operating Policies and Procedures Standard 29: Management Systems	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Staff are attending information and training sessions on policies and procedures as part of the training plan submitted to the inspectorate.	Ongoing

11. The person in charge has failed to comply with a regulatory requirement in the following respect: Medication administration practices were not in line with professional guidelines.	
Action required: Put in place appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents and ensure that staff are familiar with such policies and procedures.	
Reference: Health Act, 2007 Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines Standard 14: Medication Management	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**

Provider's response: We have undertaken a review of our current medication management processes and procedures on 11 May 2012. As a result of this review, we are currently updating our medication management practices in a number of areas. These will be outlined in a revised and updated medication management policy which will be submitted to the inspectorate. Nursing staff have received sessions on medication management updates from our pharmacist. Additionally, nursing staff will attend a one day An Bord Altranais Category 1 Approved Medication Management Training Programme on 21 May 2012, which will be repeated for staff who are unable to attend.	Completed 18/05/2012 Commence 21/05/2012

12. The person in charge has failed to comply with a regulatory requirement in the following respect: The policy in place for end-of-life care was not reviewed and updated to reflect practice as required further to previous inspections.	
Action required: Establish and implement a written operational policy and protocol for end-of-life care.	
Reference: Health Act, 2007 Regulation 14 : End of Life Care Standard 16: End of Life Care	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: We are awaiting involvement of the Hospice Friendly Hospital Programme to initiate the End of Life Care pilot project in the centre. In the meantime, we have met with the community care nurse for this area, who has agreed to facilitate two meetings with nurses to outline the role of the community care team in end of life care. We have decided that, based on her involvement, we will establish and develop and end of life care policy for the centre by the end of June 2012.	29/06/2012

13. The provider has failed to comply with a regulatory requirement in the following respect:

All parts of the designated centre and all equipment contained within the centre were not clean, and measures to ensure good infection prevention and control were not in place in the centre.

Action required:

All parts of the designated centre are to be kept clean and suitably decorated.

Reference:

Health Act, 2007
Regulation 19: Premises
Standard 25: Physical Environment

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The assistant director of nursing has been designated responsibility for infection prevention and control in the centre. To assist her in her role, we have arranged for an external consultant to provide mentoring to her on 22 and 23 May 2012. As part of this activity, the assistant director, under the guidance of her mentor, will conduct an audit of infection prevention control in the centre and develop an action plan to address improvements. The findings will be reviewed by the clinical governance committee on 24 May 2012. All staff will attend training on standard precautions for infection prevention and control.	24/05/2012 18/06/2012

14. The provider is failing to comply with a regulatory requirement in the following respect:

All notifications were not submitted by the provider as required by the Regulations.

Action required:

Give notice to the Chief Inspector without delay of the occurrence in the designated centre of any serious injury to a resident.

Reference:

Health Act, 2007
Regulation 26: Notification of Incidents
Standard 32: Register and Residents Records

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: Since the inspection all outstanding notifications have been submitted to the inspectorate by the person in charge.	Completed

Any comments the provider may wish to make:

Provider's response:

We welcome the inspector's acknowledgement of improvements that have been made since the previous inspection. In response to the inspection of January this year, we have put in place a very comprehensive action plan to address all areas of concern identified and significant work has already been undertaken in the centre to meet the requirements outlined by the inspection reports. We have achieved partial compliance in areas where there were longer time frames identified to make improvements because of the nature of activities involved.

It is our intention to continue to make improvements in all aspects of our care and service to ensure that we address the needs of all of our residents and are happy to continue to work with our inspectors to achieve this.

Provider's name: Joseph Kenny
Date: 17 May 2012