Health Information and Quality Authority
Social Services Inspectorate

Compliance Monitoring Inspection Report
Designated Centres under Health Act 2007

Centre name:	McBride Community Nursing Unit
Centre ID:	0647
Centre address:	The Crescent Westport Co. Mayo
Telephone number:	098-25592
Email address:	Aoife.scholfield@hse.ie /pauline.odonohue@hse.ie
Type of centre:	☐ **Private** ☐ **Voluntary** ☒ **Public**
Registered provider:	Health Service Executive
Person authorised to act on behalf of the provider:	Michael Fahey
Person in charge:	Aoife Scholfield
Date of inspection:	24 October 2012
Time inspection took place:	**Start:** 09:15 hrs **Completion:** 18:00 hrs
Lead inspector:	Mary McCann
Support inspector(s):	None
Purpose of this inspection visit:	☐ to inform a registration/renewal decision ☒ to monitor ongoing regulatory compliance ☐ following an application to vary conditions ☐ following a notification ☐ following information received
Type of inspection	☐ **announced** ☒ **unannounced**

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 their 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
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Social Services Inspectorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or well-being 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. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.

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

This inspection report sets out the findings of a monitoring inspection, in which 11 of the 18 outcomes were inspected against. The purpose of the inspection was:

- ☐ to inform a registration decision
- ☐ to inform a registration renewal decision
- ☒ to monitor ongoing compliance with regulations and standards
- ☐ following an application to vary registration conditions
- ☐ following a notification of a significant incident or event
- ☐ following a notification of a change in person in charge
- ☐ following information received in relation to a concern/complaint

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

Outcome 1: Statement of Purpose	☒
Outcome 2: Contract for the Provision of Services	☐
Outcome 3: Suitable Person in Charge	☒
Outcome 4: Records and documentation to be kept at a designated centres	☒
Outcome 5: Absence of the person in charge	☐
Outcome 6: Safeguarding and Safety	☒
Outcome 7: Health and Safety and Risk Management	☒
Outcome 8: Medication Management	☒
Outcome 9: Notification of Incidents	☐
Outcome 10: Reviewing and improving the quality and safety of care	☒
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	☒

This monitoring inspection was unannounced and took place over one day. As part of the monitoring inspection the inspector met with residents and staff members. The inspector observed practices and reviewed documentation such as care plans, medical records, accident and incident logs, policies and procedures and staff files.

The inspection report from the last inspection which was carried out in March 2012 identified non compliance in 26 regulatory matters. The original action plan response was forwarded to the Authority on the 24 April 2012. An update to this action plan was forwarded to the Authority on 6 November 2012.

This was the fifth inspection of this centre by the Authority. The inspection focused on those areas of practice that required improvement from the previous inspection carried on in March 2012 and to monitor compliance with the regulations to ensure conformity to an acceptable standard. Overall, a positive attitude to compliance was demonstrated and the majority of the actions from the previous inspection had been addressed. A number were partially addressed and the inspector was informed of the plans that were in place to address these.

Areas requiring improvement on this inspection included a requirement to address deficits in care planning, continued analysis and review of the quality of care and the quality of life of residents, assess re requirement for window restrictors and to progress work on environmental matters to enhance and improve the environment for the residents.

An action post the previous inspection related to the requirements set out to meet the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2009. Under these regulations the provider was required to submit written confirmation from a properly and suitably qualified person with experience in fire safety design and management that all statutory requirements relating to fire safety and building control have been complied with. The provider has complied with this requirement. The inspector noted that the fire safety system had been upgraded at the centre.

The inspector reviewed records of accidents and incidents that had occurred in the designated centre and was satisfied that all relevant incidents were notified to the Chief Inspector. Residents spoken with were very complimentary of the service provided. One resident told the inspector “I would hope you would get better than here, but I don’t think you would, this is the best you can get”.

There were still aspects of the physical environment which did not meet the Authority’s standards. The centre has some multiple-occupancy rooms. Due to the reduction in numbers the centre has plans to reconfigure the centre and allow a combination of twin and single bedrooms. As a consequence of the decrease in numbers this will increase the physical space for residents providing greater privacy and improve access for staff in the delivery of safe quality care by way of increased accessibility to use equipment to include hoists for transferring residents.

The Action Plan at the end of this report identifies actions that are mandatory to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009(as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

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 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

Theme: Governance, Leadership and Management
Effective governance, leadership and management, in keeping with the size and complexity of the service, are fundamental prerequisites for the sustainable delivery of safe, effective person-centred care and support.

Outcome 1
There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

References:
Regulation 5: Statement of Purpose
Standard 28: Purpose and Function

No actions were required from the previous inspection.

Inspection findings

While the Statement of Purpose had been updated in June 2012 and described the service that was to be provided and the manner in which it was to be provided it requires review to include date of registration, conditions of registration and details and qualifications of the current person in charge.

Outcome 3
The designated centre is managed by a suitably qualified and experienced nurse with authority, accountability and responsibility for the provision of the service.

References:
Regulation 15: Person in Charge
Standard 27: Operational Management

Outstanding actions required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

Aoife Scholfield is the person in charge. She commenced this post on 1 June 2012. (She is known in the centre as the Director of Nursing). She holds a full-time post. She is appropriately qualified and has the relevant experience to meet the regulatory requirements with regard to the post of person in charge. She has completed a Masters in leadership and has undertaken training in staff management, appraisals and complaints management. She has up-to-date training in adult protection, safe moving and handling and fire safety.

She told the inspector that she was committed to meeting the regulatory requirements and has experience of working in other jurisdictions where her post entailed meeting regulatory requirements. She was aware of her reporting responsibilities under the Health Act, 2007.

Outcome 4

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

References:

Regulations 21-25: The records to be kept in a designated centre
Regulation 26: Insurance Cover
Regulation 27: Operating Policies and Procedures
Standard 1: Information
Standard 29: Management Systems
Standard 32: Register and Residents' Records

Inspection findings:

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

Resident's Guide

Substantial compliance ☒ Improvements required * ☐

A residents' guide has been developed which complies with current legislation. A copy has been given to every resident. A copy in large print was available for residents who are visually impaired.

Records in relation to residents (Schedule 3)

Substantial compliance ☐ Improvements required * ☐

Medical and care files reviewed. Improvements required with regard to care planning. Commented upon in the report.

General Records (Schedule 4)

Substantial compliance ☐ Improvements required * ☐

Not checked on this inspection.

Operating Policies and Procedures (Schedule 5)

Substantial compliance ☐ Improvements required * ☒

Operational policies and guidance documents were in place to guide and inform staff. However, many of these required review. For example the restraint policy available

was the generic HSE national policy. A policy on the prevention, detection and investigation of alleged abuse required revision to include guidance to staff as to the action to take in the event of an allegation of abuse involving senior staff of the centre. While a safety statement was available this requires updating.

Directory of Residents

Substantial compliance ☐ Improvements required * ☐

Not checked on this inspection.

Staffing Records

Substantial compliance ☒ Improvements required * ☐
Three staff files were reviewed by the inspector. These contained all the information required by the regulations. Verified evidence of medical and physical fitness for the purposes of the work which the staff member were to perform at the designated centre was available, by way of an occupational health form, completed on appointment. One of these was completed in 2006 but there was no change in status or post of this staff member since appointment.

Medical Records

Substantial compliance ☒ Improvements required * ☐
Two medical files were reviewed by the inspector. Additionally, a sample of medication charts were reviewed by the inspector. Commented upon in the report.

Insurance Cover

Substantial compliance ☒ Improvements required * ☐
The property of residents is covered by the national HSE insurance.

Records requested were generally complete, accurate and up-to-date. They were maintained in an organised manner and were easily retrievable and secure. The person in charge confirmed that records were accessible to the residents to whom they referred to on request.

The person in charge had a file which contained reports from other inspections for example the most recent environmental health officers report from her inspection on the 26 September 2012 was available.

Theme: Safe care and support
Safe care and support recognises that the safety of service users is paramount. A service focused on safe care and support is continually looking for ways to be more reliable and to improve the quality and safety of the service it delivers.
In a safe service, a focus on quality and safety improvement becomes part of a service-wide culture and is embedded in the service's daily practices and processes rather than being viewed or undertaken as a separate activity.

To achieve a culture of quality and safety everyone in the service has a responsibility to identify and manage risk and use evidence-based decision-making to maximise the safety outcomes for service users.

Outcome 6
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse.

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

Outstanding actions required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

Measures were in place to protect residents from being harmed or suffering abuse. The inspector was provided with a copy of the centre's policy on prevention, detection and response to elder abuse. This required revision to include guidance to staff as to the action to take in the event of an allegation of abuse involving senior staff of the centre. The person in charge confirmed that she would review this policy as a matter of priority.

Access to the centre was open but was controlled via key-code lock when the receptionist was not on duty or when staff felt it was necessary to protect residents. The inspector found that residents were well cared for and felt safe in the centre. They attributed this to the quality of the care provided by the staff and the availability of staff being readily available. There was a receptionist on duty full-time on entry, a visitors log was kept and all staff were trained in Adult protection. The clinical nurse manager is an accredited trainer of elder abuse.

Staff informed the inspector of the procedures to be followed in the event of an alleged incident of elder abuse and they were clear how they would report an allegation of abuse and that the welfare of the residents was their primary responsibility. The person in charge confirmed that all staff had been Garda Síochána vetted. No incidents, allegations or suspicions of abuse have been recorded to date at this centre.

The centre had a policy on management of residents' finances but did not manage any of the of resident's finances at the time of this inspection.

Outcome 7
The health and safety of residents, visitors and staff is promoted and protected.

References:
Regulation 30: Health and Safety

Regulation 31: Risk Management Procedures Regulation 32: Fire Precautions and Records Standard 26: Health and Safety Standard 29: Management Systems
Outstanding actions required from previous inspection: Ensure that the risk management policy covers the arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents. Ensue policies and procedures and practice are consistent with best practise guidelines on prevention of infection and ensure staff are aware of these guidelines.

Inspection findings

The actions required from the previous inspection were satisfactorily implemented.

There were systems in place to manage risk and a risk register was kept up-to-date. The inspector reviewed the risk register and found that this was up to date. The most recent risk assessment was completed on the 15 October 2012. A risk assessment was in place with regard to the car park. This details the risk, the current controls in place to minimise the risk and any additional controls required to reduce and manage the risk to ensure residents are protected. Upgrading of the car park is planned as part of the refurbishment programme. The inspector noted that there were no restrictors on the windows to protect the safety of residents.

The most recent risk management policy was dated 5 March 2012. This complies with current legislation. Measures in place to prevent accidents included handrails, grab-rails and safe floor covering. The inspector reviewed records of accidents and incidents that had occurred in the designated centre and was satisfied that all relevant incidents were notified to the Chief Inspector as required by regulation.

Not all staff had up-to-date training in manual handling. The person in charge showed the inspector an email she had forwarded to the centre for nurse education requesting moving and handling training for staff.

Policies, procedures and practice in relation to infection control have been reviewed. A link nurse in infection control is available in the centre and she has completed specific training in infection control and has done updates for staff. The centre was clean and the person in charge has reviewed all the cleaning schedules. A cleaning schedule is available for all areas which staff sign and this is reviewed and by the person in charge.

While there was a policy in place to guide practice when responding to emergencies, this did not detail the procedure to be followed with regard to loss of water. This is kept in the main reception office. An emergency box which has gloves, aprons, a torch and the residents' personal details and medication details in the event of an

evacuation. Contingency arrangements with a list of all staff that could/would assist should evacuation be necessary was available.

Overall, fire safety was well managed. The centre had upgraded the fire safety management in the centre and had submitted a fire safety declaration and all staff had received up to date training in fire safety and prevention. The fire safety upgrade allows the centre to now complete lateral evacuation if it is deemed necessary to evacuate.Procedures for fire detection and prevention were in place. Smoke detectors were located in all bedrooms and general purpose areas. The inspector reviewed service records which showed that the fire alarm system, emergency lighting and fire equipment were monitored regularly. An individual evacuation plan was available for each resident. The inspector found that all fire exits were clear and unobstructed on the day of inspection. The director of nursing informed the inspector that all fire exits are checked daily to ensure they are unobstructed. A record was not maintained of this procedure. However, the person in charge stated that she would commence documenting this procedure immediately. The inspector viewed the fire training records and found that all staff had received up-to-date mandatory fire safety training and this was confirmed by staff. All staff spoken to knew what to do in the event of a fire.

Outcome 8
Each resident is protected by the designated centres' policies and procedures for medication management.

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

Outstanding action required from previous inspection:

Put in place appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents and ensure that staff are familiar with such policies and procedures.

Inspection findings

The action required from the previous inspection was satisfactorily implemented.

A revised medication management policy was in place which provided guidance to staff. This was comprehensive and detailed procedures in place in relation to the ordering, prescribing, and storing and administration of medication. The inspector observed a nurse administering medications and found that medication was administered in accordance with the centre's policy and An Bord Altranais guidelines. The staff nurse on the medication round was knowledgeable of the medications being administered and ensured that residents took the medication. Prescription and administration sheets were reviewed and they accurately outlined the residents' details and their prescribed medication. Each medication prescribed was individually signed by the prescribing medical officer. A photograph of each resident was available provided on each residents prescription chart.

The maximum amount of PRN (as required) medications was detailed on the prescription sheets reviewed by the inspector.

A system is in place for reviewing and monitoring safe medication management practices. The person in charge had completed an audit to assess whether there was a link between residents falling and the use of psychotropic medication. The audit found that there was not a link but the person in charge confirmed that they are going to complete this audit at intervals. A medication audit had also been completed in June 2012; this looked at medication charts and their completeness. Good compliance was noted.

Medications that required strict control measures (MDAs) in accordance with the Misuse of Drugs (Safe Custody) Regulations, 1984 were not checked by the inspector on this inspection. The person in charge told the inspector that a register of medications that require strict control measures is in place at the centre.

Theme: Effective care and support
The fundamental principle of effective care and support is that it consistently delivers the best achievable outcomes for people using a service within the context of that service and resources available to it. This is achieved by using best available national and international evidence and ongoing evaluation of service-user outcomes to determine the effectiveness of the design and delivery of care and support. How this care and support is designed and delivered should meet service users' assessed needs in a timely manner, while balancing the needs of other service users.

Outcome 10
The quality of care and experience of the residents are monitored and developed on an ongoing basis.

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

Outstanding actions required from previous inspection:

1. Establish and maintain a system for reviewing the quality and safety of care provided to, and the quality of life of, residents in the designated centre at appropriate intervals.

2.Make a report in respect of any review conducted by the registered provider for the purposes of Regulation 35, and make a copy of the report available to residents and, if requested, to the Chief Inspector.

Inspection findings

The actions required from the previous inspection were partially implemented.

The person in charge had established a system for reviewing the quality and safety of care provided to, and the quality of life of, residents in the designated centre. An audit calendar was described to the inspector.

A report on reviews conducted for the purpose of regulation 35 - Quality and Safety of Care and Quality of Life was made available to the inspector. Aspects of this report had been discussed at a residents meeting, this was evidenced by review of the minutes that were available of the resident's meeting.

An audit of activity provision was also completed by the person in charge. Post analysis of this, a meeting was held with residents and attendees of day care. Residents stated that they enjoyed the activities Monday to Friday but they wished to keep the weekend free from scheduled activities. One aspect of activity provision that they wanted increased was live entertainment in the afternoons. The person in charge has contacted local musicians and singers to try to secure more live entertainment in the afternoon. This was in the process of being arranged. The person in charge has also completed a pastoral audit. The results were very positive and Mass continues to be available on the radio every morning and the local priest celebrated Mass at the centre every Wednesday. The rosary is said daily. Residents commented to the inspector how much they enjoyed the religious aspect of the activity programme.

Other audits completed by the person in charge included an assessment of whether residents were wearing appropriate and correctly fitting footwear, call bell audit to check if all call bells were working - three were broken and these were replaced, quality of bins in the centre, safety audit which looked at the location, issue , action taken and resolution. One safety aspect identified was a lighted candle in the oratory; this has been replaced by a battery candle. An audit of the mobility of each resident and the aid they were currently using was completed by the physiotherapist and the person in charge.

A cleaning audit had been completed which looked at all areas in the centre. A care plan audit had been completed by the clinical nurse manager. This identified deficits in care planning. This was completed from the 12 to 16 October 2012. The person in charge explained to the inspector that she was going to allocate protected time to staff nurses to remedy the deficits identified.

While the person in charge had completed a good analysis of the information gathered and there was evidence of change/improvement brought about as a result of the learning from the review there was poor evidence available of how the information was cascaded to all staff.

The person in charge informed the inspector that there had been no complaints received since the person in charge took up post on 1 June 2012. A system is in place to address complaints received. A satisfaction questionnaire was completed in June 2012. This is to be repeated in December 2012 by the advocate as the person in charge feels that this will be a more independent process. The results of this survey were discussed with the inspector. Residents were unanimously complimentary of the service provided and the care received.

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

References:
Regulation 6: General Welfare and Protection
Regulation 8: Assessment and Care Plan
Regulation 9: Health Care
Regulation 29: Temporary Absence and Discharge of Residents
Standard 3: Consent
Standard 10: Assessment
Standard 11: The Resident's Care Plan
Standard 12: Health Promotion
Standard 13: Healthcare
Standard 15: Medication Monitoring and Review
Standard 17: Autonomy and Independence
Standard 21: Responding to Behaviour that is Challenging

Outstanding actions required from previous inspection:

1.Develop operational policies and procedures to ensure that residents are discharged from the designated centre in a planned and safe manner and discuss, plan for and agree the discharge with each resident and, where appropriate, with his or her family and/or carer.

2. Residents and/or their significant other should be involved in the completion and review of their care plan. Written evidence should be available of this.

3. Ensure assessment findings are reflected in the implementation and planning of care and care plans are updated in light of revised assessments including measures that address nutritional care.

4. Keep each resident's care plan under formal view as required by the resident's changing needs or circumstances, as and no less frequent than at thee-monthly intervals.

Inspection findings

The actions required from the previous inspection were satisfactorily implemented.

1. A policy entitled 'the discharge of a resident' was reviewed by the inspector. This had been implemented in June 2012. This policy covers planned discharges and discharges against medical advice. This policy had been discussed at a recent staff

meeting. The person in charge confirmed that when a resident is being discharged, this is a planned to protect the welfare of the resident. All appropriate personnel are communicated and the discharge is agreed with the resident and where appropriate their significant other. Any correspondence that is deemed appropriate is completed.

The inspector found that a good standard of nursing care was provided. Residents reported that they were very well cared for and residents looked well cared for. There were no residents with pressure sores on the day of inspection. The inspector observed the delivery of appropriate care to residents and observed that nurses spoken with described the delivery of good care to residents which met their needs. Staff were observed to be caring and kind in their approach to residents and residents told the inspector “the staff are great, I have never observed a cross word said or a voice raised, they look after us well”. “A day care resident told the inspector “I can’t wait to get in here”.

2 and 3: A new care documentation system had been enacted since the last inspection. The inspector found that there had been substantial improvements to the nursing assessments, clinical risk assessments and care plans since the previous inspection. However, there were still some aspects of the care documentation that required review. All nursing staff had received training on this system prior to its enactment. The inspector reviewed a sample of residents’ care plans. The inspector noted that generally assessments informed the care plans. There were some preventative care plans in place for example a risk reduction care plan. While the care plans were person centred the contents required further detail with regard to the delivery of care. For example, where a resident was prescribed supplements, while there were nutritional care plan in place the type of supplement was not documented. The only evidence available of involvement of the resident or their significant in the development and review of their care plan was a signature, but no narrative note was available of the resident’s or significant others view or understanding or agreement of the care plan. It was not possible to judge whether reviews were completed at a minimum every three months or with regard to changing circumstances.

A record of the residents’ health condition and treatment given which was linked to the care plan was completed on a daily basis.

4. The person in charge described good access to general practitioner (GP) services The inspector reviewed three medical files and found that there was documentary evidence that residents were seen by the GP. The person in charge stated that reviews of medication were occurring at three monthly intervals but this was not documented by the GP in the medical notes or on the medication charts. There was incomplete documentation in one medical file reviewed re end of life wishes. While the GP had documented that he/she was going to discuss these with the family and would document the consensus opinion in the medical notes this had not been complete although staff confirmed that the family had attended the meeting with the GP. The staff contacted the GP on the day of inspection and this matter was brought to their attention.

There was good access to allied health professional services including physiotherapy, occupational Therapy dietician and speech and language therapy services.
A chiropodist attended the service regularly. Audiology services were arranged as required via GP referral. Eye checks were also arranged as required. There was access to the local palliative care team.

The inspector found that the provision of meaningful activity for residents was an area that required improvement. Bingo, skittles and vintage films were a feature on the activity programme. Daily and provincial newspapers and the farmer's journal were available. However, the inspector noticed that some residents particularly those who were cognitively impaired were sitting in the dayroom for periods of time where there was a lack of opportunities for residents with cognitive impairment to engage in meaningful activity. The television was the only stimulation available in the day room. Social care assessments were not completed in the care files reviewed. The person in charge had obtained funding for a specific project with regard to reminisance therapy. She had plans to utilise these funds in conjunction with the availability of transitional year students to complete a project on obtaining photographs from areas where residents had lived and completing life histories with the residents.

The person in charge informed the inspector that there was no resident exhibiting behaviour that challenges at the time of inspection. The person in charge confirmed that they had good input from mental health services who attended the centre as requested.

The policy on restraint was the new national policy on promoting a restraint free environment. Restraint measures in place included the use of bedrails, lap belts (which were described as safety belts) and monitoring bracelets by a small number of residents. The inspector reviewed records with regard to restraint measures in place. There was a risk assessment completed prior to the use of the restraint. A rationale was provided for the requirement of the restraint measure. The risk assessments documented the safety issues with regard to using or not using the restraint measure and a balancing clinical judgement was made as to whether it was in the best interest of the residents to use the restraint measure. Where residents were assessed as at risk due to the use of bedrails low-low beds were available. However, areas which required further work was to ensure that the restraint measure used, was used when all other less restrictive methods had failed. On files reviewed there was an absence of evidence available with regard to trialling alternative options.

Outcome 12
The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

References:
Regulation 19: Premises
Standard 25: Physical Environment

Outstanding actions required from previous inspection:

1. Ensure the external grounds are maintained in a safe manner and are suitable for use by the residents.

2. Take all reasonable measures to prevent accidents to any person in the designated centre and in the grounds of the designated centre.

3. Provide grab-rails in bath, shower and toilet areas.

4. Provide adequate facilities for resident's laundry, and make arrangements for their clothes to be sorted and kept separately.

5. Put in place a private visitors' area for residents separate from their own private room.

6. Provide suitable adequate space for drying clothes.

7. Provide adequate and secure storage space for all equipment.

8. Provide a wash-hand basin in the sluice and laundry room.

Inspection findings

The actions required from the previous inspection were partially completed. Actions 1,2,3,5 and 7 were complete. Actions 4, 6 and 8 are included in the refurbishment programme.

1 and 2.The car park has been upgraded. Car parking spaces are clearly marked and there is no parking allowed directly to the front of the building to ensure ease of access. Plans are in place to upgrade the car park. These plans were made available to the inspector which showed that the parking is going to be reviewed to include an additional six car parking spaces. Space at the main entrance door will be eliminated and alternative spaces are to be provided at the main entrance gate. Policies, procedures and guidelines were in place to guide practice in the prevention accidents to residents and others. The risk register was a live document and was updated as risks were identified. The centre has falls prevention guidelines and residents are accompanied when they are in the grounds of the centre. A fence has been erected around the perimeter of the centre.

3. Grab rails have been fitted in shower and toilet areas.

5. A visitors' room is available.

7. An equipment room is available for storage of all equipment with a keypad on the door.

The inspector found there was suitable and sufficient equipment such as hoists, pressure relieving mattresses and mobility aids available to meet residents' needs. There was a service contract in place which covered breakdown and repair for all beds, air mattresses and other equipment used by residents.

The layout and design of the multi occupancy rooms renders it difficult to provide for residents' individual and collective needs in a comfortable and homely way on a daily basis. The residents' personal space is not designed and laid out in a manner to ensure their safety, encourage and aid their independence and assure their comfort, privacy and dignity. The physical environment continues to pose challenges to meet residents' needs safely. There is a lack of space to use hoist and aids in the multi occupancy rooms and to ensure that residents have a comfortable chair by their bed. A plan for refurbishment of the centre to address issues has been developed. This relates to the laundry, car park, visitors' room, relocation of the oratory and wash-hand basins in the sluice and laundry rooms will be addressed as part of the refurbishment programme.

There is an ongoing programme of maintenance to ensure the premises and furnishings will be well maintained. The inspector did not note any immediate maintenance issues on the day of inspection.

Those actions not completed with regard to structural improvements to the physical environment to ensure compliance with the regulations and standards are repeated in this report.

Theme: Person-centred care and support
Person-centred care and support has service users at the centre of all that the service does. It does this by advocating for the needs of service users, protecting their rights, respecting their values, preferences and diversity and actively involving them in the provision of care. Person-centred care and support promotes kindness, consideration and respect for service users' dignity, privacy and autonomy.

Outcome 14
Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.

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

Outstanding action required from previous inspection:

Document end of their life care wishes in all resident's care plans.

Inspection findings

There were no residents receiving end of life care on the days of inspection. The inspector discussed end-of-life care planning with the person in charge. The person in charge informed the inspector that they had good access to palliative care services. The centre have an analgesia review chart in place to ensure analgesia

administered provides effective relief. On the sample of files reviewed there were no end of life care wishes documented.

Theme: Workforce
The workforce providing a health and social care and support service consists of all the people who work in, for, or with the service provider and they are all integral to the delivery of a high quality, person-centred and safe service. Service providers must be able to assure the public, service users and their workforce that everyone working in the service is contributing to a high quality safe service.

Outcome 18
There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

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

Outstanding action required from previous inspection:

Provide a comprehensive assessment of staffing levels using recognised assessment tools and contemporary evidence-based practice, to ensure suitable and sufficient care is provided to maintain each resident's welfare and wellbeing, having regard to the nature and extent of each resident's assessed dependency and needs.

Inspection findings

The action required from the previous inspection were satisfactorily implemented.

The inspector reviewed staffing rosters and discussed the staffing levels with the person in charge. An actual and planned roster was available. The inspector noted that the hours staff worked were not recorded on the rosters and shorthand of 'LD' for long day was inserted. The roster also failed to clearly identify who was in charge when the person in charge or clinical nurse manager was not available. A staff handover occurred at the commencement of the morning and night shift. All nursing staff had the required up-to-date registration with An Bord Altranais.

The person in charge had carried out a comprehensive audit to assess whether the required staffing level were adequate to meet the needs of the residents taking into account multi-factorial aspects of resident's needs and the layout of the building.

These factors included the resident's dependency levels, staff response times to call bells, release times for residents with restraints, accident and incident records, training days for staff and supervision of residents and day service attendees in the day room. The report from this review was made available to the inspector. This detailed that there an excess of care hours available per week. This will be done again on an annual basis or if there are any significant changes in staffing levels. Documentation was available to support that the residents' dependency levels are reviewed monthly or sooner if required. The inspector observed good interactions between staff and residents who chatted with each other in a relaxed manner. Staff spoke with were knowledgeable of residents' individual needs.

As discussed in outcome seven not all staff have up-to-date fire or manual handling training. All staff has elder abuse and fire safety training. The inspector reviewed the training records and found that staff had recently completed the following training:

- basic life support
- fire safety training
- training on care planning.

The person in charge had attended the recent seminar facilitated by the Authority for providers and persons in charge.

Training on the recently acquired new hoist and on appropriate use of supplements and different types of supplements was planned.

Closing the visit

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

Acknowledgements

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

Report compiled by:

Mary McCann

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

7 November 2012

Health Information and Quality Authority
Social Services Inspectorate

Action Plan

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

Provider's response to inspection report *

Centre Name:	Mac Bride Community Nursing Unit
Centre ID:	0647
Date of inspection:	24 October 2012
Date of response:	26 November 2012

Requirements

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

Theme: Governance, Leadership and Management

Outcome 1: Statement of purpose and quality management

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

While the statement of purpose had been updated in June 2012 and described the service that was to be provided and the manner in which it was to be provided it requires review to include date of registration, conditions of registration and details and qualifications of the current person in charge (PIC).

Action required:

Compile a Statement of purpose that consists of all matters listed in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

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

Reference: Health Act, 2007 Regulation 5: Statement of Purpose Standard 28: Purpose and Function	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The statement of purpose has been updated to include the qualifications of the current PIC and the date of registration and the conditions of registration.	26 November 2012

Outcome 4: Records and documentation to be kept at a designated centre

2.The provider is failing to comply with a regulatory requirement in the following respect: **Policies** Operational policies and guidance documents were in place to guide and inform staff, however many of these required review. For example the restraint policy available was the generic HSE national policy. A policy on the prevention, detection and investigation of alleged abuse required revision to include guidance to staff as to the action to take in the event of an allegation of abuse involving senior staff of the centre. While a safety statement was available this requires updating.
Action required: Review all the written operational policies and procedures of the designated centre on the recommendation of the Chief Inspector and at least every three years.
Reference: Health Act, 2007 Regulation 27: Operating Policies and Procedures Standard 29: Management Systems

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The restraint policy and the safety statement have been updated. A policy and procedure group has been formed recently to review and update policies in operation. The director of nursing has discussed the matter of abuse against senior staff with the CNM and with all staff and they are aware of the procedure to follow in the event of an allegation of abuse against senior staff. This has been recorded in minutes of meetings.	26 November 2012

Theme: Safe care and support

Outcome 7: Health and safety and risk management

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

While there was a policy in place to guide practice when responding to emergencies, this did not detail the procedure to be followed with regard to loss of water.

The inspector noted that there were no restrictors on the windows to protect the safety of residents.

Not all staff had received up-to-date safe moving and handling training.

The car park requires realignment to ensure access to the premises is maintained at all times.

Action required:

Put in place an emergency plan for responding to emergencies to include information and guidance on all possible emergencies in the centre.

Action required:

Take all reasonable measures to prevent accidents to any person in the designated centre and in the grounds of the designated centre.

Action required:

Provide training for staff in the moving and handling of residents.

Reference:

Health Act, 2007
Regulation 31: Risk Management Procedures
Standard 26: Health and Safety
Standard 29: Management Systems

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The action to be taken in the event of a loss of water was documented in the emergency plan. Window restrictors have been ordered for every window in the centre. A study day has been arranged on the 6th of December to update 12 staff in moving and handling techniques. A further two dates will be arranged in the new year as a matter of urgency.	26 January 2013

There are plans in place to upgrade the car park and the final meeting with the architect and the contractor has taken place. The commencement date is imminent.	

Outcome 8: Medication management

4.The provider is failing to comply with a regulatory requirement in the following respect: There was no documentary evidence available that medication was reviewed at three monthly intervals.
Action required: Put in place appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents and ensure that staff are familiar with such policies and procedures.
Reference: Health Act, 2007 Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines Standard 14: Medication Management

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: A date has been set for the provider and the PIC to meet with the local general practitioners to discuss the 3 monthly reviews of resident's medication.	26 January 2013

Theme: Effective care and support

Outcome 10: Reviewing and improving the quality and safety of care

5.The provider is failing to comply with a regulatory requirement in the following respect: While the person in charge had completed a good analysis of the information gathered and there was evidence of change/improvement brought about as a result of the learning from the review there was poor evidence available of how the information was cascaded to all staff.
Action required: Establish and maintain a system for reviewing the quality and safety of care provided

to, and the quality of life of, residents in the designated centre at appropriate intervals.
Reference: Health Act, 2007 Regulation 35: Review of Quality and Safety of Care and Quality of Life Standard 30: Quality Assurance and Continuous Improvement

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: All the audits conducted have been discussed at staff meetings and has been documented in the minutes. In order to have one document with all the information on it, the PIC will add a narrative on the audit document as to the action taken, who the information has been given to and the date when it has been completed.	26 November 2012

Outcome 11: Health and social care needs

Regulation 6: General Welfare and Protection

6.The provider is failing to comply with a regulatory requirement in the following respect: The inspector noticed that some residents particularly those who were cognitively impaired were sitting in the dayroom for periods of time where there was a lack of opportunities for residents with cognitive impairment to engage in meaningful activity. The television was the only stimulation available in the day room. Social care assessments were not completed in the care files reviewed.
Action required: Provide opportunities for each resident to participate in activities appropriate to his/her interests and capacities.
Reference: Health Act, 2007 Regulation 6: General Welfare and Protection Standard 13: Healthcare Standard 18: Routines and Expectations

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

Provider's response: There has been a big review of the activities being provided. Relatives of those residents or day care attendees with dementia have been written to inform them of the plan to create a rummage box for their relative - this work is ongoing. The PIC met with a local musician to arrange for more 'live' music and singing in the afternoons, The PIC has downloaded a recipe for playdo so that residents can be encouraged to make things. A recipe for biscuits has also been downloaded. The PIC has copied crosswords and these will be added to the programme as well as noughts and crosses. Poems have also been printed and a poetry half hour will be added. The PIC has asked the residents what their favourite songs are and will compile a song book in large print. Other creative games will be added to the programme.	Ongoing

Regulation 8: Assessment and Care Plan

7.The person in charge is failing to comply with a regulatory requirement in the following respect: While there was a signature on some of the care plans of the relative, there was no narrative note to inform whether a discussion had occurred and any comment or suggestion or additional information the resident or relative may wish to make or had made.	
Action required: Revise each resident's care plan, after consultation with him/her.	
Action required: Notify each resident of any review of his/her care plan.	
Reference: Health Act, 2007 Regulation 8: Assessment and Care Plan Standard 11: The Resident's Care Plan	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Every registered nurse is being given protected time to come in to complete their care plans. They are aware that residents and their relatives must be involved and all conversations/wishes to be documented as a narrative note.	26 January 2013

8.The Person in Charge is failing to comply with a regulatory requirement in the following respect:	
Social care assessments were not completed for all residents.	
Action required: Set out each resident's needs in an individual care plan developed and agreed with the resident.	
Reference: Health Act, 2007 Regulation 8: Assessment and Care Plan Standard 3: Consent Standard 10: Assessment Standard 11: The Resident's Care Plan Standard 17: Autonomy and Independence	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: All social care assessments are currently being completed and are almost finished.	26 January 2013

9.The Person in Charge is failing to comply with a regulatory requirement in the following respect:	
On files reviewed there was an absence of evidence available with regard to trialling alternative less restrictive options prior to the use of restraint.	
Action required: Set out each resident's needs in an individual care plan developed and agreed with the resident.	
Reference: Health Act, 2007 Regulation 8: Assessment and Care Plan Standard 3: Consent Standard 10: Assessment Standard 11: The Resident's Care Plan Standard 17: Autonomy and Independence	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**

Provider's response: Restraint is used as a last resort following a discussion with the PIC. This will be documented from now on and what other alternatives have been considered /trialed.	26 January 2013

Outcome 12: Safe and suitable premises

10.The provider is failing to comply with a regulatory requirement in the following respect: Hand-washing facilities have not been provided in the sluice room or the laundry. The residents' personal space is not designed and laid out in a manner to ensure their safety, encourage and aid their independence and assure their comfort, privacy and dignity. The laundry was inadequate in that it did not provide adequate space for sorting and drying clothes.
Action required: Provide suitable premises for the purpose of achieving the aims and objectives set out in the statement of purpose, and ensure the location of the premises is appropriate to the needs of residents.
Action required: Ensure the physical design and layout of the premises meets the needs of each resident, having regard to the number and needs of the residents in accordance with *the National Quality standards for Residential Care Settings for older People in Ireland* within the timeframe allowed.
Action required: Provide sufficient numbers of wash-basins, fitted with a hot and cold water supply, which incorporates thermostatic control valves or other suitable anti-scalding protection, at appropriate places in the premises.
Reference: Health Act, 2007 Regulation 19: Premises Standard 25: Physical Environment

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

Provider's response: A thermostatic valve has been installed previously to regulate water temperature. There is a planned upgrade of the facilities and the Health Information and Quality Authority inspector has a copy of the planned works. These works should be completed by March 2013.	31 March 2013

Outcome 14: End of life care

11.The person in charge is failing to comply with a regulatory requirement in the following respect: On the sample of files reviewed there were no end of life care wishes documented.
Action required: Identify and facilitate each resident's choice as to the place of death, including the option of a single room or returning home.
Action required: In the event of the sudden death of a resident, facilitate his/her religious and cultural practices, insofar as is reasonably practicable.
Reference: Health Act, 2007 Regulation 14: End of Life Care Standard 16: End of Life Care

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: All staff are aware that end of life wishes must be documented and staff are currently being given time to complete these. The care plans are currently being audited.	26 January 2013

Any comments the provider may wish to make:

Provider's response:

None supplied.

Provider's name: Michael Fahey

Date: 26 November 2012