

**Health Information and Quality Authority  
Regulation Directorate**

**Compliance Monitoring Inspection report  
Designated Centres under Health Act 2007,  
as amended**



<b>Centre name:</b>	Birr Community Nursing Unit
<b>Centre ID:</b>	OSV-0000522
<b>Centre address:</b>	Community Nursing Unit, Sandymount, Birr, Offaly.
<b>Telephone number:</b>	057 912 3244
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<b>Type of centre:</b>	The Health Service Executive
<b>Registered provider:</b>	Health Service Executive
<b>Provider Nominee:</b>	Jude O'Neill
<b>Lead inspector:</b>	Catherine Rose Connolly Gargan
<b>Support inspector(s):</b>	Leanne Crowe, Una Fitzgerald
<b>Type of inspection</b>	Unannounced Dementia Care Thematic Inspections
<b>Number of residents on the date of inspection:</b>	71
<b>Number of vacancies on the date of inspection:</b>	5

## **About Dementia Care Thematic Inspections**

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor compliance with specific outcomes as part of a thematic inspection. This monitoring inspection was un-announced and took place over 1 day(s).

**The inspection took place over the following dates and times**

From: 24 March 2017 09:00 To: 24 March 2017 18:00

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

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

**Summary of findings from this inspection**

This inspection report sets out the findings of a thematic inspection which focused on specific outcomes relevant to dementia care in the centre. Inspectors also considered pre-inspection documentation forwarded by the provider/person in charge, notifications and other relevant information. Four actions from the last inspection in February 2016 were found to be satisfactorily completed, the remaining five actions were progressed but not completed within the agreed timeframe and are restated in this report. Inspectors also reviewed unsolicited information received by HIQA on 23 February 2017 regarding management of residents with responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) in terms of the safety of other residents in the centre. This information was not substantiated on this inspection.

As part of the thematic inspection process, providers were invited to attend information seminars given by the Authority. In addition, evidence-based guidance was developed to guide the providers on best practice in dementia care and the inspection process. Prior to the inspection, the provider completed the self-assessment document by comparing the service provided with the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 and the National Standards for Residential Care Settings for Older People in Ireland (2016).

The inspectors met with residents and staff members during the inspection. Residents who spoke with inspectors expressed their satisfaction and contentment with living in the centre. The journey of a sample of residents with dementia within the service was tracked. Inspectors observed care practices and interactions between staff and residents who had dementia using a validated tool and saw that staff engaged positively during care tasks with residents who had dementia. Inspectors reviewed documentation such as nursing assessments, care plans, medical records and examined relevant policies including those submitted prior to inspection.

Documentation in relation to staff employment information and evidence of completed appropriate vetting procedures were not held in the centre as required and were therefore not available for inspection. Not all staff had completed updated mandatory training requirements. Staff were knowledgeable regarding residents and their care needs. All interactions between staff and residents observed by inspectors were respectful and kind.

Residents' accommodation in the centre was provided at ground floor level and residents with dementia integrated with other residents. The design and layout of the centre met its stated purpose with the exception of multiple occupancy bedrooms. Otherwise the centre provided a comfortable and therapeutic environment for residents with dementia. Inspectors found that the management team and staff were committed to providing a quality service for residents with dementia. While there was evidence of effort made to ensure residents with dementia were supported and facilitated to enjoy a meaningful and fulfilling life in the centre, significant improvement was necessary in provision of suitable one to one and small group activities to meet the interests and capabilities of residents with dementia. There was an absence of an comprehensive sensory based activation programme for residents with advanced dementia.

Inspectors found that the physical and mental health needs were met to a good standard. There were policies and procedures in place to safeguard residents from abuse. While not all staff had completed up-to-date training in safeguarding residents from abuse, they were knowledgeable about the steps they must take if they witness, suspect or are informed of any abuse taking place. There were also policies and practices in place around managing responsive behaviours, and the use of restraint in the service.

The Action Plan at the end of this report identifies areas where improvements are required to comply with the Health Act 2007 (Care and Welfare of Residents in

Designated Centre's for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland (2016).

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

***Outcome 01: Health and Social Care Needs***

**Theme:**

Safe care and support

**Outstanding requirement(s) from previous inspection(s):**

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

**Findings:**

This outcome sets out the inspection findings relating to healthcare, clinical assessments and care planning. The centre catered for residents with a range of healthcare needs. On the day of inspection there were 72 residents residing in the centre, one of whom was in hospital. There were five residents receiving care on a respite admission basis. 25 residents had a diagnosis of dementia and one resident had symptoms of dementia. Residents with a diagnosis of dementia integrated with other residents in the centre.

On this inspection, inspectors focused on the experience of residents with a diagnosis of dementia living in the centre. The journey of a sample of residents with dementia was tracked. Specific aspects of the care of residents tracked and other residents with dementia were also reviewed such as safeguarding, nutrition, wound care and end-of-life care.

Inspectors found that there were systems in place to ensure communications were satisfactory between the centre and residents, families and the acute hospital. The person in charge visited prospective residents in hospital, other nursing homes or in their home in the community prior to their admission. Some residents currently in receipt of continuing care transitioned from respite care in the centre or in another nursing home. Prospective residents and their families were welcomed into the centre to view the facilities and discuss the services provided before making a decision to live in the centre. These measures gave residents and their family members information about the centre and also provided assurances that the service could adequately meet their needs.

Common Summary Assessments (CSARs) documentation which details pre-admission assessments undertaken by the multidisciplinary team for residents admitted under the 'Fair Deal' scheme was obtained. This information was reviewed as part of their pre-admission assessment completed by the person in charge. The files of residents' admitted to the centre from hospital also held their hospital discharge documentation including a medical summary letter, multidisciplinary assessment details and a nursing

assessment summary. Inspectors examined the documentation that accompanied residents who were transferred to hospital from the centre. This summary documentation comprehensively detailed their needs and included information about their physical, mental and psychological health, medications and nursing needs. The information also detailed interventions to support residents with physical and psychological symptoms of dementia (BPSD) or responsive behaviours. While a communication passport was not currently in use for residents with communication needs going to hospital, evaluation of this tool as part of transfer documentation was being considered by the team. This communication tool is of value in supporting the communication needs of residents with dementia accessing services outside the centre to outline their individual preferences, dislikes and the strategies to prevent or to support those with physical and psychological symptoms of dementia. The communication policy also required revision to guide practices and support residents with dementia and residents with sensory deficits such as hearing, speech and visual impairments.

Residents had good access to a general practitioner (GP), including out-of-hours medical care. There was also evidence that residents received timely access to health care services. Residents were facilitated to attend out-patient appointments and were referred as necessary to the acute hospital services or community specialist medical services. The person in charge confirmed that a number of local GPs were attending to the needs of residents in the centre, giving them a choice of general practitioner. Some residents who lived in the locality chose to retain the services of the GP they attended prior to their admission to the centre. Residents had good access to allied healthcare professional specialist care. A physiotherapist and a speech and language therapist were located on-site. Occupational therapy services were recently replaced. Arrangements for dental and ophthalmology services were in place. The chiropody service to residents was under review to ensure residents had sufficient access. Community psychiatry of later life specialist services supported residents with mental health issues and responsive behaviours. A community psychiatric nurse visited the centre at regular intervals to monitor progress of residents referred to the psychiatric team. Staff were trained to administer subcutaneous fluids to treat dehydration if required. This measure supported residents with avoiding unnecessary hospital admissions.

Comprehensive assessments with respect to the health, personal and social care needs of all new residents was carried out within 48 hours of their admission and care plans were developed accordingly. Inspectors observed that the centre utilised dementia specific assessment tools to guide and inform the care needs of residents with dementia. Assessment tools such as behavioural analysis assessment sheets, a dementia and mealtime experience guide and a communication strategies in dementia tool known as 'MESSAGE' were used. Care plans were updated routinely and to reflect their changing needs. While, residents and their families were involved in care plan development and reviews thereafter, there was opportunity for improvement in records of these consultations regarding the issues discussed and attendees.

A palliative care suite was provided to promote the comfort of residents receiving end-of-life care. This accommodation provided a single bedroom with an adjoining kitchenette/sitting room and an en-suite toilet, shower and wash basin. Community palliative care services supported staff with management of residents' pain and

symptom management during end-of-life care as necessary. Palliative care services also supported other residents with chronic pain symptoms. Pain assessment tools suitable were available, however were not consistently used to inform residents' pain management. Inspectors found that there was insufficient evidence that one resident had a comprehensive pain assessment and monitoring carried out to guide intervention management in line with best practice. On the day of inspection one resident was receiving end-of-life care. There were written operational policies and protocols in place for end-of-life care which staff were familiar with. The centre provided a small oratory for use by residents and their families. Residents had good access to clergy from the various faiths. The religious and cultural need of the residents was also documented. End-of-life care plans reviewed referenced residents wishes including arrangements for their physical, psychological and spiritual care including place of death.

There were no incidents of residents developing pressure related skin injuries in the centre. There were comprehensive care procedures in place to prevent residents developing pressure related skin injuries. Each resident had their risk of developing pressure wounds assessed. Pressure relieving mattresses, cushions and repositioning schedules were in use to mitigate risk of ulcers developing. Tissue viability specialist services were available to support staff with management of any resident with a wound that was deteriorating or slow to heal. A policy document informed wound management and procedures.

There were systems in place to ensure residents' nutritional needs were met, and that they did not experience poor hydration. Residents were screened for nutritional risk on admission and reviewed regularly thereafter. Residents' weights were checked on a monthly basis, and more frequently if clinically indicated. There was access to a safe supply of fresh drinking water at all times. Residents care plans outlined the recommendations of the dietician and speech and language therapists where appropriate. Inspectors saw that residents had a choice of appetising and nutritious meals. Staff confirmed that alternatives were also available to the menu if residents did not like the dishes on offer. The menu was varied and was displayed in written text on the dining room notice board. Staff were observed to restate the choice of menu on offer to residents at mealtimes, this gave them choice regarding what they wanted to eat. There were arrangements in place for communication of residents' dietary needs between nursing and catering staff to support residents with special dietary requirements. Residents on specialised diets such as diabetic, fortified and modified consistency diets and thickened fluids received their correct diets and fluid consistencies. Residents spoken with by inspectors confirmed that they enjoyed the dining experience. Staff engagement with residents was meaningful and interactive. While residents were encouraged to maintain their independence with eating, they were assisted discreetly by staff as necessary.

The centre has a falls management programme in place in the centre for the monitoring and learning from all incidents. There were arrangements in place to review accidents and incidents to residents within the centre. There was a low incidence of resident falls in the centre resulting in serious injury. Residents were assessed to determine their risk of falls on admission and regularly thereafter. Each fall incident was reviewed with controls put in place to prevent recurrence. The centre's physiotherapist reviewed residents following a fall incident. The staff team encouraged residents to remain mobile

ensuring that they maintained their independence and quality of life. A number of residents in the centre used motorised wheelchairs. Residents spoken with by inspectors expressed their satisfaction with support given to them by staff and the physiotherapist. Residents at risk of falling had controls in place to prevent injury such as increased supervision and assistance, low-level beds and sensor alarm equipment.

Residents were protected by safe medicines management procedures and practices. There was a written operational policy informing ordering, prescribing, storing and administration of medicines to residents. Residents had a choice of pharmacy services. Practices in relation to prescribing and medicine reviews met with regulatory requirements. Nursing staff were observed administering medicines to residents and practices reflected professional guidelines with the exception of medication administered in crushed format. Inspectors observed that nurses were administering medicines in a format that were not prescribed by the doctor. This was an action required for completion from the last inspection. Appropriate storage and checking procedures were in place for medicines controlled under misuse of drugs legislation and medicines requiring refrigerated storage. Medication administration records contained a space to record comments on withheld or refused medication. The person in charge had implemented a process where residents receiving medicines in a crushed format were reviewed by the speech and language therapist. There were comprehensive policies in place for the administration of subcutaneous fluids. Pharmacists completed regular medication audits. The person in charge also had medication audits in place and learning from same was communicated appropriately.

**Judgment:**

Non Compliant - Moderate

***Outcome 02: Safeguarding and Safety***

**Theme:**

Safe care and support

**Outstanding requirement(s) from previous inspection(s):**

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

**Findings:**

Procedures were in place to protect residents with a diagnosis of dementia and all other residents from being harmed or suffering abuse. A policy was in place to inform staff on management of any allegations, suspicions or incidents of abuse to residents. There were systems in place to ensure that allegations of abuse were investigated, and that pending such investigations measures were in place to ensure the safety of residents. Staff spoken with by inspectors were knowledgeable regarding types of abuse and their responsibility to report any allegations, suspicions or incidents of abuse. Since the last inspection in February 2016, the inspectors observed that one peer-to-peer incident occurred which was managed in line with the centre's policy. Training records given to

inspectors indicated that with the exception of two staff, all staff had attended training on the protection of residents from abuse. This was an action required from the last inspection in February 2016. The person in charge told inspectors that training on protection of residents from abuse was scheduled for the two staff who required updated training.

Residents spoken with by inspectors confirmed that they felt safe in the centre and commented positively on staff caring for them. All staff interactions with residents observed by the inspectors were respectful, encouraging and kind. While arrangements were in place to prevent unauthorised access to residents' accommodation, review was required to ensure unauthorised access through some parts of the day-service area was prevented.

There was evidence that staff were committed to and working towards achieving a restraint-free environment. A policy informing the use of restraint was available and was demonstrated in practice, however some areas for improvement were identified to ensure restriction by use of full-length bedrails to enable some residents' mobility while in bed was minimised. Nearly 50% of residents had bedrails in use. The inspectors saw that many full-length bedrails were appropriately used as determined by trial of less-restrictive alternatives such as low level beds, wedge supports and foam floor mats. However the absence of bedrails that did not restrict residents' freedom to exit their beds independently if they wished required review. A restraint register recorded any type of restraint used and the duration the restraint was in place. While inspectors were told that practice procedures by staff were in place to ensure residents with bedrails did not have their independence restricted for prolonged periods, there was an absence of records maintained to confirm this practice occurred as required. Use of bedrails was informed by risk assessments to ensure that residents' safety was not compromised by the use of a bedrail. One resident used a lap belt attached as part of their assistive chair, and this was used to promote their safety. Some residents received psychotropic medications on a PRN (a medicine only taken as the need arises) basis for management of responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) when all other interventions were tried and failed. There was insufficient evidence available that the administration of this medication was subject to review on each occasion.

A low number of residents experienced responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). A policy was available to inform staff how to work with residents who had responsive behaviours. A two-day staff training programme in dementia had commenced and the person in charge planned to facilitate all staff to complete this programme by 2018. Staff spoken with by the inspectors could describe person-centred de-escalation techniques that they used to manage individual resident's responsive behaviours. Inspectors were told that no residents were experiencing responsive behaviours at the time of this inspection and inspectors did not observe any incidents of responsive behaviour on the day of inspection. This finding indicated that this aspect of residents' care was satisfactorily managed. Inspectors observed that staff responded to residents with a history of responsive behaviours in a sensitive, person-centred and compassionate way and

residents responded positively to the techniques they used. Behaviour support care plans were found to be person-centred and described the most effective person-centred strategies to implement to de-escalate any responsive behaviours. However, this documentation required improvement to include details of the responsive behaviour and the triggers where known to the behaviours to comprehensively inform care procedures for individual residents. Residents with responsive behaviours were referred appropriately to community psychiatry of older age services. Good support from this community psychiatry team was reported and referenced in the records reviewed.

Systems and arrangements were in place for safeguarding residents' finances and property. The accounting process was demonstrated. The procedures and processes for collecting residents' social welfare pensions on their behalf were transparent and were subject to annual audit. Residents' monies were deposited on their behalf in a personal interest bearing account Residents or their relatives on their behalf were provided with quarterly statements of their accounts. All lodgements and withdrawals were documented signed with two signatures. The system in place was found to be sufficiently robust to protect residents and staff.

**Judgment:**

Non Compliant - Moderate

***Outcome 03: Residents' Rights, Dignity and Consultation***

**Theme:**

Person-centred care and support

**Outstanding requirement(s) from previous inspection(s):**

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

**Findings:**

Residents were consulted in relation to the running of the centre. Inspectors found that the person in charge and staff valued residents' feedback and views and worked with them to make the environment homely and comfortable. Residents' meetings were convened at regular intervals and were minuted. There was evidence from the minutes of good discussion and suggestions made. The inspectors saw where suggestions were carried through to actions taken. For example changes made to a communal sitting room to create a parlour-type décor, creation of colourful and interesting gardens and a raised bed for growing vegetables. A garden shed was provided close to this area to store garden equipment for the convenience of residents. Residents with an interest in gardening were encouraged to utilise their past experiences in protecting the vegetable patch and inspectors saw they used a string of empty milk cartons hanging across the patch to frighten any scavengers away. Birds were encouraged to other areas of the garden with bird feeders and shrubs and small trees that produced berries. Flowers that reflected the seasons were planted and daffodils were in bloom in the gardens. Evidence of residents' art and craft work facilitated by an artist who attended the centre was

displayed on the walls along the corridors and in communal rooms. Residents had experienced positive outcomes from art therapy. The person in charge told inspectors that she had also recruited a music therapist who was scheduled to attend the centre with the artist on the week following the inspection.

There was a policy of open visiting in the centre, with protected mealtimes in line with the residents' wishes. Inspectors observed visitors visiting residents on the day of inspection. There were some comfortable seated areas available in the centre where residents could meet their visitors in private if they wished.

Inspectors observed care practices and interactions between staff and residents who had dementia using a validated tool and saw that staff engaged positively during care tasks with residents who had dementia. Inspectors found that arrangements for meeting the activity needs of residents with dementia required significant improvement to ensure they were provided with activities that met their interests and capabilities, especially residents with a diagnosis of dementia. This finding was also detailed as an action required from the last inspection of the centre by HIQA in February 2016. The centre's activity co-ordinator had responsibility for meeting residents' recreational activity needs in the centre during weekdays. However, improvement was necessary in the co-ordination of activities provided over the weekend. Inspectors were told that some staff currently facilitated activity sessions on an unplanned basis in addition to the occasional organised music to mark significant events. The centre's activity co-ordinator was on planned leave on the week of this inspection.

The schedule of activities detailed a variety of interesting group activities provided for residents. The schedule of activities was displayed for residents' information in the units. However this information was not clearly visible and the inspectors observed that notices in one unit were in small text and partially covered by other information. The schedule displayed also did not clearly indicate the location of the group activities within the centre. For example, a group activity was held in the communal room in one of the units on the afternoon of the day of inspection, but information advising the location and time of this group activity was not clearly displayed. This did not ensure all residents could decide whether to join this group. While inspectors observed that some residents with dementia enjoyed bingo on the afternoon of the inspection, this group activity did not meet the needs of other residents with a diagnosis of dementia. Inspectors were told that residents who could not participate in the group activities were provided with sensory based care such as hand massage and music on a one to one or small group basis. However, this was not observed by inspectors on the day of inspection and was not evidenced in residents' records. Residents' records that indicated the activities they participated in were blank with the exception of one entry indicating one resident with a diagnosis of dementia was visited by a relative in the sample reviewed by inspectors. There was an absence of a comprehensive sensory based activation programme for residents with advanced dementia.

Residents were facilitated to meet their religious and spiritual needs. Arrangements were in place to ensure they could exercise their right to vote in elections. Inspectors observed that staff got consent from residents and gave them choice regarding all care activities in the centre. Residents' privacy and dignity needs were met. Inspectors observed staff knocking on residents' bedroom doors and closing doors to bedrooms and

toilets during personal care activities. Residents in twin, triple and four-bed bedrooms had screening provided which was closed during personal care activities. Since the last inspection, there was evidence of work done to the layout of some residents' personal bed spaces to ensure they had sufficient space between their bed and screen curtains to undertake personal activities in private. This finding is discussed further in Outcome 6. Residents were provided with discreet assistance with eating as necessary.

**Judgment:**

Non Compliant - Moderate

***Outcome 04: Complaints procedures***

**Theme:**

Person-centred care and support

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

The person in charge and staff demonstrated that they welcomed feedback from residents and their relatives and had arrangements in place to ensure all feedback was actioned where necessary. There was a complaints policy available to inform procedures and practices in relation to complaints management in the centre. The complaints procedure was in line with the requirements of the Regulations and included an appeals process. The person in charge was the designated person to address complaints. The complaints procedure was on display in the centre and was summarised in the residents' guide document. Advocacy services were available to residents and were in place to support one resident's views.

A complaints log was maintained in the centre. Verbal and written complaints were recorded. All complaints were investigated and the investigation details and actions taken were documented. The satisfaction of complainants was also ascertained and documented. Inspectors was informed that there were no active complaints under investigation at the time of this inspection.

Residents spoken with by inspectors on the day of this inspection indicated that they and their relatives knew who to approach if they were dissatisfied with any aspect of the service. Residents spoken with said they believed their concern would be listened to and that it would be actioned.

**Judgment:**

Compliant

***Outcome 05: Suitable Staffing***

**Theme:**  
Workforce

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

While there were appropriate staff numbers and skill-mix on duty to meet the assessed clinical needs of residents, the activity needs of residents with dementia were not met. The arrangements in place to cover planned leave by the activity co-ordinator were not adequate.

Twelve nurses up to 17:00hrs and twelve care staff up to 16:30hrs were rostered in the centre each day. The staffing levels reduced to nine nurses and nine care staff from 16:30hrs to 20:30hrs each day and to three staff nurses, three care staff and a nurse manager each night. The person in charge was supported in her role by two assistant directors of nursing. An actual and planned staffing roster was in place and reflected the number of staff on duty on the days of the inspection. Residents spoken with confirmed that staff responded quickly to their call bells and their care needs were satisfactorily met. While inspectors were assured that the staffing levels and skill-mix provided met residents' clinical needs, a review of residents' activation provision was necessary to ensure activities were facilitated to meet the needs of residents with one-to-one or small group needs. Inspectors' findings are discussed further in Outcome 3.

Staff attended an annual appraisal with the person in charge. This process also informed training resources needed. Recruitment policies and procedures were in place to inform practice and were supported by an induction programme for new staff to the centre. The person in charge held meetings with the various levels of staff and the minutes of these meetings were reviewed by an inspector.

Inspectors reviewed staff training records, observed practices and spoke with staff. Inspectors found that not all staff working in the centre had up-to-date mandatory training in fire safety, safeguarding residents and safe moving and handling procedures. Training was organised for staff in fire safety and safeguarding residents from abuse in the weeks immediately following the inspection. While inspectors observed that all moving and handling procedures by staff were carried out safely, mandatory training in safe moving and handling procedures was overdue for 16 staff since 2016. Training records also evidenced attendance by staff at training to inform and refresh their knowledge and skills to meet residents' assessed needs. Staff spoken with could describe the learning they received from training they had attended.

Inspectors found from speaking with staff that they were well-informed and knowledgeable regarding residents' needs and the care they required to address their needs. The person in charge confirmed that no volunteers worked in the centre. The person in charge maintained a records confirming that all nursing staff were registered with An Bord Altranais agus Cnáimhseachais na hÉireann. Staff employment details, records of qualifications and evidence of appropriate vetting procedures were not held in

the centre as required.

**Judgment:**

Non Compliant - Moderate

***Outcome 06: Safe and Suitable Premises***

**Theme:**

Effective care and support

**Outstanding requirement(s) from previous inspection(s):**

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

**Findings:**

The centre is a single-storey premises with accommodation for 76 residents in three suites, Laurel, Sandymount and Camcor. The centre was bright, homely, welcoming and visibly clean. The centre was generally well-maintained. The person in charge coordinated maintenance work as required. With the exception of multiple occupancy bedrooms, the centre provided a therapeutic environment for resident with dementia.

Communal sitting and dining rooms were comfortable and decorated in a style reminiscent of residents' own homes. There was good use of colour and traditional domestic memorabilia that enhanced the familiarity of the environment for residents with dementia. There was good use of lamps, pictures and photographs on walls, ornaments, cushions and design of fabric on furniture and curtains. Dining tables were covered with colourful table cloths, dressers were filled with boldly designed delph and kitchenware. The communal corridors were adorned with numerous colourful wall hangings, paintings and ornaments, many of which were produced by residents who participated in a previous art therapy project. Every opportunity to introduce natural light to corridors and communal rooms was taken with large windows that also had views of the gardens. Shades were fitted to the windows in the communal rooms to control glare from sunlight. Floor covering contained no bold patterns and handrails were painted in a contrasting colour to the surrounding walls which supported ease of access for residents with dementia. Each of the three resident accommodation suites was distinguished by the colour of the handrails. The name of the suite was displayed in bold print over the entrance door. Definition of the residents' accommodation suites could be improved further with a different colour on the walls in each. A variety of communal and some quiet areas were available to residents which also facilitated them to meet with their visitors in private if they wished. There were a number of safe external garden and courtyard areas with safe pathways, seating and planting arrangements. Inspectors saw evidence of resident involvement in decorating and painting work done in the internal gardens.

Residents' bedrooms consisted of single, twin three and bedrooms with four beds. Each room had an en-suite toilet, shower and handbasin fitted. Residents with a diagnosis of

dementia were accommodated throughout the centre. The inspectors found that the person in charge and staff team had made efforts since the last inspection to ensure the space available between screen curtains and beds was sufficient to meet privacy and dignity of residents with assistive equipment needs. However, the layout of some multiple occupancy bedrooms did not provide a therapeutic environment for residents with dementia. These residents had limited personal space available to them and insufficient accessible space for displaying their personal mementoes. They did not have choice of television viewing as they shared a television with a resident in the adjacent bed and could not view it when screen curtains were closed around the adjacent bed. Two televisions were made available in most multiple occupancy rooms. There was no individual discreet listening equipment provided that ensured individual residents could view and hear different programmes on each television device. The only space available to one resident with a diagnosis of dementia who remained in bed for her radio was the top of her locker. Her personal ornaments were stored on a high shelf behind her bed which she was unable to view or reach. A similar shelf was fitted over the head of residents' beds in all multiple occupancy bedrooms and was located beyond their reasonable reach.

**Judgment:**

Non Compliant - Moderate

## Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

### **Acknowledgements**

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

### ***Report Compiled by:***

Catherine Rose Connolly Gargan  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority

# Health Information and Quality Authority Regulation Directorate

## Action Plan



### Provider's response to inspection report<sup>1</sup>

<b>Centre name:</b>	Birr Community Nursing Unit
<b>Centre ID:</b>	OSV-0000522
<b>Date of inspection:</b>	24/03/2017
<b>Date of response:</b>	05/05/2017

### Requirements

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

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

### Outcome 01: Health and Social Care Needs

#### Theme:

Safe care and support

#### **The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

There was opportunity for improvement in records of consultations with residents or their family members regarding the issues discussed at care plan reviews.

#### **1. Action Required:**

Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise

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

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

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

3 monthly reviews of care plans with residents and their families where appropriate take place. CNM 2's will audit to ensure this is taking place and is documented correctly.

**Proposed Timescale:** 30/06/2017

**Theme:**

Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Pain assessment tools suitable were available, however were not consistently used to inform residents' pain management.

**2. Action Required:**

Under Regulation 06(1) you are required to: Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

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

Pain assessment tool was in use in the resident's care plan. Nursing staff directed to ensure consistent documentation.

Proposed Timescale: Completed

**Proposed Timescale:** 05/05/2017

**Theme:**

Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Inspectors observed that nurses administered medicines in a crushed format which was not prescribed by the doctor.

**3. Action Required:**

Under Regulation 29(5) you are required to: 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.

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

Drug Kardex updated to ensure correct prescribing and administration (document

attached).

**Proposed Timescale:** 31/05/2017

## **Outcome 02: Safeguarding and Safety**

### **Theme:**

Safe care and support

### **The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

There was insufficient evidence available that the administration of PRN psychotropic medication was subject to review on each occasion.

The absence of bedrails that did not restrict residents' freedom to exit their beds independently required review.

While inspectors were told that practice procedures by staff were in place to ensure residents with bedrails did not have their independence restricted for prolonged periods, there was an absence of records maintained to confirm this practice occurred, as required.

### **4. Action Required:**

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

### **Please state the actions you have taken or are planning to take:**

1. Drug Kardex updated to ensure correct prescribing and administration (document attached).
2. Full review of all bedrails currently taking place also trying to source shorter beds rails where required. Low Low beds have been ordered where suitable.
3. Review chart introduced to ensure accurate record of safety during use put in place.

Proposed Timescale:

1. 31st of May 2017
2. 30th June 2017
3. Completed

**Proposed Timescale:** 30/06/2017

### **Theme:**

Safe care and support

### **The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

While arrangements were in place to prevent unauthorised access to residents' accommodation, review was required to ensure unauthorised access through some parts of the day-service area was prevented.

**5. Action Required:**

Under Regulation 08(1) you are required to: Take all reasonable measures to protect residents from abuse.

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

Key pad lock system put in place 28th of March 2017.

Proposed Timescale: Completed

**Proposed Timescale:** 05/05/2017

**Theme:**

Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Not all staff had completed up-to-date training in safeguarding residents from abuse.

**6. Action Required:**

Under Regulation 08(2) you are required to: Ensure staff are trained in the detection and prevention of and responses to abuse.

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

Training took place on the 28th March 2017 and training updates for all staff taking place.

Proposed Timescale: Completed

**Proposed Timescale:** 05/05/2017

**Outcome 03: Residents' Rights, Dignity and Consultation**

**Theme:**

Person-centred care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Inspectors found that arrangements for meeting the activity needs of residents required significant improvement to ensure residents with a diagnosis of dementia were provided with activities that met their interests and capabilities.

**7. Action Required:**

Under Regulation 09(2)(b) you are required to: Provide opportunities for residents to

participate in activities in accordance with their interests and capacities.

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

1. Music therapist now in place for one to one reminiscence sessions and also with small groups.
2. Full review of all activity programmes for residents with dementia taking place to ensure their needs are met.

**Proposed Timescale:** 31/05/2017

**Outcome 05: Suitable Staffing**

**Theme:**

Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The arrangements in place to cover planned leave by the activity co-ordinator were not adequate.

**8. Action Required:**

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

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

Leave arrangements being reviewed with staff and Director of Nursing has applied for the recruitment of .5 WTE activates S/N to ensure a full service is in place for resident's.

**Proposed Timescale:** 31/07/2017

**Theme:**

Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Not all staff working in the centre had updated mandatory training in fire safety, safeguarding residents and safe moving and handling procedures.

**9. Action Required:**

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

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

1. Fire training on-going 13th April 2017 and 16th May 2017 and on-going training booked for the remainder of the year.
2. Safe guarding training completed for staff outstanding 28th of March 2017.

3. Outstanding staff for Manual Handling training on-going 19th April and 16th May and on-going training booked for the remainder of the year.

Proposed Timescale: As above

**Proposed Timescale:** 16/05/2017

**Theme:**

Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Staff employment details, records of qualifications and evidence of appropriate vetting procedures were not held in the centre as required.

**10. Action Required:**

Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

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

Staff records are kept in the central HSE HR department in Tullamore. The registered provider is making arrangements for them to be available at the centre.

**Proposed Timescale:** 31/05/2017

### **Outcome 06: Safe and Suitable Premises**

**Theme:**

Effective care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Residents in multiple occupancy bedrooms had limited personal space available to them and insufficient accessible space for displaying their personal mementoes. They did not have choice of television viewing as they shared a television with a resident in the adjacent bed and could not view it when screen curtains were closed around the adjacent bed.

**11. Action Required:**

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

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

1. Multi-occupancy rooms to meet requirements by 2021.
2. Shelve behind each bed to be removed and maintenance to put shelving for personal

items within view of the resident.

3. Funding to be secured for Television for each resident.

Proposed Timescale:

1. 1st July 2021

2. 31st of July 2017.

3. 31st of July 2017

**Proposed Timescale:** 01/07/2021