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:	Clontarf Private Nursing Home
Centre ID:	OSV-0000127
Centre address:	5 - 7 Clontarf Road, Clontarf, Dublin 3.
Telephone number:	01 833 5455
Email address:	clontarf@silverstream.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Clontarf Private Nursing Home Limited
Lead inspector:	Sarah Carter
Support inspector(s):	None
Type of inspection	Unannounced Dementia Care Thematic Inspections
Number of residents on the date of inspection:	37
Number of vacancies on the date of inspection:	3

About Dementia Care Thematic Inspections

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

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

Please note the definition of the following term used in reports:
responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor compliance with specific outcomes as part of a thematic inspection. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
13 August 2018 09:15	13 August 2018 17:30
14 August 2018 09:00	14 August 2018 13:30

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

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

Summary of findings from this inspection

As part of the thematic inspection process, providers were invited to attend information seminars given by the Authority. In addition, evidence-based guidance was developed to guide the providers on best practice in dementia care and the inspection process.

In April of this year, the person in charge completed the self-assessment and scored the service against the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland. They identified their service as substantially compliant across all six outcomes and detailed the actions taken or being planned to address the issues they identified. However in June 2018, a new person in charge was appointed and as a result some of the actions had

been delayed.

The inspector met with residents, relatives, and staff members during the inspection. The journey of a number of residents with dementia was tracked. Care practices and interactions between staff and residents who had dementia were observed and scored using a validated observation tool. Documentation such as care plans, medical records and staff training records were also reviewed.

The centre does not have a dementia specific unit. On the day of inspection, over two thirds of the residents had a formal diagnosis of dementia, a cognitive impairment with similar symptoms to dementia, or were suspected of having dementia.

Through conversation with residents and observations of the care being provided the inspector found that residents needs were being met. Residents rights were being respected and choice was being offered to ensure residents where able to make decisions about how they were living in the centre. There was a range of activities being provided by a designated staff member and residents were seen to be enjoying the social aspect of the day.

The centre's last inspection took place in August 2017, and the detail of its' judgments and the improvements made following the inspection will be discussed in the body of the report.

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

Outcome 01: Health and Social Care Needs

Theme:
Safe care and support

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

Findings:
This outcome sets out the findings relating to healthcare, nursing assessments and care planning. The findings in relation to the social care of residents with dementia will be discussed in Outcome 3. On the day of inspection approximately 70% of the residents in the center had a diagnosis of dementia or a similar condition. Care plans for a number of these residents were reviewed, focusing on the management of the symptoms of dementia, their nutritional needs, end of life plans, the management of falls and any specialist input the resident may have required following a change in their condition.

Residents had a range of general practitioners (GPs) available to them within the centre. They could retain access to their own GP if they wished. There was good access available to all residents who required specialist treatment, for example with dieticians, speech and language therapists and physiotherapy. The physiotherapist was available for a day per week in the centre, and the other allied health practitioners were available privately or through local HSE services.

The centre rated themselves as substantially compliant in this outcome; and detailed some actions they were taking to come into compliance. In the centre's last inspection in August 2017, this outcome was judged as a moderately non compliant. The actions identified included re-writing care plans and conducting monthly audits on care plans.

The inspector found the care planning process had improved. Care plans were recorded on a main sheet and when they were reviewed the review date was recorded, and the care plan updated. The assistant director of nursing (ADON) was completing monthly audits on samples of care plans. The majority of care plans reviewed had been reviewed every four months or sooner if the residents condition changed. Some gaps in care planning were identified in the in restrictive practices, however this will be addressed in Outcome 2. Care plans were clear and contained person-centered language and information that could guide staff practice.

Resident's end of life care plans were reviewed. The center had a policy to guide practice in this area, however the policy required updating to reflect the preferences of

families and residents for differing funeral arrangements. In a small sample of care plans reviewed, one resident was identified who did not have a care plan in place for their end of life.

Records were seen that indicated residents who were transferred to and from hospital had the correct information sent with them and discharge reports and subsequent follow up appointments were in place. The resident's care plans had been updated to include any new directions from the discharging hospital.

There was a system in place to ensure that residents nutritional needs were met, and that they did not experience unintentional weight loss or dehydration. Residents were screened for their nutritional risk and were weighed monthly. If a resident lost weight a new assessment was completed, and they were monitored closely. A more detailed daily record was available for these residents nutritional intake and they were seen appropriately by a dietician. Care plans were updated to reflect the dietician's recommendations.

The inspector observed a mealtime in the centre, using a standardised tool. Overall example of positive connected care were observed, and residents were being assisted by staff where required. However some residents with additional needs not attended to as quickly as their care plan indicated, and as a result their behaviours attracted the attention of other residents in a negative way. The dining area could not accommodate all residents at one sitting, and some residents with higher dependency needs were being assisted with eating their meals in a separate day room. As these residents were not seated together, a review was required to ensure their mealtime experience was an meaningful as possible and offered stimulus and social engagement. The main dining area was a long room slightly below ground level, with a bay window at the front and a long conservatory area with roof windows towards the rear of the room. The level of light varied substantially throughout the room, as did the use of the space, with a higher concentration of residents in the area with the least amount of light. The menu in the centre was not dementia friendly, and the tables were not decorated in any way prior to the meals to enhance the mealtime experience. The person in charge showed the inspector that this item was on the agenda for a management meeting the week following the inspection. The centre had completed its own formal observations of the dining experience using the QUIS tool, and the findings mirrored those of the inspector. However the findings of the most recent observation had not been actioned to date.

Medications were handled correctly and stored safely in the centre. Medication practices observed by the inspector were safe and followed requirements. There were both internal and external audits taking place on medication practices in the centre. An external audit had been completed by the centre's pharmacy service prior to the inspection day, and its results had been published and shared with the person in charge. Specific actions to address the findings in the audit were yet to be addressed, however the person in charge had had some discussion with the senior management team about addressing the findings.

Judgment:
Substantially Compliant

Outcome 02: Safeguarding and Safety

Theme:
Safe care and support

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

Findings:
There were systems in place to ensure residents were safeguarded from abuse. There was an up to date policy to guide staff and staff had been trained in protecting vulnerable adults. Staff were aware of the different abuses that could occurr and were able to outline the steps they would take if a resident reported information to them. There were no recent incidents or allegations of abuse in the centre, as a result there was no documentation available to review. The inspector spoke with a number of residents who reported that they felt safe and secure in the centre, and some visitors spoken to reported that they also felt the service was running safely.

There was a policy available to inform staff on how to manage residents who experienced behavioural and psychological symptoms of dementia (BPSD). There was a small number of residents in the centre who experienced episodes of responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort or discomfort with their physical or social environment). Records showed that some care plans on the management of residents responsive behaviours required additional information to fully inform staff of the types of behaviours and likely triggers for it. Additional behavioural records were being maintained after incidents of responsive behaviours separate to the care plan. The use of PRN (as required) psychotropic medication was reviewed, however there had been no recent incidents where medication was used in this way.

There was a policy in place to guide the use of restrictive practices, however gaps were identified in how this policy was being implemented. Residents who used bedrails ware documented as having had an assessment, however the assessment did not include details of alternatives that were trailed or the rationale for not using them. No evidence was seen that indicted this assessment was repeated at regular intervals or when the resident's condition changed. The care plans which should have indicated the requirement for bedrails to be in use, did not include that detail, and in some case where the bedrail were in use they were was recorded in different places, for example in a care plan on ''sleep'' or in a care plan on ''mobility''. The register of bedrail use which was being maintained was not accurate as it did not reflect a recent change where a resident had discontinued using them.

The centre was a pension agent for some of its residents and they managed this arrangement in line with requirements. The centre also had a facility to manage residents day-to-day finances and the record seen were accurate and correct. Residents could access their finances without restriction.

Judgment:
Non Compliant - Moderate

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:
Person-centred care and support

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

Findings:
Residents with dementia were consulted and supported to participate in the organisation of the service. Regular residents meetings took place and the centre also facilitated support groups for the relatives of resident's with dementia, one of which had taken place in the early part of 2018, with another planned for the weeks after inspection. Advocacy was available within the centre both from an external company and from an advocate appointed by the group that ran the nursing home.

Residents communication was assessed, and care records were seen indicating the communication challenges that residents lived with and guided staff on the best approach to take with the resident. No resident in the centre was using cue or picture cards.

Communication with residents with dementia was enhanced by careful signage around the building, that would help them find their way, However there was no signage in use to mark individual bedroom doors. Posters displaying the activity programme were small and not easily identified by residents with dementia and while there were clocks around the building and signs informing the residents what nursing staff were on duty, there was no large orientation board or boards in key locations that could prompt residents to know the day of the week, the date or the weather conditions outside.

Resident's were seen to be enjoying magazines or TV in their own time, and on the days of inspection there was planned activities taking place in the communal day rooms. There were parallel sessions taking place so residents could choose between activities or spend their time alone. The centre had recently gained access to a dog, who was in the centre everyday. This brought a great deal of enjoyment to residents, and all were complimentary about this initiative. Residents also confirmed thy could spend time alone if they wished and didn't feel any pressure to attend a programme. Residents had had outings to the community and recently a barbeque party had taken place in the garden, both of which resident said they enjoyed.

Residents religious needs were catered for in the centre and residents were facilitated to vote in a recent election.

In the center's last inspection some of the multi-occupancy room on the first floor required reconfiguration to ensure residents privacy and dignity was upheld. These works had been completed and had improved the level of privacy and dignity for residents who lived there, however some further physical work was still required, and this will be discussed in the outcome on premises.

Judgment:
Compliant

Outcome 04: Complaints procedures

Theme:
Person-centred care and support

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

Findings:
The complaints process was not assessed on the previous inspection. In the self assessment, the person in charge indicated the process was substantially compliant; however all action listed to come into compliance were processes that were already in place, for example meeting residents regularly and ensuring there was regular advocacy meetings.

There was a clear policy in place to guide complaint management in the centre. The policy outlined the responsibilities of the people involved in the management of complaints. There was an appeals procedure and accurate information given about raising complaints with the Ombudsman. The complaints process was also displayed at reception and outlined who the person should raise their complaint with. The person in charge (PIC) was the appointed complaints officer, with a senior manager reviewing the complaints data regularly. The records of complaints were reviewed, and indicated the processes in the policy were followed. the records included the information that was required by the regulations. Residents who spoke with the inspector said they know how to, and who to, raise their complaints with.

Judgment:
Compliant

Outcome 05: Suitable Staffing

Theme:
Workforce

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

Findings:
The centre rated itself as substantially compliant in this outcome, identifying mentoring staff and training staff in activity provision as their actions to come into full compliance. In the centers last inspection, staffing was found to be compliant.

During this inspection, staffing was sufficient in the center to meet the daytime needs of residents. A look back exercise completed by the person in charge after a recent incident had resulted in an additional staff member allocated during day time hours to facilitate increased supervision at mealtimes.

At night time, one full time nurse was assisted by three health care assistants. Due to the size and layout of the building, a review was required to ensure the needs of all residents could be attended too at night. The center's own emergency response plan cited that staff could evacuate residents horizontally, vertically, partially or conduct a total evacuation, depending on instructions from senior staff, during an emergency.

Following the inspection, the centre furnished a list of residents by unique identifiers, their bedroom location and their dependency. Almost three quarters of residents live on either the the basement (lower ground floor) level or the first floor, and approximately 10 residents between these floors were defined as requiring maximum assistance as they were bed-bound and / or wheelchair users. The person in charge and senior manager agreed during the inspection to review staffing levels to ensure residents needs could be managed in the event of an emergency with nighttime staffing resources.

It was reported that the assistant director of nursing (ADON) completed the roster with skill mix and experience in mind and new starters did not work on nightshift. Staff also rotated from day to night shift and night shift staff were facilitated to attend re-training.

Following the inspection last year, the staff undertook a fire drill that simulated nighttime conditions, this had not been repeated in the last 12 months, however day time conditions had been repeated.

Staff had received training in safeguarding, fire and manual handling. A small number required re-training, and these dates were scheduled in the weeks following the inspection. The majority of staff had also received training in dementia care and the management of behaviours that challenge. Staff were yet to receive training in activity provision as per the center's self-assessment.

A sample of staff files were reviewed and found to include all the documents required by the regulations. The centre did not have any volunteers at the time of inspection.

Judgment:
Substantially Compliant

Outcome 06: Safe and Suitable Premises

Theme:
Effective care and support

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

Findings:
The center consisted of two large period houses that were joined together that provided accommodation on a lower ground, ground and first floor levels. There was a mix of single en-suite rooms, twin room and bedrooms with triple occupancy. The reception area was on the main ground floor accessible up a set of outdoor steps. However a gently sloping ramp was also available for access which would bring users directly to the the lower ground floor level. The building was served by two lifts, which reached different levels in the building. Due to the size of the lifts, residents in wheelchairs would have the footplates removed off their wheelchairs to ensure they could fit in the lift safely.

In the centre's previous inspection, bedrooms on the first floor required re-configuration to ensure residents privacy and dignity could be maintained. An additional bathroom was also highlighted as required on the first floor, and this work had been completed by the time this inspection took place. Overall the re-configuration afforded the residents with the privacy they required, however some further work was required in one of the multi-occupancy rooms to ensure all residents had access to their furniture and storage areas. Additional handails were identified as required, and these had been installed.

Storage of adaptive equipment required further review. It was observed that equipment was being stored in bathrooms, and commodes frames were left in residents' bedrooms as there was no separate area for storage. Incontinence wear was not discreetly stored in bathrooms seen by the inspector, and was left on surfaces and open shelving in bathrooms.

Adaptive equipment was in use throughout the center to facilitate residents independence. In the document submitted following inspection with residents dependency needs, approximately 18 residents were designated as wheelchair users. Approximately one third of these wheelchairs were observed in use on the days of inspection without the correct footplates and leg-rests in position. In the centre's own policy on using correct manual handling technique, equipment was required to be in good working order. The use of wheelchairs without footplates increased the residents' risk of falls and injury.

Levels of light varied in the dining room. This room spanned the full depth of the building, with a below ground level bay window at the front and ceiling windows in the section towards the rear. Residents were viewed to be concentrated in the darker section of the dining area for mealtimes and also for relaxation time between meals.

The centre had completed an audit on its own levels of dementia friendly features, and received a rating of 77%. The inspector found that signage was well used on bathrooms and in general hallway areas, however there was no signage on residents' bedrooms doors. The centre also had different sets of stairs and two separate lifts which required further sign posting to facilitate residents finding their way.

There were sufficient day room and sitting room spaces on the ground floor levels to facilitate residents, and allowed activities for different abilities to take place at the same time. These large rooms could be closed off in the middle, to provide separate rooms if required.

The residents noticeboard in the dining room displayed some information more suitable for staff. There were clocks throughout the building however residents with dementia would benefit from more orientation boards to highlight the day, date and outdoor conditions.

The dining experience has been described earlier in this report, and required review to ensure residents with dementia were able to participate and have a meaningful dining experience.

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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Regulation Directorate
Health Information and Quality Authority

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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:	Clontarf Private Nursing Home
Centre ID:	OSV-0000127
Date of inspection:	13/08/2018
Date of response:	19/09/2018

Requirements

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

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

Outcome 01: Health and Social Care Needs

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The person in charge is required to ensure all care plans have been reviewed at intervals not exceeding four months.

1. 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

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

it, after consultation with the resident concerned and where appropriate that resident's family.

Please state the actions you have taken or are planning to take:
The person in charge has completed a full review of all care plans and all care plans have been reviewed within 4 months. An audit will be completed to identify all residents who require a care plan for their end of life care and wishes. We have established an end of life care plan register to ensure compliance that discussions and development of a care plan is in place for every resident.
As noted during the inspection under Health and Social care we have increased the lighting in the dining room, the donning room has been reconfigured to ensure residents avail of the maximum amount of natural lighting this improving the dining experience. Dementia friendly menus are being prepared. Bothe the QUIS review and medication audit reviews have been actioned and communicated to staff.

Proposed Timescale: 20/10/2018

Outcome 02: Safeguarding and Safety

Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The assessment and use of bedrails in the center required reviewed to ensure the process was in line with national policy.

2. 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:
The assessment for residents that use bedrails now includes the alternatives that were trailed including the rational for the use of bedrails. Each resident that uses a bedrail has it recorded in a detailed care plan. The care plans includes the rational for the use of the bedrails and is reassessed and reviewed on a 3 monthly basis or after any significant change in health. Care plans of residents with responsive behaviours will be reviewed to include all possible triggers and best practice interventions, this is to ensure that the use of chemical restraints is kept to a minimum. The care plan review process will include all restrictive practices and their alternatives, with their rational being documented. Training in restrictive practice will be scheduled for care staff.

Proposed Timescale: 20/11/2018

Outcome 05: Suitable Staffing

Theme:
Workforce

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The registered provide is required to review the needs of residents and ensure the numbers of staff scheduled to work at night-time can meet the residents needs.

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

Please state the actions you have taken or are planning to take:
The registered provider and the PIC carries out an audit and review of dependency levels on a monthly basis to ensure staffing levels are appropriate, to meet the needs of residents both at day time and night time. Staff receive Fire training and a fire drill evacuation on an annual basis. These drills include a night time evacuation simulation. The PIC also completes a night check and will review the Fire drill evacuation with staff that are on duty. The last night drill simulation was on the 6th June 2018.

Proposed Timescale: 20/09/2018

Outcome 06: Safe and Suitable Premises

Theme:
Effective care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The register provider is required to ensure that residents have adequate space and suitable storage facilities for their personal possessions in the private area of their bedroom, in rooms with more than one occupant.

4. 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:
The registered provider has now ensured that residents have adequate space and suitable storage facilities for their personal possessions in the private area of their bedroom, in rooms with more than one occupant.

Proposed Timescale: 20/09/2018

Theme:

Effective care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The registered provider is required to ensure all equipment in use by residents in the centre is in good working order.

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

Please state the actions you have taken or are planning to take:
The home maintenance office is required to review all equipment on a regular basis. A full review of equipment is underway and any equipment identified as requiring repair will be fixed or replaced. A review of wheelchairs has been completed and all wheelchairs in use in the home now have footplates and are assigned for use to specific residents.

Proposed Timescale: 20/10/2018

Theme:
Effective care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The registered provider is required to ensure there is suitable storage available in the center to safely store equipment and commodes.

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

Please state the actions you have taken or are planning to take:
The registered provider will ensure that there is suitable storage available in the centre to safely store equipment and commodes. Areas have been identified as storage areas for equipment and additional outside storage will be put in place to store unused equipment.

Proposed Timescale: 20/10/2018