Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	St David's Nursing Home
Name of provider:	St. Davids Nursing Home Limited
Address of centre:	Gentian Hill, Knocknacarra, Salthill, Galway
Type of inspection:	Unannounced
Date of inspection:	17 February 2021
Centre ID:	OSV-0000391
Fieldwork ID:	MON-0031384

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

St. David's is a residential home situated in Gentian Hill, a quiet area of Salthill, Galway. As St.David's is a small home, every resident is assured of individual attention to their needs. St. David's is committed to providing a safe and secure environment for our residents. We endeavour to provide high quality care in a homely environment. The centre comprises of 16 single bedrooms and one double. The living area comprises of a communal day and dining room and a conservatory with views of Galway Bay.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	18

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 17 February 2021	13:00hrs to 17:00hrs	Catherine Sweeney	Lead
Thursday 18 February 2021	10:30hrs to 13:30hrs	Catherine Sweeney	Lead

What residents told us and what inspectors observed

This inspection was conducted during the COVID-19 pandemic. The centre had remained free of COVID-19. National restrictions meant that leaving the centre or having family and friends to visit was restricted. Residents were aware of the interventions in place and while they expressed their frustration at the restrictions, they understood why they were in place. Window visits were observed to be facilitated on the day of inspection. Both the resident and their family member were very satisfied with this arrangement and looked forward to a time when 'things could get back to normal'.

Feedback from all the residents spoken with on the days of inspection was overwhelmingly positive. All residents spoken with told the inspector that they loved living in the centre. They explained that the staff made them feel safe and well looked after.

Residents told the inspector that they 'generally had nothing to complain about, but if they did, they would be happy to speak with any member of staff. Residents were observed to know all the staff by name. Staff speaking with residents did so in a kind and respectful manner.

One resident told the inspector that the staff are always kind to them, and treated them with respect. The inspector observed this to be the case throughout the two days of inspection.

The inspector observed the residents to be actively involved in every part of the centre. A resident-led culture was evident with residents choosing mealtimes, bedtimes and the activity schedule. Staff communicated with the residents throughout the day and sought resident consent prior to each care interaction.

Meal times were observed to be relaxed and social occasions. Food appeared wholesome and nutritious. Residents were highly complimentary of the food, stating that they were always offered choice and that the food was of a consistently high quality.

Residents were observed to be mobilising independently around the communal area of the centre, others enjoyed spending time in their bedrooms. All residents spoken with stated that they had plenty to do during the day. They had access to television, radio and newspapers. A schedule of activities was in place and was facilitated by the care assistants on duty. The inspector observed the residents being socially engaged with the ongoing activities such as exercises and quizzes. Other residents watched a current affairs programme on the television and were actively discussing the days news with the care staff.

Residents had access to an advocacy service if required. A monthly resident

meeting had been chaired by an independent advocate, however, this had not been possible with the pandemic restrictions. Resident meeting's continued to be chaired by staff where concerns relating to COVID-19 or any other issue could be discussed. Residents and their families completed a satisfaction survey in December 2020. The feedback from this survey reflected the positive feedback voiced by the residents.

Capacity and capability

This was a risk inspection carried out by an inspector of social services to monitor compliance with regulations.

The centre has a clear organisational structure. The provider representative was the general manger and had a strong presence in the centre. The provider was well known to the residents and the staff. The person in charge communicated daily with the provider in relation to the day-to-day management of the centre. The lines of responsibility and accountability were clear and understood by all staff.

The information requested by the inspector over the two days of inspection was made available in a timely and organised manner. The provider and person in charge had systems in place to ensure that they had oversight and governance of the quality of care received by residents. A review of the action plan developed from these audit was required to ensure that each action had an appropriate time line identified.

The provider and person in charge had regular meetings with staff. The COVID-19 pandemic restrictions had resulted in fewer meetings being scheduled however, the smaller size of the centre allowed for effective systems of communication and staff reported that they were kept up to date with any changes or quality improvement relating to the governance of the centre.

The provider was in the process of upgrading both the nursing documentation system and the medication management system in the centre. A plan was in place to upgrade the paper-based nursing documentation system to an electronic system to facilitate improvements in information governance.

A review of the complaints log in the centre found that complaints were not management in line with the centre's policy or the requirements under regulation 34. A review of the management of complaints was required to ensure that all complaints are investigated, learning opportunities can be identified and that complainant satisfaction is recorded.

The centre accommodated 18 residents. Of these residents, seven were assessed as having high or maximum care needs and the remaining 11 residents requiring low to medium levels of care. A review of the rosters found that the centre had adequate staff to meet the assessed needs of the residents and the size and layout of the centre. However, a high rate of absence and staff turnover during the pandemic had

resulted in a need for on-going recruitment to ensure that the number of staff available matched the staffing committed to in the centre's statement of purpose. The provider was in the process of recruiting a staff nurse and a second person for cleaning duties.

The centre had a nurse on duty day and night. The person in charge and the general manger were on-site during the week to support the staff. A team of three carers were on duty in the morning reducing to two in the afternoon and one carer at night. The carers delivered both health and social care to the residents.
The activity schedule was facilitated by the care assistants. The provider informed the inspector that staffing levels remained under review to ensure that the physical, social and psychological needs of each resident was met.

Each member of staff had received training appropriate to their roles including safeguarding, fire safety, infection prevention and control, and manual handling. A training schedule was in place for all newly recruited staff. Staff had received update training in Infection control specific to COVID-19 infection including infection prevention and control, the safe and effective use of personal protective equipment (PPE), and Hand Hygiene.

Staff were well supervised and supported in the centre. The inspector observed effective communication between staff members in relation to resident care needs.

A review of staff files files found that the centre had a robust recruitment and induction system in place. On-going staff appraisal was recorded. All staff had a Garda (police) vetting certificate on file.

Regulation 15: Staffing

Staffing levels in the centre were adequate to meet the assessed needs of the residents and for the size and layout of the centre.

Judgment: Compliant

Regulation 16: Training and staff development

All staff had received training appropriate to their role. Staff were supervised and supported in their role by the management team.

Judgment: Compliant

Regulation 23: Governance and management

The provider had management systems in place to ensure that the service provided was maintained to a high standard.

A system of clinical and environmental audits had been completed. Quailty improvement issues had been identified and an action plan was developed. However, it was not clear if the actions identified had been completed. The audit system required review to ensure that a person responsible to complete the action was identified and that there was an appropriate time-line identified.

An annual review from 2020 was in development but had not yet been completed.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The management of complaints required review. A complaints register reviewed lacked the detail required under regulation 34. A small number of complaints had been documented however, there was no evidence of a follow up investigation or evidence that the complainant was satisfied with the outcome of the investigation.

Complaints were not documented in line with centre's complaints policy.

Judgment: Not compliant

Quality and safety

Overall, the inspector found that health and social care was delivered to a high standard in the centre. Some improvements were required in the area of medication management, care plan documentation and the risk management policy in the centre.

The inspection took place during the COVID-19 pandemic. The inspector found that infection prevention control practice was maintained to a high level. A cleaning schedule was in place and signed by staff. All cleaning staff had received training in infection prevention and control.

The provider was guided by the Health Protection Surveillance Centre (Hpsc) Interim Public Health, Infection Prevention and Control Guidelines on the Prevention and Management of COVID-19 Cases and Outbreaks in Residential Care Facilities

guidance.

The inspector observed care delivery in the centre to be resident-centred and resident-led. Resident spoken with described how care was delivered in line with their needs and their personal wishes. Each resident in the centre had an individual assessment and care plan completed. Care plans were updated with any changes to residents care and reviewed every four months. However, some care plans were found to be based solely on the medical needs of the residents and did not reflect the high quality physical, social and psychological care observed to be delivered.

A review of the medicine management systems in the centre required review. The system of medicine administration and some residents' medicine charts were not documented in line with professional guidelines.

All residents in the centre had access to a general practitioner (GP) of their choice. Residents had a medical and medicine review documented every three months or as required. Access to GP services was restricted during the time of the pandemic, however, residents had been reviewed as required.

The support of allied health care professionals such as physiotherapy, speech and language therapy, dietitian, chiropody, palliative care and psychiatry of later life were also available to the residents.

While risks were identified and managed in the centre, a review of the risk policy was required to ensure that it contained all the requirements under regulation 26.

Residents rights were respected in the centre. Staff interaction with the resident was observed to be kind and respectful. Residents spoke of how the centre felt like 'a home from home' and that staff treated them like 'one of the family'. Residents meeting were scheduled to give the residents an opportunity to discuss their concerns in relation to the COVID-19 restrictions, food and mealtimes, activity schedules and any other concerns they had. Residents also had access to an advocacy service.

Regulation 26: Risk management

A risk register was reviewed and found to include clinical and environmental risk management. Hazards such as kitchen risks, management of waste, and open stair-wells, and were identified and included control measures in place to manage the risks. However, a review of the risk management policy found risk assessment in relation to abuse, unexplained absence, accidental injury and self-harm was not included in either the risk register or the risk management policy as required under regulation 26.

Judgment: Substantially compliant

Regulation 27: Infection control

The centre has a COVID-19 policy available for review. The centre had protocols in place to prevent the spread of infection. A procedure was in place to check the temperature and symptoms of staff and visitors to the centre. The centre was visibly clean on the day of inspection.

The centre had remained COVID-19 since the start of the outbreak.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

A review of medication management was required. Non-compliance observed on the day of inspection included

- poor practice in administration of medication
- incomplete detail on medicine administration charts including resident photo and prescriber's signature.

The provider had a plan in place to update medication administration systems and had engaged with local pharmacy services. This plan had not yet been implemented.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

While the quality of some assessments and care plans was high and completed in a timely and effective manner, some resident files reviewed were less person-centred and documented the physical needs of the resident rather that the holistic person-centred care observed.

A review of the documentation of assessments and care plans was planned by the provider in line with an upgrade of an electronic system of documentation.
This system was not yet in place.

Judgment: Substantially compliant

Regulation 6: Health care

All residents had access to a doctor of their choice and the support of a team of allied health care professionals. Recommendations from the multi-disciplinary team were incorporated into the residents care plans.

Judgment: Compliant

Regulation 9: Residents' rights

Residents rights were respected in the centre. Staff were observed to communicate with residents in a kind and respectful manner. Residents were offered choice in every area of their daily lives.

Residents were actively involved fire training and participated in all fire drill scenarios.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 26: Risk management	Substantially compliant
Regulation 27: Infection control	Compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for St David's Nursing Home OSV-0000391

Inspection ID: MON-0031384

Date of inspection: 17/02/2021

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant 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 document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

<table>
<tr><th>Regulation Heading</th><th>Judgment</th></tr>
<tr><td>Regulation 23: Governance and management</td><td>Substantially Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 23: Governance and management:
Actions Identified,Post Cinical, and Environmental Audits, will be completed in a timely manner.
Nurse Manager will be responsible for completing any actions required, post audit.

Annual Review for 2020 is now complete.</td></tr>
<tr><td>Regulation 34: Complaints procedure</td><td>Not Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
We have reviewed our complaints policy and in accordance with regulation 34,we will ensure that all complaints are investigated and followed through to the residents satisfaction. We will observe and learn to further improve our service to residents with immediate effect.</td></tr>
<tr><td>Regulation 26: Risk management</td><td>Substantially Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 26: Risk</td></tr>
</table>

management: We will review, and update our risk management policy. We will include Abuse, Unexplained absence, Accidental Injury, and Self Harm.	
Regulation 29: Medicines and pharmaceutical services	Not Compliant
Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services: We have already initiated upgrading of our medication management system, along with our paper documentation. This will ensure good practice in our administration of medication. All prescibers signatures are now present, along with resident's photo, in medication cardex. Timescale on Epicare system: 1 month. Medication management : Secure medication trolley: 2 weeks	
Regulation 5: Individual assessment and care plan	Substantially Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan: We have begun to review our care plans. Going forward our goal will be to evaluate the current and future medical, social and emotional needs of our residents.	

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Substantially Compliant	Yellow	31/05/2021
Regulation 23(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.	Substantially Compliant	Yellow	31/05/2021

Regulation 26(1)(c)(i)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control abuse.	Substantially Compliant	Yellow	31/05/2021
Regulation 26(1)(c)(ii)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the unexplained absence of any resident.	Substantially Compliant	Yellow	31/05/2021
Regulation 26(1)(c)(iii)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control accidental injury to residents, visitors or staff.	Substantially Compliant	Yellow	31/05/2021
Regulation 26(1)(c)(iv)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control aggression and violence.	Substantially Compliant	Yellow	31/05/2021
Regulation 26(1)(c)(v)	The registered provider shall ensure that the	Substantially Compliant	Yellow	31/05/2021

	risk management policy set out in Schedule 5 includes the measures and actions in place to control self-harm.			
Regulation 29(5)	The person in charge shall ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.	Not Compliant	Orange	19/03/2021
Regulation 34(1)(d)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall investigate all complaints promptly.	Not Compliant	Orange	19/03/2021
Regulation 34(1)(f)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall ensure that the nominated	Not Compliant	Yellow	19/03/2021

	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.			
Regulation 34(1)(g)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall inform the complainant promptly of the outcome of their complaint and details of the appeals process.	Not Compliant	Yellow	19/03/2021
Regulation 34(1)(h)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall put in place any measures required for improvement in response to a complaint.	Not Compliant	Yellow	19/03/2021
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for	Substantially Compliant	Yellow	19/03/2021

	a resident no later than 48 hours after that resident’s admission to the designated centre concerned.			