Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	The Croft Nursing Home
Centre ID:	0028
Centre address:	2 Goldenbridge Walk Inchicore Dublin 8
Telephone number:	01 454 2374
Email address:	smcmahon@silverstream.ie
Type of centre:	☒ **Private** ☐ **Voluntary** ☐ **Public**
Registered provider:	Croft Nursing Home Limited
Person authorised to act on behalf of the provider:	Joseph Kenny
Person in charge:	Stephanie McMahon
Date of inspection:	25 June 2013
Time inspection took place:	**Start:** 09:30 hrs **Completion:** 18:30 hrs
Lead inspector:	Gary Kiernan
Support inspector(s):	N/A
Type of inspection	☒ **announced** ☐ **unannounced**
Number of residents on the date of inspection:	39
Number of vacancies on the date of inspection:	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 their 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
- 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. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.

Summary of compliance with 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*.

This inspection report sets out the findings of a monitoring inspection, in which 11 of the 18 outcomes were inspected against. The purpose of the inspection was:

- ☐ to inform a registration decision
- ☐ to inform a registration renewal decision
- ☒ to monitor ongoing compliance with Regulations and Standards
- ☐ following an application to vary registration conditions
- ☐ following a notification of a significant incident or event
- ☒ following a notification of a change in person in charge
- ☐ following information received in relation to a concern/complaint

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

Outcome 1: Statement of Purpose	☐
Outcome 2: Contract for the Provision of Services	☒
Outcome 3: Suitable Person in Charge	☒
Outcome 4: Records and documentation to be kept at a designated centres	☐
Outcome 5: Absence of the person in charge	☐
Outcome 6: Safeguarding and Safety	☒
Outcome 7: Health and Safety and Risk Management	☒
Outcome 8: Medication Management	☒
Outcome 9: Notification of Incidents	☐
Outcome 10: Reviewing and improving the quality and safety of care	☐
Outcome 11: Health and Social Care Needs	☒
Outcome 12: Safe and Suitable Premises	☒
Outcome 13: Complaints procedures	☒
Outcome 14: End of Life Care	☒
Outcome 15: Food and Nutrition	☐
Outcome 16: Residents' Rights, Dignity and Consultation	☒
Outcome 17: Residents' clothing and personal property and possessions	☐
Outcome 18: Suitable Staffing	☒

This monitoring inspection was announced and took place over one day. As part of the monitoring inspection the inspector met with residents, relatives, and staff members. The inspector observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files.

While the inspector found evidence of good practice in many areas a number of areas of improvement were identified in order to meet 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.*

Arrangements were in place for the management of health and safety; however, the risk management policy was not implemented in full and was not guiding practice in this area. Improvements were also required with regard to the arrangements in place for residents who smoked.

Residents' healthcare needs appeared to be met and residents had good access to the general practitioner (GP) and allied health professionals. However, some improvements were required in the management of wound care, falls and restraint. The arrangements for consultation with residents on the development of their care plans were not satisfactory. The quality of residents' lives was enhanced by the provision of a choice of interesting things for them to do during the day.

There were two multi-occupancy rooms which did not meet the requirements of the Regulations and the Authority's Standards. Changing facilities for staff were not satisfactory.

These issues are further discussed in the body of the report and in the Action Plan at the end of the report.

Section 41(1)(c) of the Health Act 2007

Compliance with 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*.

Theme: Leadership, Governance and Management

Effective governance, leadership and management, in keeping with the size and complexity of the service, are fundamental prerequisites for the sustainable delivery of safe, effective person-centred care and support.

Outcome 2

Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

References:

Regulation 28: Contract for the Provision of Services
Standard 1: Information
Standard 7: Contract/Statement of Terms and Conditions

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

Contracts of care were in place in line with the requirements of the Regulations.

The inspector read a sample of completed contracts and saw that they had been agreed and signed by the resident or next of kin as appropriate. The contracts stated the monthly fee and described the services which were covered by the monthly fee and which the resident could expect to receive. The contracts also described those services which incurred additional fees and also the additional fee incurred.

Outcome 3
The designated centre is managed by a suitably qualified and experienced nurse with authority, accountability and responsibility for the provision of the service.

References:
Regulation 15: Person in Charge
Standard 27: Operational Management

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

The arrangements for the post of person in charge met the requirements of the Regulations.

Stephanie McMahon commenced in the role of person in charge on 20 May 2013 and had previously held this position at another designated centre. A fit person interview was held with the person in charge during this inspection during which she demonstrated a good knowledge of the Regulations and the Authority's Standards. The person in charge was a registered general nurse, had the relevant necessary experience and worked full-time in the centre. She demonstrated a good understanding of her role and responsibilities as outlined in the Regulations and also demonstrated a commitment to developing and improving the service. Although she had only been in position for a short time she was knowledgeable about the residents in her care and had taken time to get to know them and their families. She had held a meeting with all staff to introduce herself and was also in the process of organising a resident and family meeting. Staff in the centre spoke highly of the new person in charge and stated that she was supportive of them.

The person in charge had attended a number of short courses in relevant clinical areas such as dementia, medication management and infection control. She had also successfully completed a ‘Train the Trainer’ course for the management of restraint. The person in charge stated that she had identified the need to complete a gerontology-related postgraduate qualification as part of her own continued professional development. In response to this she had enrolled in a one year diploma course in dementia care which was due to commence in September 2013.

She was supported in her role by the assistant director of nursing (ADON) who deputised in the absence of the person in charge. The ADON was present throughout the inspection, participated fully in the inspection process and demonstrated a strong knowledge of her roles and responsibilities under the Regulations.

Theme: Safe care and support

Safe care and support recognises that the safety of service users is paramount. A service focused on safe care and support is continually looking for ways to be more reliable and to improve the quality and safety of the service it delivers.

In a safe service, a focus on quality and safety improvement becomes part of a service-wide culture and is embedded in the service's daily practices and processes rather than being viewed or undertaken as a separate activity.

To achieve a culture of quality and safety everyone in the service has a responsibility to identify and manage risk and use evidence-based decision-making to maximise the safety outcomes for service users.

Outcome 6

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.

References:

Regulation 6: General Welfare and Protection
Standard 8: Protection
Standard 9: The Resident's Finances

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

The inspector found that measures were in place to protect residents from being harmed however, some improvements were required.

A policy was available which gave guidance to staff on the assessment, reporting and investigation of any allegation of abuse. The person in charge and all staff spoken with displayed sufficient knowledge of the different forms of elder abuse and all were clear on reporting procedures and their responsibilities as described in the policy. All residents spoken with said that they felt safe and secure in the centre. The training records showed that five staff members had not attended annual refresher training on identifying and responding to elder abuse, in accordance with the centre's policy although they had attended training in 2012. The person in charge was aware of this and had a plan in place for staff members to attend the training in another centre.

The inspector reviewed the systems in place for safe guarding residents' money. The majority of residents managed their own finances. The centre was responsible for safekeeping money and valuables for a small number of residents. A locked, safe was provided for this purpose and it was accessible to the person in charge and the administrator. Documentation was in place to monitor and record all transactions. The inspector checked a number of the balances and found them to be in order.

Outcome 7
The health and safety of residents, visitors and staff is promoted and protected.

References:
Regulation 30: Health and Safety
Regulation 31: Risk Management Procedures
Regulation 32: Fire Precautions and Records
Standard 26: Health and Safety
Standard 29: Management Systems

Action(s) required from previous inspection:

Take all reasonable measures to prevent accidents to any person in the designated centre and in the grounds of the designated centre.

Inspection findings

While some procedures were in place to promote the health and safety of residents, a number of improvements were required with regard to the implementation of the risk management policy and the safety arrangements for residents who smoked.

There was a safety statement in place and this document had been reviewed and updated since the previous inspection with the aid of a health and safety consultant. There was also a risk register in place which recorded the identified risks for the centre and the associated control measures. There was a centre-specific risk management policy in place which addressed the risks specified in the Regulations. However, the inspector found that the policy was not being implemented with regard to the procedures for the ongoing identification and management of risks in the centre. For example, the health and safety committee responsible for reviewing risks and updating the risk register did not meet at the quarterly intervals specified in the policy. The person in charge stated that the most recent health and safety meeting took place in January 2013 but minutes were not available.

The previous inspection found that supervision arrangements for residents who smoked were not satisfactory. The inspector found that this matter had not been addressed. The inspector visited this area a number of times throughout the day and found that the smoking room was busy with up to five residents present at a time. The inspector noted four residents present in the smoking room for a prolonged period during the morning without any supervision. There was a system in place for regular checks to be carried out and an "allocation sheet" which outlined who was responsible for checking this room but the inspector found that regular checks were

not being carried out. Staff questioned were unsure as to how often the room should be checked and no record of these checks was maintained. No risk assessment was available for the smoking room. A risk assessment was carried out for residents who smoked, however, the inspector noted that this assessment was not reviewed periodically or when there was a change in the condition of the resident. In the case of two residents who smoked this assessment was carried out in August 2011. The assessment did not consider the ability of the resident to smoke independently or with assistance and therefore supervision arrangements for residents who smoked were not described.

The inspector reviewed the fire safety procedures and found that there while there was a system of fire safety checks in place 21 members of staff did not have up-to-date mandatory training in fire safety. The person in charge stated that she had been addressing this issue as a matter of priority and a further training date had been organised for 28 June 2013. The inspector spoke with a number of staff who were able to describe the correct procedure to follow in the event of a fire. The records showed that the fire equipment including fire detection and alarm system, fire fighting equipment and the emergency lighting system were regularly serviced by an external consultant. There was also a documented, in-house, daily check of all escape routes. A weekly in-house check on fire fighting equipment and the fire alarm system was also carried out.

The centre had an emergency plan in place which provided information to guide staff on the procedures to follow in the event of an emergency such as loss of heat, water supply or power. The plan also provided guidance with regard to the evacuation of the centre and details of alternative accommodation and transport in the event that an emergency evacuation was required.

The inspector found that there was a serious of routine safety checks on issues such as hot water, call bells and equipment which was carried out and documented by the maintenance person on a weekly basis.

The inspector found that systems were in place to learn from accidents, incidents and near misses which were recorded in detail. The records detailed the action taken and the treatment given where this was required. The person in charge reviewed each individual incident and the minutes of staff meetings showed that incidents were discussed with staff to promote learning.

The training matrix showed that staff had up-to-date training in moving and handling. Residents' moving and handling assessments were routinely assessed and instructions for assisting residents to mobilise were discretely displayed in a location where staff could easily access them. The inspector identified one resident who had been recently admitted for whom no moving and handling assessment was available. The inspector saw that this assessment was carried out and appropriate instructions put in place before close of the inspection.

Outcome 8
Each resident is protected by the designated centres' policies and procedures for medication management.

References:
Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines
Standard 14: Medication Management

Action(s) required from previous inspection:

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

Inspection findings

The inspector found that policies and processes were in place for the safe management of medication.

The inspector reviewed the prescription sheets for a number of residents and found each medication was accompanied by a signature from the prescribing GP. The previous inspection identified improvements in relation to medications which were required to be crushed. The inspector found that this matter had been addressed. Where a medication was intended to be crushed the GP indicated this beside each individual medication. There was a system in place to ensure residents' medications were reviewed on a three monthly basis by the GP. Medication management audits were routinely carried out by the pharmacist. The inspector reviewed the findings of the most recent audit in April 2013 and found that where recommendations had been made they were promptly addressed. The person in charge discussed her plans to introduce in-house medication management audits within the coming weeks.

The inspector observed and discussed medication management practices with the nurse on duty. Each medication administered was recorded and signed and the nurse was knowledgeable with regard to the procedure to follow if a resident refused prescribed medications. Records showed that nursing staff received regular training in medication management. A comprehensive policy was in place which guided staff on all aspects of medication management including the administration of "as required" (PRN) medication.

A locked medication fridge was provided and the temperature was monitored and recorded daily. There were appropriate procedures for the handling and disposal of unused and out of date medicines.

The inspector noted that a small number of medication errors were recorded. These incidents were recorded in detail and the GP was informed where appropriate. Follow-up action was taken and there was documented evidence of prompt learning and review to prevent any reoccurrence. Medication errors were discussed at staff meetings to promote learning amongst the staff.

The medication policy provided guidance to staff on the management of residents who wished to self-medicate. There were no residents availing of this at the time of inspection.

Medications that required strict control measures (MDAs) were carefully managed and kept in a secure cabinet in keeping with professional guidelines and the centre's policy. Nurses kept a register of MDAs. The stock balance was checked and signed by two nurses at the time of administration and change of each shift. The inspector checked the balances and found them to be correct.

Theme: Effective care and support

The fundamental principle of effective care and support is that it consistently delivers the best achievable outcomes for people using a service within the context of that service and resources available to it. This is achieved by using best available national and international evidence and ongoing evaluation of service-user outcomes to determine the effectiveness of the design and delivery of care and support. How this care and support is designed and delivered should meet service users' assessed needs in a timely manner, while balancing the needs of other service users.

Outcome 11

Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. 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.

References:

Regulation 6: General Welfare and Protection
Regulation 8: Assessment and Care Plan
Regulation 9: Health Care
Regulation 29: Temporary Absence and Discharge of Residents
Standard 3: Consent
Standard 10: Assessment
Standard 11: The Resident's Care Plan
Standard 12: Health Promotion
Standard 13: Healthcare
Standard 15: Medication Monitoring and Review
Standard 17: Autonomy and Independence
Standard 21: Responding to Behaviour that is Challenging

Action(s) required from previous inspection:

Provide a high standard of evidence-based nursing practice.

Inspection findings

While there was evidence of good practice in some areas a number of improvements were required in the area of falls, wound care and the management of restraint.

The inspector reviewed a sample of residents' care plans and found that relevant risk assessments, such as skin integrity, continence, falls and nutrition were routinely carried out. Residents had care plans in place for their identified needs however, there was inconsistent evidence of resident or next of kin involvement in the care planning process. There was a daily nursing record of each resident's condition and the medical notes showed that residents had regular access to their GP. Residents also had good access to allied health professionals when needed such as speech and language therapist (SALT), dietician, chiropodist, dentist and the psychiatry of old age team. Records of these referrals were written up in the residents' records.

Improvements in the documentation associated with wound management were required. The inspector reviewed the records of a resident who had a wound and found that the resident had been seen by the tissue viability nurse (TVN). However, wound assessment documentation was not accurately completed and did not show that the wound was being managed in accordance with the schedule specified by the TVN. Staff stated that they did not always complete the wound assessment documentation following each dressing change which might result in inconsistency of treatment. The inspector saw that nutritional supplements had been prescribed for the resident and appropriate pressure relieving equipment was in place. A documented check was in place to ensure pressure reliving equipment was set correctly.

Improvements were required in the management of restraint. Approximately one quarter of residents used bedrails and two residents used a lap belt while sitting out. There was a policy in place to guide practice in this area and the inspector noted that risk assessments for the use of bedrails were carried out. However, these assessments were not reviewed routinely or when there was a change in the condition of the resident. The inspector also found that in the case of lap belts the restraint assessment procedure outlined in the policy was not followed and a record of when restraint was used and periods of release was not maintained. Records were in place to show that consultation took place with the resident or next of kin and nursing staff prior to a decision to use restraint.

Residents' falls risk was assessed after admission and routinely thereafter. Residents at a high risk of falls had been provided with a range of interventions to reduce this risk of injury and these included low beds, suitable foot wear and increased supervision arrangements where appropriate. The inspector reviewed the records of a resident who had a history of falls and found that improvements were required. The inspector saw that following a fall, a falls diary was completed and a reassessment carried out however, there was no evidence that additional interventions were identified or implemented to prevent recurrence. The care plan was not updated following the most recent fall and there was no evidence that additional preventive measures had been considered or trialled. Neurological

observations were carried in the event of any un-witnessed fall or possible injury to the head.

There was evidence of good practice in relation to the management of nutrition. Resident's weights were monitored monthly and more frequently where indicated. Residents who had lost weight were seen by the dietician and supplements were prescribed as necessary. Residents who had experienced weight loss had care plans in place which incorporated the recommendations of the dietician. A daily monitoring record of nutritional intake was also implemented where appropriate.

The inspector found some evidence of good practice in relation to the management of behaviours that challenged. The person in charge stated that a small number of residents sometimes displayed these behaviours. Behaviour monitoring records were routinely used in order to identify the triggers to this behaviour and possible interventions. Meetings with family members were also used to develop care plans. The inspector also found that there was good access to the psychiatry of old age team for those residents who required this. The inspector found that staff were knowledgeable about meeting the needs of residents who displayed behaviours that challenged in accordance with the instructions set out in the care plan.

Residents were seen enjoying a variety of activities during the inspection. It was the responsibility of all staff to interact with residents and provide interesting things for residents to do based on residents' individual preferences each day. Activities included singing, board games, exercise classes, pet therapy and Sonas (a therapeutic technique based on communication for residents with a cognitive impairment). Residents were encouraged to be independent and many went outside for walks or used the gardens which were well maintained and included a variety of seating areas. Social assessments were carried out with all residents and care plans for social interaction had been drawn up. Residents stated they were satisfied with the range of activities available. Residents who were confused or who had dementia-related conditions were encouraged to participate in the activities. A range of one-on-one activities were provided for residents who did not wish to participate in the group setting.

Outcome 12

The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

References:

Regulation 19: Premises
Standard 25: Physical Environment

Action(s) required from previous inspection:

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

Inspection findings

While the premises were maintained to a good standard and were found to be clean and hygienic there were two multi-occupancy rooms which did not meet the requirements of the Regulations.

There were two multi-occupancy bedrooms in total, one room for three residents and one room for four residents. The inspector found that these rooms did not meet the requirements of the Regulations and the Authority's Standards and no plan was in place to address these deficiencies in advance of 2015. The inspector also observed an issue with privacy and dignity as described under Outcome 16 below. The person in charge stated that the group maintenance manager had surveyed these rooms in order to devise a plan to ensure that no more than two residents shared a room but this process had not yet been completed.

The previous inspection found that changing facilities for staff were not satisfactory. The inspector found that this matter had been partially addressed. Following the previous inspection a new self-contained, pre-fabricated unit had been provided adjacent to the centre. The inspector found that this unit contained a changing area and three shower cubicles. However, the unit was not available for use by the staff. The inspector also found that provision had not been made for storage in order to facilitate staff to change and store clothing and personal belongings.

The inspector visited a number of other bedrooms and found them to be clean and well maintained. Rooms were provided with suitable lighting and call bells which were within easy reach. The inspector was satisfied that there was suitable and sufficient communal space for residents. There was a large sitting room, large dining room, sun room and a smoking room for residents' use. There were a sufficient number of wheelchair accessible toilets, showers and baths for use. There were three toilets very near the main sitting room and one of these was wheelchair accessible.

Safe and secure garden space was available with an enclosed garden accessible directly off the sun room and main sitting room. Garden furniture was provided as well as a number of raised flower beds to facilitate residents who had an interest in gardening.

The inspector found that the premises and equipment were maintained in good order. A maintenance person was employed and the documentation showed that equipment such as beds, pressure relieving mattresses and hoists were regularly serviced.

Provision for storage was found to be adequate and it was noted that assistive equipment such as hoists, specialised beds, mattresses and chairs were appropriately stored and did not hinder the movement of residents at the time of inspection.

The inspector was satisfied with the arrangements in place for infection control. Protective aprons and gloves were available throughout the centre. The inspector

spoke with staff who were knowledgeable about infection control. Appropriate arrangements were in place for the disposal of clinical waste. Cleaning equipment was appropriately stored. Staff demonstrated good infection control practices, for example, there was colour coding of cleaning cloths and mops for different areas of the centre.

The inspector visited the laundry and found that, although small, it was clean and well organised and systems were in place to promote infection control. The staff member in the laundry area had attended infection control training and demonstrated a clear understanding of her duties in this area.

Theme: Person-centred care and support
Person-centred care and support has service users at the centre of all that the service does. It does this by advocating for the needs of service users, protecting their rights, respecting their values, preferences and diversity and actively involving them in the provision of care. Person-centred care and support promotes kindness, consideration and respect for service users' dignity, privacy and autonomy.

Outcome 13
The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

References:
Regulation 39: Complaints Procedures
Standard 6: Complaints

Action(s) required from previous inspection:

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).

Inspection findings

There was evidence of good practice in the area of complaints management; however, the complaints policy did not comply with the Regulations.

The inspector noted that there was a policy in place which provided guidance to staff on the management of complaints. However, the complaints policy did not identify an independent person other than the complaints officer and the appeals officer to oversee the management of complaints. The complaints procedure was displayed in the entrance hall and it clearly identified the person in charge as the complaints officer. Complainants who were not satisfied with the initial response to their complaint were directed to the operations manager who acted as the appeals officer for complaints.

The person in charge demonstrated a positive attitude towards complaints. The complaints log was read and the inspector found evidence of good complaints management, including a record of the complainant's level of satisfaction with the outcome of a complaint investigation.

Outcome 14
Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.

References:
Regulation 14: End of Life Care
Standard 16: End of Life Care

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

The inspector found evidence of good practice in this area. There was a comprehensive policy on end of life care which was centre-specific. One resident was receiving end of life care at the time of inspection. The inspector saw that this resident was being attended to by a member of the palliative care team on the day of inspection further to a referral for palliative management on the previous day. The person in charge stated that staff in the nursing home had maintained strong links with the local hospice service. There was a care plan in place and evidence of consultation with the GP and next of kin.

The records showed that a number of staff had received training in this area. The person in charge stated that residents at this stage of life had regular access to a priest or other religious ministers as required. The person in charge stated that relatives who wished to stay over-night were facilitated in one of the lounge areas.

Outcome 16
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.

References:
Regulation 10: Residents' Rights, Dignity and Consultation
Regulation 11: Communication
Regulation 12: Visits
Standard 2: Consultation and Participation
Standard 4: Privacy and Dignity
Standard 5: Civil, Political, Religious Rights
Standard 17: Autonomy and Independence
Standard 18: Routines and Expectations
Standard 20: Social Contacts

Action(s) required from previous inspection:

Provide residents with privacy to the extent that each resident is able to undertake personal activities in private.

Inspection findings

There was evidence that staff respected resident's privacy and dignity, however, some improvements were required.

The previous inspection identified a lack of privacy and dignity in one of the multi-occupancy rooms due to poor screening. The inspector found that while screening in this room had been improved the layout of this room did not afford privacy as it was not possible to access the ensuite in this bedroom without entering the private space of another resident which was unscreened.

Staff were observed knocking on bedroom, toilet and bathroom doors and waiting for permission to enter. Residents were dressed well and according to their individual choice. The inspector observed staff interacting with residents in a courteous manner and addressing them by their preferred name.

Residents could attend weekly mass in the centre. Eucharistic ministers also visited. The person in charge said that residents from all religious denominations were supported to practice their religious beliefs and ministers from other faiths also visited the centre. Transition year students also attended the centre in order to promote links with the community. There were also plans in place to hold a garden party in order to provide opportunities for residents to socialise with friends and family.

The person in charge stated that residents did not currently wish to take part in a residents' committee. In lieu of this resident and relative meetings were held regularly. An independent advocate visited the centre on a monthly basis in order to canvass the views of residents and a record of this visit was maintained. Staff, spoken with, confirmed that the advocate visited all residents including those who were cognitively impaired. In addition to this the person in charge facilitated a dementia support group which was for relatives of the residents. The person in charge stated that she met with residents and relatives informally on a daily basis in order to ascertain their feedback. Relatives also stated that there was good communication between staff and families.

Theme: Workforce

The workforce providing a health and social care and support service consists of all the people who work in, for, or with the service provider and they are all integral to the delivery of a high quality, person-centred and safe service. Service providers must be able to assure the public, service users and their workforce that everyone working in the service is contributing to a high quality safe service.

Outcome 18
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.

References:
Regulation 16: Staffing
Regulation 17: Training and Staff Development
Regulation 18: Recruitment
Regulation 34: Volunteers
Standard 22: Recruitment
Standard 23: Staffing Levels and Qualifications
Standard 24: Training and Supervision

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

The inspector found evidence of good practice in relation to the level of staffing and skill mix, however, some improvements were required with regard to the maintenance of recruitment documentation.

There was 24-hour nursing cover. Two nurses and seven healthcare assistants were providing care to 39 residents on the morning of inspection. Residents, staff and relatives stated there were adequate numbers of staff on duty.

There was a comprehensive written operational staff recruitment policy in place. A sample of staff files was reviewed and the inspector noted that some of the required documentation such as evidence of physical and mental fitness and three references was not in place for all staff in line with the requirements of Schedule 2 of the Regulations. The inspector requested the an Bord Altranais agus Cnáimhseachais na hÉireann registration numbers for all nursing staff and found that all were in place.

Staff were encouraged to maintain their continued professional development. The records showed that a range of training had been provided since the previous inspection and this included nutrition, dementia care, wound care and palliative management. Staff members stated to the inspector that they were supported to attend any relevant training. A system of annual staff appraisals was also in place and the inspector saw evidence of this on the staff files.

No volunteers were working at the centre at the time of inspection. However, the person in charge was aware of the need to maintain documentation for volunteers including evidence of Garda Síochána vetting and written agreement of roles and responsibilities.

Closing the visit

At the close of the inspection visit a feedback meeting was held with the person in charge and the assistant director of nursing to report on the inspector's findings, which highlighted both good practice and where improvements were needed.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of the residents, relatives, provider and staff during the inspection.

Report compiled by:

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Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

27 June 2013

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report *

Centre Name:	The Croft Nursing Home
Centre ID:	0028
Date of inspection:	25 June 2013
Date of response:	31 July 2013

Requirements

These requirements set out the actions that must be taken to meet the requirements of the Health Act 2007 as amended, 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*.

Theme: Safe care and support

Outcome 7: Health and safety and risk management

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

The risk management policy was not fully implemented in the centre.

The safety arrangements for residents who smoked, as outlined under outcome seven, required improvement.

The smoking room had not been risk assessed in accordance with the risk management policy.

Action required:

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

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

Action required: Take all reasonable measures to prevent accidents to any person in the designated centre and in the grounds of 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: The organisational risk management policy is in place for staff to view in the home. The policy clearly identifies and defines - hazards, risk, risk management, the risk register and identifies those persons responsible for managing these risks. A risk assessment was carried out on the smoking room in order to identify the risks posed. These risks were addressed and entered into the risk register. A risk management meeting is scheduled for the 22 July 2013 with staff members with a view of identifying risks which are not already included in the current risk register for the home. Management is conscious that this register is a live document hence risk meetings will be conducted on a monthly basis going forwards. A health and safety meeting is planned for the nursing home for the 29 July 2013. Residents that smoke have been assessed using the smoking risk assessment tool in order to ascertain their current health and safety needs. One resident risk assessed was deemed to require one to one assistance while smoking .This has been put in place in consultation with the resident and their family. Two residents in particular who previously declined the use of the smoking aprons are now cooperating fully with staff and wear the aprons whenever they are having a cigarette. A third smoking apron has also been purchased.	 Completed - 26 June 2013 Completed - 26 June 2013 Completed - 22 July 2013 - quarterly Completed - 29 July 2013 Completed - 26 June 2013 26 June 2013 - completed Completed - 26 July 2013

Residents that are in the smoking area will be checked every 20 minutes by staff delegated to carry out this check on the allocations sheet on display. Staff responsible will sign that the designated smoking area has been checked and will document and report any immediate risks identified during this check to the Senior person on duty. This will be monitored by the Director of Nursing/ADON or the staff nurses on duty. A fire blanket is now available in the smoking room itself which is easily accessible in the event of a fire.	Completed - 26 July 2013 Completed - 26 July 2013

Theme: Effective care and support

Outcome 11: Health and social care needs

The provider and person in charge is failing to comply with a regulatory requirement in the following respect: Improvements were required in relation to the management of wound care, falls and restraint. Residents were not consulted on the development of their care plans.
Action required: Provide a high standard of evidence-based nursing practice.
Action required: Set out each resident's needs in an individual care plan developed and agreed with the resident.
Reference: Health Act, 2007 Regulation 8: Assessment and Care Plan Standard 13: Healthcare Standard 10: Assessment Standard 11: The Resident's Care Plan

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The Director of Nursing has contacted the tissue viability nurse to assess the wounds currently in the Croft. The residents with wounds have had their care plans up dated in consultation with	Completed - 25 June 2013

the resident and the family.	
The Director of Nursing will audit wound care and documentation on a monthly basis or as needed in order to evaluate adherence to appropriate wound care management.	Monthly - 31 July 2013
After a review of the falls procedure in the Croft the Director of Nursing has identified the need of a falls prevention plan for one resident. As a result and after consultation with the resident, they have been referred to the Community Medicine for the Older Person by their GP with a view of attending a falls clinic to assess their needs.	31 July 2013
Residents who are identified as being a high risk of falling will have a falls prevention plan initiated to reduce the falls risk and risk of injury to a resident. These plans will be overseen by the risk management group. These residents will also be discussed at health and safety meetings.	
All residents who have restraints such as side rails, seat belts or grab-rails will have their assessments and care plans updated. This assessment will be carried out by nursing staff in consultation with the resident and their families every six months to ensure best practise.	31 July 2013
Proof of restraint release such as lap belts will be documented where required on a daily basis and bed rail safety checks will be completed and reviewed as needed and/or every 6 months.	31 of July
Care plans that have been identified as not being reflective of residents needs will be re-written in consultation with the resident and/or their family. This will ensure the high standard of care will be accurately reflected in the plan of care for each individual resident.	31 August 2013
The Director of Nursing will audit care plans and put in place a system that ensures the resident and family consultation with their care plans is clear and well documented and up to date.	Monthly - 31 July 2013

Outcome 12: Safe and suitable premises

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

There were two multi-occupancy bedrooms which did not currently meet the requirements of the Regulations and will not meet the Authority's Standards by 2015.

The four-bedded room did not provide adequate privacy and dignity for residents.

Adequate staff changing facilities were not available for use by staff.	
Action required: 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.	
Action required: Provide residents with privacy to the extent that each resident is able to undertake personal activities in private.	
Action required: Provide suitable changing and storage facilities for staff.	
Reference: Health Act, 2007 Regulation 19: Premises Standard 25: Physical Environment Regulation 10: Residents' Rights, Dignity and Consultation Standard 4: Privacy and Dignity	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: All building and physical non-compliance issues identified in the report continue to be under review with a view of fully complying with 'The National Quality Standards for Residential care Settings for Older People in Ireland' by 2015. We have commissioned a restructuring plan with our architects for the multi occupancy rooms in order to make them compliant with the standards. We will submit this plan in full with our re registration application in June 2014 The home is currently full, all residents & their families have been interviewed and they have expressed their satisfaction with the room and how it is managed to observe residents dignity & respect. Residents' advocates expressed how comforted they were by the companionship the room offers. We will continue to survey residents & families' satisfaction levels with the multi occupancy rooms, through the forum of family meetings. All staff are continuously reminded on the virtues of providing	1 January 2015 31 June 2013 In Place

dignity & respect to each resident when assisting them with activities of daily living. This is communicated through handover & staff meetings. The Director of Nursing will continue to supervise care given throughout the day to ensure Dignity & respect is observed for all residents. Going forwards, In the eventuality of a resident vacating a bed within the four bedded room the resident will not be replaced and that bed will be decommissioned. This will reduce the occupancy to 3 in this room. Staff changing rooms will be fully available for staff by the end of July.	31 July 2013

Theme: Person-centred care and support

Outcome 13: Complaints procedures

The provider is failing to comply with a regulatory requirement in the following respect: The complaints procedure did not include details of an independent person, other than the complaints officer and appeals officer, to oversee all complaints within the centre.
Action required: 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).
Reference: Health Act, 2007 Regulation 39: Complaints Procedures Standard 6: Complaints

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The name and contact details of the independent appeals person for the Croft is now displayed on the complaints procedure notice and will be included in the internal complaints procedure policy for the home.	26 June 2013

Theme: Workforce

Outcome 18: Suitable staffing

The provider and person in charge is failing to comply with a regulatory requirement in the following respect: All required recruitment documentation was not maintained on staff files.	
Action required: Put in place recruitment procedures to ensure no staff member is employed unless the person is fit to work at the designated centre and full and satisfactory information and documents specified in Schedule 2 of the Regulations have been obtained in respect of each person.	
Reference: Health Act, 2007 Regulation 16: Staffing Regulation 18: Recruitment Standards 22: Recruitment	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: A comprehensive audit of all staff files has commenced and any shortfalls with Schedule 2 requirements will be identified and followed up immediately.	31 September 2013