

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	The Croft Nursing Home
Centre ID:	OSV-0000028
Centre address:	2 Goldenbridge Walk, Inchicore, Dublin 8.
Telephone number:	01 454 2374
Email address:	info@silverstream.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Croft Nursing Home Limited
Provider Nominee:	Joseph Kenny
Lead inspector:	Jim Kee
Support inspector(s):	Sheila McKeivitt
Type of inspection	Unannounced
Number of residents on the date of inspection:	36
Number of vacancies on the date of inspection:	1

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, 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 following receipt of unsolicited information. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 30 March 2016 09:10 To: 30 March 2016 18:30

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

Outcome	Our Judgment
Outcome 02: Governance and Management	Non Compliant - Major
Outcome 06: Absence of the Person in charge	Compliant
Outcome 07: Safeguarding and Safety	Non Compliant - Major
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 09: Medication Management	Non Compliant - Moderate
Outcome 10: Notification of Incidents	Compliant
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 12: Safe and Suitable Premises	Non Compliant - Major
Outcome 14: End of Life Care	Substantially Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Non Compliant - Moderate
Outcome 18: Suitable Staffing	Non Compliant - Moderate

Summary of findings from this inspection

The purpose of this inspection was to follow up on non-compliances identified during the last inspection of the centre on 18/8/2015 and to monitor on-going compliance with the Health Act 2007 (Care and Welfare of Residents in Designated centres for Older People) Regulations 2013. The Health Information and Quality Authority (HIQA) had also received information relating to this centre, primarily regarding end of life care and issues affecting residents' privacy and dignity. On the day of the inspection inspectors found that there were procedures in place to ensure residents received appropriate end of life care including input from specialist palliative care services. However inspectors did find that some care practices in the centre did not fully respect residents' privacy and dignity at all times. As part of the inspection, the two inspectors met with residents and staff members. The inspectors observed practices and reviewed documentation such as care plans, accidents and incident forms, medical records, policies and procedures, and staff files.

There were 35 residents living in the centre at the time of inspection, with one

additional resident in hospital, and one vacancy. The person in charge had recently resigned, and HIQA had been appropriately notified. The inspectors briefly met with the provider nominee during the inspection. Overall inspectors found that the governance and management systems in place in the centre were not sufficient to ensure the service provided was safe, appropriate, consistent and effectively monitored. The outcome on governance and management was found to be in major non-compliance with the regulations. Eight of the actions identified to address non-compliances found during the inspection in August 2015 had not been satisfactorily implemented.

Two outcomes were deemed to be in compliance with the regulations, outcome 6, absence of person in charge, and outcome 10, notification of incidents. The outcome on end of life care was found to be in substantial compliance with the regulations.

The outcomes on health and safety and risk management, medication management, health and social care needs, residents' rights dignity and consultation and suitable staffing were found to be moderately non-compliant.

The outcome on safe and suitable premises was found to be in major non-compliance with the regulations, as was the outcome on safeguarding and safety. The restraint risk assessment and processes in place for the safe appropriate use of bed rails required review.

The action plan at the end of the report identifies those areas where improvements were required in order to comply with the regulations and the authority's (HIQA) standards. Nine actions are the responsibility of the registered provider to address, and six actions are the responsibility of the person in charge.

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 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):

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

Findings:

The aspects of this outcome reviewed during the inspection included the actions to be completed by the provider to address the non-compliances identified during the previous inspection on 18/08/2015. The management structure in the centre had changed as the person in charge (director of nursing) had recently resigned. The assistant director of nursing was now the acting director of nursing. The senior management team had also arranged for another senior clinical nurse manager to work in the centre to support the acting director of nursing. However the management systems in place in the centre required further review to ensure the service being provided was safe, appropriate, consistent and effectively monitored.

Inspectors reviewed the monthly operational compliance reporting and care quality indicators for the centre. This included the monitoring of a number of different areas including compliance with care planning, dependency levels, monitoring of restraint, monitoring of residents' weights, and the number of residents with wounds or pressure sores. Monthly clinical audits of a sample of resident care plans were also conducted. A new handover sheet and allocation system had been introduced to the centre and a weekly care quality indicator report was completed. However the monthly audit review system as outlined in the action plan response to the previous inspection had not been implemented in full. There was no evidence that medication prescription and administration sheets had been reviewed as part of this audit process. As outlined in outcome 9 here was no evidence that an action plan had been implemented to ensure issues identified by the most recent audit of medication management practice by the pharmacist were fully addressed. Further to this there was no evidence that medication drug round audits or medication competency assessments had been conducted. The actions that had been identified as being necessary to address non-compliances in outcome 9 following the inspection of the centre in August 2015 had not been

implemented fully to ensure an appropriate standard of care in medication management practices. The management system in place in the centre was ineffective in that actions necessary to address non-compliances identified in outcomes 2,7,8,9,16 and 18 had not been satisfactorily implemented. The system of staff supervision was inadequate as outlined in outcome 18. The system in place to monitor the service being provided within the centre was ineffective as reflected by the findings in outcomes 7,8,9,11,12,16 and 18.

The annual report for the centre for 2015 was made available to the inspectors. The report contained the business and development plan for the centre, details of incident and accident reporting and care quality indicators and also the training and development plan. The report did not contain reference to consultation with residents and their families as required by the regulations.

Judgment:
Non Compliant - Major

Outcome 06: Absence of the Person in charge
The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:
Governance, Leadership and Management

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

Findings:
The authority had been appropriately informed that the person in charge (director of nursing) had resigned. Information had been provided to the authority regarding the arrangements in place for management of the designated centre. The assistant director of nursing was acting as the director of nursing, with support provided by the clinical governance and operations manager and also by another senior nurse manager.

Judgment:
Compliant

Outcome 07: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe care and support

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

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

Findings:

The inspectors reviewed the aspects of this outcome that had been found to be non-compliant during the last inspection of the centre. The action plan submitted by the provider to address the identified non-compliance relating to the use of bed rails in the centre had not been satisfactorily implemented. The restraint risk assessment and processes in place for the safe appropriate use of bed rails required review.

The inspectors reviewed the restraint risk assessments completed for a number of residents with bed rails in place. This risk assessment included a review of the gap between the bed rail and the mattress side. However inspectors observed that for one resident there was a significant gap between the edge of the mattress and the bed rail when in place, which could put the resident at risk of entrapment. Nursing staff informed inspectors that wedges or other appropriate equipment were not put in place when this resident was in bed to ensure the risk of entrapment was mitigated. The inspectors observed that wedges were put in place for other residents with bed rails in place but that the wedges were not appropriately used to ensure the risk of entrapment along the entire length of the bed was reduced. Bed rail extensions were being used for a number of residents but the risk assessments completed were not sufficiently comprehensive to ensure the risks associated with the use of the bed rail extensions were being considered. The care plans in place were not sufficiently detailed to provide guidance to staff on the use of the bed rails, including the use of extensions and any equipment used to reduce the risk of entrapment. Inspectors reviewed a sample of the assessments for bed rails and found that there was not always documented evidence of the trial/consideration of alternatives to ensure the use of bed rails was in accordance with national policy. Inspectors were informed that a number of new low low beds and new mattresses suitable for use with pressure relieving mattresses had been purchased since the last inspection.

Judgment:

Non Compliant - Major

Outcome 08: Health and Safety and Risk Management

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

Theme:

Safe care and support

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

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

Findings:

The aspects of this outcome reviewed during the inspection included the non-compliances identified during the previous inspection in August 2015. All of the actions included in the action plan response submitted by the provider had not been completed. The actions not completed included the following:

- The missing persons folder had not been updated for one of the most recent admissions to the centre, even though this resident had been assessed as being at risk of absconion. There was no information in the missing persons folder for three of the residents residing in the centre on the day of the inspection. Inspectors found that the information available in the residents' profiles required review to ensure sufficient information was readily available to assist in the event of a resident going missing. The action plan response had stated that missing persons drills would be conducted on a monthly basis. There was no documentation to indicate that any missing persons drills had been conducted, and staff spoken to by the inspectors confirmed that these drills had not taken place. Staff spoken to by the inspectors were not all knowledgeable of the procedure to be followed in the event of a resident going missing. This issue had been raised at the previous inspection as there is direct access to the canal opposite the main gate of the centre. A documented system of staff checks was in place including checks of exit points and frequent checks on the residents. The risk management policy had not been updated to reflect the measures and actions in place to control the risk of the unexplained absence of any resident.
- The risk management policy and risk register did not include the measures and actions in place to control the risk of abuse. Inspectors reviewed the risk register which had been reviewed in January 2016.

Inspectors reviewed records of accidents and incidents in the centre. The person in charge was reviewing all accidents and incidents.

A system of auditing had been implemented in the centre to ensure appropriate infection control and prevention measures were in place. The audits conducted in 2015 included cleaning audits and hand hygiene audits. A number of staff had also received training in hand hygiene and infection control.

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):

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

Findings:

The inspectors reviewed the actions completed within the centre to address the non-compliances identified during the previous inspection in August 2015 and also reviewed administration practice during the morning medication administration round. The action plan submitted in response to the previously identified non-compliances had not been fully implemented in that:

- there was no evidence that management within the centre had conducted monthly audits on the prescription and administration sheets.
- there was no evidence that medication drug round audits had been conducted on a fortnightly basis
- there was no evidence that medication competency assessments had been completed for nursing staff including newly recruited nurses.

Inspectors observed nursing staff administering medicines during the morning medication administration round and noted a number of issues which did not conform with appropriate medication management practice including:

- nursing staff crushing medicines for one resident as indicated on the prescription sheet but the crushed medicines were subsequently added to a full bowl of porridge. This practice could result in the crushed medicines affecting the taste of the entire bowl of porridge, and if the resident didn't eat the entire portion the resident would not have taken the entire prescribed dose of the medicines.
- Two prescribed nutritional supplements had been unavailable for a number of days. The prescriber had not been informed or consulted regarding alternative nutritional supplements.
- Medicines were being administered from a prescription sheet which had not been signed by the prescriber within the required timeframe as specified in the centre's medication management policy. The centre had a copy of the original prescription on file.

Inspectors also observed that medication administration records for insulin were signed by staff before administration of the prescribed dose of insulin to the resident. This finding is included under outcome 11.

Medication management audits were conducted by the pharmacist on a regular basis and inspectors reviewed the most recent audit completed in February 2016. There was no evidence that an action plan had been implemented to ensure issues identified were fully addressed. This is included under outcome 2.

Judgment:

Non Compliant - Moderate

Outcome 10: Notification of Incidents

A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:

Safe care and support

<p>Outstanding requirement(s) from previous inspection(s): The action(s) required from the previous inspection were satisfactorily implemented.</p> <p>Findings: A record of all incidents occurring in the designated centre was maintained and where required notified to the chief inspector.</p>
<p>Judgment: Compliant</p>

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

Findings:
Residents had good access to general practitioner (GP) services, and GP's attended the centre on a regular basis. Residents had access to a wide range of allied health professional services including, physiotherapy, speech and language therapy, chiropody, and dietetics. Residents had also been referred to the community palliative care team to ensure appropriate pain management.

Inspectors reviewed a number of admission assessment forms and care plans. The care planning process involved the use of validated tools to assess residents' risk of falls, nutritional status, level of cognitive impairment, skin integrity and dependency levels. Inspectors noted that the assessment and care planning process had improved since the last inspection in the centre, with care plans in place for the majority of the assessed needs. However there was no nutritional care plan in place for one resident who had been assessed as being at risk of malnutrition. Inspectors found that care plans were not consistently updated to reflect recommendations made by allied health care professionals including recommendations from dieticians.

Inspectors also observed that medication administration records for insulin were signed by staff before administration of the prescribed dose of insulin to the resident.

A new handover sheet had been introduced to the centre to ensure effective transfer of

information to relevant staff regarding the residents. A new system of weekly care indicators had been introduced, that included information on residents' nutritional needs, resident specific information including residents with infections, and information on residents with issues related to skin integrity, continence, challenging behaviour, falls, end of life care and restrictive practices.

Judgment:

Non Compliant - Moderate

Outcome 12: Safe and Suitable Premises

The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

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:

The premises did not meet the requirements of regulation 17 or standard 25 of the National Quality Standards for Residential Care settings for Older People. This outcome had been found to be in major non-compliance with the regulations during the inspection of the centre in August 2015. The proposed timescale on the action plans submitted to address the non-compliances had not elapsed at the time of the inspection. Inspectors were informed that new plans had recently been drawn up with a view to extending the centre with additional bedrooms, communal space, storage and bathroom facilities.

The Croft Nursing Home is a single storey detached building situated on a quiet walkway alongside Dublin's Grand Canal. The centre was not purpose built and while currently registered to provide care for 38 residents, has 37 places due to a reconfiguration of one room. Facilities included; 10 single, 12 twin and one multi-occupancy room accommodating three residents. Six of the single rooms had en suite shower and toilet facilities. The three bedded room contained a small toilet en suite. None of the en suite toilet facilities were wheelchair and hoist accessible and were only suitable for independently mobile residents or those using walking frames with staff assistance. There were three other assisted shower rooms, two with toilets, which were wheelchair and hoist accessible. In one part of the centre nine residents had nearby access to two toilets, with the nearest shower facilities and further toilets accessible by crossing the main dining room.

There was an enclosed garden to the rear of the centre with grassy areas and safe walkways. There was also a sunny patio area with garden furniture, enclosed by old stone walls and surrounded by flower beds and a herb garden. There was some evidence of on-going maintenance and refurbishment. The centre was clean, and had suitable heating and lighting. A system of household cleaning had been implemented.

However, a number of the bedrooms required repainting. There was limited communal space available for residents, and the main communal day room was full to capacity for the majority of the day during the inspection. Information had been received by HIQA in relation to the lack of space in communal areas. Inspectors were informed that efforts were being made to ensure residents could use the other communal spaces when possible. Inspectors observed that storage facilities in the centre were inadequate to appropriately store equipment such as hoists, trolleys, chairs, and wheelchairs. On the day of the inspection two of the assisted shower rooms were being used to store equipment. Inspectors discussed the size of the proposed store room on the new proposed plans for the extension and the importance of ensuring adequate storage was available. There was no space available in the centre to store commode chairs during the day, resulting in commode chairs being present in bedrooms throughout the day and night.

The three bedded room was not suitable to meet residents' needs in terms of privacy and dignity and in ensuring the delivery of safe and suitable care. Sufficient space is required to allow safe access to residents who require use of assistive moving and handling equipment or allowing staff to provide safe assistance to residents with varying levels of dependency needs. There was limited space available for storage of personal possessions for three people and no space to enable residents bring any familiar objects of furniture from home should they wish to do so. Space and privacy would be further compromised if residents preferred to remain in their rooms and sit by their bedside. There was limited circulation space within the room for three persons. This space would be further compromised where residents using the rooms may require additional mobility aids such as walking frames, rollators, transit or powered wheelchairs.

Judgment:
Non Compliant - Major

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

Theme:
Person-centred care and support

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

Findings:

There were policies and procedures in place in the centre for end of life care, including referral to palliative care services. HIQA had received information of concern relating to the provision of end of life care in the centre. However there was no evidence found during this inspection to substantiate this information.

At the time of the inspection there were no residents receiving end of life care. The inspectors reviewed in detail the file of the most recent resident to pass away in the centre. There was evidence of the development and implementation of a palliative care plan to ensure appropriate care was provided. Nursing notes indicated regular assessment of the resident for pain and distress. The resident had been reviewed by the community palliative care team and the resident's general practitioner (GP), and the nursing staff had access to further support from the local hospice if necessary.

The inspectors reviewed a number of resident files and noted that there was no documented discussion of end of life preferences to ensure residents' wishes regarding their end of life care could be recorded to facilitate the provision of care that met their individual needs and wishes in a way that fully respected their dignity and autonomy.

Judgment:
Substantially Compliant

Outcome 16: Residents' Rights, Dignity and Consultation
Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

Theme:
Person-centred care and support

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

Findings:
The aspects of this outcome reviewed during the inspection included the non-compliances identified during the previous inspection and the action plan response submitted by the provider to address the issues identified. The action plan submitted had not been fully implemented in that at the time of the inspection there was still very limited provision of one to one individualised activities based on residents' individual interests and capacities particularly for those residents with cognitive impairment and or limited mobility.

The centre had recently employed a new activities co-ordinator to work 25 hours per week. There was an activities programme in place with activities such as baking, arts

and crafts, fitness classes, aromatherapy, Sonas and sing alongs scheduled to occur between 10am and 3pm Monday to Friday. One to one therapies were scheduled by the activities co-ordinator on a daily basis for a half hour time slot before lunchtime. There were no scheduled activities for evenings or Sundays with very limited activities planned for Saturdays. On the day of the inspection a number of residents were observed to participate in arts and crafts facilitated by the activities co-ordinator. The inspectors were informed that further dementia specific activities and more one to one activities were planned for the centre in the near future.

Interactions between staff and residents were observed to be kind, personable and respectful throughout the inspection. However good person centred practice that ensured residents' right to privacy and dignity was not observed at all times. At times some staff members were observed to stand over the resident while providing assistance with meals. Residents' privacy was not always protected and staff were observed to check blood sugar levels in communal areas. Information of concern had been received by HIQA in relation to issues compromising residents' privacy and dignity. Staff were observed to place bibs on residents before serving meals without any consultation with the residents.

Judgment:

Non Compliant - Moderate

Outcome 18: Suitable Staffing

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

Theme:

Workforce

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

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

Findings:

Inspectors found that the levels and skill mix of staff were sufficient to meet the needs of residents at the time of this inspection. However the system of staff supervision in place was not sufficient to ensure appropriate supervision of all staff.

Inspectors observed that staff on duty during the inspection were familiar with the needs of the residents, and for the majority of the time provided care in a considerate and respectful manner. However, as outlined in outcome 16 inspectors observed that

some staff stood over residents while assisting residents with their meals, and placed bibs on residents without consulting the resident. This practice had also been observed during the previous inspection in August 2015. The lack of appropriate supervision of practice was further demonstrated by the issues relating to medication management practices as outlined in outcome 9, and also by issues identified relating to the use of bed rails. Inadequate supervision of practice had been identified during the last inspection in the centre in August 2015 but the actions taken had not fully addressed the identified non-compliance.

Staff rosters were reviewed and found to reflect the nursing and care staff on duty during the inspection. The senior management in the centre consisted of the acting director of nursing and one other senior clinical nurse manager, who were both rostered to work 8-4 Monday to Friday at the time of the inspection. On the day of the inspection there were two staff nurses on duty. A number of the staff nurses had started working in the centre at the beginning of the year, and were the most senior member of staff on duty at times particularly at night and at weekends. There was an on call roster for directors of nursing within the group to provide support if necessary.

There was a staff training matrix in place to identify staff members requiring refresher mandatory training and training was scheduled to be provided as per the training calendar for 2016. Deficits in the training provided to staff had been identified during the last inspection, and the action plan response had included a list of training to be provided to staff. However there was no evidence that the all training outlined in the action plan response had been provided. There were no records available to confirm that staff had received training in pressure ulcer and wound care, training on MUST, or assessment, planning, evaluation and documentation of care training. Newly recruited staff nurses had not received training in care planning, and there was no plan in place at the time of the inspection to ensure newly recruited staff received training in the areas where deficits in training had been identified during the previous inspection. Training records confirmed that a number of staff had received training on topics including nutrition in dementia, hand hygiene and infection control as outlined in the action plan response following the inspection in August 2015. Training records also confirmed that training in 2016 had included training on elder abuse, manual handling, CPR, and fire safety training.

Inspectors reviewed a sample of the nursing staff registrations to ensure up to date registration information from the professional registration body was available.

Judgment:
Non Compliant - Moderate

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:

Jim Kee
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:	The Croft Nursing Home
Centre ID:	OSV-0000028
Date of inspection:	30/03/2016
Date of response:	03/06/2016

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 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 annual review did not contain reference to consultation with residents and their families as required by the regulations.

1. Action Required:

Under Regulation 23(e) you are required to: Prepare the review referred to in regulation 23(1)(d) in consultation with residents and their families.

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

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

The home adopts a multifaceted proactive and robust approach to addressing complaints and ascertaining the views of residents and visitors regarding service matters. Key forums include the Residents Committee which meets each month where issues/complaints/suggestions are formally documented and progressed for resolution through the Director of Nursing initially, the outcome of which is reported to the next meeting. The Relatives Information and Support Group meets on a quarterly basis with the Director and the company's Chief Executive to address any issues or suggestions which relatives may wish to raise. Both these forums are facilitated by our advocate who also provides 1-2-1 visitation to residents who may have individual service issues. Also a complaints/suggestion box is located in the main reception area. All matters raised through these various channels are progressed in accordance with the home's formal complaints policy. This is widely published throughout the home on notice boards, residents guides etc).In addition to these procedures, the company's clinical governance committee meets on a monthly basis to review: a) all complaints/ issues received by the home, b)the minutes of the above forums, c)advocacy visits and issues which residents/relatives may have raised with the advocacy services or staff. This committee serves as an additional checking mechanism to ensure compliance and full oversight and also helps with learning outcomes. The members of the senior management team also receive the aforementioned documentation for review at management meetings. The home also works with external advocates (SAGE etc) as required and their inputs are progressed through the mechanisms outlined above. Going forward we will ensure the Annual Report clearly sets out the improvements made to the home as a result of the feedback from the resident and relative forums and the work of the in-house advocate, and also ensure that any outstanding actions are included in the quality improvement plan for the year going forward. This will be included as a separate section within the Annual Report. Furthermore, a programme will be rolled out in the home to get feedback on the service through resident interviews. This will begin in September 2016. The overall report for 2016 will be available in January 2017.

Proposed Timescale: 31/01/2017

Theme:

Governance, Leadership and Management

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

The management system in place in the centre was ineffective in that actions necessary to address non-compliances identified in outcomes 2, 7,8,9,16 and 18 had not been satisfactorily implemented. The system of staff supervision was inadequate as outlined in outcome 18. The system in place to monitor the service being provided within the centre was ineffective as reflected by the findings in outcomes 7,8,9,16 and 18.

2. 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:

The home has in place sufficient resources to effectively deliver the care as outlined in the homes statement of purpose. The home has a management structure that includes the newly appointed Person in Charge, and an Assistant Director of Nursing. Nursing staff and Care staff provide direct care to residents. Nursing staff manage/oversee the care provided by the carers on a daily basis, however overall care provision in the home is the responsibility of the PIC.

Induction has been and will be provided to new staff nurses to ensure they are clear that it is their responsibility to direct the care of care assistants, and where they identify care assistants continually failing to deliver care in line with best practice that they must report this to the PIC.

The home has a comprehensive set of Policies and Procedures to guide staff in care delivery and these set out each staff members responsibility as regards a particular care area. All staff have access to the policies and are encouraged at team meetings to familiarise themselves with policies.

The PIC will carry out monthly audits and reviews of care delivery, care practice, and nursing documentation to identify gaps with the view to mentoring staff and getting them access to the appropriate training to carry out their roles effectively. Areas audited and reviewed include care plan development and documentation to cover all areas of the care plan, weight management, restraint use in the home, dependency levels, medication management. The incident accident reporting procedure and complaints reporting procedure within the home requires the PIC to review each incident/complaint whether a fall, skin issue, behavioural incident, to assure themselves that procedures have been followed. Issues identified by the PIC, following an incident review/investigation resulting from a complaint, are discussed at meetings with staff. These meetings can happen on a needs basis and may fall outside the monthly meetings to discuss the results of monthly audits and reviews that the PIC would have with their staff.

The PIC also has responsibility for ensuring that all staff are aware of the homes policies and procedures and going forward will be required to present and review key policies to staff at team meetings to get assurance that staff are familiar with them.

Another task of the PIC is to implement actions required by the provider to meet regulation and national guidelines in care delivery.

The Group Clinical Governance Team provides support to the PIC on clinical issues as well as management issues, this happens on an adhoc basis ie as issues arise, as well as formally on a quarterly basis. Its role includes, getting assurances that the care delivery and documentation is continually improving and that the management systems in the home are adequate. This team will cover the same areas as the PIC ie care planning, weight management, restraint, dependency levels and incident accident reporting to include quarterly trend analysis. Furthermore the Group advocacy manager visits the home on a monthly basis to speak to residents and leads relative meetings on

a 3 monthly basis. Actions required from these meetings are discussed with the PIC to ensure issues raised are actioned.

Proposed Timescale: 30/06/2016

Outcome 07: 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 not always documented evidence of the trial/consideration of alternatives to ensure the use of bed rails was in accordance with national policy. The risk assessment process was not sufficiently comprehensive to ensure all risks associated with the use of bed rails was considered and measures put in place to mitigate such risks.

3. 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:

A team meeting will take place with the staff nurses in the home led by the PIC and the ADON to highlight the issue re documenting in a residents care plan the trial/consideration of alternatives to ensure bed rail use is in accordance with the nursing homes policy & procedure on the use of restraint and that of national policy.

Going forward care plans will be audited by the PIC and the results of these audits discussed with staff at team meetings to improve compliance in this area and to reinforce the homes policy on restraint and the national guidelines on the promotion of a restraint free environment in the home.

Prior to use of a restraint such as bed rails it is the homes policy that a resident restraint risk assessment is carried out. This assessment provides a comprehensive assessment of the risks associated with use of for example bed rails, to include issues such as -

Are bed rails actually required?

Is the bed rail suitable for use in combination with the bed, mattress and occupant, safe fitting of the bed rail?

Safe fitting of a bed rail?

About the resident?

Again as part of the team meeting with staff nurses led by the PIC, the importance of the correct documentation & assessments around restraint and restraint use, to include the restraint risk assessment.

The nursing staff have been informed of the importance of carrying out this assessment prior to using bed rails. Again the PIC will audit the resident documentation and bring to

the attention non compliances in this area at staff meetings.

Furthermore, when bed rails are in use regular checks of the the bed rail are carried out by the carers to ensure the bed rail is safe and the resident is comfortable and not agitated. This is over seen by the staff nurses.

All bed rails in use currently have now been risk assessed to ensure appropriateness and safety. This review has been carried out by the PIC in conjunction with the Group Clinical Manager.

Proposed Timescale: 30/06/2016

Outcome 08: Health and Safety and Risk Management

Theme:

Safe care and support

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

The risk management policy did not include all the measures and actions in place to control the risk of the unexplained absence of any resident. The procedures in place to ensure this risk was appropriately managed had not been fully implemented as outlined in the action plan response in August 2015.

4. Action Required:

Under Regulation 26(1)(c)(ii) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the unexplained absence of any resident.

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

Currently the home has a comprehensive set of organizational policies and procedures used for risk management to insure that the amount of risk for the residents is as low as possible. Thus in place currently, is a general risk management policy that refers to other policies such as our absconsion policy. Within the individual policy are details of controls in place to mitigate against this risk in the home.

Going forward we will include as an appendix to our risk management policy the homes risk register. This logs all the risks that threaten the ability of the home to provide safe and effective care to residents and comply with national standards and regulations. This register will include the risk of resident absconsion and the controls in place to manage this in the home

The missing person folder has now been updated. A copy of the missing persons folder consisting of a copy of the profiles of each resident in the home will be maintained by the administrator.

A copy of the missing persons record will also be kept within each residents care plan.

Furthermore all residents will be assessed for risk of absconsion to ensure residents who are a high risk are known to staff in the home, and that the measures in place to mitigate this risk are implemented at all times.

The PIC will audit the care plans to ensure compliance with the homes policy on absconsion. Furthermore the PIC will review the missing persons folder to assure themselves it is maintained contemporaneously.

Staff will be given the opportunity to become familiar with this policy during induction/ other in-house training opportunities where they will be required to sign off that they have read and understood the policy.

Proposed Timescale: 30/06/2016

Theme:

Safe care and support

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

The risk management policy did not include the measures and actions in place to control the risk of abuse.

5. Action Required:

Under Regulation 26(1)(c)(i) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control abuse.

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

Currently the home has a comprehensive set of organizational policies and procedures used for risk management to ensure that the amount of risk for our residents is as low as possible. Thus, in place currently is a general risk management policy that refers to other policies such as our Elder Abuse policy. Within the individual policy are details of controls we have in place to mitigate against the risk.

Going forward we will include as an appendix to our risk management policy the homes risk register which logs all the risks that threaten the ability of the home to provide safe and effective care to residents and comply with national standards and regulations. This Register will include the risk of resident abuse and the controls we have in place currently to manage this.

Furthermore, all staff will take elder abuse training at periods in line with national guidelines.

Staff will be given the opportunity to become familiar with this policy during induction/ other in-house training opportunities where they will be required to sign off that they have read and understood the policy.

Outcome 09: Medication Management

Theme:

Safe care and support

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

Inspectors observed nursing staff administering medicines during the morning medication administration round and noted a number of issues which did not conform with appropriate medication management practice including:

- nursing staff crushing medicines for one resident as indicated on the prescription sheet but the crushed medicines were subsequently added to a full bowl of porridge. This practice could result in the crushed medicines affecting the taste of the entire bowl of porridge, and if the resident didn't eat the entire portion the resident would not have taken the entire prescribed dose of the medicines.
- Two prescribed nutritional supplements had been unavailable for a number of days. The prescriber had not been informed or consulted regarding alternative nutritional supplements.
- Medicines were being administered from a prescription sheet which had not been signed by the prescriber within the required timeframe as specified in the centre's medication management policy.

6. 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:

All nursing staff take medication management training, and take refresher courses at intervals in line with national guidelines. The PIC/ADON will carry out a twice weekly audit of the drug round for the next two months to eliminate the poor practices identified and get assurances staff nurses are administering medications in accordance with professional guidelines and their training. This review will continue after the two months but at less regular intervals, but at least audited monthly so that the PIC can get assurances that practice of administering medications is as per guidelines.

The stock of nutritional supplements will be managed by the Assistant Director of Nursing. The home has facility to store up to a month's supply of nutritional supplements. The ADON will carry out a monthly stock check of nutritional supplements and re-order on this basis.

The GP (prescriber) signed prescription sheets are sent to the pharmacist who provides a transcribed prescription which is use by the nursing staff to administer the medications. The transcribed prescription will reviewed each month by the PIC and ADON who will then request the GP to sign prior to administering the drugs.

Proposed Timescale: 30/06/2016

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:

Inspectors found that care plans were not consistently updated with recommendations from allied healthcare professionals.

7. 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:

The issue of not documenting recommendations made by allied health care professionals within the care plan will be raised at team meetings with staff nurses. Care Plan training has been arranged for staff nurses. This will be provided by the Group trainer and will include the importance of documenting recommendations from allied healthcare professionals within the care plan.

Documenting recommendations within the care plan will be audited by the PIC. Gaps identified by the PIC will be brought to the attention of staff nurses at team meetings with the view to improving care plans in this area.

Proposed Timescale: 30/06/2016

Theme:

Effective care and support

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

Care plans were not in place for all assessed needs.

8. 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:

It is the homes policy to have a care plan for all assessed needs of the residents in the home and within 48 hours for residents newly admitted to the home. Care plan training has been arranged in the home with the view to improving staff nurses writing of care

plans.

A team meeting led by the PIC will be had with the staff nurses to reinforce the importance of writing care plans for each assessed need and as those needs change for all residents and within 48 hours for newly admitted residents.

The PIC will carry out monthly audits of care plans to identify gaps and at team meetings bring to attention of nursing staff gaps in care plans so as to improve the overall care plans in the home.

Proposed Timescale: 30/06/2016

Theme:

Effective care and support

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

Inspectors also observed that medication administration records for insulin were signed by staff before administration of the prescribed dose of insulin to the resident.

9. 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:

All nursing staff have been provided with medication management training. The issue of signing administration records prior to administration has been raised with staff nurses. To eliminate this poor practice the PIC/ADON will observe and review the drug round twice weekly for the next two months with the view to eliminating this practice.

After the two months the PIC will continue to observe and review drug rounds on an ad-hoc basis but at least once per month to get assurances that the medication round is carried out in accordance with professional guidelines.

Proposed Timescale: 30/06/2016

Outcome 12: 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 centre does not currently meet the requirements of Regulation 17 or Standard 25

of the National Quality Standards for Residential Care settings for Older People.

- the three bedded room did not facilitate residents' privacy and dignity, and did not provide sufficient physical space to meet their needs.
- there was insufficient storage space to appropriately and safely store equipment such as hoists, trolleys, transit wheelchairs and other equipment.
- limited communal space available to residents
- a number of the bedrooms required painting
- commode chairs were stored in residents' bedrooms at all times.
- accessible toilet and shower/bath facilities were not located in close proximity to all bedrooms

10. Action Required:

Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

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

Rooms requiring painting have now been painted. Since the last inspection the Group Clinical Governance & Operations Manager has reviewed the equipment in the home removing commodes from the rooms of residents not using them. A review of medical safety equipment of the home has also been carried out to remove equipment not in use and to free up essential storage space.

A planning application has been recently submitted to Dublin City Council to extend the home to provide for further storage and bathroom facilities. This extension will also provide resident accommodation and when this accommodation become available we will look to reconfiguring the existing resident accommodation.

Currently in the home, there is a dayroom, a conservatory, a smoking room and separate dining facility. The PIC will look to encouraging greater use of the conservatory by residents and their families, through for example providing more activities for residents to do in the conservatory. The PIC will also monitor the situation to ensure staff are also managing the use of space in the home more effectively and encouraging residents and their families to make use of the conservatory.

Proposed Timescale: 31/12/2017

Outcome 14: End of Life Care

Theme:

Person-centred care and support

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

The inspectors reviewed a number of resident files and noted that there was no documented discussion of end of life preferences to ensure residents' wishes regarding their end of life care could be recorded to facilitate the provision of care that met their individual needs and wishes in a way that fully respected their dignity and autonomy.

11. Action Required:

Under Regulation 13(1)(a) you are required to: Provide appropriate care and comfort to a resident approaching end of life, which addresses the physical, emotional, social, psychological and spiritual needs of the resident concerned.

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

The care plans will be reviewed by the PIC to ensure all residents have a documented discussion of end of life preferences. This will ensure that each residents' wishes regarding their end of life care is facilitated with the provision of end of life care that meets the needs and wishes of the resident and at the same time respecting their dignity and autonomy.

The PIC will monitor the number of residents in the home that have an end of life care plan in place and will work towards ensuring all residents have such a plan in place. When a discussion is had with a resident this will be documented in the care plan.

Proposed Timescale: 30/06/2016

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

Person-centred care and support

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

Residents' right to privacy was not upheld at all times and activities such as checking blood glucose levels were performed in communal areas.

12. Action Required:

Under Regulation 09(3)(b) you are required to: Ensure that each resident may undertake personal activities in private.

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

The home has a policy "respecting the privacy & dignity of the resident". Within this policy the importance of providing care or carrying out a check such as blood glucose level, that this should be done in a respectful way and a way that does not compromise the privacy of the resident. This activity and other examinations will be carried out in a private setting going forward.

This issue has been raised with staff nurses and also the importance of recognising and respecting the resident's right to privacy and dignity. The PIC will monitor staff as to adherence to this policy, with the view to maintaining delivery of care in the home that is both respectful and maintains the privacy & dignity of our residents.

Staff nurses have also been briefed on the importance of managing the care provided by the Health Care Assistants and ensuring that such care follows procedure and is carried out in a manner that is respectful to residents. Where they identify carers who

continually fail to provide such care they must report this issue to the PIC.

Proposed Timescale: 30/06/2016

Theme:

Person-centred care and support

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

There was limited provision of one to one individualised activities based on residents' individual interests and capacities particularly for those residents with cognitive impairment and or limited mobility.

13. 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:

There is a part time activity co-ordinator in the home. With the guidance of the PIC it is their responsibility to develop the activity care plans of all residents in the home, including those residents with cognitive impairment and limited mobility.

The Group trainer is currently in the process of providing all staff in the home with Dementia training. Included as part of this training, the trainer is using the Quality of Interaction schedule and observation visits to identify areas of care delivery requiring improvement. This will include one to one interaction and how this is to be documented and delivered by the care staff and the activities co-ordinator.

Proposed Timescale: 30/08/2016

Outcome 18: Suitable Staffing

Theme:

Workforce

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

Appropriate training had not been provided to staff to ensure standards of care in all areas where non-compliances had been identified during the previous inspection were addressed. Training was required to ensure appropriate standards of care in areas such as medication management, bed rail risk assessments and national policy on restraint, and person centred care.

14. 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:

All nursing staff have taken medication management training and going forward this will be carried out at intervals in line with national guidelines.

The Group trainer will provide training on care planning, as well as communication training which will include "person centred care".

At a recent meeting of the PIC's in the Silver Stream Group led by the Clinical Governance & Operation Manager, The "Towards a Restraint free environment in nursing homes" document was reviewed and discussed along with the homes policy on restraint, and the homes forms for documenting the use of restraint. The PIC will have a number of initial team meetings to ensure all nursing staff are aware of the principles of a restraint free environment. Through the PIC's monthly audit and review of care plans and the home restraint register the PIC will identify gaps which will be brought to the attention of staff nurses, so as to reinforce proper implementation the homes policy by all staff.

Proposed Timescale: 30/06/2016

Theme:
Workforce

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

The system of staff supervision in place was not sufficient to ensure appropriate supervision of all care practices.

15. 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:

There has been a significant change in the management of the home in the last 12 months.

All new staff nurses have been given induction, to include their responsibility in managing the delivery of care by care assistants. This induction highlights the importance of using the HR process to eliminate poor practice, in that staff nurses have responsibility to bring poor practice to the attention of the PIC, where care staff continually fail to follow home protocols as regards the delivery of care.

Nursing staff are overseen and supported by the PIC/ ADON in the home on a day to day basis. Annual Appraisals are given to staff nurses with the view to identifying training needs or further professional development.

Support is also being provided to the PIC to assist with the mentoring of staff nurses. This is being provided by a member of the Group who has experience of a Person In Charge role.

Proposed Timescale: 30/06/2016