Health Information and Quality Authority
Regulation Directorate

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

Centre name:	St. Joseph's Centre
Centre ID:	OSV-0000102
Centre address:	Crinken Lane, Shankill, Co. Dublin.
Telephone number:	01 282 3000
Email address:	stjosephs@sjog.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Saint John of God Hospital Limited
Provider Nominee:	Emma Balmaine
Lead inspector:	Deirdre Byrne
Support inspector(s):	Linda Moore
Type of inspection	Announced
Number of residents on the date of inspection:	60
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 his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

▪ to monitor compliance with regulations and standards
▪ to carry out thematic inspections in respect of specific outcomes
▪ following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
▪ arising from a number of events including information affecting the safety or wellbeing of residents.

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
19 August 2014 09:00	19 August 2014 20:00

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

Outcome 02: Governance and Management
Outcome 04: Suitable Person in Charge
Outcome 05: Documentation to be kept at a designated centre
Outcome 09: Medication Management
Outcome 11: Health and Social Care Needs
Outcome 15: Food and Nutrition
Outcome 18: Suitable Staffing

Summary of findings from this inspection

This inspection was carried out following receipt of a notification of a serious injury to a resident and an allegation of abuse which was submitted to the Health Information and Quality Authority (the Authority) in July 2014 in accordance with the Regulations. The purpose of the inspection was to review and assess if the systems in place ensured residents health, wellbeing and welfare was maintained by a high standard of care. The inspection also assessed compliance with requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

On the day of inspection, inspectors identified a number of non compliances that required immediate attention. The provider had failed to ensure residents had care delivered that encouraged early prevention and detection of ill health. In addition improvements were required in the provision of clinical care in areas such as falls, behaviours that challenge, wound care and nutrition. The system in areas for care planning and clinical supervision of residents care also required improvement. Inspectors were also concerned that appropriate action had not been taken following a fall resulting in a serious injury to a resident in line with evidence based practice.

An immediate action plan was issued on the 20 August 2014 requiring the provider and person in charge to take immediate action, and provide assurances to the Authority of the measures in place to ensure residents wellbeing and welfare was

maintained by a high standard of evidence based care in the centre.

Inspectors found improvements were also required in relation to the mealtime experience for residents and the supervision of staff in the centre.

There was a very committed and dedicated staff, with a very strong emphasis on training and education in the centre. Almost all residents had a cognitive impairment or a dementia diagnoses. The person in charge and director of services outlined a dementia care programme that was being introduced on a phased basis. Plans were outlined to inspectors of proposed changes to the physical layout of the centre, which will make it more user friendly for residents with a dementia. While planning permission had been applied for they were waiting for final documentation before commencing the works.

These and all other matters are outlined in the report below and 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 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

Outcome 02: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.

Theme:
Governance, Leadership and Management

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

Findings:
Inspectors found there was a governance structure in place and sufficient resources to ensure the effective deliver of care. However, improvements were identified as the management system was not effective or robust to effect positive outcomes for residents.

The governance arrangements and management structure in the centre were outlined to inspectors. However, they found the lines of authority and accountability were not robust and resulted in poor outcomes as outlined in outcome 11. While there were weekly management meetings, they were not effective to ensure appropriate care. A number of significant incidents were noted to have occurred. However, there was no evidence of an investigation completed. Where incidents were investigated there was no evidence of the learning and improvement to prevent similar incidents occurring again.

Judgment:
Non Compliant - Moderate

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

Theme:
Governance, Leadership and Management

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

Findings:
While this action is compliant in that the requirements for the role of person in charge were met, with regard to qualifications and experience, inspectors had concerns regarding the involvement of the person in charge in clinical governance for the service.

The person in charge was in the role since 1 July 2014. A fit person interview was held during the inspection. At the interview, inspectors found the person in charge demonstrated good knowledge of the Regulations and had a clear understanding of her responsibilities under the legislation. However, the person in charge did not demonstrate adequate clinical governance as per her responsibilities under the Regulations. For example, there was a failure to ensure adequate management of residents health care and the provision of care plans for residents (outcome 11). The supervision of staff (outcome 18) required improvement and the mealtime experience for residents (outcome 15) was not appropriately staffed and managed. In a discussion with the person in charge and the director of services during the inspection, both gave a commitment to inspectors to address the issues raised, and ensure appropriate supports would be provided.

The person in charge was a registered general nurse and had the relevant length of experience required by the Regulations. She had participated in ongoing professional development by attending training days in topics such as dementia care, end-of-life care, and Sonas. She attended seminars in care of the elderly. The person in charge had previously completed a diploma in management and industrial relations and a masters in health services management.

Satisfactory deputising arrangements were in place. The person in charge was supported in her role by the director of services and who also deputised in the absence of the person in charge. She participated fully in the inspection process.

Judgment:
Compliant

Outcome 05: Documentation to be kept at a designated centre
The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:
Governance, Leadership and Management

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

Findings:
Inspectors found the policies required by Schedule 5 of the Regulations were in place however, improvements were required as key operational policies did not fully guide practice.

Inspectors reviewed the policies required to be maintained by Regulations and Schedule 5. However, a number of key operational policies did not fully guide staff in line with evidence based practice such as the medication policy, falls policy and nutrition management policy.

Judgment:
Non Compliant - Moderate

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

Theme:
Safe care and support

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

Findings:
Overall inspectors found this action was compliant in that residents were protected by the designated centres' policies and procedures for medication management. An area of improvement was identified in relation to the policy and the administration of medications and these are discussed under outcomes 4 and 11.

There were written medication policies in place. However, as outlined in outcome 5 there were no written reporting procedures in place.

Inspectors read completed prescription and administration records and overall good practice was identified. A number of residents were prescribed "as required" (PRN) medications and procedures were in place to guide practice. Some areas of improvement in relation to practice were identified and these are discussed in more detail under outcome 11.

Staff nurses involved in the administration of medications had undertaken training updates in best practice. The person in charge informed inspectors that medication audits were completed by the pharmacy. The records of recent audits were reviewed by inspectors, and areas of improvements were identified along with the action to be taken.

Medication errors were reported and appropriately investigated. The person in charge had completed an investigation and there was evidence that appropriate action had been taken with the learning for staff.

At the time of the inspections no residents were self medicating. There was a system of transcribing medications in the centre and procedures in place to guide practice.

Written evidence was available that medications were regularly reviewed by residents GP were carried out.

Medications that required strict control measures (MDAs) were carefully managed and kept in a secure cabinet in keeping with professional guidelines. Nurses kept a register of MDAs. The stock balance was checked and signed by two nurses at the change of each shift. Inspectors checked the balance of a sample of medication and found it to be correct.

Judgment:
Compliant

Outcome 11: Health and Social Care Needs
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

Theme:
Effective care and support

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

Findings:
Inspectors were concerned that residents health care needs were not met in a timely manner to ensure early detection or intervention to prevent ill health and care was not provided in line with evidence based practice. Furthermore, improvements were required to ensure residents assessed needs were set out in individual care plans that reflect the residents involvement and changing needs.

Falls prevention and management:

The overall management of falls required improvement. A notification submitted to the Authority regarding a fall resulting in a serious injury to a resident was followed up. Additionally, the provider was required to submit a provider led investigation in relation to the matter. Although a full and complete investigation was submitted, inspectors were concerned that the system in place to assess and manage falls was not effective. Records for 2014 showed that a number of residents had repeated unwitnessed falls with some resulting in serious injuries. Resident's records did not demonstrate that appropriate care was provided for all residents following a fall. There was no assessment completed after each fall. There were care plans in place but they were not

comprehensive enough to guide practice and were not updated following each fall. While there was evidence that the GP had been notified inconsistent records of reviews were maintained. While there were eight crash mats available to minimise the risk of future falls, these measures were not adequate, such as the need for increased supervision. Appropriate and timely emergency care was not provided to one resident following a fall.

Nutrition management:

Inspectors found the system in place to monitor residents' nutritional needs and weight required improvement. There was a policy in place however, it did not guide practice. There was evidence residents weights were taken every month however, there was no working weighing scale for the month of July. Inspectors found that one resident had experienced significant weight loss yet there was no plan to manage this residents needs. There were no care plans in place to address identified weight loss. Staff did not know and records did not show the care that was being delivered to these residents. Where residents had been seen by a dietician, there was inconsistent evidence of these visits. Furthermore, where recommendations were made from the dietician they were not always followed through in a timely manner. For example, the increased monitoring of residents weights. There was no evidence if residents who had lost weight had been reviewed by the GP as planned.

Inspectors were concerned regarding the care in place for one resident with a percutaneous endoscopic gastronomy (PEG) tube. The prescribed feeding regime was not followed by nursing staff. For example, over four days, there were differing times between the recommended breaks in feeds and inconsistent evidence of supplements being administered. There was no nutritional care plan for the resident.

Dysphagia:

The management of residents at risk of chocking (dysphagia) required improvement. Inspectors found a resident had a choking incident in 2014. There was no incident report and no risk assessment completed, no care plan to guide the care for the resident. Records confirmed the resident had been seen by a speech and language therapist, and while the resident was too tired for a full assessment to be completed, there was no evidence of follow up. Residents with swallowing difficulties were not provided with the altered consistency diets as prescribed by the speech and language therapist at evening meal times which placed these residents at risk.

Wound care:

Inspectors found that he management of wounds required improvement. Documentation reviewed did not consistently identify the location of the wound. There were no care plans to guide care therefore it could not be ascertained the frequency and type of dressing to be delivered. Inspectors found a number of residents were assessed as at risk of developing pressure sores. However, care plans were not in place to outline the preventative measures in place. There was no system of checking pressure relieving equipment, and one mattress reviewed for a residents was incorrectly set.

Epilepsy management:

Staff did not demonstrate competence in the management of residents with epilepsy. There was no policy or procedure to guide staff in the management of epilepsy. There was no care plan or guidance for staff in relation to the management of this medical condition in caring for any resident during and after seizures, responding to any potential complications or for recording of epileptic activity to guide future interventions. While one residents was administered a PRN ("as required") medication there was no evidence of a seizure diary in place, no protocol to guide practice and no rational for why this was administered.

Bruising incidents:

Inspectors found one resident had extensive bruising on their forehead. There was no evidence of an investigation into the cause or the actions taken in response to the incident in July 2014.

Behaviour that is challenging:

Inspectors were concerned that the systems were in place to manage behaviours that challenge were not adequate. Incident reports and nursing notes read for 2014 confirmed there were a high number of episodes of behaviours that were challenging that placed residents at risk. There was no evidence that an investigation into the incidents and no action had been taken. Evidence based tools were not used to assess residents. There were no care plans developed for residents whose files were reviewed. During the inspection, one resident was administered a PRN medication but there was no documented rationale and no alternatives had been considered. While there was access to the services of a specialist institute; there was no evidence if residents had been seen or referred. There were no staff members in the centre with expertise in the development of these plans.

Development of care plans:

The overall system of care planning required improvement. Since the last inspection, a new system of care planning had been introduced. However, the new care plans developed were not detailed enough to guide the care to be provided for each residents individual health care needs. Inspectors reviewed a number of residents files and although risk assessments were completed, they were not linked to care plans. There were no care plans for developed for residents identified needs for example, wounds, restraint, nutrition, epilepsy, dementia care.

Administration of medications:

Inspectors found improvements were required in the administration of medications to residents for example, there were no records of administration of supplements that were prescribed to residents whose files were read. This was not in line with professional guidelines as outlined in outcome 9.

In addition records required to be maintained for residents were not accurately and fully completed. For example, the fluid balance sheets for one resident were completed retrospectively by staff at the end of the day and there were gaps bowel movements charts.

There procedures in place for the administration of PRN medications was not fully implemented in practice. For example, the PRN medications administered during the inspection were not given a rationale as to why they were administered, no alternatives were considered and there was no evidence of review of the effectiveness of this medication on the resident.

Judgment:
Non Compliant - Major

Outcome 15: Food and Nutrition
Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.

Theme:
Person-centred care and support

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

Findings:
Inspectors were not satisfied that residents were provided with a choice of meals at mealtimes in accordance with their assessed needs, and the failure to ensure a proper consistency diet was provided placed residents at risk. Improvements were also required to ensure assistance was offered in a discrete and sensitive manner where required.

Inspectors were concerned that the practices observed throughout the inspection did not afford residents with assistance in a discreet or a sensitive manner that enabled them to eat and drink. Inspectors observed the lunch time meal in the dining rooms in the two units. Almost all of the residents required assistance. The mealtime was a delayed, uncomfortable and unsociable experience for residents at times, and inspectors observed the following:

1. In one unit residents had to wait up to one hour for their meal to be served, and some appeared to be hungry. One resident leaned across another resident and started taking food off their plate. This food was not a consistency suitable to the residents assessed needs and put the resident at risk of chocking. Inspectors intervened at this point and brought the matter to staff attention.

2. The residents were not consistently assisted by staff to eat their meal. During the mealtime a number of residents were observed sitting alone with food on their face and clothing. Staff had not ensured residents had swallowed their food or took action to

assist residents. Inspectors were concerned that one resident had food on their face, and had still not been addressed after inspectors had left and returned to the dining room a short time later. Some residents were left to sit at the dining table long after their meal had been eaten.

3. Inspectors observed that some residents were not appropriately positioned either before, during or after their meal. One resident was observed to be in a semi recumbent position for the duration of their meal time which may pose a risk of choking. This matter was raised by inspectors and addressed.

4. While the provider appointed health care assistants to oversee the management of residents meals, the system was not effective in that the supervision was inadequate to ensure residents received the correct consistency diet.

5. Inspectors noted that modified consistency diets prescribed for residents by the speech and language therapist was not provided at evening mealtime. This was raised by the inspector on the day the inspection and discussed with the catering department. While staff were familiar with the consistency of meals to be provided to residents, they acknowledged the evening meal time did not reflect residents prescription. However, no action was taken to ensure these diets were provided.

6. A choice of meals was not available to residents on a modified consistency diet. Staff informed inspectors residents on a normal meal had a choice. But there was generally no choice available to residents on a modified diet. These arrangements were not based on the needs or preferences of individual residents.

As inspectors were so concerned about meals and the mealtime experience they reported their concerns to the CNM2 and the person in charge during the inspection. The evening meal time was later observed by inspectors and appropriate action was found to have been taken in response to inspectors comments.

Judgment:
Non Compliant - Major

Outcome 18: Suitable Staffing
There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

Theme:
Workforce

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

Findings:
While inspectors found there was an adequate number and skill mix of staff, the supervision and organisation of work did not ensure consistent safe practices was delivered.

There was an actual and planned staff rota and inspectors reviewed the rosters in place for the centre. Although there was evidence of sufficient staff numbers and skill mix on duty, the organisation and management of staff did not ensure residents were appropriately supervised. The majority of residents were assessed as high to maximum dependency and had a cognitive impairment or a dementia diagnosis. However, inspectors found supervision arrangements in place did not meet the residents needs. At different times of the day residents were observed unsupervised in sitting areas and the dining room. Staff informed inspectors they did not have the time to get one resident out of bed, this resident was observed in bed at lunchtime. Inspectors also observed a group of 26 residents corralled together to watch a large television screen. There was only one staff to supervise all these residents. Some residents were attempting to get out of their chairs and mobilise, and in another corridor four residents sat alone unsupervised. A second staff member was asked how many staff were on duty and the inspector was informed fourteen staff were on duty.

There were nursing staff on duty at all times in the centre, and three nurses oversaw the care of the elderly throughout the night. However, the arrangements in place for the nurse in charge were not robust at night time. For example, the emergency procedures if a resident fell.

There was a training and education programme for staff in place. Inspectors read records that confirmed staff had completed up-to-date training in all mandatory areas. A training matrix outlined a broad range of training that staff had received in areas such as infection control, medication management, dementia care, nutrition and wound care. However, training was not implemented in practice, particularly around behaviours that challenge and nutrition as outlined in outcome 11.

The person in charge had plans to introduce a new programme of dementia care into the centre on a phased basis that included re-configuration of the layout of the centre. This included an education and training programme for staff, reconfiguration and building works to the internal layout of the building. It was anticipated to commence building works as soon as all documentation regarding the approved plans were in place.

Judgment:
Non Compliant - Major

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

Deirdre Byrne
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	St. Joseph's Centre
Centre ID:	OSV-0000102
Date of inspection:	19/08/2014
Date of response:	17/09/2014

Requirements

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

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

Outcome 02: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The person in charge did not ensure demonstrate appropriate clinical governance in the provision of care to residents.

The system of investigation and review of incidents in the centre was not effective

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

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

Please state the actions you have taken or are planning to take:
On the 22nd August 2014, weekly meetings of the Director of Nursing, CNM 2 and CNM 1 for each unit commenced to review and investigate all adverse incidents including wounds/pressure areas. These meetings include a review of all documentation to ensure:
Care plans are updated
Appropriate assessments are carried out using the appropriate tools,
Appropriate referrals are made
GP review occurs where required
A plan is in place to prevent reoccurrence
HIQA/HSE/Gardai informed where necessary

A Health Care Risk Officer will attend these meetings where possible beginning the week of the 15th September 2014 – 30th September 2014

Database set up to include all information included on the adverse incident form and in addition, the outcome of the review, recommendations made and evaluation.

Monthly trends of individual incidents e.g. falls or need driven behaviours
Monthly trends of overall incidents.

The Clinical Audit and Effectiveness Committee will oversee the above

The Clinical Audit and Effectiveness Committee meet every two months and report directly into Clinical Governance, Quality and Safety Committee.

St. Joseph’s Centre Clinical Governance, Quality and Safety Committee reports to St. John of God Hospital, Clinical Governance, Quality and Safety Committee.

Results of investigations, trends identified and learning from the incidents will be discussed and feedback given to all staff at monthly Heads of Department meetings and individual department’s staff meetings.

Overview and analysis of trends will take place on a quarterly basis with specific learning and changes to be implemented identified – 31st October 2014

Proposed Timescale: 31/10/2014

Outcome 05: Documentation to be kept at a designated centre

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Key operational policies and procedure as outlined in the inspection report did not provide sufficient guidance to staff.

Action Required:
Under Regulation 04(3) you are required to: Review the policies and procedures referred to in regulation 4(1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.

Please state the actions you have taken or are planning to take:
Key operational policies for review:
The Prevention and Management of Resident Falls Policy – 31th October 2014
Nutrition, Food and Hydration Policy - 31st August 2014
Medication Policy – 30th September 2014
These policies will all be reviewed to ensure that they provide sufficient clinical guidance to staff

Proposed Timescale: 31/10/2014

Outcome 11: Health and Social Care Needs

Theme:
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The overall system of care plan documentation and review required improvement.

Care plans were not developed for all resident identified needs such as wound care, nutrition, behaviours that challenge, epilepsy.

Care plans in place did not guide practice and care to be delivered.

Care plans in place were not kept under regular review.

The recommendation of allied health professionals were not consistently incorporated into care plans.

Action Required:
Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's

family.

Please state the actions you have taken or are planning to take:
All residents who have an identified need e.g. falls risk, wound care, nutrition, dysphasia, behaviours that challenge, epilepsy have had care plans revised and updated to ensure that the care plan guides practice – 31st August 2014
All residents will have an individualised care plan that guides practice and care to be delivered for each identified need – September 2014
Recommendations of allied health professionals following a review will be incorporated into the resident's care plan in a timely fashion – September 2014

All nursing documentation will be incorporated in the same file e.g. care plans and assessment tools, observation charts, allied health professional recommendations, intake and output charts, dietary records – 31st October 2014.

An audit of the Enriched Care Plan will be carried out by the 30th September 2014.
The Enriched Care Plan will be completely reviewed based on the outcome of the audit – 31st December 2014

Proposed Timescale: 31/12/2014

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Appropriate health care was not provided to residents in the areas such as:
Falls prevention and management,
Nutrition management,
Dysphagia,
Wound care,
Epilepsy management,
recording and investigating of bruising to a resident.,
Behaviour that is challenging.

The records to be maintained for residents were not consistently up-to-date or accurate.

The administration of PRN medications was not in line with best practice or policy.

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

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

Falls prevention and management
1. All falls since June 1st 2014 have been reviewed, all residents who have fallen in this timeframe have been reassessed in terms of falls risk and confirmation of medical review evidenced.
2. Revised Care plans have been put in place to guide staff on prevention and management of falls for each of these residents, including supervision, use of landing mats, low-low beds, location charts, awareness of surroundings, importance of footwear and health status/clinical presentation of the resident.
3. All falls care plans have been updated, completed by Sunday August 31st 2014.
4. All falls diaries have been checked to ensure that they are up to date.
5. The Registered Provider has arranged for compliance checks and validation to be carried out on behalf of the Provider Nominee by the Quality and Safety team. These compliance checks will be unannounced.
6. The falls policy has been reviewed and updated in August 2014 to incorporate the flow chart devised following a recent fall. This policy has been circulated to all staff to read and sign to indicate that they have read and understand the policy. This policy will be further revised by October 31st 2014 in order to revise our falls risk assessment tools and preventative measures.
7. Education sessions in relation to falls prevention and management commenced August 27th 2014. To date 59 staff have received education. Another session is planned for the 30th of September. Further sessions will be arranged to ensure all staff receive education.
8. On the job training in documentation for staff to reflect the level of care being provided post falls will take place commencing September 2014. 9. Simulation of emergency drills have commenced under the supervision of the Director of Service. To date, five have been carried out, on August 22nd, August 24th and September 22nd 2014. Two simulations involved the emergency care to an unconscious resident, were unannounced, and followed through to documentation of the event. Three simulations involved the emergency care to a pulseless patient, were unannounced and followed through to documentation of the event. Plans for further simulations to respond to serious incidents such as cardiac events, fractures, haemorrhage, and head injuries will take place in the coming weeks and will be on-going. These simulations will continue under the guidance of the Director of Service/Director of Nursing in order to maintain staff competence to deal with emergencies. Records of participation are being maintained.

Nutrition management:
1. A comprehensive audit of Food and Nutrition was carried out in April 2014 and all actions are being implemented.
2. All resident’s weights have been rechecked and all MUST scores reviewed.
3. All actions indicated to support weight loss are being implemented.
4. The nutrition policy has been reviewed to incorporate practice guidance in relation to weight loss and weight gain. This policy has been circulated to staff for them to sign to indicate that they have read and understand the policy.
5. An individualised care plan has been put in place to manage the needs of the resident referred to in the report.
6. A nutrition care plan has been put in place for all residents who score ≥1 on MUST.

MUST is reviewed at least monthly for every resident – completed by 31st August 2014.
7. The Registered Provider has arranged for compliance checks and validation to be carried out on behalf of the Provider Nominee by the Quality and Safety team. These compliance checks will be unannounced.
8. 16 staff have received additional training in MUST.
9. Guidelines for the management and care of Percutaneous Endoscopic Gastrostomy (PEG) Tubes have been put in place.
10. An individual PEG protocol has been put in place for the resident with the percutaneous Endoscopic Gastrostomy Tube.
11. A nutritional plan is in place for this resident to guide care since his admission. This will be reviewed on an on-going basis as required. 12. Three educations sessions have been provided for the staff caring for this resident. 13. The Registered Provider has arranged for compliance checks and validation to be carried out on behalf of the Provider Nominee by the Quality and Safety team. These compliance checks will be unannounced.

Dysphagia:
1. The resident referred to in the report was reviewed by a Speech and Language Therapist on August 26th 2014, a risk assessment has been carried out and a care plan has been put in place to guide care for this resident for her dysphagia.
2. All choking incidents since June 1st 2014 have been reviewed, those two identified residents (one a near miss) have been reassessed and their care plans updated to guide care.
3. All residents with a diagnosis of dysphagia have had their care plans reviewed and updated as required completed 31st August 2014.
4. Meal time recording sheets have been reviewed and amended to ensure that all residents receive the recommended consistency of diet as prescribed by the Speech and Language Therapist.
5. A staff nurse carries out mealtime supervision, thus further ensuring that residents receive the recommended consistency of diet as prescribed by the Speech and Language Therapist. This staff nurse is identified on the roster, and wears an apron to indicate that they are the person leading and overseeing mealtimes. This is reflected in the revised policy.
6. The Registered Provider has arranged for compliance checks and validation to be carried out on behalf of the Provider Nominee by the Quality and Safety team. These compliance checks will be unannounced.
7. 2 chefs and catering staff have received training on dysphagia and consistency of food and fluids.
8. Additional training on dysphagia is being organised for staff nurses and HCAs to commence in October 2014.

Wound Care:
1. All existing wounds have been reviewed and care plans updated to guide care, including the frequency and type of dressing recommended.
2. The location of the wound is included on the wound assessment and management plan, this will be incorporated into the residents care plan.
3. All pressure relieving equipment has been checked to ensure that all are correctly set.
4. The existing system of checking pressure relieving equipment has been reviewed.

Additional training is being organised for staff in this regard in early September 2014.
5. On the job training in documentation for staff to reflect the level of care being provided in relation to wound care will take place commencing September 2014.

Epilepsy Management:
1. A guideline document for the management of residents with epilepsy has been developed – 31st August 2014.
2. A care plan is now in place for residents in the Centre who have a diagnosis of epilepsy to guide staff.
3. A seizure diary is now in place for residents with epilepsy.
4. On the job training in documentation for staff to reflect the level of care being provided before, during and post seizure activity will take place commencing September 2014.

Bruising incident:
1. An investigation is underway concerning the bruising to a resident noted in the report. This investigation is being carried out by the Quality and Safety team.
2. The resident had already been medically reviewed.
3. Any necessary actions will be carried out on receipt of the report.
4. Any learning from this report will be communicated to the staff.
5. On the job training in documentation for staff to reflect the level of care being provided will take place commencing September 2014.

Behaviour that is challenging:
1. All reports of episodes of behaviour that challenge have been reviewed.
2. Care plans are in place for all residents presenting with behaviours that challenge (needs driven behaviour) including the use of evidenced based tools, RAGSTER, ABC's, Multi-Element Behaviour Support.
3. Further training in Multi-Element Behaviour Support for residents presenting with needs driven behaviour is scheduled for staff commencing in September 2014.
4. On the job training in documentation for staff to reflect the level of care being provided in terms of needs driven behaviour will take place commencing September 2014.

Proposed Timescale: 31/10/2014

Outcome 15: Food and Nutrition

Theme:
Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Residents on a modified consistency diet were not provided with a choice at mealtimes.

Action Required:
Under Regulation 18(1)(b) you are required to: Offer choice to each resident at mealtimes.

Please state the actions you have taken or are planning to take:
This action has now been completed and all residents with a modified consistency diet are provided with a choice at mealtimes.

Proposed Timescale: 31/08/2014

Theme:
Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Residents were not consistently provided with meals in the consistency as prescribed.

Action Required:
Under Regulation 18(1)(c)(iii) you are required to: Provide each resident with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional assessment in accordance with the individual care plan of the resident concerned.

Please state the actions you have taken or are planning to take:
All residents are now consistently provided with meals in the consistency prescribed for them.

The resident's Enriched Care Plan has an individualised care plan for nutrition and dysphagia which incorporates the recommendations of the Dietician +/ Speech and Language Therapist guiding the correct consistency of diet and fluid for the resident and the appropriate amount of food and drink to meet the resident's needs.
A dietary record sheet is kept in each dining room at meal times indicating the consistency of diet and fluids recommended for each resident.
This dietary record sheet is updated immediately following review of any resident by a SLT.
The resident's care plan is updated immediately following review by a dietician or SLT to incorporate their recommendations and guide clinical practice.
A folder is kept in the dining room with a copy of all residents dietary and SLT reviews to ensure compliance with their recommendations.
Each dining room has a visual picture of modified food and fluid displayed as to aid to guide staff.

Proposed Timescale: 31/08/2014

Theme:
Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The overall system of supervision at mealtimes required improvement.

The staffing level at mealtimes was inadequate to ensure:
- appropriate assistance was provided to residents before, during and after meals
- meals were served in a timely manner
- assistance was provided to residents who were not in correct seating positions .

Action Required:
Under Regulation 18(3) you are required to: Ensure that an adequate number of staff are available to assist residents at meals and when other refreshments are served.

Please state the actions you have taken or are planning to take:
A staff nurse supervises meals.
Supervision involves:
Wearing an apron to identify them as the person supervising.
Ensuring that all staff are present to assist at mealtime.
Ensuring that all staff assist appropriately at meal time; residents are assisted discretely, sensitively and with dignity.
That all residents receive their meal in a timely manner.
All residents are seated correctly especially residents with a diagnosis of dysphagia.
Only residents with a diagnosis of dysphagia are seated together.
Residents are offered a choice of meal.
Residents receive the appropriate consistency as prescribed for them by the SLT.

Proposed Timescale: 31/08/2014

Outcome 18: Suitable Staffing

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The system of staff supervision to ensure care provided was not robust to ensure good quality care, improved practice and accountability.

Action Required:
Under Regulation 16(1)(b) you are required to: Ensure that staff are appropriately supervised.

Please state the actions you have taken or are planning to take:
The Director of Nursing and CNM 2 are reviewing all systems of reporting and communication for CNM 1s, Staff Nurses and HCAs.

The Director of Nursing, CNM 2 and CNM 1s will review all roles and responsibilities of CNM's, Staff Nurses and HCAs including:
Charge Nurse responsibilities when in charge of the centre day or night
Charge Nurse responsibilities on day duty
Charge Nurse responsibilities on night duty

Staff Nurse responsibilities on day duty
Staff Nurse responsibilities on night duty
HCA responsibilities on day duty
HCA responsibilities on night duty
All roles and responsibilities will be clearly documented and all staff will be aware of their role and accountabilities.

Proposed Timescale: 31/10/2014

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff did not put demonstrate knowledge of residents health care needs for example, nutrition and behaviours that challenge.

Action Required:
Under Regulation 16(1)(a) you are required to: Ensure that staff have access to appropriate training.

Please state the actions you have taken or are planning to take:
16 staff have received additional training in MUST.

Chefs and catering staff have received training on dysphagia and consistency of food and fluids – 15th September 2014.
Additional training on dysphagia is being organised for staff nurses and HCAs to commence in October 2014.

All residents with identified nutrition needs have a specific care plan to guide clinical practice for staff and will incorporate all recommendations by the dietician, speech and language therapist and GP, where appropriate.

Four staff commenced education in Multi-Element Behaviour Support for residents presenting with needs driven behaviour 15th September 2014. This is a one year course. 2 staff are completing training in Multi Element Behaviour Support for residents with needs driven behaviour in September 2014.

On the job training in documentation for staff to reflect the level of care being provided in terms of needs driven behaviour will take place commencing September 2014.

All residents with identified Need Driven Behaviour have a specific care plan to guide clinical practice for staff and it incorporates their individual Multi-Element Behaviour Support Plan if they have one.

Proposed Timescale: 31/10/2014