

Health Information and Quality Authority
Social Services Inspectorate

Registration Inspection report
Designated Centres under Health Act
2007



Centre name:	Gascoigne House Nursing Home
Centre ID:	0038
Centre address:	37/39 Cowper Road
	Rathmines
	Dublin 6
Telephone number:	01 4066414
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Email address:	ctuliao@cowpercare.ie
Type of centre:	<input checked="" type="checkbox"/> Private <input type="checkbox"/> Voluntary <input type="checkbox"/> Public
Registered provider:	Cowper Care Centre Limited
Person authorised to act on behalf of the provider:	Seamus Shields
Person in charge:	Cheryl Tuliao
Date of inspection:	26 October 2011
Time inspection took place:	Start: 09:00 hrs Completion: 18:30 hrs
Lead inspector:	Fiona Whyte
Support inspector:	Mary O'Donnell
Type of inspection:	<input checked="" type="checkbox"/> Registration <input checked="" type="checkbox"/> Announced <input type="checkbox"/> Unannounced

About registration

The purpose of regulation is to protect vulnerable people of any age who are receiving residential care services. Regulation gives confidence to the public that people receiving care and support in a designated centre are receiving a good, safe, service. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected.

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.

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.

As part of the registration process, the provider must satisfy the Chief Inspector that s/he is fit to provide the service and that the service is in compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centre for Older People) Regulations 2009 (as amended).

In regulating entry into service provision, the Authority is fulfilling an important duty under section 41 of the Health Act 2007. Part of this regulatory duty is a statutory discretion to refuse registration if the Authority is not satisfied about a provider's fitness to provide services, or the fitness of any other person involved in the management of a centre. The registration process confirms publicly and openly that registered providers are, in the terminology of the law, "fit persons" and are legally permitted to provide that service.

Other elements of the process designed to assess the provider's fitness include, but are not limited to: the information provided in the application to register, the Fit Person self-assessment, the Fit Person interviews, findings from previous inspections and the provider's capacity to implement any actions as a result of inspection.

Following the assessment of these elements, a recommendation will be made by inspectors to the Chief Inspector. Therefore, at the time of writing this report, a decision has not yet been made in relation to the registration of the named service.

The findings of the registration inspection are set out under eighteen outcome statements. These outcomes set out what is expected in designated centres and are based on the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended); the *National Quality Standards for Residential Care Settings for Older People in Ireland*. Resident's comments are found throughout the report.

The registration inspection report is available to residents, relatives, providers and members of the public, and is published on www.hiqa.ie in keeping with the Authority's values of openness and transparency.

About the centre

Location of centre and description of services and premises

Gascoigne House Nursing Home is a purpose-built single-storey building. It is located on private grounds in a residential area between Rathmines and Rathgar villages on the south side of Dublin city. It has accommodation for 44 people providing residential, convalescence, palliative, respite and dementia care. There is a twelve-bedded secure unit specifically for the care of people with dementia.

The main entrance hall is to the front of the building and access throughout the centre is by a swipe card system. Administration offices are located just off the entrance hall which in turn leads into an open-plan communal area consisting of a sitting area, a large dining area, two assisted toilets, nurses' station and office.

There are five sitting rooms, two dining rooms, a hair salon and a prayer room. There is a large kitchen with servery adjacent to the dining room. There is also a laundry on site.

There are three wings leading from the open-plan communal area to the bedroom accommodation. There are 30 single rooms, four twin rooms and two three-bedded rooms, all of which have en suite toilet, wash-hand basin and shower facilities. Each wing has a small sitting room and a sluice room. There are six additional assisted toilets and three assisted bathrooms with shower and bath.

There is an on site day-care facility providing care for up to 12 residents from the local area.

There are two gardens one of which is accessed from the secure dementia unit and the second from the main dining/sitting room area. There is ample car parking on site for visitors and staff.

Date centre was first established:			1 August 2000	
Number of residents on the date of inspection:			43	
Number of vacancies on the date of inspection:			1	
Dependency level of current residents as provided by the centre:	Max	High	Medium	Low
Number of residents	16	9	10	8
Gender of residents			Male (✓)	Female (✓)
			7	36

Management structure

The Provider is Cowper Care Centre Limited and Seamus Shields is the Chief Executive Officer and named person on behalf of the Provider. The Person in Charge is Cheryl Tuliao who is also the Person in Charge for the two other centres within the Cowper Care Group. The General Manager is Guy Kilroy and both the Person in Charge and the General Manager report to the Provider. There is a full time Care Manager, Catherine Shine, who is responsible for the day-to-day clinical governance and she reports to the Person in Charge. Nurses and care assistants report to the Care Manager. The catering and housekeeping staff report to a Services Manager who in turn reports to the General Manager. The administrator reports to the General Manager.

Summary of compliance with Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

This report set out the findings of a registration inspection, which took place following an application to the Health Information and Quality Authority for registration under Section 48 of the Health Act, 2007.

Inspectors met with residents, relatives, and staff members over the one day inspection. Inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files. Separate fit person interviews were carried out with the provider and the person in charge, both of whom had completed the fit person self-assessment document in advance of the inspection. This was reviewed by inspectors, along with all the information provided in the registration application form and supporting documentation. A fit person interview was also carried out with the care manager.

The provider had systems in place to support strong clinical governance and both the provider and person in charge demonstrated their knowledge of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*. While areas for improvement were identified, overall inspectors found that the provider and person in charge met the requirements of the Regulations and had established good management and leadership processes.

There was evidence of good practice in all areas. The provider, person in charge and staff demonstrated a comprehensive knowledge of residents' needs, their likes, dislikes and preferences. Staff and residents knew each other well, referring to each other by first names. Residents were observed to be relaxed and comfortable when conversing with staff.

The health needs of residents were met. Residents had access to medical cover, to a range of other health services and evidence based nursing care was provided. Care plans were in place, the process and documentation was regularly reviewed and there was evidence of resident and relative involvement.

The provider and the person in charge promoted the safety of residents. Staff had received training and were knowledgeable about the prevention of elder abuse. Fire precautions such as fire drills, fire training for staff and servicing of equipment were in place.

Improvements were required in risk assessments, wound care and maintaining the privacy and dignity of all residents. There was also a need to review staffing levels.

Areas for improvement are discussed further in the report and are included in the Action Plan at the end of the report.

Section 50 (1) (b) of the Health Act 2007

Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

1. Statement of purpose and quality management

Outcome 1

There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the statement of purpose, and the manner in which care is provided, reflect the diverse needs of residents.

References:

Regulation 5: Statement of Purpose

Standard 28: Purpose and Function

Inspection findings

Inspectors were satisfied that the statement of purpose accurately described the service that was provided in the centre and met the requirements of Schedule 1 of the Regulations.

As described in the statement of purpose, inspectors noted that the centre was owned and operated by a not-for-profit body with charitable status and the sole objective was to assist residents in achieving the best quality of life by offering an environment that facilitated living and dying with dignity. Inspectors observed that the service's capacity to meet the diverse needs of residents, as outlined in the statement of purpose, was reflected in practice.

The statement was kept under review by the provider and was made available to residents on admission, and following review.

Outcome 2

The quality of care and experience of the residents are monitored and developed on an ongoing basis.

References:

Regulation 35: Review of Quality and Safety of Care and Quality of Life
Standard 30: Quality Assurance and Continuous Improvement

Inspection findings

Inspectors were satisfied that the quality of care and experience of the residents were monitored and developed on an ongoing basis.

The person in charge had a robust system in place to gather and audit both clinical and non-clinical information to identify possible trends and for the purpose of improving the quality of service and safety of residents. Information was gathered on areas such as falls, medication management, accidents and incidents, weight loss, pressure sores, restraint, hospital admissions, infections, complaints and privacy and dignity. Inspectors read where the results of audits were used to improve practice and outcomes for residents. For example, it was noted that there were no medication errors in 2011 and that following a review of privacy and dignity practices a recommendation was made that the general practitioner (GP) would not examine residents in communal areas, instead residents would be examined privately in the treatment room or in their bedrooms.

The care managers from each of the three centres carried out an unannounced night inspection of the other centres to monitor and audit the practices. This inspection focussed on such areas as staffing levels, staff knowledge relating to fire and evacuation procedures and response times to call bells. There was definite evidence of action plans put in place to improve the quality of the service. For example, it was noted that laundry was being done by care assistants at night and this took up a lot of staff time, this practice had ceased and care assistants were now responsible for care delivery only.

Inspectors felt that improvements could be further enhanced if information was audited and trends identified more frequently. Currently the information was being analysed on an annual basis.

Outcome 3

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

References:

Regulation 39: Complaints Procedures
Standard 6: Complaints

Inspection findings

Inspectors found evidence of good complaints management. The management team had a positive attitude to receiving complaints and considered them a means of learning and improving the service. The provider had ultimate responsibility for complaints management including investigation and resolution.

The complaints procedure was accessible and clearly displayed. It outlined the name of the complaints officer and the independent appeals process. Residents and relatives said that they would be able to make a complaint should the need arise - some said they would approach the person in charge and others referenced the nursing staff. Inspectors reviewed the complaints log and noted that 12 complaints had been received in 2011. Details of the complaints were recorded including action taken, outcomes and the complainants' level of satisfaction.

Inspectors also noted that a book was maintained at the entrance hall for visitors and residents to record their comments. Some comments were complimentary while others voiced concerns. There was documentary evidence to show that these concerns were acted upon and the complainant notified of the outcome.

2. Safeguarding and safety

Outcome 4

Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse.

References:

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

Inspection findings

Inspectors were satisfied that sufficient measures were in place to protect residents from being harmed or suffering abuse.

All staff had received training on identifying and responding to elder abuse. A centre-specific policy was available dated 2008. The person in charge, care manager and staff spoken to displayed sufficient knowledge of the different forms of elder abuse and all were clear on reporting procedures. A whistle blowing policy had been developed to ensure that staff rights would be protected in the event of reporting any allegations of abuse.

Residents spoken to confirmed to inspectors that they felt safe in the centre. They primarily attributed this to the staff being available to them at all times. There were no reports or allegations of abuse to date.

There was a policy in place on managing and protecting residents' property and accounts. Residents' accounts were managed by an off site finance department while the administrator received and managed three residents weekly allowances.

Inspectors reviewed the records of a number of residents' accounts received from the finance dept and were satisfied that robust safe procedures were in place. In addition, an annual audit was carried out by an external auditor to ensure compliance with the policy. Inspectors also reviewed the finances managed by the administrator and were satisfied that these were managed appropriately. Balances were correct and all transactions were signed by the resident, staff member and administrator or two staff members if the resident was unable to sign. The signed receipts were then sent to the finance department.

Outcome 5

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

References:

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

Inspection findings

Inspectors noted that risk management procedures required improvements.

There was a site-specific health and safety statement dated 2011. Inspectors reviewed the risk management policy which had been implemented in 2010. The policy included guidelines on such areas as self-harm and missing persons but did not include guidelines on all of the risks required in the Regulations, such as accidental injury to residents or staff and assault. Some risks had been identified such as needle stick injury, blood spillage and infections but a comprehensive risk assessment had not been completed to identify all risks in all areas. Monthly environmental safety checks were carried out to identify where improvements were required. At the time of inspection, this practice had not been linked to the risk assessment process.

Inspectors reviewed the emergency plan dated 2011. The plan contained comprehensive and clear guidance for staff on their roles in the event of fire and medical emergency but did not provide guidance on emergencies such as discontinuation of water supply, loss of telephone, power outage, heat outage, flooding and evacuation of the building. There were no details of arrangements in place for alternative accommodation in the event of the building having to be evacuated.

Inspectors reviewed the fire policies and procedures. Records indicated that a service contract was in place to service the fire equipment. The fire alarm was serviced on a yearly basis but the contract was recently amended to reflect quarterly servicing. Inspectors reviewed the fire register which included records of daily checks on the fire panel and fire exits. Fire drills were carried out on a monthly basis and staff signed to show attendance, the last drill was carried out in October 2011. Fire orders were displayed prominently throughout the building. Staff spoken with confirmed

that they had received fire safety training in the use of fire fighting equipment and evacuation and were knowledgeable on what to do in the event of fire. Records confirmed that all staff had completed fire safety training. The general manager and the person in charge had some difficulty locating some of the fire servicing records and inspectors noted the records were maintained in four different files and locations. Inspectors discussed with the general manager and the person in charge the importance of good record management and consolidated easily accessible files.

All staff had received up-to-date training in relation to moving and handling. Inspectors read training records which confirmed this. Inspectors observed best practice in relation to moving and handling of residents during the inspection. Records showed that staff received fire, moving and handling and elder abuse training at induction and prior to commencing employment.

The provider had submitted written confirmation from a competent person confirming that the centre was in substantial compliance with all fire and building control Regulations.

The environment was kept clean and was well maintained and there were measures in place to control and prevent infection. Hygiene audits were undertaken and the results used to improve practices. Arrangements were in place for the segregation and disposal of waste, including clinical waste. Household and laundry staff spoken with were knowledgeable on infection control and how to prevent cross contamination. Staff had access to supplies of latex gloves and disposable aprons and they were observed using the alcohol hand gels which were available throughout the centre.

The design and layout of the building promoted a safe environment for residents. Handrails were provided to all circulation areas and grab rails were provided in all toilets and bathrooms. Call bell facilities were provided in all rooms and call bells were noted to be answered promptly. Safe floor covering was provided throughout the building.

Inspectors reviewed the incident/accident log. A separate log was maintained for staff incidents and accidents. Details were recorded comprehensively and outcomes discussed at staff meetings to ensure learning. Neurological observations were recorded when a resident sustained a head injury or where a fall was unwitnessed.

Outcome 6

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

References:

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

Inspection findings

Inspectors found evidence of good medication management practices.

One inspector accompanied the nurse on a medication round. The nurse demonstrated her competence and knowledge when outlining procedures and practices on medication administration. Inspectors reviewed a sample of residents' medication charts and found that all medications were being reviewed on a three-monthly basis and all had been signed by the GP.

The inspectors reviewed the medication policy dated 2009 which was generally found to be comprehensive and gave clear guidance to nursing staff on areas such as medication administration, refusal and withholding of medications, medications requiring strict controls, self medication, disposal of medications and medication errors. However, the medication management policy did not provide guidance on 'as required' medication (PRN) and the maximum PRN dosage was not prescribed by the GP.

Medications that required strict control measures (MDAs) were carefully managed and appropriately stored. They were being counted, recorded and signed by two nurses at the change of each shift.

A medication fridge was in place in a locked room and the inspector noted that the daily temperatures were recorded.

Inspectors noted that three-monthly audits of medication prescribing and administration were carried out by the care manager. This data was then used to improve practices. For example, blood testing had been improved recently for residents on specific medications. Inspectors also saw where data was being collected on the use of night sedation since October 2011. The person in charge stated the information would be used to make further improvements.

3. Health and social care needs

Outcome 7

Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied healthcare. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

References:

Regulation 6: General Welfare and Protection
Regulation 8: Assessment and Care Plan
Regulation 9: Health Care
Regulation 29: Temporary Absence and Discharge of Residents
Standard 3: Consent
Standard 10: Assessment
Standard 11: The Resident's Care Plan

Standard 12: Health Promotion
Standard 13: Healthcare
Standard 15: Medication Monitoring and Review
Standard 17: Autonomy and Independence
Standard 21: Responding to Behaviour that is Challenging

Inspection findings

Inspectors were satisfied that residents' wellbeing and welfare was maintained by a high standard of evidence-based nursing care and appropriate medical and allied healthcare. However, some areas for improvement were identified relating to wound management and provision of activities.

Medical services were provided by three local GPs. Regular medical reviews were undertaken and all residents spoken with expressed satisfaction with the service. Residents had access to a range of allied health professionals and inspectors noted that records of appointments and referrals were maintained in residents' files. Peripatetic services such as occupational therapy (OT), physiotherapy, speech and language, dietetic and psychiatry of later life were available on a referral basis by the GP. Ophthalmology, dental and chiropody services were also available.

Inspectors reviewed some residents' files and noted that a pre-admission assessment was undertaken either in the community or in hospital. A comprehensive nursing assessment, including a social needs assessment, was carried out following admission. This was updated on a three-monthly basis. Risk assessments such as falls risk, risk of developing pressure ulcers, risk of constipation and continence were carried out. Comprehensive care plans including a social care plan were developed and implemented in a meaningful and person-centred way. There was evidence that residents and relatives were involved in the development of these care plans.

Improvement in the management of wounds was required. Inspectors read the assessment and care plan of a resident who had a wound and noted that the wound assessment did not include the size and dimensions of the wound. Dressing changes were not carried out consistently therefore it was difficult to track the progress of the wound.

Inspectors reviewed the procedures in place for responding to behaviours that challenged. There was a policy which provided guidance to staff and inspectors noted that the ABC assessment was carried out on residents. Inspectors reviewed residents' files and noted that appropriate intervention strategies were in place. Staff spoken to were aware of the policy and knowledgeable of appropriate strategies. Additional support, advice and training were available to staff from the psychiatry of later life services. Training had been provided to all staff and it was evident to the inspectors that the learning was being applied in practice. For example, staff were observed managing residents who had behaviour that challenged using diversion techniques.

There was a policy on the use of restraint which guided practice. Inspectors noted that some residents were using bedrails. A risk assessment was undertaken for residents' and the risk of using restraint was balanced against the risk of not using restraint. Where the risk of using was equal to the risk of not using a restraint inspectors noted that restraint was not used. Alternatives had been tried and were documented and consent had been sought. A detailed care plan was in place to manage the use of restraint and release times were recorded.

Inspectors checked the number of falls that occurred in the previous six-month period. The person in charge and staff had collected and analysed this information. Strategies were put in place for those residents who were at high risk of falling. Assessment was carried out to identify any intrinsic or extrinsic causes of falls. Inspectors read the care plans of residents who had fallen and noted that the strategies had been implemented including provision of an alarm mat for one resident who did not use his call bell at night when he required assistance. The mat was linked to the call bell and alerted staff when he stood up. Hip protectors and gait belts were provided for other residents to promote independence while enhancing their safety.

Inspectors noted that while comprehensive social assessments were undertaken and a schedule of activities was available, there was not much recreational activity during the day of inspection except for mass. There was no dedicated staff member to coordinate and provide activities - instead it was the responsible of all the care assistants to do so if time permitted. Staff and residents spoken with stated that staff often they did not have time to interact or carry out activities with residents due to the workload especially in the morning times.

Inspectors, when visiting the dementia-specific unit, noted a very high noise level in the sitting room. The radio was on very loudly in the background which seemed to agitate residents. One resident was extremely agitated and demanded a high level of supervision and diversion therapy from the staff member. As a result other residents did not have a staff member to supervise or undertake activities with them. Staff spoken with stated that while some staff members working in the unit were trained to provide specific activities suitable for this client group, none of the staff members working in the unit on the day of inspection had this training.

Outcome 8

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

References:

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

Inspection findings

Inspectors were satisfied that caring for a resident at end of life was regarded as an integral part of the care service provided in centre.

There was a comprehensive policy on end of life care dated April 2010. One resident was receiving care at the end of her life. The hospice home care team was attending and providing guidance to staff. The policy included guidelines for involving the residents and their families in planning the end of life care and there was evidence that each resident's wishes were identified and made clear in the care plan. The care manager had extensive experience in palliative care and a nurse had been identified as a link nurse for palliative care across the three centres.

Pain assessment and pain charts were in place to assess and monitor the need for and the effectiveness of pain medication.

Following death, residents' personal possessions were returned to relatives in a respectful manner by using a discreet but specific container/bag. This area was being further explored at the time of inspection to enhance the dignity of residents.

Staff told inspectors that families were facilitated to stay overnight in the sheltered accommodation adjacent to the centre and could have their meals with their relatives if they wished.

Outcome 9

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.

References:

Regulation 20: Food and Nutrition
Standard 19: Meals and Mealtimes

Inspection findings

Inspectors were generally satisfied that residents received a nutritious and varied diet and mealtimes were unhurried social occasions that provided opportunities for residents to interact with each other and staff. However, inspectors did note some issues relating to choice and availability of nutritional snacks.

There was a policy on nutrition dated 2011. There was a nurse identified as a link nurse in nutrition across the three centres. She attended specific training and transferred the learning to staff members in the three centres.

Weight records were examined which showed that residents' weights were checked monthly and many residents were being weighed weekly. Nutrition assessments were used to identify residents at risk of losing weight and equally those at risk of obesity. These assessments were repeated on a monthly basis. Some residents had been referred for dietetic review or speech and language assessment. The recommendations made were incorporated into the residents' care plans. Medication records showed that supplements were prescribed by a doctor and administered appropriately.

Inspectors had some concerns around the availability of nutritional foods and refreshments between the evening meal and breakfast time. The evening meal was at 4.30 pm and breakfast commenced at 8.30 am. There was no nutritional snack or meal provided between the evening meal and breakfast. The provider stated that sandwiches were provided in the past but residents refused them. He stated he would explore other options to ensure residents received a nutritional snack if they wished at night time. He also stated he would ensure that the more dependent and confused residents were catered for.

The chef in the kitchen worked one day a week as the services manager. His role as services manager was to supervise and manage the laundry, household and catering services. Inspectors visited the kitchen and spoke with the services manager. He was well organised and knowledgeable regarding residents modified and specialised diets. A four week menu cycle was in place which provided choice but some staff stated there was no choice for the evening meal while residents were unsure if there was choice or not.

There was a large open plan central dining room and most of the residents choose to eat there. Residents in the dementia unit dined there as opposed to the main dining room. The tables were nicely laid and residents went to the servery to choose what they wanted for their midday meal. Staff were seen to assist residents discreetly and respectfully if required. Residents confirmed that they enjoyed the food. Residents told inspectors they could have anything they wanted at meal times.

Inspectors noted that residents who needed their food pureed or mashed had the same menu options as others and the food was presented in appetising individual portions on a plate designed for this purpose.

4. Respecting and involving residents

Outcome 10

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

References:

Regulation 28: Contract for the Provision of Services

Standard 1: Information

Standard 7: Contract/Statement of Terms and Conditions

Inspection findings

Inspectors were satisfied that this outcome was achieved.

Contracts were in place and complied with the Regulations. The contracts set out the overall care and services provided to the residents and the fees charged, including any additional fees charged.

Outcome 11

Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence.

References:

Regulation 10: Residents' Rights, Dignity and Consultation

Regulation 11: Communication

Regulation 12: Visits

Standard 2: Consultation and Participation

Standard 4: Privacy and Dignity

Standard 5: Civil, Political, Religious Rights

Standard 17: Autonomy and Independence

Standard 18: Routines and Expectations

Standard 20: Social Contacts

Inspection findings

Residents' privacy and dignity were respected by staff although one aspect required improvement. Inspectors noted one incident where a resident's privacy and dignity was not respected. The bedroom door was not closed and the screens in one multi-occupancy room were not pulled around the resident's bed when personal care was being delivered.

Staff were observed knocking on bedroom, toilet and bathroom doors and waiting for permission to enter. 'Care in progress' signs were placed on bedroom and bathroom doors when care was being delivered. Residents were dressed well and according to their individual choice. Inspectors observed staff interacting with residents in a courteous manner and addressing them by their preferred name.

Care plans were in place for residents on maintaining dignity and privacy. They were meaningful and focussed on the tone to use when addressing residents, speaking to residents in an age appropriate way and using short sentences so that residents could get a clear understanding of what was being said to them.

Residents' civil and religious rights were respected. The person in charge outlined the arrangements in place to take residents out to vote in the presidential election the following day. The day-care bus was being used to transport the residents to the polling station. A Roman Catholic mass and a Church of Ireland service took place on a weekly basis and inspectors noted mass was taking place on the day of inspection. The person in charge and the residents confirmed that all religious denominations were supported to practice their religious beliefs.

A residents' committee had been established and although the person in charge said the group met every two or three months, the last meeting had been held in April 2011. She explained that the facilitator was a volunteer and that due to personal reasons had to cancel the previous meeting. Inspectors read the minutes of some of these meetings and noted that suggestions made by residents had been addressed

by the person in charge. Residents discussed the summer BBQ and the development of a sensory garden for the residents with dementia to enjoy. This was to be in place by spring 2012. There was an independent advocacy service provided by the Friends of the Elderly group attached to the hospice and a religious sister resident in the adjacent sheltered housing was also available to residents as an advocate. Each staff member was assigned three or four residents to be the link person between the resident, their family and the centre.

The person in charge told the inspector how she promoted links with the local community. Transition year students attended on work placement projects and volunteers from the local community attended daily. Inspectors met with these volunteers who gave refreshments to residents and chatted with them.

A separate visitor's room was provided to allow residents to receive visitors in private. Relatives spoken to stated that they could visit at any time and were always made feel welcome.

Outcome 12

Adequate space is provided for residents' personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.

References:

Regulation 7: Residents' Personal Property and Possessions

Regulation 13: Clothing

Standard 4: Privacy and Dignity

Standard 17: Autonomy and Independence

Inspection findings

Residents spoken to told inspectors that they were satisfied with the laundry arrangements and had no issues with regard to mislaid clothing. Clothing was labelled which reduced the risk of getting mislaid.

All bedrooms had adequate personal storage space and clothes were stored in a neat and tidy manner. A lockable storage space was provided to all residents. A list of residents clothing and personal property was completed at admission, kept up-to-date and attached to the contract of care.

5. Suitable staffing

Outcome 13

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

References:

Regulation 15: Person in Charge

Standard 27: Operational Management

Inspection findings

The post of person in charge was full-time and held by a registered nurse with the required experience in the area of nursing older people. A care manager was always on call at weekends and out of hours in the event of an emergency. One of the care managers from one of the three centres normally deputised for the person in charge.

The person in charge had a good knowledge of the Regulations and Standards and her statutory responsibilities were sufficiently demonstrated both during the interview and by the documentation available. All documentation requested by the inspectors was readily available.

The person in charge was a facilitator for the implementation of best practice in dementia care health care assistant course. Throughout the inspection process the person in charge demonstrated competence, insight and a commitment to delivering good quality care to residents informed by on-going learning and review of practice.

Outcome 14

There are appropriate staff numbers and skill-mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

References:

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

Inspection findings

Inspectors found there were insufficient staff on duty at times during the day to meet the needs of the residents.

Residents' dependency levels were assessed monthly using a validated tool. There were generally two nurses and seven care assistants on duty in the morning and two nurses and five care assistants on duty in the evening time for 44 residents. While staffing levels had been reviewed since the previous inspection and some additional staffing hours allocated, both staff and residents told inspectors that the workload was very heavy, especially in the morning time and staff did not have sufficient time to spend with residents either interacting or providing activities. They stated they spent most of the morning delivering personal care and assisting residents to get up. The assistant director of care had recently left the post and had not yet been replaced. The person in charge told inspectors that they were currently seeking to fill this post. The provider and the person in charge gave a commitment to reviewing

and increasing staffing levels where required. Inspectors also noted that staff turnover in the previous 12 months was high. Two nurses, five care assistants and two kitchen assistants had left the service. The person in charge could not attribute any specific reasons for the staff leaving.

There was a comprehensive recruitment policy in place which met the requirements of the Regulations. The inspectors reviewed a sample of staff files. Most of the staff files reviewed contained the documentation required by Schedule 2 of the Regulations such as photographic identification, evidence of physical and mental fitness and three written references. However, one staff file contained a self declaration for medical fitness rather than evidence of fitness.

Volunteers in the centre received supervision and support and were vetted appropriate to their role and level of involvement. A personnel file was maintained on each volunteer and included information on training received and Garda Síochána vetting. Their roles and responsibilities were set out in a written agreement.

Inspectors were shown comprehensive staff induction and orientation packs for nurses and care assistants which were signed on completion and maintained on staff files. A week of orientation and induction was provided prior to staff commencing employment. Induction included all mandatory training and working with a more senior member of staff. Staff performance reviews were undertaken and were used to highlight areas of strength and weakness as well as identifying education needs. Outside of mandatory training, staff were required to attend an additional number of clinical training days each year. These records were maintained on staff files.

The provider and person in charge were committed to providing ongoing training to staff in response to the needs of the residents they cared for. A comprehensive training schedule had been facilitated during 2011 and many staff had received training in such areas as dementia care, non-violent crisis intervention, food safety, principles in best practice on the use of restraint, nutrition for wounds and management skills for clinical nurse managers and staff nurses. Some staff had also completed the 'Train the Trainers' course in moving and handling and non-violent crisis intervention instructor certificate. All care assistants had completed the Further Education and Training Awards Council (FETAC) Level 5 training.

Inspectors confirmed that up-to-date registration numbers were in place for nursing staff.

6. Safe and suitable premises

Outcome 15

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

References:

Regulation 19: Premises

Standard 25: Physical Environment

Inspection findings

The layout and design of the centre generally met the residents' needs but there were two three-bedded rooms, which did not meet the requirements of the Regulations or Standards. A plan will be required to address the issue by 2015.

The premises were bright, clean and well maintained throughout. Bedroom accommodation was well designed and laid out meeting residents' needs for leisure and comfort. All en suite shower and toilet facilities were assisted. Bedrooms had specialised beds, call bell facilities and adequate personal storage space. They were personalised with residents' own items.

There was appropriate assistive equipment available such as profiling beds, hoists, pressure relieving mattresses and cushions, wheelchairs and walking frames. The wide corridors enabled easy accessibility for residents in wheelchairs or those with mobility aids. They also aided safety as residents could pass each other without any difficulty. Handrails were available to promote independence. The maintenance and records of servicing for assistive equipment was reviewed by inspectors and found to be up-to-date.

Since the previous inspection additional storage facilities had been provided and equipment was stored safely and appropriately.

The large kitchen facility was bright and clean. It was found to be well organised and equipped with sufficient storage facilities. Inspectors observed a plentiful supply of fresh and frozen food.

The open-plan communal area had strong natural light. Residents could choose the seating areas which suited them best. At previous inspections it was noted that noise levels in the communal area were very high especially during mealtimes. The provider showed inspectors the new sound absorbing wall covering which had been provided to reduce noise levels. Inspectors noted that the noise level during the lunchtime meal was not as intrusive as previously.

The dementia-specific unit was small and domestic in character. All bedrooms were single en suite. Rooms were comfortably furnished which created a very homely and warm environment. Doors and signage were colour coded and used effectively in rooms to promote independence for people with memory impairment.

Cleaning staff were observed working in an unobtrusive manner which did not disturb residents. They were able to tell inspectors about the arrangements to manage the risk of infection. A high level of cleanliness and hygiene was maintained in the centre. Sluice rooms were fully equipped with bedpan washers and there were locked storage facilities for chemicals. Laundry facilities were available as discussed under Outcome 12.

Gardens were safe and secure and all residents had unrestricted access to them at all times

7. Records and documentation to kept at a designated centre

Outcome 16

The records listed in Part 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

References:

Regulation 21: Provision of Information to Residents

Regulation 22: Maintenance of Records

Regulation 23: Directory of Residents

Regulation 24: Staffing Records

Regulation 25: Medical Records

Regulation 26: Insurance Cover

Regulation 27: Operating Policies and Procedures

Standard 1: Information

Standard 29: Management Systems

Standard 32: Register and Residents' Records

Inspection findings

** Where "Improvements required" is indicated, full details of actions required are in the Action Plan at the end of the report.*

Resident's guide

Substantial compliance

Improvements required*

Records in relation to residents (Schedule 3)

Substantial compliance

Improvements required*

General records (Schedule 4)

Substantial compliance

Improvements required*

Operating policies and procedures (Schedule 5)

Substantial compliance

Improvements required*

Directory of residents

Substantial compliance

Improvements required*

Staffing records

Substantial compliance

Improvements required*

One staff file contained a self declaration of medical fitness.

Medical records

Substantial compliance

Improvements required*

Insurance cover

Substantial compliance

Improvements required*

Outcome 17

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

References:

Regulation 36: Notification of Incidents

Standard 29: Management Systems

Standard 30: Quality Assurance and Continuous Improvement

Standard 32: Register and Residents' Records

Inspection findings

Practice in relation to notifications of incidents was not satisfactory.

The person in charge was aware of the legal requirement to notify the Chief Inspector regarding incidents and accidents but was not aware of the requirement to notify the Chief Inspector in relation to wounds grade two and upwards.

Two residents had pressure ulcers at the time of inspection and these had not been notified to the Chief inspector. Notifications were subsequently made following the inspection.

Outcome 18

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.

References:

Regulation 37: Notification of periods when the Person in Charge is absent from a Designated Centre

Regulation 38: Notification of the procedures and arrangements for periods when the person in charge is absent from a Designated Centre

Standard 27: Operational Management

Inspection findings

The person in charge and provider were aware of their responsibilities to notify the Authority but as yet this was not required. The inspector was informed that there have been no absences of the person in charge for such a length that required notification to the Chief Inspector.

Closing the visit

At the close of the inspection visit a feedback meeting was held with the provider, the person in charge, and the care manager to report on the inspectors' findings, which highlighted both good practice and where improvements were needed.

Acknowledgements

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

Report compiled by:

Fiona Whyte

Inspector Manager of Social Services
Social Services Inspectorate
Health Information and Quality Authority

2 November 2011

Provider's response to inspection report*

Centre:	Gascoigne House Nursing Home
Centre ID:	0038
Date of inspection:	26 October 2011
Date of response:	30 November 2011

Requirements

These requirements set out the actions that must be taken to meet the requirements of the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care settings for Older People in Ireland*.

Outcome 5: Health and safety and risk management

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

Some practices in relation to the health and safety of residents and the management of risk did not sufficiently promote the safety of residents, staff and visitors.

The risk management policy did not include guidelines on risks such as accidental injury to residents or staff and assault.

A comprehensive risk assessment had not been completed to identify all risks in all areas.

The emergency plan did not provide guidance on emergencies such as discontinuation of water supply, loss of telephone, power outage, heat outage, flooding and evacuation of the building. There were no details of arrangements in place for alternative accommodation in the event of the building having to be evacuated.

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

Action required:	
Ensure that the risk management policy covers, but is not limited to, the identification and assessment of risks throughout the designated centre and the precautions in place to control the risks identified.	
Action required:	
Ensure that the risk management policy covers the precautions in place to control the following specified risks: assault and accidental injury to residents or staff.	
Action required:	
Put in place an emergency plan for responding to all emergencies.	
Reference:	
Health Act, 2007 Regulation 31: Risk Management Procedures Standard 26: Health and Safety Standard 29: Management Systems	
Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response:	
Our policy on accidents of residents has now been incorporated in with our Risk Management Policy.	Complete
Policy on assault to residents or staff is being developed and will be incorporated in with our Risk Management Policy.	30/11/2011
Monthly safety checks will be linked to a risk assessment tool which will be more comprehensive and will include precautions in place to control risks identified.	30/11/2011
Emergency plan to include guidance for emergencies such as discontinuation of water supply, a loss of telephone, power outage, heat outage, flooding and evacuation of building has been developed and completed. The emergency plan also includes details of arrangements in place for alternate accommodation in the event of our building having to be evacuated. This policy will be disseminated to staff.	Complete

Outcome 6: Medication management

<p>2. The provider is failing to comply with a regulatory requirement in the following respect:</p> <p>The medication policy did not provide guidance on specific areas such as 'as required' medication (PRN).</p> <p>The maximum dosage of PRN medications was not included on the prescriptions by the GP.</p>	
<p>Action required:</p> <p>Put in place appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents and ensure that staff are familiar with such policies and procedures.</p>	
<p>Reference:</p> <p>Health Act, 2007 Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines Standard 14: Medication Management</p>	
<p>Please state the actions you have taken or are planning to take with timescales:</p>	<p>Timescale:</p>
<p>Provider's response:</p> <p>Guidance on PRN or as required medication has been incorporated into our existing policy on ordering, prescribing, storage and administration of medication to residents. Staff will be required to read and understand this policy.</p> <p>Maximum dosage of medication will be included in prescription of GP.</p>	<p>Complete</p> <p>30/11/2011</p>

Outcome 7: Health and social care needs

<p>3. The provider is failing to comply with a regulatory requirement in the following respect:</p> <p>Wound assessment did not include the size and dimensions of the wound. Dressing changes were not carried out consistently therefore it was difficult to track the progress of the wound.</p> <p>There was not much recreational activity on during the day. There was no dedicated staff member to coordinate and provide activities instead it was the responsible of all the care assistants to do so if time permitted. Staff and residents stated that staff often did not have time to interact or carry out activities with residents due to the workload</p>

<p>especially in the morning times.</p> <p>A very high noise level was noted in the dementia unit sitting room. One resident was extremely agitated and demanded a high level of supervision and diversion therapy from the staff member. As a result other residents did not have a staff member to supervise them or undertake activities with them.</p>	
<p>Action required:</p> <p>Provide a high standard of evidence based nursing practice.</p>	
<p>Action required:</p> <p>Provide opportunities for each resident to participate in activities appropriate to his/her interests and capacities.</p>	
<p>Reference:</p> <p>Health Act, 2007 Regulation 6: General Welfare and Protection Standard 13: Healthcare Standard 18: Routines and Expectations</p>	
<p>Please state the actions you have taken or are planning to take with timescales:</p>	<p>Timescale:</p>
<p>Provider's response:</p> <p>Nurses to complete training on wound management with emphasis on documentation of wound assessment and dressing changes.</p> <p>An 8.00 am to 2.00 pm staff member was added to core staff from previous inspection whose main responsibility is to provide activities to residents which start at 10.45 am and not in time permitting way as stated on the report. This is a scheduled task for the allocated care assistant and not a time permitting task.</p> <p>Following on from the registration inspection a review of duties, practices and activities commenced with a meeting between Nurses, Carers, Care Manager and Person in Charge on 8 October 2011. This process will be completed with a review at a meeting with the same parties on 6 December 2011. Agreed changes to meet the objective of providing more time for direct resident interaction will be implemented with effect from 12 December 2011.</p> <p>Review of external activities was also done to further improve our provision of activities, i.e. holistic therapy, dog therapy, fit for life. Activities for residents are also scheduled at 11.00 am, 2.30 pm and 6.00 pm which are carried out by allocated staff and external</p>	<p>30/11/2011</p> <p>Complete</p> <p>12/12/2011</p>

providers of activities.	
In addition to the 8.00 am to 2.00 pm additional staff member, one care assistant was also approved an additional four hours to provide art classes.	

Outcome 9: Food and nutrition

4. The person in charge is failing to comply with a regulatory requirement in the following respect:	
There was no choice offered at the evening meal.	
There was no availability of nutritional foods and refreshments between the evening meal and breakfast time. The evening meal was at 4.30 pm and breakfast commenced at 8.30 am, there was no nutritional snack or meal provided between the evening meal and breakfast.	
Action required:	
Provide meals, collations and refreshments at times as may reasonably be required by residents.	
Action required:	
Provide each resident with food that is varied and offers choice at each mealtime.	
Reference:	
Health Act, 2007 Regulation 20: Food and Nutrition Standard 19: Meals and Mealtimes	
Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response:	
There are two choices in evening meals. We will ensure that the second choice is shown clearly on the published menu in the future. Residents' special requests are also catered for.	Complete
There is no general provision of snacks at night. Individual requests for light food, sandwich, fruit, yogurt are always met. Dementia residents are routinely offered snacks, particularly if they awaken during the night. This was re-emphasised to nursing and care staff at the meeting of 6 October 2011. There was no indication from these staff that they were unaware of this policy. In the past, we provided trays of sandwiches and other suitable food, as we do in our other homes, but this was discontinued because of	09/12/2011

<p>non-use. We commenced a survey of our residents and try to identify the need that was voiced to inspectors. To date the survey is producing no defined result. In the meanwhile sandwiches and soup are prepared by catering staff and served by care staff with tea/drinks during 8.15 pm supper. Individual requests are always met, as stated above.</p>	
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Outcome 11: Residents' rights, dignity and consultation

<p>5. The provider is failing to comply with a regulatory requirement in the following respect:</p> <p>Inspectors noted one incident where a resident's privacy and dignity was not respected. The bedroom door was not closed and the screens in one multi occupancy room were not pulled around the resident's bed when personal care was being delivered.</p>	
<p>Action required:</p> <p>Provide residents with privacy to the extent that each resident is able to undertake personal activities in private.</p>	
<p>Reference:</p> <p>Health Act, 2007 Regulation 10: Residents' Rights, Dignity and Consultation Standard 4: Privacy and Dignity</p>	
<p>Please state the actions you have taken or are planning to take with timescales:</p>	<p>Timescale:</p>
<p>Provider's response:</p> <p>This was an unforgivable and uncharacteristic lapse of our policy.</p> <p>Staff are reminded at staff meetings, communication book, review of policy on privacy and dignity regarding use of screens when providing personal care to residents in multi occupancy rooms. This will also be reiterated in induction programme and orientation of new employees.</p>	<p>Ongoing</p>

Outcome 14: Suitable staffing

<p>6. The person in charge is failing to comply with a regulatory requirement in the following respect:</p> <p>Inspectors found there were insufficient staff on duty at times during the day to meet the needs of the residents. There were generally two nurses and six care assistants on duty in the morning and two nurses and five care assistants on duty in the evening time for 44 residents. While staffing levels were reviewed since the previous inspection and some additional staffing hours allocated, both staff and residents told inspectors</p>
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that the workload was very heavy especially in the morning time and staff did not have sufficient time to spend with residents either interacting or providing activities.

Action required:

Ensure that the numbers and skill-mix of staff are appropriate to the assessed needs of residents, and the size and layout of the designated centre.

Reference:

Health Act, 2007
Regulation 16: Staffing
Regulation 18: Recruitment
Standard 23: Staffing Levels and Qualifications
Standards 22: Recruitment

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

Timescale:

Provider's response:

There are two nurses and seven care assistants on duty in the morning. We will continue to review our staffing levels depending on dependency levels of residents. Use of external activity providers at a more suitable time will also be reviewed.

A review of dependency levels has been completed and this would indicate that adequate staff are on duty in the mornings. This will be kept under close review and will be adjusted if dependency levels increase. We are also satisfied that a rearrangement of practices, as mentioned earlier, will re-direct additional time into direct resident engagement in the mornings.

Day staff have always served breakfast – there has been no change in that regard. Care staff at night previously prepared trays for breakfast and this duty was reassigned to catering staff three months ago. Water jug duty was also reassigned from care staff at this time.

These measures have and will continue to provide care staff with more time for direct resident interaction.

Outcome 14: Suitable staffing

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

One staff file contained a self declaration for medical fitness.

Action required:	
Put in place recruitment procedures to ensure that no staff members are employed in the designated centre unless they are physically and mentally fit for the purposes of the work which they are to perform.	
Reference: Health Act, 2007 Regulation 18: Recruitment Standards 22: Recruitment	
Please state the actions you have taken or are planning to take with timescales:	Timescale:
<p>Provider's response:</p> <p>Our recruitment procedure ensures that all staff employed are physically and mentally fit for purpose of their work. All staff employed after January 2009 undergo a pre-employment medical including Hep B screening and subsequent vaccination if appropriate.</p> <p>Some self-declarations are in place relating to staff employed prior to that date. Those specific staff members have been requested to obtain a certification from their GP in this regard during their next visit.</p>	Ongoing

Outcome 17: Notification of incidents

8. The person in charge is failing to comply with a regulatory requirement in the following respect:	
Two residents had pressure ulcers at the time of inspection and these were not notified to the Chief inspector.	
Action required:	
Give notice to the Chief Inspector without delay of the occurrence in the designated centre of any serious injury to a resident.	
Reference: Health Act, 2007 Regulation 36: Notification of Incidents Standard 29: Management Systems	
Please state the actions you have taken or are planning to take with timescales:	Timescale:

<p>Provider's response:</p> <p>A notification schedule was reviewed by the person in charge and care manager to ensure that all occurrences are notified to Chief Inspector without delay.</p>	<p>Complete</p>
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Any comments the provider may wish to make:

Provider's response:

None.

Provider's name: Seamus Shields

Date: 30 November 2011