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:	Gascoigne House
Centre ID:	OSV-0000038
Centre address:	37/39 Cowper Road, Rathmines, Dublin 6.
Telephone number:	01 496 9944
Email address:	sshields@cowpercare.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Cowper Care Centre Limited
Provider Nominee:	Seamus Shields
Lead inspector:	Linda Moore
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	44
Number of vacancies on the date of inspection:	0

About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

▪ Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
▪ Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration renewal decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
13 August 2014 09:30	13 August 2014 18:30
14 August 2014 07:00	14 August 2014 16:45

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

Outcome 01: Statement of Purpose
Outcome 02: Governance and Management
Outcome 03: Information for residents
Outcome 04: Suitable Person in Charge
Outcome 05: Documentation to be kept at a designated centre
Outcome 06: Absence of the Person in charge
Outcome 07: Safeguarding and Safety
Outcome 08: Health and Safety and Risk Management
Outcome 09: Medication Management
Outcome 10: Notification of Incidents
Outcome 11: Health and Social Care Needs
Outcome 12: Safe and Suitable Premises
Outcome 13: Complaints procedures
Outcome 14: End of Life Care
Outcome 15: Food and Nutrition
Outcome 16: Residents' Rights, Dignity and Consultation
Outcome 17: Residents' clothing and personal property and possessions
Outcome 18: Suitable Staffing

Summary of findings from this inspection

This was an announced inspection which took place over two days and was for the purpose of informing an application to renew the registration of Gascoigne Nursing Home. The provider had applied for registration for 44 places. This report sets out the findings of the inspection.

Overall, inspectors found that the provider met the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.

There was a very committed management team who were undergoing structural changes to the management team to strengthen the governance in the centre.

Inspectors found that the health needs of residents were mainly met. Residents had access to general practitioner (GP) services and to a range of other health services.

Residents were consulted about the operation of the centre and there was open communication in the centre. Residents and relatives knew the management on a first name basis. The collective feedback from residents was one of satisfaction with the service and care provided.

There were improvements required in risk management and there was insufficient numbers of nurses on night duty. The care plans did not guide care.

The provider and person in charge promoted the safety of residents.Staff had received training and were knowledgeable about the prevention of elder abuse and other relevant areas. Staff had an in-depth knowledge of residents and their needs. Recruitment practices met the requirements of the Regulations. Two actions identified at the previous inspection in August 2013 were addressed and one action was partly completed.

Areas for improvement identified included:
Risk management
Staffing levels
Premises issues
Dining experience
Activity provision
Care planning

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

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

Outcome 01: Statement of Purpose
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.

Theme:
Governance, Leadership and Management

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

Findings:
Inspectors found that the statement of purpose contained almost all of the information as required by the Regulations. The provider had made a copy available to residents. This clearly described the range of needs that the designated centre intended to meet. However, the supervision arrangements for allied health services, arrangements for the review of the care plans were not included. The complaints policy also included did not meet the regulations. The emergency planning was not inclusive of all arrangements to manage emergencies in the centre.

Judgment:
Non Compliant - Moderate

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

Theme:
Governance, Leadership and Management

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

Findings:
Inspectors were satisfied that there were systems to review the quality of care and experience of the residents, however there were areas for improvement. The systems to learn from audits were not robust.

A schedule of audit was in place, which included behaviour management audit, elder abuse, food and nutrition and medication management. Inspectors found that the results of these audits were mainly positive, however there was no robust system to review the findings and use these to improve practice and outcomes for residents. There was no system to involve residents or relatives in a review of the service.

The person in charge collected clinical information weekly that was reviewed by the provider. The provider detailed to inspectors the plans to improve the governance arrangements in the centre. While the management team met on a monthly basis, there was no formal system to identify and manage clinical risk in the centre and respond to audits.

Judgment:
Non Compliant - Moderate

Outcome 03: Information for residents
A guide in respect of the centre is available to residents. 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.

Theme:
Governance, Leadership and Management

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

Findings:
A resident's guide is available to each resident which describes the services.

The inspector read a sample of completed contracts and saw that they adequately met the requirements of the Regulations as they included adequate details of the services to be provided and the fees to be charged.

Judgment:
Compliant

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

Theme:
Governance, Leadership and Management

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

Findings:
The person in charge was a registered nurse with the required experience in the area of nursing older people and worked full-time in the centre. He was new to the role and a fit person interview was held with him during the inspection. He was supported in his role by an assistant director of nursing, the clinical director and the provider. The person in charge was yet to fully engage in the governance, operational management and administration of the centre. The previous person in charge still worked with the person in charge and there was a mentoring programme in place. Each of the persons in charge from the other centers within the group met on a monthly basis with the provider and shared practice. There were appropriate deputising arrangements in place.

The person in charge demonstrated a good knowledge of the Regulations, the Authority's Standards and his statutory responsibilities. Throughout the inspection

process, the person in charge demonstrated a commitment to delivering good quality care to residents. All documentation requested by inspectors was readily available. Inspectors noted that improvements in the governance arrangements were required. This is discussed further under risk management in outcome two and seven.

Inspectors observed that he was well known to staff, residents and relatives with many referring to him by his first name and were very complementary of the care they received. He maintained his continuous professional development and had recently completed MSc in Healthcare management. He was a train the trainer in elder abuse. He had attended courses in palliative care and nutrition and all other courses mentioned in outcome 18.

Judgment:
Compliant

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

Theme:
Governance, Leadership and Management

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

Findings:
Inspectors were satisfied that the records listed in Part 6 of the Regulations were maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre had all of the written operational policies as required by Schedule 5 of the Regulations. However some of the policies were not guiding practice, such as the risk management and the policy on the protection of vulnerable adults.

The residents register was up to date and reflected schedule three of the Regulations.

An up to date insurance policy was in place for the centre which included cover for resident's personal property.

Records were stored securely at all times during the inspection.

Judgment:
Non Compliant - Minor

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

Theme:
Governance, Leadership and Management

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

Findings:
The provider was aware of their responsibility to notify the Chief Inspector of the absence of the person in charge. The assistant director of nursing deputised in the absence of the person in charge.

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:
Inspectors found that measures were in place to protect residents from being harmed or abused. All staff had received training on identifying and responding to allegations of elder abuse. A policy was available which gave some guidance to staff on the assessment, reporting and investigation of any allegation of abuse. However it did not include the requirement to notify the Authority. The reporting arrangements were also not fully described.

The person in charge and staff spoken to displayed sufficient knowledge of the different forms of elder abuse and all were clear on reporting procedures.

Residents spoken to and those who had completed the Authority's questionnaire commented that they felt safe and secure in the centre. They attributed this to the fact that the doors were locked. Residents said "they always feel safe and they could talk to

any of the staff if they had an issue". A review of incidents showed that there were no allegations of abuse in the centre.

Overall restrictive practices were used infrequently in the centre. Inspectors noted that there had been a reduction in the use of bedrails since the previous inspection. There was a policy in place which would guide practice and residents were observed while using restraint. However the use of medication to manage resident's behaviour required improvement. There was no evidence of alternatives that were tried prior to the use of the medication. Inspectors noted that one resident received PRN medication daily to manage behaviours that were challenging. This resident's medication was reviewed during the inspection.

There were a number of residents in the centre who displayed behaviours that were challenging. While staff had been provided with input from psychiatry and psychology services, they told inspectors they were not sufficiently supported at times to manage this behaviour. While care plans were in place, they were not comprehensively completed; they did not include the triggers or the therapeutic interventions and therefore were not being implemented. While ABC charts were being completed, they were not comprehensive and did not include the antecedent, behaviour and consequence.

Inspectors read the restraint policy and the behaviours that challenge policy and noted that overall that these policies did not adequately guide practice.

There were appropriate systems in place to manage residents' finances in line with the policy.

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 were concerned that the provider and person in charge had not prioritised the safety of residents or had they a robust system in place to manage risk.

There was a comprehensive health and safety statement for the centre which related to the health and safety of residents, staff and visitors. A risk management policy was in place; however it did not meet the requirements of the Regulations or guide practice. There was no formal system in place to identify and respond to risk.

The risk management policy did not fully include the arrangements for the identification, recording, investigation and learning from serious incidents.

There were some risk assessments completed but they were not comprehensive and did not include all of the control measures to mitigate the risk of future occurrences. The staff told inspectors they were not sufficiently trained in risk assessment. This was confirmed from a review of the training records.

A number of accident and incidents for 2014 were being recorded and these were reviewed by the person in charge and the clinical director. There was evidence of the actions taken, for example, low low beds and monitoring alarms in place.

The risks associated with smoking, resident going missing, self harm and healthcare issues as per outcome 11 were identified.

Inspectors found that reasonable measures had not been taken to prevent accidents in the centre.

Inspectors noted that residents were at risk of going missing, while there were risk assessments completed, these would not control the risk and there were no care plans to guide the practice. There were no missing person profiles in place for residents at risk of elopement.

Inspectors found that there were a number of residents who smoked in the centre. While there were risk assessments and care plans in place to prevent an accident to these residents. These did not include the controls required and the care plan would not guide care. There was no risk assessment of the smoking area and the supervision arrangements of these residents was not clearly identified or known by staff.

One resident was identified as being at risk of self harm, while the resident was being checked half hourly while in the centre, there was no risk assessment or care plan to manage this risk when the resident went out of the centre.

Inspectors observed that cleaning products were left unattended at times during the inspection in areas where residents with a cognitive impairment walked.

An emergency plan was in place which identified what to do in the event of fire, flood, loss of power or heat and any other possible emergency. Staff spoken to were aware of the emergency plan. Individual evacuation plans were in place for residents.

Inspectors were satisfied that fire procedures were in place. There was one area for improvement. While fire procedures were prominently displayed throughout the centre, they would not guide night staff in responding to a fire in the dementia unit. Service records showed that the emergency lighting and fire alarm system was serviced regularly and fire equipment was serviced annually. Inspectors noted that the fire panels were in order and fire exits, which had daily checks, were unobstructed. Inspectors read the training records which confirmed that all staff had attended training within the last year. Regular fire drills were conducted. Staff spoken with were knowledgeable of the

procedure to follow in the event of a fire apart from the dementia unit. Many of the staff on night duty had not been involved in a fire drill at night time and told inspectors that they would welcome the opportunity.

The provider had submitted written confirmation from a competent person that all requirements of the statutory fire authority had been complied with.

Inspectors found that there were measures in place to control and prevent infection. Staff had access to supplies of gloves and disposable aprons and they were observed using the alcohol hand gels which were available discretely throughout the centre.

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:
Inspectors were satisfied that each resident was protected by the designated centre's policies and procedures for medication management. However there were areas for improvement. While there was a medication policy, this was not been implemented in practice.

Written evidence was available that three-monthly reviews were carried out.

Medications that required strict control measures (MDAs) were carefully managed and kept in a secure cabinet in keeping with professional guidelines. Nurses kept a register of MDAs. The stock balance was checked and signed by two nurses at the change of each shift. However, this did not include each individual medication requiring strict controls. Inspectors checked a sample of balances and found them to be correct.

Medication audits were completed to identify areas for improvement and there was documentary evidence to support this. There were a small number of medication errors since the previous inspection, there was a system to review these incidents to minimise the risk of future incidents. The pharmacist was involved in medication safety and review in the centre.

Medication fridges which had daily temperature checks were available in a locked room, however there were gaps in the daily checks. Inspectors found that some of these medications did not have the date they were opened recorded on the medication. There

were appropriate procedures for the handling and disposal of unused and out of date medicines. All staff nurses involved in the administration of medications had undertaken medication management training.

Overall Inspectors were satisfied with the administration practices in the centre. However inspectors found that oxygen had been administered to two residents which had not been prescribed.

Medication that required to be crushed had not been individually prescribed. The maximum dose of as required medication was not prescribed for all residents. Each medications were not individually prescribed. There was one signature for all of the medications and not an individual signature for each medication.

While there were residents in the centre who had epilepsy. There was no medication management protocol in place for the resident who may experience status epilepticus. There was no policy to guide staff.

Judgment:
Non Compliant - Moderate

Outcome 10: Notification of Incidents
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:
Safe care and support

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

Findings:
Overall practice in relation to notifications of incidents was satisfactory.

The person in charge was aware of the legal requirement to notify the Chief Inspector regarding incidents and accidents. To date and to the knowledge of the inspector, all relevant incidents had been notified to the Chief Inspector by the person in charge.

Judgment:
Compliant

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

Theme:
Effective care and support

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

Findings:
Inspectors were satisfied that aspects of the residents healthcare needs were met to a good standard, however residents were not all provided with opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. Improvements were required in care planning, the management of epilepsy and behaviours that challenge.

Residents had access to GP services and a full range of other services were available on referral including speech and language therapy (SALT), physiotherapy and dietetic services. Chiropody, dental and optical services were also provided. Inspectors reviewed residents' records and found that residents had been referred to these services and results of appointments were written up in the residents' notes.

Inspectors reviewed a sample of residents' files and noted that a nursing assessment and additional clinical risk assessments were carried out for residents. Daily notes were being recorded in line with professional guidelines. Overall care plans contained some information to guide the care for residents. Residents and/or relatives were involved in the development of their care plans and they discussed this with inspectors. However, there was evidence that the care plans did not guide the practice in place and did not consistently reflect the assessed needs of residents. Care plans for a resident with epilepsy and those with behaviour that was challenging did not guide the care.

Falls Management
Inspectors read the care plans of residents who had fallen and saw that risk assessments were undertaken. Falls were reviewed monthly and there were systems in place to minimise the risk of future falls, such as sensor alarms and half hourly checking of residents. Access to the physiotherapist was provided. Records showed that some residents had unwitnessed falls in 2014. Neurological observations were not completed following these falls. Inspectors noted that the care plans for these residents would not guide practice.

Wound Care
None of the residents had pressure sores in the centre. Adequate records of assessment

and appropriate plans in place to manage the wounds. Staff spoken to were knowledgeable of the strategies to be taken to prevent pressure ulcers.

Nutrition
Policies on nutrition and hydration, on the whole were being adhered to and supported good practices but there were areas for improvement as identified in outcome 15. Care plans did not fully guide practice. For example, one resident was being administered subcutaneous fluids but these were not included in the care plan. The malnutrition assessment screening tools had been incorrectly completed.

Restraint Management
Inspectors found that while restraint in the form of bedrails was only used as a last resort, there were areas for improvement. There was a restraint register in the centre but it had not been updated to include the actual number of residents who required all forms of restraint. There was an evidence-based policy in place. Inspectors noted that risk assessments were completed. The assessment did not always include evidence of the alternatives tried and for how long. Residents had been provided with low low beds and crash mats to reduce the use of restraint.

Epilepsy management
Staff did not demonstrate competence in the management of residents with epilepsy. Appropriate care was not delivered to one resident in the management of seizures. There was no policy or procedure to guide staff in the management of epilepsy. While there was a care plan for a resident with epilepsy, it did not guide practice. It did not provide guidance for staff in relation to the management of this medical condition in caring for any resident during and after seizures, responding to any potential complications or for recording of epileptic activity to guide future interventions.

It was evident that all staff did not have training in behaviours that challenge, epilepsy or activation provision.

Judgment:
Non Compliant - Moderate

Outcome 12: Safe and Suitable Premises
The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:
Effective care and support

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

Findings:
Overall the physical environment in the centre met the requirements of the Regulations and the needs of all residents.

At the previous inspection, there had been two three bedded rooms which were reduced in size to two twin rooms and two single rooms, inspectors found that there was insufficient space between the beds in these twin bedrooms for the use of assistive equipment and staff described how they moved the furniture around the rooms in order to assist residents. The provider said this would be addressed following the inspection.

The centre was clean, comfortable, welcoming and well maintained both internally and externally. Inspectors found that the communal spaces and bedrooms were homely in design, decor and furnishings and this was also frequently mentioned by residents and their relatives. The laundry complied with the requirements in the Authority's Standards.

The provider furnished the Authority with a certificate of compliance with planning orders and building regulations.

There were handrails and safe floor covering throughout the centre. Inspectors viewed the servicing and maintenance records for equipment such as hoists and found they were up to date.

Inspectors visited some residents' bedrooms and found that most were personalised with their possessions. All bedrooms had television and telephone.

The kitchen was found to be well equipped. The inspector observed a plentiful supply of fresh food. Inspectors read the two recent environmental health officer reports and found that the actions identified were addressed.

There were secure garden areas for residents to access unaccompanied with a seating area and planting.

There were sluice rooms with mechanical sluicing facilities available throughout the centre to ensure that best practice in infection control could be adhered to if there was an outbreak of infectious disease.

Inspectors identified there was a need for increased signage in the dementia unit in particular, to meet residents needs, there were plans already in place to address this.

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:
Complaints were well managed but there were areas for improvement. The complaint's policy did not fully meet the requirements of the Regulations. It did not include the complaints officer and the nominated person as per regulation 34.The complaints procedure was on display at the entrance the centre. Relatives and residents who spoke with inspectors knew the procedure if they wished to make a complaint.

Complaints and feedback from residents were viewed positively by the provider and the person in charge. A complaints log was maintained and inspectors found that it contained some details of the complaints and the action taken to respond to the complaint. However, the records of complaints were not comprehensive, they did not include all of the detail of the action taken and the satisfaction of the complainant.

Inspectors found that complaints were discussed at the management team meeting.

Judgment:
Non Compliant - Minor

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:
Residents received a high standard of end-of-life care which was person centred and respected the values and preferences of the individual and resulted in positive outcomes for residents. However there were areas for improvement.

There was a policy on end-of-life care which was centre specific and provided detailed

guidance to staff. However this was not being implemented in practice.

The self assessment for the thematic inspection was submitted prior to the inspection and reviewed by inspectors. The person in charge had not identified any areas for improvement. However they were actively updating the documentation and providing training to staff. Inspectors found that while appropriate care had been provided to a resident who had been recently deceased. However there was no system in place to capture resident's wishes. One resident at this stage of life had a care plan but it did not guide practice.

Family meetings were held and were attended by the GP and nursing staff as appropriate. The decisions concerning future health care needs had been discussed with the GP and were documented as required. However there was no system of review in place and this information was not documented in the residents care plans. Staff were not fully aware of the resuscitation status of residents.

While some of the residents resided in single rooms, others were in multi occupancy rooms and a single room was always facilitated for end-of-life care.

Overnight facilities were provided for visiting family members who wished to stay with their loved one. The person in charge said that he would facilitate a family member to stay in residents bedrooms if they were in a single room. Inspectors noted that resident received support from the local palliative care team when required. This service was accessible upon referral by the GP and inspectors saw that there was prompt access to the service when required including out of hours.

Records showed that a number of staff had received training in end-of-life care in 2014.

Mass and other denominations service was provided weekly.

Residents and visitors were informed sensitively when there was a death in the centre. The person in charge informed the residents.

Judgment:
Non Compliant - Minor

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:
Residents received a varied and nutritious diet that overall was tailored to meet individual preferences and requirements. However, some improvement was required in the maintenance of the documentation, assistance at meal times and the care plans which did not fully direct care to be delivered.

The self assessment for nutrition was submitted prior to the inspection and reviewed by inspectors. There were no areas for improvement identified.

Inspectors noted that meals were well presented and all residents expressed satisfaction with their meals. Overall staff were seen assisting residents discreetly and respectfully as required. However the assistance of residents required improvement. Inspectors observed that residents were not sitting in an upright position during the meal, which may have placed them at risk. This was fully addressed when raised with the person in charge on the first day of the inspection. One resident's recliner chair was maintained during the inspection which facilitated the resident to sit in an appropriate position. Inspectors were satisfied that residents received a varied main meal that offered choice on the day.

Inspectors noted that in the two dining rooms residents sat for long periods while other residents at their table were provided or assisted with a meal.

Residents who needed their food served in an altered consistency such as pureed had the same choice of main menu options as others and this was well presented.

Inspectors saw residents being offered a variety of drinks throughout the day. Inspectors met with the chef who demonstrated an in depth knowledge of residents dietary needs, likes and dislikes and this was documented. Inspectors also observed that a drinks trolley was available to residents during the day.

Records showed that some residents had been referred for and received a recent dietetic and SALT (speech and language) review. The treatment plans for these residents was recorded in the residents' files. Medication records showed that supplements were prescribed by a doctor and administered as prescribed and meals were fortified as required.

Inspectors found that weight records showed that residents' weights were checked monthly or more regularly if required. Nutrition assessments were used to identify residents at risk and were also repeated on a regular basis. However inspectors noted the nutrition care plan did not guide care.

There was a four week menu. Inspectors met the dietician employed by the provider who discussed the plans to review the menu to ensure it was balanced and met the needs of residents on a modified diet.

Judgment:
Non Compliant - Minor

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

Theme:
Person-centred care and support

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

Findings:
The privacy of residents was maintained. Staff were observed knocking on bedroom, toilet and bathroom doors and waiting for a response to enter and this was confirmed by residents. Inspectors observed staff interacting with residents in a friendly and courteous manner.

A residents' committee and family meetings had continued. The minutes showed that while some of the issues identified were responded to by the provider and person in charge, not all issues were . For example, Residents requested more activities. Residents said they had opportunities to discuss issues as they arose with the provider, person in charge or any staff members. Relatives were satisfied with information provided by staff about residents' healthcare and general wellbeing. Relatives were pleased to be involved in care planning process.

Residents were provided with the opportunity to vote in the recent election. Residents had access to newspapers, television and the radio.

Inspectors noted that while there were some activities for residents in the morning and afternoon, these included mass, chiropody and the hair dresser. There was limited access to any activation for many of the residents in the morning time, particularly for those with a cognitive impairment. There was an activity schedule and this included SONAS programme (a therapeutic communication activity primarily for older people, which focuses on sensory stimulation), dog therapy and physiotherapy programmes. While a staff member was allocated to provide activation from eleven am, many of the residents sat for long periods and slept in their chairs. Residents told inspectors there were limited activities and they found the day long. Some residents went out alone during the day and others went out with families.

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

Judgment:
Non Compliant - Moderate

Outcome 17: Residents' clothing and personal property and possessions
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.

Theme:
Person-centred care and support

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

Findings:
Residents could have their laundry attended to within the centre. Inspectors spoke with the staff member working there and found that she was knowledgeable about the different processes for different categories of laundry. However the staff was not made aware of the residents with an infection in the centre.

Residents and relatives expressed satisfaction with the laundry service provided. There were procedures in place for the safe segregation of clothing to comply with infection control guidelines.

Residents had access to a locked space in their bedroom if they wished to store their belongings.There was a policy in place of residents' property in line with the Regulations. There were residents' property lists maintained.

Judgment:
Non Compliant - Minor

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 found that there was a committed and caring staff team. The person in

charge and provider placed strong emphasis on training and continuous professional development for staff. All staff told inspectors that they felt well supported by person in charge and provider.

Relatives and staff stated that at times, there were inadequate levels of staff on duty. Inspectors were not satisfied with the staff nursing numbers on night duty based on the number of residents and layout of the centre. There was one nurse and three care assistants on duty over night with a twilight nurse was on duty until nine pm. However inspectors were concerned that the medication round took up to 2.5 hours and the nurse would not be in a position to supervise and deliver care in the main area and the dementia unit.

Inspectors found that there were 11 residents with low dependency needs, eight residents with medium dependency, nine high and 16 maximum dependency needs.

The provider and person in charge said they were satisfied with the staffing numbers and that there were ongoing unannounced visits at night time. These were reviewed by inspectors. The provider said he would review this following the inspection.

There was a recruitment policy in place and inspectors was satisfied that staff recruitment was in line with the Regulations. A sample of staff files were examined and inspectors noted that all relevant documents were present. A checking system was in place to ensure that all documents required by the Regulations were in place. There was an orientation programme for new staff and staff appraisals in place.

Staff told inspectors they had received a broad range of training which included, nutrition and medication management and there was evidence to support this. All staff had completed mandatory training and many had received training in dementia care and CPR (Cardio pulmonary resuscitation). However further training was required in the area of epilepsy, use of restraint, behaviours that challenge.

Inspectors reviewed all files and found that nursing staff had up to date registration with An Bord Altranais agus Cnáimhseachais na hÉireann (Nursing and Midwifery Board of Ireland) for 2014.

There were volunteers in the centre. Inspectors noted that they were appropriately vetted.

Staff told inspectors there was open informal and formal communication within the centre where they could raise issues and discuss resident's needs. These forums were also used to review and improve the service. Such as the nurses and care assistant meetings

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:

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Action Plan

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

Provider's response to inspection report[1]

Centre name:	Gascoigne House
Centre ID:	OSV-0000038
Date of inspection:	13/08/2014
Date of response:	19/09/2014

Requirements

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

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

Outcome 05: Documentation to be kept at a designated centre

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
All policies did not meet the requirements of the Regulations and guide practice.

Action Required:
Under Regulation 04(1) you are required to: Prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.

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

Please state the actions you have taken or are planning to take:
1. We are currently reviewing and revising our risk management policy and procedure specifically on identification, recording, investigating and learning from all incidents. The revision will be centre specific and will provide clear guidelines to all staff. We have also recently trained our staff on electronic recording of incidents and risks in the facility.

2. Identified risks, actions and learnings will also be discussed in the monthly management and multidisciplinary meetings. Any learning actions and learnings as outcome of these meetings will be implemented by the person in charge and clinical nurse managers.

3. The policy on the protection of vulnerable adults was reviewed and revised to fully describe the reporting arrangements for any allegation of elder abuse and the requirement to notify HIQA and referral to Social Case Worker for Protection of Older People as appropriate.

Proposed Timescale: 30/09/2014

Outcome 07: Safeguarding and Safety

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The management of restraint was not in line with evidenced based practice.

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

Please state the actions you have taken or are planning to take:
1. The Person in Charge has commenced a training programme to guide the staff in appropriate use of restraints which will also include documentation of alternatives trialled prior to the use of any form of restraint. Staff will also receive training from PIC on completion of restraints' risk assessment forms and use of ABC charts to include documentation of antecedent, behaviour and consequences.

2. The Care plans will also be monitored by clinical nurse managers on a weekly basis to ensure that all sections are fully completed by allocated nurse and that the care plan will sufficiently guide the practice.

Behavioural charts will also be reviewed as part of care planning process in order to accurately document triggers of behaviours identified and therapeutic interventions specific to the resident.

Proposed Timescale: 30/09/2014

Outcome 08: Health and Safety and Risk Management

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risk management policy did not meet the requirements of the Regulations. There were a number of potentilal risks identified under outcome 07.

Action Required:
Under Regulation 26(1)(d) you are required to: Ensure that the risk management policy set out in Schedule 5 includes arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.

Please state the actions you have taken or are planning to take:
1. RISK MANAGEMENT
• Arrangements for identification, recording, investigation and learning from serious incidents or adverse involving residents are already included in our risk management policy. However as discussed in outcome 5, we are in the process of reviewing and revising this policy to incorporate our new system of recording of incidents which will enhance our reporting system and earlier identification of risks, implementation of actions and communication of learnings to both staff and residents.
• Risk assessments will be completed comprehensively post incident by the allocated staff nurses. This will include all of the control measures to reduce the risk of future occurrences. These documents will be reviewed on a monthly basis or earlier as residents condition change and will be audited by clinical nurse manager under the supervision of the Person in Charge.
• Missing person profiles were completed and implemented for use of all residents who are going out independently and those at risk of wandering.
• All relevant staff will be trained on risk management.
• Smoking areas will be included in the ongoing risk assessment of the physical environment.
• The care plan of residents who smoke has been revised to include provision for safe environment and supervision. Controls to address potential risks such as access to the nearest fire extinguisher are detailed in their care plans.

2. CHALLENGING BEHAVIOUR
• We have a robust training programme in place to meet the needs of residents with challenging behaviour. All of our staff has completed training in nonviolent crisis intervention/ dementia capable behaviours on commencement of their employment and refresher training is mandatory every 2 years. Some of our staff have also completed best practice in dementia care. We however acknowledge the need to train some of our staff in areas of documentation of assessments, behavioural charts, care planning as discussed in response to outcome 5.

• We are currently reviewing and revising the policy and procedure for challenging behaviour which will guide our staff in meeting the needs of these residents.

Proposed Timescale: 30/09/2014

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Staff in the laundry were not informed of the residents in the centre with an infection.

Action Required:
Under Regulation 27 you are required to: Ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.

Please state the actions you have taken or are planning to take:
The Person in charge and clinical nurse managers will ensure that the laundry staff and other relevant non clinical staff will be informed by nurse on duty of any infection in the facility. We have a comprehensive checklist form for informing all staff in the Nursing Home. This will be modified to note the confirming signature of the nurse providing the information and staff member receiving it.
They will also be provided with infection control guidelines to follow in order to minimize the risk and spread of infection in the facility.

Proposed Timescale: Complete

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The fire procedures would not guide night staff in the event of a fire.

Action Required:
Under Regulation 28(3) you are required to: Display the procedures to be followed in the event of fire in a prominent place in the designated centre.

Please state the actions you have taken or are planning to take:
The fire procedure has been and revised to guide staff on who will inform Dementia unit staff on what action to take in the event of fire alarm activation as they are required to remain with residents.

We are preparing an unobtrusive methodology for conducting fire drills during the course of a night shift.

Proposed Timescale: 30/09/2014

Outcome 11: Health and Social Care Needs

Theme:
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Residents care plans did not guide practice.

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

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

1. The residents' Care Plans are being audited and all those where deficiencies are identified will be modified to reflect needs of residents.
2. The clinical nurse managers will take an active role in the audit process to ensure that care plans are sufficiently guiding the practice.
3. A training programme on writing Care Plans including descriptive narratives has been commenced by person in charge.

Restraint management:

1. The restraint register has been updated to include residents who require any form of restraints.

2. Staff has been instructed to ensure that alternatives are trialled prior to use of restraints and documented in restraint assessment.

3. The monthly review of restraint register will also include review of restraint assessment carried out on residents and ensure that care plans are updated accordingly.

Proposed Timescale: 14/09/2014

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A high standard of evidenced based care was not delivered in medication management, falls management and epilepsy.

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:
Medication Management:

1. As part of medication management review for staff nurses, they are instructed to ensure that GPs document maximum doses of PRN medications and Oxygen are prescribed.

2. Medication management protocol has been developed for all residents who have epilepsy.

3. The stock balance for medications which require strict control measures (MDA's) has been reviewed and now includes each individual medication.

4. The staff nurses are instructed to ensure that they consistently date medication they open and that fridge temperature checks are completed and documented on the daily bases.

5. The clinical nurse managers will monitor compliance with medication management as part of weekly medication audits.

6. Learnings from these audits will be discussed in multidisciplinary meetings

7. A discussion with specific GP has been commenced in relation to individually signing each medication instead of one signature for all medications. A letter from one particular GP outlining his reason for this practice of using only one signature on all medications has been previously accepted by previous inspectors.

8. We are also currently in the process of reviewing the layout of our drug kardex and adapting a design that will ensure compliance from the GP to sign each individual medication.

Falls Management:

The nursing staff has been instructed to ensure that all residents who experience falls will have neurological observations completed. A copy of this observation tool will be attached to the incident report and will also be documented in the nurses' notes.

Epilepsy management

1. The care plan of residents with epilepsy have been updated to sufficiently guide staff in caring for residents with this medical condition. They were discussed and agreed with resident/family, GP and relevant members of multidisciplinary team.
2. A clear protocol on the management of epilepsy has been developed specific for each resident and was designed to guide the staff in their decision making and to achieve

consistency in the management of these residents.
3. The individualized epilepsy management of each resident outlines description of seizure, usual duration, frequency, emergency management and current epilepsy medication.
4. These documents will be kept under review by the allocated nurses under the supervision of clinical nurse managers and Person in Charge.

Proposed Timescale: 30/09/2014

Outcome 12: Safe and Suitable Premises

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Two twin rooms did not meet the needs of residents.

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

Please state the actions you have taken or are planning to take:
We have identified a bed with a shorter frame but with the same overall mattress size that will provide easier access to the rooms in question without the staff feeling that they have to re-position the bed.

Proposed Timescale: 30/09/2014

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 records of complaints were not comprehensive.

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:
1. The complaint procedure has been reviewed and revised to clearly identify the complaint officer. In the event of a complaint escalating unresolved to the Chief Executive he will allocate an appropriate person from the organisation management team, external to Gascoigne House, as independent complaints appeals officer.

2. Staff will be trained in complaints management specifically on documentation of details of actions taken and level of the satisfaction of complainant.

Proposed Timescale: Complete

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The complaints policy did not meet the requirements of the Regulations.

Action Required:
Under Regulation 34(1) you are required to: Provide an accessible and effective complaints procedure which includes an appeals procedure.

Please state the actions you have taken or are planning to take:
The registered Provider will review the complaints procedure to allow for nomination of an independent complaints appeals officer who would engage with residents, visitors or NOK's to resolve issues should there be any need .

Proposed Timescale: Complete

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:
Appropriate assistance was not provided to residents at meal times.

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

Please state the actions you have taken or are planning to take:
The person in charge has reviewed meal times and the seating arrangements of residents to ensure that staff are available to provide the required assistance to residents.

Staff nurses and CNM's are instructed to continuously monitor the sitting position of residents at meal times.

Proposed Timescale: Complete

Outcome 16: Residents' Rights, Dignity and Consultation

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents were not provided with activities in accordance with their interests and wishes.

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

Please state the actions you have taken or are planning to take:
1. The person in charge will review the range of activities to ensure that residents have opportunity to engage in activities that interest them.

2. The residents and visitors committee will be more involved in identifying volunteers from the community who can provide activities.

3. We have recently recruited care assistant / physiotherapist who will lead the exercises programme of residents and co-ordinate activities suitable to their needs and preferences.

4. The care staff will be trained to provide diverse activities for residents as part of their daily allocated responsibilities.

Proposed Timescale: 30/10/2014

Outcome 18: Suitable Staffing

Theme:
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were insufficient numbers of staff nurses on night duty based on the number and dependency of residents and the layout of the centre.

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:
I have re-assessed our staffing in the evenings – particularly around the time of the night medication round. The current position is that the night medication round can go

on until 22:00.
I have addressed the situation in a two-phased approach.
The first phase is as follows:
• I have directed the Care Manager that with effect from October 6th, the start of our next roster period, the nursing shift scheduled to end at 20:00 be extended to 22:00. This nurse will administer the medication to residents in one of the 16 bedded wings and the nurse coming on duty at 20:00 will administer the medication in the second wing. The medication in our dementia specific wing is unaffected by this as the nurse there finishes at 21:00 and the medication is completed by that nurse before going off duty. This arrangement will cease when Phase 2 comes into operation.
• A critical review of the night medication times has been commenced and this will inform us as to what time the medication round can commence (it may be possible, in many cases, to administer night medication from, say, 19:30. That would also improve matters.

The second phase is as follows:
• Following consultation with our Clinical Director, I have directed our HR Department to commence a process that will result in the skills mix at night to be adjusted to provide two nurses and two health care assistants on the 20:00 to 08:00 shift instead of one nurse and three health care assistants as has been the case to date. This process will, realistically, take at least three months to complete. I am, therefore, stating that the anticipated completion date for this phase will be January 26th 2015. This time frame appears realistic because of Christmas but will be commenced earlier if we are able to recruit suitable nurses earlier.

Proposed Timescale: 26/01/2015

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff were not provided with access to appropriate training in the areas of epilepsy, restraint and behaviours that challenge.

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

Please state the actions you have taken or are planning to take:
The training needs of the staff in the areas of epilepsy and restraint has been reviewed. A training has commenced and will be completed on 12 September 2014.
We will continue to train our staff on behaviours that challenge as part of induction programme and the refresher course.

Proposed Timescale: Complete