

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Greystones Nursing Home
Centre ID:	OSV-0000045
Centre address:	Church Road, Greystones, Wicklow.
Telephone number:	01 287 3226
Email address:	greystones@arbourcaregroup.com
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Greystones Nursing Home Limited
Provider Nominee:	Donal O'Gallagher
Lead inspector:	Deirdre Byrne
Support inspector(s):	Gearoid Harrahill
Type of inspection	Unannounced Dementia Care Thematic Inspections
Number of residents on the date of inspection:	56
Number of vacancies on the date of inspection:	8

About Dementia Care Thematic Inspections

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor compliance with specific outcomes as part of a thematic inspection. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 24 February 2016 07:30 To: 24 February 2016 18:00

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

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

Summary of findings from this inspection

This inspection report sets out the findings of a thematic inspection which focused on specific outcomes relevant to dementia care. In 2015, information seminars for providers on evidence-based guidance and procedures were held. Guidance material on the thematic inspection process is published on the Health Information and Quality Authority's (the Authority) website.

Inspectors met with residents, relatives and staff members. They tracked the journey of five residents with dementia within the service. They observed care practices and interactions between staff and residents who had dementia using a formal recording tool. Inspectors also reviewed documentation such as care plans, medical records and staff files. Inspectors examined relevant policies and the self assessment questionnaire which was submitted prior to the inspection.

The person in charge completed the provider self-assessment and compared the service with the 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 2009.

The centre provides a service for people requiring long term care and support and also dementia care. On the day of the inspection there were 56 residents (one was in hospital), and about 26 residents had a dementia diagnosis. There was no special dementia care unit, and all residents lived together in the centre.

The centre provided an environment for residents to move around as they wished. There were sitting rooms, communal and private areas and dining rooms. All were an appropriate size to meet the needs of up to 64 residents.

There were policies and procedures in place around safeguarding residents from abuse. All staff had completed training, and were knowledgeable about the steps they must take if they witness, suspect or were informed of any abuse taking place. There were good practices and training for staff around managing responsive and psychological behaviour, and using methods of restraint in the service. There was good access to general practitioner and a wide range of allied health professionals, and staff in turn were very familiar with resident health care needs.

The staff were familiar with residents social care needs. An activities coordinator facilitated activities in the centre and detailed programme of interesting things to do during the day was displayed. Residents were supported to be involved in the running of the centre, and an open complaints process was in operation.

There were some improvements identified: the management of hot radiator surfaces required immediate action during the inspection. However, appropriate action was taken during the inspection to mitigate any risks to residents. Aspects of the design and layout of parts of centre to meet the specific needs of residents with a dementia diagnosis also required improvement. There were areas of improvements in the assessment and care planning process required and aspects of the management of restrictive practices required improvement.

The actions from the previous thematic inspection of May 2014 were found to be fully addressed. The actions from this inspection are outlined in the body of the report, and the action plan at the end of the report.

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

Outcome 01: Health and Social Care Needs

Theme:

Safe care and support

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

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

Findings:

Residents' wellbeing and welfare was maintained to a good standard of nursing care, with good access to allied health services. The documentation of care plans and aspects of medication management required improvement.

There was a policy in place that set out how resident's needs would be assessed prior to admission and on admission. A review of the records showed residents were assessed prior to admission. All residents had an interim care plan that was developed on admission, and individualised assessments and care were developed as the staff got to know the resident better.

The person in charge advised inspectors that the pre-admission assessment of resident's would consider if the centre was able to meet their needs. There was pre-admission assessments and checklist in place for all residents, and there were also a common summary assessment form (CSAR).

There was good access to services of a general practitioner (GP) and residents' could also retain the services of their own GP if they wished. Records showed that where medical treatment was needed it was provided. There was evidence of referrals made to other services as required for example, dietician, speech and language therapist, optician or dentist. There was good access to geriatrician and psychiatry of older age services in the area also.

Records showed that where there were known risks related to a residents care, they were set out in the care planning documentation on admission. Inspectors were told nurse key workers completed assessments for residents and the care plans in relation to their identified needs, for example communication, nutrition, daily living skills, mobility and pain management.

Care plans were seen to cover healthcare needs, with information about residents social, emotional and spiritual needs included. A range of recognised assessment tools were used by nurses in identifying any changes or risks in areas such as nutrition,

dependency, skin integrity and mobility. These were completed on a four monthly or more frequent basis. However, aspects of the documentation of assessments and care plans required improvement. For example:

- a resident assessed as moderate falls risk and able to use the stairs had a care plan that stated they were a high risk of falls and unable to use the stairs
- some residents identified at risk of developing pressure sores had no care plans in place
- Some care plans did not fully guide staff practice. For example, the monitoring of weight loss and falls management.

These matters were discussed with the person in charge who explained action was being taken. All care plans were in the process of being re-formatted and she anticipated this would make improve the completion of care plans.

Consultation with residents or their families in care plan reviews was not evident. The person in charge said families and residents were regularly updated on any changes made to their care plans but there was no documentation available to demonstrate if consultation had taken place. A communication sheet was provided, but was not completed for residents whose files were reviewed.

The residents religious or spiritual beliefs recorded in their care plan, and it was set out how they would continue with them in the centre, for example, their preference to remain in the centre, attending the services provided in the centre, or receiving sacrament of the sick from the visiting priest. This was an action at the previous inspection and completed.

Evidence was seen during the inspection that residents were closely monitored, and where there was a change in the presentation of the resident, action was taken quickly in response. Records showed that residents had been seen by a GP, or in some cases went to hospital for further assessments. Where residents had been admitted to hospital, transfer records were seen that detailed what the residents needs were, and included any medication they were prescribed.

There were systems in place to ensure residents' nutritional needs were met, and that they did not experience poor hydration. Residents were screened for nutritional risk on admission and reviewed regularly thereafter. Residents' weights were checked on a monthly basis. Nutritional care plans were in place that detailed residents' individual food preferences. There was evidence of referrals and visits from dieticians and speech and language therapists. Nutritional and fluid intake records, when required were appropriately maintained.

Inspectors joined residents having their lunch in the dining room, and saw that a choice of meals was offered. A menu was displayed on the wall, and residents were asked what choice of meal they would like to eat. Inspectors observed that staff sat with residents while providing encouragement or assistance with the meal. This was an improvement from the previous inspection.

There was a system of communication between nursing and catering staff on the residents with special dietary requirements. Inspectors found that residents on weight reducing, diabetic, high protein and fortified diets and modified consistency diets received the correct diet and modified meals were attractively served.

There were arrangements in place to review accidents and incidents within the centre, and residents were regularly assessed for risk of falls. Care plans were in place and following a fall, the risk assessments were revised, with an area of improvement identified, as outlined above. The person in charge described the post falls procedures carried out that included the completion of neurological observations and a physiotherapist review. The centre employs a physiotherapist who visits the centre three days per week. During the time inspectors were in the centre, they saw evidence of staff supporting residents to maintain their mobility, encouraging them to walk with staff and relatives who were visiting.

There was evidence seen during the inspection that residents were able to make choices about the care and treatment they received. Some had recorded their wishes around end of life care, and any discussions around 'do not resuscitate' requests had been signed by the GP. At the time of the inspection no resident was receiving end-of-life care.

During the inspection there were a number of activities taking place in the main sitting room. An activities room was also provided and residents could attend drawing, art and baking classes. Inspectors observed residents having one to one activities such as hand massage, talking and walks. An activities programme was displayed on the residents' notice board that outlined the activities planned for the month. Activities available included music, exercise, art, and therapy dog. In some cases, residents were seen to choose not to take part in activities, or social interactions taking place, and spent time doing something of their own choosing such as moving round the centre or resting in their room.

Inspectors spoke with nursing staff who administered medication, and noted there was a clear system in place for safe administration of medication. There was a policy in place that provided guidance. However, there were no specific procedures for the use of 'as required' (PRN) medications to guide staff. This was discussed with the nurse and the person in charge.

Inspectors reviewed the prescription sheets for a sample of residents with a nurse. There were some improvements required:

- There was no records of medications administered as per their prescription for three residents on a number of days, and these had not been identified by staff. This was brought to the attention of the nurse and person in charge. Following the inspection, a report was submitted to the Authority with assurances that an investigation had been completed and action had been taken.
- Some medication prescribed on an as required basis (PRN) basis did not have maximum dose to be given in 24 hours recorded.

There was evidence of review of the residents' medications by the GP. All nurses had completed on line medication management training.

This outcome was judged to be compliant in the self assessment and inspectors judged it as moderate non compliant.

Judgment:

Non Compliant - Moderate

Outcome 02: Safeguarding and Safety

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

Inspectors found the systems were in place to promote the safeguarding of residents and protect them from the risk of abuse and the management of responsive behaviours that challenge. There were some improvements required around the use of restrictive procedures.

There was an elder abuse policy in place dated 2015. It had not yet been updated to reflect or incorporate the principals of the Health Service Executive Safeguarding Vulnerable Residents at Risk of Abuse, National Policy and Procedures of 2014.

Inspectors spoke with staff who knew what action to take if they witnessed, suspected or had abuse disclosed to them. Staff also explained what they would do if they were concerned about a colleagues behaviour.

Records that were reviewed confirmed that all staff had received training on recognising and responding to elder abuse. The person in charge facilitated the training in the centre, which was completed on an annual basis.

There had been no suspicions or allegations of abuse in the centre since the last inspection. The person in charge was aware of the requirement to complete an investigation and was familiar with the procedures to be followed.

There were no residents' personal monies held in safekeeping at the time of the inspection.

There were policies in place about managing behaviour that challenges (also known as behavioural and psychological signs and symptoms of dementia) and restrictive practices. Inspectors were informed by some nurses and care assistants that they had training in how to support residents with dementia. Training records read for the last 12 months showed some staff had attended training related to the care of people with

dementia. This is discussed further in Outcome 5.

Inspectors saw staff dealing with all residents' in a calm and dignified manner, where there were incidents of responsive behaviours read, these were noted in the documentation. For example, inspectors reviewed a sample of care plans and saw that specific triggers and possible suitable interventions were identified. There was evidence of specialist input when required.

Nurses spoken with were clear that they needed to consider the reasons why people's behaviour changed, and would also consider and review them for issues such as infections, constipation and changes in vital signs.

Inspectors found the use of restrictive practices included bedrails, lap belts and alarms for residents at risk of elopement and falls. The records of assessments were reviewed and inspectors found there was inconsistent evidence of the alternatives considered or consultation with residents or relatives where required. Some assessments completed were not clear as to what type of restraint was in place, for example, when PRN medications were utilised to manage residents' behaviours.

It was noted that a number of residents were prescribed as required psychotropic medications in the centre. Inspectors reviewed good practices in relation to this. There was a record maintained each time the medication was administered. However, it did not clearly outline what alternatives had been considered prior to administering the medication. These matters were discussed in detail with the group operations manager and the person in charge.

There was a policy on restrictive practices, which made reference to the National Policy "Towards a Restraint Free Environment". While it promoted a restraint free environment, this was still work in progress in the centre. For example, a recent bedrail record read stated 21 of the 56 resident used bedrails. Furthermore, the use of bedrails in the centre had not been notified to the Authority on a quarterly basis. Inspectors discussed these matters with the person in charge and the requirement to submit this information. Following the inspection, the Authority was informed bedrails would be notified in the quarterly returns.

This outcome was judged to be compliant in the self assessment, and inspectors judged it as substantially compliant. The improvement relates to the implementation of the National Policy "Towards a Restraint Free Environment".

Judgment:
Substantially Compliant

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:
Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

Inspectors found residents' could choose how they went about their day, were consulted with about how their day went, their civil and religious rights were respected and they were consulted with about the operation of the centre. An area of improvement was identified regarding the provision of meaningful activities for some residents with dementia.

Inspectors observed staff quietly going about their duties on arrival in the centre at 7.30 am. The centre was calm and staff respected residents who were asleep and not yet up. One resident was met having a snooze in the sitting room, looking well dressed, including jewellery and makeup. During the day, one resident told inspectors she liked to get her hair done, and another resident said the hair dresser came weekly. This was confirmed by the staff, who said they would come more frequently if required by residents.

As part of the inspection, inspectors spent a period of time observing staff interactions with residents with a dementia. Inspectors used a validated observational tool (the quality of interactions schedule, or QUIS) to rate and record at five minute intervals the quality of interactions between staff and residents in the three communal areas. The scores for the quality of interactions are +2(positive connective care), +1 (task orientated care), 0 (neutral care), -1 (protective and controlling), -2 (institutional, controlling care). The observations took place at two different times for one hour in the main sitting area of the centre. the findings of the observational tool is as follows:

In the first observation- a 60 minute period- inspectors found the overall quality of interaction was 50% scores of +1 (task orientated care), and 50% scores of 0 (neutral). The observation took place in the main sitting room of the centre. A small group of six residents sat in the room. During the time, staff would enter to accompany a resident in a wheelchair into the room. The staff spoke kindly to the residents they were supporting and they asked them were they ok and comfortable, but they did not engage in any further conversation. They ensured good physical care was provided. Another staff member entered the room to clean the floor near a resident where some fluid had spilled, but they did not look at or speak to the resident. The other residents in the room were not spoken to by staff who entered the room. During this time, an activities coordinator entered the room to spend time with residents. She engaged in friendly one to one conversation with the residents, providing hand massage or making cups of tea for residents. Another staff member who supported residents to mobilise was found to take the time to talk to residents and explain what she was doing in a kind friendly manner, ensuring good physical care was provided. 6 scores +1 were awarded where staff provided good physical care, were kind to the residents but with limited conversation and 6 scores of 0 were awarded when residents sat for long periods with no engagement.

During the second observation in the same area, inspectors found 75% of the hour observed to have an overall quality of interaction score of +1 (task oriented care). Residents were having snacks, watching TV and doing 1:1 activities with the activities coordinator before dinner was served. Staff were kind and respectful towards residents and promptly responded to residents' calls for assistance. Staff interactions with residents were friendly, however rarely went beyond talking the resident through the task at hand. Residents were asked how they were or did they want a drink but were rarely engaged in any more personally meaningful conversation. With regard to dementia friendly interactions, staff were sometimes observed asking a resident a question without establishing eye contact or ensuring the resident's attention was attained first. Nine scores of +1 were awarded when staff provided good physical care, where the conversation focused on the task such as assisting residents to sit or have their meals. Neutral scores were noted where residents not currently in need of assistance would sit for extended periods of time without staff interaction, or when staff were observed walking with or wheeling residents in silence.

Staff were observed knocking on bedroom, toilet and bathroom doors if residents were in these rooms. Some residents with dementia spent time in their own rooms, and enjoyed reading and watching TV, or taking a nap. Other residents were seen to be spending time in the communal areas of the centre. Activities were provided in the main sitting room area by staff who facilitated these. There were assessments, resident profiles and a social care plan developed that included detailed information on each resident's assessed needs, likes and interests. Inspectors spoke to an activities staff who described the range and type of activities, which included one to one time, games, exercise, music, reading.

Residents had access to a number of sitting rooms and sitting areas whereby they could meet with family and friends in private, or could meet in their rooms. Residents confirmed that their religious rights were respected and supported. A television link to the local church provided live coverage of mass for the residents. Residents were enabled to access and see representatives from their church when required.

Residents' civil rights were respected in the centre. This was discussed with the person in charge. The local county council set up a polling booth at each election in the centre. The person in charge reported this had recently taken place for the general election. In one sitting area, the residents discussed the upcoming election with inspectors, and that they would go out to vote in the election day.

The person in charge outlined details of independent advocacy services that were available to the residents. The person in charge outlined details of one resident who had been referred to the service in the recent past.

There was an open visiting policy and contact with family members was encouraged. There were facilities available should a resident or relative wish to make tea/coffee and inspectors observed this to be in use during the inspection.

A residents' committee continued to meet, this was provided for residents to give them the opportunity to express any concerns they may have and for it to be discussed with the person in charge if they wished. The minutes showed that issues identified were

responded to by the provider and person in charge. Issues raised included laundry, food and outings.

Inspectors found that most residents said they had flexibility in their daily routines, for example, residents could decide whether to participate in activities available to them. They chose when to go to bed and the time they got up.

Inspectors noted that televisions had been provided in residents' bedrooms. Televisions were also located in communal areas if residents wished to watch them.

Inspectors did not inspect the laundry facilities at this time. This would be reviewed at the next inspection.

This outcome was judged to be compliant in the self assessment, and inspectors judged it as substantially compliant.

Judgment:
Substantially Compliant

Outcome 04: Complaints procedures

Theme:
Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

A complaints policy was in place that met the requirements of the Regulations, and outlined the procedures for recording and investigating written and verbal complaints.

The complaints officer and independent appeals process were outlined in the procedures on display. There was an accessible version of procedures in simple language version in the residents' guide and on display in the main lobby.

Inspectors found there were systems in place to record all complaints, which were documented electronically. These were accompanied by records of all relevant correspondence and meetings with the complainant. A sample of complaint investigations was reviewed and it detailed the nature of the complaint, the outcomes of the investigation, the actions to be taken by the provider and the satisfaction status of the complainant.

A quarterly audit of complaints was carried out to identify any outstanding issues and notable trends in types of complaints. The key findings of these audits were then discussed at management meetings.

Judgment:

Compliant

Outcome 05: Suitable Staffing**Theme:**

Workforce

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

No actions were required from the previous inspection.

Findings:

Inspectors found the staffing level and skill mix to be appropriate for the needs of the residents. Staff were friendly and respectful towards residents, and were knowledgeable of key operational procedures and policies.

A planned and actual staff roster was maintained. At a minimum there were two nurses on shift over 24 hours. Monday to Friday, a deputy nurse manager was on duty which enhanced the management and supervision of care provided.

The induction schedule for a new staff was reviewed and this included a substantial checklist of training sessions, workshops and review meetings. There were appraisal meetings for staff held on an annual basis.

There were systems in place to track staff training and schedule training dates. Inspectors were shown reports on staff training that were used to identify training gaps and expiry dates. This was then provided to the management. Inspectors read training records that confirmed all staff working in the centre were up-to-date on training in fire safety, manual handling and prevention of elder abuse.

There was training provided to enhance the skills of staff and to meet the needs of residents with a dementia diagnosis, and this included: communicating with people with dementia, nutrition with dementia and in managing responsive behaviours. There were also training provided in wound care, infection control, continence care, falls prevention, end of life care, cardio-pulmonary resuscitation (CPR) and catheter care.

Inspectors reviewed a sample of staff files and found them to contain all information required by Schedule 2 of the Regulations. There were no agency staff employed by the centre.

A small number of volunteers provided support to the centre. The files of a sample read contained Garda vetting information and description and accountability of the person's role in the centre.

Judgment:

Compliant

Outcome 06: Safe and Suitable Premises

Theme:

Effective care and support

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

No actions were required from the previous inspection.

Findings:

The design and layout of the centre was in line with the statement of purpose. There were some aspects of the layout of the centre that required improvement to meet the needs of residents with a dementia. The systems in place to control the temperature of hot radiator surfaces required improvement but was addressed promptly by the provider.

On the day of the inspection, a number of radiator surfaces in communal areas and bedrooms felt very hot to touch, for example, one radiator measured 50 degrees celsius, which is in excess of the maximum standard of 43 degrees Celsius. When brought to the attention of management, immediate action was taken to mitigate the risk of scalds to residents. Following the inspection, a detailed update was submitted that outlined the action taken to prevent risks occurring in the future.

This nursing home was a Georgian house with a large modern extension. There was accommodation provided over two floors, and a lift was available to transfer residents' between the two floors. There was no dementia specific unit within this nursing home, and all residents lived together, with access to all areas of the centre. The accommodation consisted of 32 single bed rooms and 16 twin bedded rooms. Appropriate screening was provided in the twin rooms, with sufficient room for residents to personalise around their bed. Inspectors observed that a number of residents added small personal touches to their rooms, such as furniture, photos and ornaments. At the time of the inspection two of two bedded rooms were being use as single rooms. The person in charge explained this was to meet the needs of the residents presently residing in those rooms.

The premises were found to meet the needs of the physical needs residents at the time of the inspection. However, there were certain challenges identified in relation to the premises fully meeting the needs of all residents such as those with a dementia diagnosis. It was noted some signage to direct residents around the centre was used. But lettering and pictures to identify toilets and/or direct residents towards various parts of the centre was not consistent throughout. Inspectors discussed this with the person in charge and also the possibility of using contrasting colours to make toilets and bathrooms more easily identifiable to residents with dementia or cognitive impairment. The bedroom doors did not have photos or any other personalised features to make them more easily identifiable to residents with dementia. The person in charge showed frames for more signage she planned to hang up.

There was sufficient communal dining and sitting areas available for the number of residents accommodated. This included a large bright living room on the ground floor of the main house. There was a large main dining room. In addition, there were two sitting-dining rooms in the extended part of the centre, a private sitting room and a number of sitting areas. While the house was nicely furnished in a homely manner, in some communal areas around the centre there were no points of interest for residents with dementia to encourage them to engage with or explore their environment.

An adequate number of assisted showers, baths and toilet facilities were available. Grab rails were installed in all toilets. There were handrails provided on staircases and communal areas where required.

There was an enclosed garden, accessible from the ground floor, safe for residents' with a dementia to access independently. The premises and grounds were clean and well maintained.

The building was safe and secure. There was a key code required to enter or exit the building, and the entrance lobby was manned by a receptionist during the day. There were arrangements enabled residents to move around freely within a safe environment.

There was suitable assistive equipment available to meet the needs of the residents. These were all maintained in good working order and service records seen by inspectors confirmed regular checks were carried out.

The wide corridors enabled easy access for residents using wheelchairs and those people using frames or other mobility appliances. Inspectors observed residents moving independently around the corridors using their individual mobility aids.

This outcome was judged to be compliant in the self assessment, and inspectors judged it as substantially compliant.

Judgment:
Substantially Compliant

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 report¹

Centre name:	Greystones Nursing Home
Centre ID:	OSV-0000045
Date of inspection:	24/02/2016
Date of response:	18/03/2016

Requirements

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

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

Outcome 01: Health and Social Care Needs

Theme:

Safe care and support

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

There were no centre specific procedures for as required (PRN) medications to guide staff practice.

1. 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

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

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:

A PRN Policy has been introduced to support our Medication Management Policy.

This policy has been circulated to all nurses and a signing sheet introduced to record their learning in this matter.

Proposed Timescale: 18/03/2016

Theme:

Safe care and support

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

The consultation with residents or relatives in care plan reviews required improvement.

2. 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:

Our consultation approach has failed to deliver a consistently documented and accurate record to date. A review of our care plan policy will take place before 23/3/2016. Future Care Plan reviews will show documented consultation details and this will be completed in line with the review of each care plan as it falls due, hence the completion date of three months.

Proposed Timescale: 30/06/2016

Theme:

Safe care and support

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

The development of care plans for residents at risk of pressure sores required improvement.

Some care plans did not fully guide practice for example, weight loss and risk of falls.

The completion of some clinical risk assessments require improvements.

3. Action Required:

Under Regulation 05(3) you are required to: Prepare a care plan, based on the assessment referred to in Regulation 5(2), for a resident no later than 48 hours after that resident's admission to the designated centre.

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

The care plan review identified in 2. Action Required above will include additional requirements that will ensure that the care plans are improved leading to:
Residents at risk of pressure sores will have a specific care plan developed to protect their skin integrity.
All care plans will guide practice when changes are identified.
This will lead to an improved clinical risk assessment.

An immediate review of all residents care plans to identify any shortcomings will be conducted and any identified gaps rectified.

Proposed Timescale: 13/04/2016

Theme:

Safe care and support

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

There were records of PRN medications being administered without the maximum dosage in a 24 hours period prescribed.

4. Action Required:

Under Regulation 21(3) you are required to: Retain the records set out in Schedule 3 for a period of not less than 7 years after the resident has ceased to reside in the designated centre.

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

The attending GPs have been advised of this need to prescribe a maximum 24 hour dose of all PRN medications. 24 hour doses have been entered on all Kardex sheets.

Proposed Timescale: 16/03/2016

Theme:

Safe care and support

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

A number of medication errors were identified during the inspection that required investigation.

5. Action Required:

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

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

A full investigation has taken place and the staff responsible for the medication management errors spoken to.

A nurse meeting has taken place and our policy for medication management reiterated to all. All nurses have committed to updating their on-line medication management training within a month.

Proposed Timescale: 15/04/2016

Outcome 02: Safeguarding and Safety**Theme:**

Safe care and support

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

There was inconsistent evidence of the alternatives considered in the assessment of restrictive practices.

There was inconsistent evidence of consultation with residents or their relatives in the decision to use restrictive practices.

6. Action Required:

Under Regulation 07(3) you are required to: Ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.

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

We will improve the documentation of the alternatives considered.

We will expand our consultation with residents and their relatives to ensure the best possible options for the residents are reached and documented.

Proposed Timescale: 30/04/2016

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

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

The provision of meaningful activities for some residents with a dementia required improvement.

7. Action Required:

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

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

We have a full and detailed range of activities available for residents to partake in should they so wish. Each resident is assessed and a Social Care Plan devised. In addition our Activity Coordinator records the participation of each resident in the range of activities. Using both of these sources of detailed information, the range of activities provided is constantly reviewed through assessment of the preferences of the residents, their participation in activities and their suggestions from the residents committee meetings.

Many of our activities are arranged specifically with residents with a dementia in mind such as one to one activities and reminiscence based ones.

We will continue to consider all possible activities more suited to residents with a dementia during each review.

The next review will be completed before the end of April.

Proposed Timescale: 30/04/2016

Outcome 06: Safe and Suitable Premises

Theme:

Effective care and support

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

The use of best practice design dementia care facilities should be further explored to meet the needs of all residents in the centre.

8. Action Required:

Under Regulation 17(1) you are required to: Ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.

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

We do not offer a dementia specific care environment within Greystones Nursing Home but instead include residents with a dementia in our general population of the home and include them in the general daily living within the home. We therefore strive to

ensure that a homely environment is achieved for all residents.
We will continue to expand our use of best practice design features while attempting to ensure that the environment offers a homely appeal to the full population.
A detailed review of signage, way finding tools and dementia design will be conducted and a resulting action plan devised for identified improvements by 30th April. The action plan completion will only then be clarified depending on the scale of the works to be carried out.

Proposed Timescale: 30/04/2016