Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	Carechoice Malahide
Centre ID:	OSV-0005205
Centre address:	Mayne River Street, Northern Cross, Malahide Road, Dublin 17.
Telephone number:	01 847 5093
Email address:	paul.kingston@carechoice.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Sabatino Limited
Provider Nominee:	Paul Kingston
Lead inspector:	Jim Kee
Support inspector(s):	Sheila McKevitt
Type of inspection	Unannounced
Number of residents on the date of inspection:	76
Number of vacancies on the date of inspection:	15

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 to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
01 June 2016 09:30	01 June 2016 19:30

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

Outcome	Our Judgment
Outcome 02: Governance and Management	Non Compliant - Moderate
Outcome 06: Absence of the Person in charge	Compliant
Outcome 07: Safeguarding and Safety	Non Compliant - Moderate
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 09: Medication Management	Non Compliant - Major
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 13: Complaints procedures	Non Compliant - Moderate
Outcome 14: End of Life Care	Substantially Compliant
Outcome 15: Food and Nutrition	Non Compliant - Moderate
Outcome 18: Suitable Staffing	Non Compliant - Moderate

Summary of findings from this inspection

This report sets out the findings of an unannounced inspection of this centre. The purpose of this inspection was to monitor on-going compliance with the Health Act 2007 (Care and Welfare of Residents in Designated centres for Older People) Regulations 2013. This was the second inspection of this centre, and the first inspection since the centre had started to admit residents in November 2015. The Health Information and Quality Authority (HIQA) had also received information relating to this centre, regarding staffing and the supervision of residents, restrictive practices, end of life care, falls management and referral processes. On the day of the inspection inspectors found no evidence to substantiate the information received relating to inappropriate restrictive practices, end of life care, or falls management. Inspectors found that residents were referred to appropriate health care professionals in a timely manner. However it was found that the levels of staffing in the centre required review as outlined in outcome 18.

As part of the inspection, the two inspectors met with residents, visitors 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 75 residents residing in the centre at the time of inspection, including one resident in hospital and there were 15 vacancies. The person in charge had recently resigned, and the authority had been appropriately notified. The inspectors met with the provider nominee during the inspection, the acting director of nursing and the assistant director of nursing. Overall inspectors were satisfied with the governance and management structures in place in the centre, although the system of auditing required improvement as outlined in outcome 2.

Evidence of good practice was found across all outcomes. The outcome on absence of the person in charge was found to be compliant with the regulations. The outcome on end of life care was found to be substantially compliant.

Seven of the ten outcomes reviewed were found to be moderately non-compliant. The outcomes on governance and management, safeguarding and safety, health and social care needs, food and nutrition, the complaints procedure and health and safety and staffing were found to be moderately non-compliant.

The outcome on medication management was found to be in major non-compliance with the regulations, due to the length of time taken to complete the medication administration round on the day of the inspection, and other issues identified in relation to the prescription sheets.

The action plan at the end of the report identifies those areas where improvements were required in order to comply with the regulations. Eight 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):
No actions were required from the previous inspection.

Findings:
The management structure in the centre had changed as the person in charge (director of nursing) had recently resigned. There were two assistant directors of nursing employed in the centre, one of whom was now the acting director of nursing. There was a clearly defined management structure that identified the lines of authority and accountability, and all staff with whom inspectors spoke knew the reporting structure within the centre. The acting director of nursing was supported by the assistant director of nursing, and five clinical nurse managers, and one general services manager. Inspectors were informed that the clinical director for the group had also resigned. On the day of the inspection the inspectors were introduced to the newly recruited person in charge, who was due to commence working in the centre on a full time basis at the end of June 2016. Inspectors were also introduced to the newly recruited group director of care, quality and standards who was due to commence working on a full time basis in August 2016. There was a management support team in place within the group to support the person in charge. This support team included the chief executive officer of the company, who was also the provider nominee. The team also included the director of care, quality and standards, finance director, head of human resources, and facilities and development manager. The provider nominee informed inspectors that there were weekly management meetings in the centre involving the person in charge, assistant directors of nursing, provider nominee (CEO) and the finance director, head of human resources, and the facilities manager. Clinical meetings involving the director of nursing, assistant director of nursing and the clinical nurse managers were also held. Inspectors discussed the importance of allowing senior management of the centre including the newly recruited person in charge and director of care, quality and standards time to implement a strong effective system of governance in the centre.

Audits were conducted in a number of different areas including medication management, care planning, manual handling, nutrition, falls and health and safety.

However the audits conducted did not consistently involve the use of evidence based audit tools, and did not consistently identify actions necessary to address identified deficiencies. The standard of the audits conducted varied with evidence of effective auditing in the areas of falls, while audits in other areas such as care planning required review. The inspectors were informed that there were plans to adopt new auditing tools. The auditing process including the auditing schedule needed improvement to ensure effective monitoring of the service being provided.

Judgment:
Non Compliant - Moderate

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:
HIQA 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. One of the assistant directors of nursing was acting as the director of nursing, with support provided by the second assistant director of nursing.

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):
No actions were required from the previous inspection.

Findings:
There was a policy in place outlining procedures to be followed for the prevention,

detection and response to abuse within the centre. Access to the centre was monitored by the receptionist on duty during the day, and a visitors book was maintained. Staff spoken to by the inspectors stated that they had received training on elder abuse, and were knowledgeable of the reporting procedure in place and of possible indicators of elder abuse. However, staff training records reviewed by the inspectors indicated that a significant number of staff (13 staff) had not received training on elder abuse. This was discussed during the feedback meeting held at the end of the inspection, and the inspectors received assurance from management of the centre after the inspection that training for staff would be provided in a timely manner. Residents spoken to by the inspector had no concerns regarding their safety in the centre.

All bedrooms had a lockable drawer available in the wardrobe for residents to secure any valuables. There was a policy in place on residents' personal property, finances and possessions. There was a system in place to store cash and other valuables for residents if required, and appropriate records were maintained, including a system of double signing to ensure all finances were fully accounted for.

There was a policy available on the management of responsive behaviours. Inspectors reviewed a sample of the care plans in place for mood and behaviour. The care plans were not consistently sufficiently comprehensive to guide care in that there was not sufficient information included regarding triggers and interventions to manage responsive behaviours. In some cases the care plans did reference the administration of PRN (as required) psychotropic medicines, but the care plan did not provide an appropriate overall management strategy including the use of non-pharmacological interventions to ensure these medicines were not being used in a restrictive manner. There were not always care plans in place for residents who could at times exhibit responsive behaviours, to ensure appropriate consistent management. This finding is included under outcome 11.

The use of physical restraints such as bed rails were monitored in the centre. Inspectors reviewed a sample of the documentation in place relating to the use of bed rails. Review of the assessments, care plans and associated documents indicated that less restrictive alternatives such as crash mats, alarms and bed position were trialled/considered before bed rails were used.

Judgment:
Non Compliant - Moderate

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):
No actions were required from the previous inspection.

Findings:

Inspectors found that there were policies and procedures in place for risk management, emergency planning and health and safety within the centre. However, practices related to fire drills and the provision of fire safety training required improvement.

There was a risk management policy in place and an associated risk register that met the requirements of regulation 26 including the measures and actions in place to control resident abuse, challenging behaviour, absconsion, self harm, accidental injury and aggression and violence. There was an emergency plan in place that outlined the evacuation of residents to arranged accommodation in a local hotel and also to another nursing home in the area.

There were policies in place relating to infection control and hand sanitising dispensers were located throughout the centre.

Fire evacuation instructions were clearly displayed throughout the centre. The records showed that there was regular servicing of the fire detection and alarm system, the fire equipment, and the emergency lighting system. A documented system of in-house checks relating to fire safety was also in place including daily inspection of the escape routes and fire alarm panels, weekly visual checks of the emergency lighting, and weekly alarm activation and closing of all fire doors. Fire drills were conducted in the centre but the documentation of these fire evacuation drills was not adequate to provide assurances that all staff had rehearsed the evacuation of a compartment under simulated night time conditions, in response to identified scenarios. There was no evidence that any issues arising during these fire drills were recorded including the timing of drills, with action plans to address any identified issues to ensure a compartment could be evacuated in a timely manner. Review of staff training records indicated that nine staff had yet to receive fire training. Fire safety training had been scheduled on a regular basis, including three dates in May 2016 and fire safety training was taking place on the day of the inspection.

Inspectors reviewed a sample of the accident and incident reports and it was evident that accidents and incidents were appropriately reviewed and measures put in place to prevent recurrence were possible. HIQA had received information regarding the management of falls in the centre. However during the inspection inspectors found no evidence that falls were not being appropriately managed. Falls prevention and management meetings were held on a monthly basis to discuss all falls, with learning outcomes and any necessary actions identified. The centre had employed a full time chartered physiotherapist who organised these meetings and completed post fall assessments of residents. The physiotherapist was also involved in providing manual handling training to staff. Four staff had been identified as having outstanding manual handling training on the day of the inspection.

Judgment:
Non Compliant - Moderate

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

Theme:
Safe care and support

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

Findings:
The inspectors reviewed the practices and documentation in place relating to medication management in the centre. The centre had operational policies relating to the ordering, prescribing, storage and administration of medicines. Medicines were supplied to the centre by a retail pharmacy business in a monitored dosage system were appropriate. All medicines were stored securely within the centre, and fridges were available for all medicines or prescribed nutritional supplements that required refrigeration, and the temperature of these fridges were monitored. All controlled (MDA) medicines were stored in secure cabinets, and a register of these medicines was maintained with the stock balances checked and signed by nursing staff at the end of each shift. Dates of opening were marked on the prescribed eye drops, liquid medicines and nutritional supplements reviewed by the inspectors.

The inspectors reviewed the processes in place for administration of medicines, and observed nursing staff administering medicines during the morning medication administration rounds. Nursing staff were knowledgeable regarding residents' individual medication requirements and were observed to administer medicines in a safe person centred manner. However medicines prescribed for administration at 8.30am were observed to be administered outside the prescribed time frame, with medicines prescribed for administration at 8.30am administered over two and a half hours later on one floor, and up to three and a half hours later on another floor. The medicines were being recorded as administered at 8.30am. The length of time taken to administer the medicines meant that there was the potential for medicines to be administered without the required time interval between subsequent doses. Inspectors observed that nursing staff were interrupted on numerous occasions during the medication administration rounds to assist residents. There were procedures in place for the handling and disposal of unused and out of date medicines.

The inspectors reviewed a number of the prescription and administration sheets and identified the following issues that did not conform with appropriate medication management practice:
- A number of residents required their medicines to be crushed prior to administration and there was a system in place to indicate the authorisation to crush each individual medicine on the prescription sheet. However it was not always clear which medicines were authorised for crushing and for some residents the prescription sheet indicated that crushing was necessary but nursing staff reported that the resident did not require their medicines to be crushed.
-The prescribed frequency of administration was not clearly indicated on the prescription sheet for all medicines and in some cases only the times for administration were ticked (the prescription did not consistently indicate if the medicine was to be administered once daily or twice daily)
-The maximum daily dosage for PRN (as required) medicines was not consistently

indicated on the prescription sheet.
-There were no indications on all PRN (as required) medicines to indicate the circumstances in which these medicines were to be administered to ensure consistent administration practice by staff.
-In some cases residents had been prescribed more than one psychotropic medicine on a PRN (as required) basis but the prescription sheet did not indicate when the medicines were to be used or which medicine was to administered first. There were no protocols in place as part of behaviour support plans or care plans to guide practice to ensure appropriate consistent administration.

The pharmacist was facilitated to meet his or her obligations to residents and conducted audits of medicines management in the centre.

There were systems in place within the centre for reviewing and monitoring medication management practices, including internal medication management audits. Audits were also conducted on the use of psychotropic and analgesic medicines in the centre. Medication related incidents including medication errors were recorded within the centre, and the incident forms reviewed contained follow up actions. At the feedback meeting held at the end of the inspection the inspectors discussed the importance of periodically reviewing all medication related incidents to facilitate identification of any trends. Inspectors reviewed a sample of the medication management competency assessments, and records of on-line medication management training completed by nursing staff.

Judgment:
Non Compliant - Major

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):
No actions were required from the previous inspection.

Findings:
The inspectors were satisfied that each resident's wellbeing and welfare was maintained by an appropriate standard of nursing care, medical and allied health care. However care plans were not always in place for all residents' assessed needs, or updated to reflect all recommendations from allied heath care professionals. The care being provided to residents including activities of daily living were not being recorded in a

timely manner to ensure accurateness.

Residents' needs were comprehensively assessed on admission and regularly assessed thereafter. The assessed needs were set out in individual care plans. The inspectors found that overall the care plans were of a good standard and directed care in a person centred manner. However care plans were not always in place for all residents' needs including management of responsive behaviours as outlined in outcome 7. Inspectors also found that care plans were not consistently updated with all recommendations following review by an allied healthcare professional such as speech and language therapists.

Residents had good access to general practitioner (GP) services, and GP's attended the centre on a regular basis. Residents had access to a range of allied health professionals including physiotherapists, occupational therapists, chiropodists, speech and language therapists and dieticians. Residents also had access to tissue viability specialist nurses and to services such as psychiatry of old age. HIQA had received information relating to referral procedures in the centre, but during this inspection inspectors found that residents were referred in a timely manner when necessary.

Inspectors reviewed records maintained by staff of records of activities of daily living which included details of assistance with personal hygiene. These records were not being maintained contemporaneously to provide assurance as to the actual care and assistance provided.

There was an activities programme in place in the centre and inspectors observed that residents were encouraged to participate in this programme by staff.

Judgment:
Non Compliant - Moderate

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

Theme:
Person-centred care and support

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

Findings:
Inspectors reviewed the centre's complaints policy and procedures. The complaints process was on display in the reception area of the centre, and information on complaints was included in the residents' guide which was provided to each resident on admission to the centre. The complaints process was not on display in any other area of the centre. The complaints policy did not include contact details for the person nominated to deal with complaints (the director of nursing), or the person nominated to ensure all complaints are appropriately responded to and appropriate records

maintained. The complaints policy stated that the company directors were the nominated persons but one director had not been designated as the nominated person responsible for this role.

The inspectors reviewed all the complaints on file since the centre had opened. The outcome of the complaint and the satisfaction of the resident were documented for all closed complaints. Inspectors were informed that meetings facilitated by an independent advocacy service had been arranged to ensure complaints could be resolved. However staff knowledge regarding the management of complaints was inconsistent. Staff spoken to by the inspectors could not confirm if all verbal complaints were documented, and stated that some resident 'concerns' were recorded on the care planning and assessment software. Complaints books were maintained on each floor of the centre.

Inspectors formed the view that the management of complaints in the centre required improvement. Staff knowledge regarding the definition and management of complaints, including appropriate recording required review to ensure consistent practice.

Judgment:
Non Compliant - Moderate

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 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 a number of residents' files and noted that for a number of residents there was no documented discussion of end of life preferences to ensure residents' wishes regarding their end of life care could be recorded. The assessments reviewed did not consistently include sufficient information regarding residents' end of life wishes. There were end of life care plans in place for a number of residents and those reviewed by the inspectors were personalised and sufficiently detailed to ensure that the provision of care would meet their individual needs and wishes in a way that fully respected their dignity and autonomy.

Judgment:
Substantially Compliant

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

Theme:
Person-centred care and support

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

Findings:
There were separate dining areas on each floor in the centre. Inspectors were present in two of the dining areas of the centre while lunch was being served to residents. Residents were offered a choice of main courses, and there was a system in place to ensure those residents who required modified consistency diets were also offered choice. Nursing and care staff monitored and provided assistance to residents in a discreet and appropriate manner when required. There were menus on the tables in the dining areas displaying the menu for the day. Inspectors noted that there was the potential for confusion regarding the choices for each meal time and this was discussed at the feedback meeting held at the end of the inspection. Inspectors observed drinks including tea and coffee, and snacks being offered to residents between breakfast and lunch.

The centre used a screening tool to identify residents at risk of malnutrition, and referrals were made to the dietician if necessary. Staff spoken to by the inspectors were knowledgeable with regard to residents' special dietary requirements, and those residents who had been assessed as requiring a modified consistency diet. A record of these requirements was maintained in the centre on each floor and included in the staff allocation sheet. Inspectors found that the food and fluid section of this sheet was not always updated to ensure it reflected the recommendations of allied healthcare professionals such as dieticians. Two residents had been reviewed by the dietician, who had recommended that the residents received a fortified diet, with snacks offered on a regular basis . However the staff allocation sheet did not contain this information to ensure all staff were aware of these recommendations.

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):
No actions were required from the previous inspection.

Findings:
Inspectors observed that staff on duty during the inspection were familiar with the needs of the residents, and provided care in a considerate and respectful manner. A number of the residents with whom inspectors spoke were complimentary of the care provided by staff working in the centre. However residents did report that staff levels were insufficient at times. Residents had also raised the issue of insufficient staffing levels at the residents' committee meeting held in May 2016.

Staff rosters were reviewed and found to reflect the nursing and care staff on duty during the inspection. Review of the rosters for a two week period at the end of May 2016 indicated that the level of nursing staff varied on the floors. On the second floor over the two week period there had been two nurses on duty each day, with no supernumerary clinical nurse manager on duty. Inspectors observed that staff on this floor were very busy, as new residents were being admitted to this floor. The staffing levels on this floor required review as evidenced by:
-Nursing staff were observed to be interrupted during the medication administration round to assist residents as no other staff were available (as outlined in outcome 9). The morning medication administration round was observed to take over three and a half hours to complete on the day of the inspection.
-Records relating to the provision of personal care and other activities of daily living had not been recorded contemporaneously as outlined in outcome 11.
Inspectors were informed that a number of staff had resigned, and that a number of staff had also been on sick leave recently. Agency staff were recruited to work in the centre to cover shifts, but in some cases agency staff were not available. Recruitment was on-going and inspectors were shown emails confirming that a number of new staff had been recruited.

There was a staff training matrix in place to identify staff members training needs. However the system in place to ensure all newly recruited members of staff received all appropriate training particularly mandatory training required review. Newly recruited staff members were working on the floors with residents without having completed mandatory training such as elder abuse (as outlined in outcome 7). There were also a number of staff who had not received fire training (nine staff), and manual handling training including instruction on the use of the hoists (four staff).

Inspectors reviewed a sample of the nursing staff registrations to ensure up to date registration information from the professional registration body was available. Inspectors reviewed a sample of staff files, all of which contained the documents specified in

schedule 2 of the regulations, including references and vetting disclosures (or signed declarations for those members of staff awaiting Garda clearance). The files reviewed also contained appraisals, which were conducted as part of the system to ensure staff were appropriately supervised. Staff meetings were also held on each of the floors.
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

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

Provider's response to inspection report[1]

Centre name:	Carechoice Malahide
Centre ID:	OSV-0005205
Date of inspection:	01/06/2016
Date of response:	02/08/2016

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 auditing system in place was not appropriate to ensure effective monitoring of the service being provided.

1. 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

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

monitored.

Please state the actions you have taken or are planning to take:
The Director of Nursing has put in place a Mandatory Audit schedule for 2016. The audits are the following :

Weekly Restraint Audit.
Monthly Infection Control Audit
Monthly Drug Kardex Audit.
Monthly Medication administration Audit.
Monthly Hand Hygiene Audit
Monthly Psychotropic and Antibiotic audit. (Use of PRN Psychotropic Medication audit weekly)
Monthly Complaints audit.
Weekly Skin Integrity Audit.
Weekly falls Audit.

These audits will be carried out by the CNM and ADON in the first week of the month .The findings will then be review at the Clinical Governance meeting, headed by the Director of Nursing and an action plan put in place.

Proposed Timescale: 14/07/2016

Outcome 07: Safeguarding and Safety

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The care plans in place relating to the management of responsive behaviours were not consistently sufficiently comprehensive to guide care in that there was not sufficient information included regarding triggers and interventions to manage responsive behaviours. Care plans did not provide an appropriate overall management strategy including the use of non-pharmacological interventions to ensure that psychotropic PRN (as required) medicines were not being used in a restrictive manner.

2. Action Required:
Under Regulation 07(2) you are required to: Manage and respond to behaviour that is challenging or poses a risk to the resident concerned or to other persons, in so far as possible, in a manner that is not restrictive.

Please state the actions you have taken or are planning to take:
The ADON and CNM have reviewed all care plans for residents with challenging behaviour .The care plans are reflective of triggers and interventions and all guide the nurses in the overall management strategy which includes the use of non – pharmalogical interventions as a first step.
The use of psychotropic medication is documented in the care plan as a last resort and

nurses will give rationale as to the need to administer in the nursing narrative notes. The audit of the PRN Psychotropic medication usage is also in place weekly and review by the Director of Nursing and the clinical governance committee

Proposed Timescale: 14/07/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Staff training records reviewed by the inspectors indicated that a significant number of staff had not received training on elder abuse.

3. Action Required:
Under Regulation 08(2) you are required to: Ensure staff are trained in the detection and prevention of and responses to abuse.

Please state the actions you have taken or are planning to take:
All Staff completed their Elder Abuse training by 6th June 2016. Elder Abuse training is scheduled for all new employees as part of their 3 day induction training. The ADONs are responsible for ensuring all employees receive training as part of their induction. This will be reviewed at the Weekly Senior Management Team meetings.

Proposed Timescale: 06/06/2016

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:
Fire drill practice was not adequate to provide assurances that all staff had rehearsed the evacuation of a compartment under simulated night time conditions, in response to identified scenarios, and that any issues arising during these fire drills was recorded with action plans to address any identified issues to ensure a compartment could be evacuated in a timely manner.

4. Action Required:
Under Regulation 28(1)(e) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and residents are aware of the procedure to be followed in the case of fire.

Please state the actions you have taken or are planning to take:
All Staff have received Fire Training from the Carechoice external Fire safety consultant.

A day shift fire evacuation drill has been completed by the external fire training consultant.
A night simulation evacuation drill is scheduled for the 13th of July 2016.
A simulated evacuation fire drill will be carried out quarterly for both day and night duty staff.

Residents and families will be regularly updated of the procedures to be followed in the event of a fire at the monthly residents meeting.

Proposed Timescale: 28/07/2016

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:
Medicines prescribed for administration at 8.30am were administered outside the prescribed time frame, over two and a half hours later on one floor, and up to three and a half hours later on another floor. The medicines were being recorded as administered at 8.30am. The length of time taken to administer the medicines meant that there was the potential for medicines to be administered without the required time interval between subsequent doses.

The following issues did not conform with appropriate medicines management practice:
- A number of residents required their medicines to be crushed prior to administration and there was a system in place to indicate the authorisation to crush each individual medicine on the prescription sheet. However it was not always clear which medicines were authorised for crushing and for some residents the prescription sheet indicated that crushing was necessary but nursing staff reported that the resident did not require their medicines to be crushed.
-The prescribed frequency of administration was not clearly indicated on the prescription sheet for all medicines and in some cases only the times for administration were ticked (the prescription did not consistently indicate if the medicine was to be administered once daily or twice daily)
-The maximum daily dosage for PRN (as required) medicines was not consistently indicated on the prescription sheet.
-There were no indications on all PRN (as required) medicines to indicate the circumstances in which these medicines were to be administered to ensure consistent administration practice by staff.

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 significant review was immediately undertaken post the inspection in relation to Medication administration. The following actions were immediately undertaken;
1. Medication rounds are audited monthly for time management, to ensure timely completion and to understand and rectify reasons for delays. The results of these audits are reviewed by Nurse management as part of the clinical governance meetings
2. All Nurses now completing their medication rounds within the administration guidelines.
3. Should there be an incident on the floor which may significantly interfere with medication rounds, the ADONs/CNMs will assist on the relevant floor.

In partnership with the pharmacist and GP review of crushed medications has been completed and a new column inserted into the drug cardex for the GP to sign same
The prescribed frequency for administration has now been completed on each cardex.
The maximum daily dosage for PRN is now indicated appropriately
The indications for all PRN medications has been completed to include which PRN is first choice.
The medication audit will be carried out monthly by CNM and ADON and discussed at clinical governance meeting and an action plan developed.
The pharmacy will also be auditing monthly and will feed back these audit result to the Director of Nursing.

Proposed Timescale: 30/07/2016

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:
Care plans were not always in place for all residents' needs. Care plans were not consistently updated with all recommendations following review by an allied healthcare professional,

6. 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:
All care plans have been updated to reflect all recommendations following allied healthcare review.

Care plans will be audited monthly by CNMs to ensure a high standard of care planning and communication is maintained between the Allied Healthcare professionals and the care team. These audits will form part of the agenda for the clinical governance meetings.

When a resident is admitted to Carechoice , the CNM will ensure the admitting nurse has guarded time to ensure the residents assessments and care plan is in place within the 48hrs as set out in the homes policy .

Resident admissions are planned and a comprehensive pre-assessment carried out to assist the nurses in the care –planning process.

Proposed Timescale: 22/07/2016

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Records of activities of daily living including assistance and provision of personal hygiene were not being recorded contemporaneously to provide assurance that the appropriate care was being provided.

7. 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:
Training has now been completed on Epic touch which is now live. Ongoing daily and weekly audits by RNs and CNMs will be conducted to ensure all records are recorded contemporaneously. Again these audits will form part of the agenda for the clinical governance meetings.

Proposed Timescale: 30/09/2016

Outcome 13: Complaints procedures

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The complaints process was on display in the reception area of the centre but not in a prominent position.

8. Action Required:
Under Regulation 34(1)(b) you are required to: Display a copy of the complaints procedure in a prominent position in the designated centre.

Please state the actions you have taken or are planning to take:
Complaints procedure is now displayed in a prominent position on each floor.

Proposed Timescale: 07/07/2016

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The management of complaints in the centre was not consistent to ensure records of all complaints were maintained.

9. Action Required:
Under Regulation 34(1)(f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.

Please state the actions you have taken or are planning to take:
A new complaints/concerns book has been placed on each floor. The complaints will go to the Director of Nursing and a complaints log and audit will be managed by her, Audits will be undertaken on a weekly basis initially to ensure all complaints/concerns are addressed in a timely manner and in line with Carechoice policy.
All staff have received training in the complaints policy and procedure.

Proposed Timescale: 07/07/2016

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was not a nominated named person available in the centre to ensure all complaints were appropriately responded to with the specified records maintained.

10. Action Required:
Under Regulation 34(3) you are required to: Nominate a person, other than the person nominated in Regulation 34 (1)(c), to be available in a designated centre to ensure that all complaints are appropriately responded to and that the person nominated under Regulation 34 (1)(c) maintains the records specified under in Regulation 34 (1)(f).

Please state the actions you have taken or are planning to take:
Ms. Anne O'Loughlin, Senior Social Worker for Safeguard and Protection of the older

person has been nominated as the independent person to ensure all complaints are appropriately responded to. All appropriate documentation has been updated to reflect same. Ms .O'Loughlin will review policy, procedure and out comes every 6 months as an independent auditor.

Proposed Timescale: 07/07/2016

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 comprehensive assessment of residents' end of life wishes or no consistently 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:
Please state the actions you have taken or are planning to take:
1. A review of the current documentation was carried out.
2. Resident's assessments are up to date and reflective of their end of life wishes.
3. The Director of Nursing will ensure that both residents and their families are supported in the advanced care planning process.
4. The above will form part of the monthly audit of Care Plan

Proposed Timescale: 30/07/2016

Outcome 15: Food and Nutrition

Theme:
Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The system in place to ensure all staff were aware of the recommendations of allied healthcare professional including dieticians was not adequate to ensure that recommendations such as fortification of food was implemented in a consistent manner.

12. Action Required:

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

Please state the actions you have taken or are planning to take:
The CNM and staff nurses have robust system in place to ensure that when an allied healthcare professional has documented a change to resident's diet, it is then reflected in the residents nursing care plan.

An updated communication format has been put in place in partnership with the Catering department so that any changes are reflected immediately and consistently. A monthly audit will be carried out to ensure the above is working by the CNMs.

The residents with dietary or weight issues will be discussed at the clinical governance meeting monthly.
The Director of Nursing has requested a Dietetic review of all residents on Nutritional supplements or modified diet.

Proposed Timescale: 29/07/2016

Outcome 18: Suitable Staffing

Theme:
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Staffing levels in the centre were not appropriate having regard for the needs of the residents and the fact that the centre was a new centre, with new staff, new residents and admitting up to four residents per week.

13. Action Required:
Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

Please state the actions you have taken or are planning to take:
The Register Provider and the Director of Nursing have reviewed the staff to resident ratio based on the dependency levels of the residents on each floor and are comfortable that appropriate staffing levels are in place to deliver excellent person centred care.

The staffing levels on each floor will be reviewed on a weekly basis or as needs require by the Clinical Governance Team, led by the Director of Nursing.

The HR department in conjunction with the Director of nursing have aggressively recruited Nurses and Healthcare Assistance.
An in-house relief panel is being extended to cover sickness and holidays.

On the day of inspection, we had 5 Staff Nurses/CNM on duty leading the care of our 76 residents.

Our new experienced Director of Nursing is commencing in post on June 29th and will lead our team in the continued delivery of excellent care to our residents.

Proposed Timescale: 24/07/2016

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The system in place to ensure all newly recruited members of staff received all appropriate training particularly mandatory training was not adequate.

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:
A system is in place to ensure all newly recruited staff members receive all appropriate mandatory training during induction. This will be audited on a weekly basis to ensure all mandatory training is delivered and will be reviewed by the ADONs and DON.

Proposed Timescale: 31/07/2016