Irish Association of Social Workers

Submissions on Clinical Governance in Nursing Homes on behalf of the Head Medical Social Workers Special Interest Group

Prepared by HMSW Co-Chairs

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Please provide a concise overview (5 points) of key consideration to enhance clinical governance in nursing homes?

1. Clinical governance structures must be designed to provide whole person care, paying attention to the various needs of residents placed in Irish nursing homes including:
   - Those with high clinical care needs
   - Those with end- of- life care needs
   - Those with social care needs who are unable to live at home but physically well (i.e. poor social coping skills, unable to manage meds e.g. insulin for diabetes management)
   - Those with communication needs.
   - People inappropriately housed in nursing homes, i.e. younger people, older people or people with disabilities who could live at home if community supports were provided.
2. Governance reform must ensure equity of access to **ALL** services in Public versus Private nursing homes.
3. Safe staffing levels are an essential requirement to support effective governance and safe, whole person care.
4. The nursing home sector in Ireland remains a medical model approach – as evidenced in the decision to move people from hospitals to nursing homes against their will and preferences, as evidenced in the Cherry Orchard scandal. While residents were understandably required to move due to health and safety issues, residents were only informed of this after the health service had made all arrangements without any consultation, ignoring the spirit and purpose of Assisted Decision Making legislation and ignoring rights based responses where staff would have been facilitated to move with patients to continue care. Medical model approaches which are unable to think creatively to provide rights based responses remains engrained in the Irish nursing home sector. Clinical governance can either address or compound this problem – vital to consider rights based leadership, including HSCP at senior grades at all levels in the system.
5. Statutory responsibility and mandate to Safeguarding Teams to assess and support concerns/allegations of maltreatment, abuse and coercion of residents in NH settings. Private NHs need to be properly integrated into the wider health and social care structures, with governance structures in place. It is concerning that services such as Safeguarding and primary care social workers/team cannot routinely go into private nursing homes. It is understood that the current practice is that the nursing home has to 'give permission' for Safeguarding services to go into private nursing homes. While this situation has improved in some areas with NHs being more readily accepting of and in many cases requesting this service, this should not be reliant on 'goodwill'.

What are your views on the current system of clinical governance structures – strengths, weaknesses, enablers, challenges?

<u>Strengths:</u>

Positive steps toward improvement since Covid. Clinical governance appears stronger within public nursing home settings.
Opportunities to learn from disability sector re move toward rights based model of care.

Weaknesses:

Lack of safeguarding legislation – Northern Irish experience (Dunmurray Manor) and CHO1, show clearly that regulatory bodies of systems, even with additional powers, cannot meet all safeguarding needs of sector.

Clear ageism in system including in governance structures. Despite Expert panel, despite prevalence of Long Covid in nursing homes, no Long Covid services were provided in nursing home sector. There is a sense that a deterioration in function is tolerated for residents and rehab potential is not valued.

Governance structures do not adequately value use of resident councils, self and peer advocacy poorly supported. Real risk that advocacy groups are default form of advocacy and 'speak for' rather than with residents now.

HIQA requirements and standards appear to have become more 'tick box' exercise rather than a safety or quality improvement measure.

There is a lack of transparency in relation to funding. For example in relation to the 'top up' additional costs that are requested from residents, sometimes for services that the person does not avail of. Family members are often held accountable for these costs.
Absence of appropriate and sufficient community supports require more people to go into nursing homes and long term care than is necessary.
Over reliance on medical care – does the term Nursing home suggest 'dependence' – would Care Home be more appropriate.
Again current Cherry Orchard protests highlights paternalism and lack of co-production with residents and families.

Enablers:

Strong governance structures promoting a rights based model of care delivery, taking a whole person, dignity of risk approach.
Governance cultures must reflect the organisational culture they wish to promote – where people can speak up, share concerns and where rights are discussed and promoted.
Co-production is key. It is routine in parts of UK with social rights based models of care for residents to interview staff for vacancies, for resident councils and self/peer advocacy groups to play leadership role at governance level. 'Do with not onto' approach.
Failure to focus on outcomes in research and evaluation – what do residents think about governance?

Challenges:

Single biggest challenge is the planned shift to rights based model of care. The Dept of Health is, in various forums, referring to a social care model, without defining it. The default continues to be the medical model. The Expert Panel of nursing homes was led by two consultants and a patient advocate who was a former nurse. We will only provide governance structures delivering whole person care when we stop solely viewing people through clinical lens. This requires a shift from the traditional consultant/nurse led models of care to a model with diverse leadership and governance where all staff have access to clinical supervision and governance.

How can it be improved?

Access and provision of GP cover.

Equitable access to all primary care services, regardless of whether someone lives in private or public nursing home.

Parallel with the above is the integration of extended care programmes within community services to include residents in nursing home settings (ongoing Clinic appointments, OPD services, ICPOP, Seating assessments via COT etc.)

There is a requirement for nursing homes to govern to regular, routine upskilling of staff around recognising progression in people's illness, move to end of life care and supporting the normal dying process in the nursing home where possible. Lack of understanding that someone may be near end of life there can be a tendency to consider ambulance conveyance to hospital inappropriately. Training and guidance should also be in place for staff to be competent in having clear and regular discussion with residents and family in relation to end of life care wishes.

Resident's forum within existing service to gain understanding and knowledge from persons already resident in nursing home settings. Not all services operate such forums.

Does the term 'Nursing Home' accurately define what the service is and what is can and should provide. Would 'Care Home' or 'Aged Care' or 'Older Persons Home' indicate a more universal term for what is provided – and signal a shift away from medical model?

Access to Safeguarding Teams and Services to appropriately respond to allegations and concerns of abuse and/or maltreatment of residents.

Implementation of Quality Improvement/Project Manager within nursing homes – a dedicated person/service – either independent or within the service – to improve patient care, look objectively at current service delivery to enhance resident care/experience.

What are your views on the duties and functions of the person in charge?

In comparing to a standard acute ward, this requires a number of layers of management from front line staff to deputy managers, managers and assistant directors.

Persons in charge require support around that management role and function from within their service and external.

They need to look at overall education of needs of staff, look at culture and values of their service/staff. There is a necessity for robust and ongoing induction for staff/new staff.

The role of person in charge could be from a different professional background rather than solely professionally nursing based. Clinical input and support can be provided in different ways to enable the manager/person in charge to discharge functions of the office. E.g. Teaghlach Model

The Teaghlach Model (Places to Flourish Booklet, page 8 see attached).

In the Teaghlach model, the Nursing Home is divided into domestic style units or households of 6-16 residents. The kitchen/dining room becomes the central focus of the household. Every effort is made to include residents in the rituals of preparing and eating meals. For some this may include assisting in the preparation of meals, for others it may about the sensory and social experience associated with family mealtimes.

The nurses' station no longer exists as the change in culture requires a different approach to 'observation'; designated space for confidential work is provided in a less overt way. Residents make most choices about their daily routines, ranging from when to get up, what to wear, what activities to be involved in, and how they want to participate in managing their health care.

Each household has dedicated staff who work almost exclusively in a single household in order to develop and foster relationships between staff, residents and residents' families.

The household team is non-hierarchical and is accountable for all outcomes within the household. This team is supported by a mentoring group (Senior Managers e.g. Director of Nursing who support the groups to develop skills such as team decision making, conflict resolution, delegation and other Leadership competencies and provide support through the provision of resources.

The households are the living quarters of the residents and residents receive care services within the household to support them to live with dignity and optimal independence. Other services are accessed as they would be if the residents were living in houses in the community

What are your views on the most appropriate model of GP care for nursing homes?

It has become apparent in rural Ireland access to GPs is impacting on a person's ability to go to a nursing home, particularly if their chosen NH is not in proximity to their own GP. It may be necessary to consider a model of GP care bespoke to NH services. This may also support additional clinical care within NH settings that could off-set unnecessary ED presentations and acute hospital admissions (i.e. if IV antibiotics/fluids can be managed in NH settings).

Consider a requirement of larger nursing home groups to include or provide GP cover within their services.

What are your views on the most appropriate composition and function of a Clinical Governance Oversight Committee?

Requires to have appropriate terms of references for service and roles of those involved in management and clinical governance.

Clear lines of communication to whom the Clinical Governance Group report to outside of NH setting.

Consider inclusion of:

- Quality and Risk manager
- HSCP professional
- Nursing professional
- Medical professional
- External advocacy service
- Resident/family representative

What are the important components of Clinical Governance for Nursing Homes?

Any structure must factor into its governance the role and necessity to adhere to ADM(C) legislation and the principle of self-determination and a human rights based approach to care.
Legal AHD will require settings to provide sufficient care and that the service can meet the expressed will and preference of the person.
Co-production with residents to ensure needs and preferences are reflected in service
Each nursing home will have different needs relating to the number of residents within the service
Guidelines and Governance need to cover and cater for different nursing homes of different sizes.
Any clinical governance needs to maintain and promote the balance of medical/clinical vs social need.

Other issues no previously identified

None noted at this time.

Additional information
Colleagues in the NRH complied a document that was published in February 2023 (and submitted to the Ireland East Hospital Group by the NRH PDOC Team in March 2023) relating to Care and Safeguarding of Patients with Prolonged Disorders of Consciousness. This documents the particular needs of this cohort of patients that are largely dependent on residential care. It notes the concerns of members of the MDT and Families in meeting the care of this group in safe and appropriate way**.**

We also attach information referred to within this submission to the Teaghlach Model of Care in Places to Flourish that echo points raised in this submission.

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