Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	St. Brigid's Hospital
Centre ID:	OSV-0000672
Centre address:	Carrick on Suir, Tipperary.
Telephone number:	051 640 025
Email address:	Ann.Guida@hse.ie
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Bridget Farrell
Lead inspector:	Gemma O'Flynn
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	14
Number of vacancies on the date of inspection:	2

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 his/her 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
▪ to carry out thematic inspections in respect of specific outcomes
▪ following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
▪ arising from a number of events including information affecting the safety or wellbeing 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. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.

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 Quality 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 ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
07 November 2016 09:10	07 November 2016 18:25

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

Outcome	Our Judgment
Outcome 02: Governance and Management	Non Compliant - Moderate
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Non Compliant - Moderate
Outcome 07: Safeguarding and Safety	Non Compliant - Major
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 09: Medication Management	Compliant
Outcome 10: Notification of Incidents	Substantially Compliant
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 12: Safe and Suitable Premises	Non Compliant - Major
Outcome 13: Complaints procedures	Substantially Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Non Compliant - Moderate
Outcome 18: Suitable Staffing	Non Compliant - Moderate

Summary of findings from this inspection

This report sets out the findings of a one day unannounced inspection, the purpose of which, was to monitor ongoing compliance with the regulations. Actions that arose following the centre's previous inspection in May 2015 were also followed up. There were 29 actions in the last inspection. Of those, 13 had been satisfactorily addressed and 16 had not been satisfactorily progressed. These are discussed throughout the report and related mainly to ongoing premises issues; care plan documentation; implementation of allied health recommendations and health and safety.

St. Brigid's is a community hospital that delivers respite, convalescence and palliative care. The average stay is approximately seven to ten days. The centre can accommodate 16 residents at any one time. The centre comprises three well appointed palliative care suites on the ground floor and the first floor comprises two five bedded wards, twin and single rooms which are utilised for convalescence and respite care.

During the course of the inspection, the inspector met with residents, relatives, staff and the person in charge. Resident and staff views were elicited, practices were observed and documentation was reviewed. Overall, the inspector found that care was delivered to a good standard. There was good interaction observed between residents and staff. Interactions observed by the inspector were seen to be timely, respectful and friendly. Visitors were seen to visit throughout the day.

Areas of non compliance were identified as set out in the table above. These are discussed throughout the report and in the associated action plan.

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 Quality Standards for Residential Care Settings for Older People in Ireland.

Outcome 02: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.

Theme:
Governance, Leadership and Management

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

Findings:
There was a clearly defined management structure that identified who was in charge and accountable and what the reporting structure was. However, as identified at the previous inspection, adequate resources for staffing were not always in place. This is discussed further and actioned under the staffing outcome.

Management systems were in place to monitor the care provided. A senior management meeting was held at regular intervals. In 2016, this meeting had been convened in January, March, July and September and agenda items included review of clinical risks, trends and frequency of incidents occurring in the centre, audit updates and health and safety issues. Minutes were reviewed for the last meeting that took place in September 2016. A clinical risk management group also met, the purpose of which was to review incidents occurring in the centre and its sister centres in the county.

An audit system was in place, the provider nominee confirmed at the feedback meeting that this was a work in progress and additional areas of care would be due for audit in the coming months such as hand hygiene and the use of restraint. In 2016, three audits had taken place: hygiene audit; documentation audit and a medication audit. Meaningful areas of improvement had been identified across these audits such as care plans not being in place for all identified problems in the documentation audit and improvements required in hand hygiene equipment such as hands free taps. Staff had signed to say to they had been informed of the oucome of an audit review and a meeting was pending for November to discuss the findings of the documentation audit. Residents' rights and consultation was not subject to audit and this was an area identified as requiring improvement as discussed below. Complaints and the management of same were not subject to review and non compliances were identified in the relevant outcome.

An annual review had been completed since the last inspection and considered the quality and safety of care. It also set out planned future improvements.

The person in charge said that she met with residents on a daily basis. However, there was no formal procedure for consulting residents on an ongoing basis about the running of the centre and eliciting feedback to improve the residents' experience. A survey had been issued in November 2015, that included topics such as activities, meals, physical environment and privacy, however, only nine respondents were on file. Given the high turnover of residents in the centre, the inspector found that a total of nine participants was insufficient to give comprehensive feedback. Although the responses had been analysed and were overall seen to be positive, there was no action plan developed to address any issues raised. This was discussed with the person in charge and the provider at the feedback session.

Some feedback from residents who spoke with the inspector said that they were satisfied with what was on offer. Staff said that they generally had time especially in the afternoon to sit and chat with residents and play cards or board games if the resident was interested in same. The inspector did not observe any form of structured or planned activity taking place. This was discussed with the person in charge at the close of inspection.

Judgment:
Non Compliant - Moderate

Outcome 04: Suitable Person in Charge
The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:
Governance, Leadership and Management

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

Findings:
There was a person in charge of the designated centre and she was engaged in the governance of the centre on a regular and consistent basis. She had held the post of person in charge since March 2011. She was employed full time and had the experience as required by the regulations.

Residents and staff could identify her and said that she was an approachable and effective manager.

She demonstrated clinical and legislative knowledge during the course of the inspection.

Judgment:

Compliant

Outcome 05: Documentation to be kept at a designated centre
The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 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 2013.

Theme:
Governance, Leadership and Management

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

Findings:
One aspect of this outcome was examined on this inspection.

Staff files were made available for inspection. Information required as per schedule 2 of the regulations was in place in most files reviewed. However, in some files reviewed, there was no evidence of identity such as a driving licence or passport or evidence of qualifications. This was discussed with the person in charge.

A vetting disclosure was in place in the sample of all files reviewed. The person in charge gave a verbal assurance that all staff working in the centre had the required vetting.

Judgment:
Non Compliant - Moderate

Outcome 07: Safeguarding and Safety
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. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe care and support

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

Findings:
There was a policy in place for safeguarding vulnerable adults in the centre. Staff were familiar with the policy. Staff could describe what abuse was and what they would do in the event of a concern arising in regards the safeguarding of residents.

Training records demonstrated that the majority of staff had been trained in safeguarding vulnerable adults from abuse, however two nurses who had been employed in the centre for approximately 10 months had not been trained in safeguarding vulnerable adults. A staff nurse was the designated officer and she confirmed that she had attended the relevant training and provided documentary evidence of same.

Residents who spoke with the inspector said that they felt very safe in the centre and that the staff were very good to them.

The inspector reviewed the complaints log and found that complaints where there was a possibility that abuse may have occurred had not been managed as potential reports of abuse. The preliminary screening was not always implemented to assist in the decision as to whether or not a safeguarding investigation was required. Although action was taken, records did not adequately set out the reported incident, investigation taken nor the subsequent follow up.

The person in charge confirmed that residents' finances were not managed or held in the centre due to the short stay duration of admissions.

There were policies in place for the management of residents with responsive behaviours and for the use of restraint. Overall, a restraint free environment was promoted and it was evident from the notifications submitted to HIQA on a quarterly basis that the numbers of bedrails utilised in the centre varied indicating that they were not used as a matter of course. This was discussed with the person in charge who confirmed same and the use of bed rails was discussed with staff nurses who were clear that the use of bedrails would be based on a clinical decision.

Overall, in the sample of files reviewed, where restraint was used it was in line national policy, however, some areas required improvement. The risk tool included consideration of risks such as likelihood of the resident to become entrapped or climb over the bed rail, however, the assessment did not demonstrate that there had been multidisciplinary input to ensure that the decision to use bed rails included a comprehensive assessment of the resident's physical, medical, psychological, emotional, social and environmental causes of factors as set out in the national policy. Staff who spoke with the inspector said that the decision would be discussed at handover. The rationale for its use was recorded. Alternatives that had been trialled, if any, prior to the implementation of the restraint were not documented. Residents had signed consent for the use of bed rails. Two hourly safety checks were carried out and documented.

The person in charge confirmed that the centre did not manage any finances for residents.

Care plans were in place to guide staff in supporting residents with responsive behaviour. These were pre-populated documents that gave general, non person specific guidance to staff and required development. For example, the care plan didn't identify specific triggers or how the behaviour might manifest, for example, a resident being up at night. Nor did it set out management strategies to support the resident in a safe and consistent way.

Training in responsive behaviour had been provided in October and November of 2015.

Judgment:
Non Compliant - Major

Outcome 08: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

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:
The centre had policies and procedures relating to health and safety and the health and safety statement was displayed in the person in charge's office. A risk management policy was in place. However, as identified in the previous inspection, not all the risks identified in the regulations had been identified such as self harm.

Procedures were in place for the prevention and control of healthcare associated infections. Staff with responsibility for the cleanliness of the centre demonstrated knowledge of their responsibilities in this regard. The centre was clean and free from odour on the day of inspection. However, improvements were required in the overall décor of the premises to ensure effective cleaning could take place. For example, there was damage and rusting to paintwork on pipes and radiators. Skirting boards had separated in some areas. The sink in the male ward had a panel of unfinished wood beneath the sink, the surface of which was damaged. Handwashing sinks in the centre's sluice facilities were domestic in design. The management of indwelling catheters required review as it was seen on inspection, that the tip of a catheter bag was lying on the floor. This contravened the associated care plan instructions and is not in line with good hygiene infection control practices.

A risk register was available for review, however, there was no formal process in place for identifying new or changing hazards prior to annual reviews of risk assessments taking place, therefore the management of new or changing hazards required review. Management meeting minutes demonstrated that it had been identified that hazard identification sheets were required for this purpose but these had not been implemented

to date. On the day of inspection, it was noted that a fire door was propped open with a piece of cardboard, therefore, preventing the door from working as it should, if the fire alarm sounded. The person in charge said that the automatic release was broken on the door, hence the interim measure. However, no risk assessment had taken place to determine the safe controls required in the absence of the release function on the door to ensure the most suitable and safe arrangements were in place.

As identified on the previous inspection, all hazards identified were not consistently responded to with control measures. For example, the stairs had been identified as a hazard in the risk register due to its location on the ward. Incident reports showed that a resident had experienced a minor fall whilst on the stairs, however, it wasn't evident that the risk assessment for that area had been reviewed to ascertain whether controls were sufficient to prevent/minimise a future reoccurrence. The overall use of restraint and the management of residents who were permitted to smoke on the grounds of the centre did not have general risk assessments in place.

A clinical risk management group had responsibility for reviewing incidents in the centre and meeting minutes evidenced that information that would contribute to the reduction of recurrences was considered, such as, the number of falls in a quarter and the time that they occurred. However, it was evident that not all incidents were recorded as required, such as a resident fall/near miss; this was discussed with the person in charge.

Staff were training in safer techniques for moving and handling of people.

Suitable fire equipment was in place and service records for same were available for review and were seen to be up to date. Fire exits were unobstructed on the day of inspection. Staff were trained in fire safety, and were clear on what was required of them in the event of the fire alarm sounding. A colour code system on the white board in the nurses' station informed staff of what assistance was required in order to mobilise a resident in the event of an emergency evacuation. However, this system required review to ensure that it gave sufficient information for all scenarios such as cognitive deficits pertinent to each resident or specific instructions for day/night time scenarios. The information displayed in the nurses' office wasn't portable if staff needed to refer to it in an emergency.

With the exception of one drill in July 2016, fire evacuation drills were taking place as part of a structured training day with an external instructor. Although carrying out drills under the supervision of an external fire safety contractor is considered good practice, additional independent drills carried out with staff are also required to determine if the fire procedures are fit for purpose and staff responses are adequate. Additional drills also identify training, staff and equipment needs.

In the absence of these additional drills, there was no evidence, documentary or otherwise, to demonstrate that the plans and practices in place were sufficient to ensure a timely evacuation if the need arose. There was no documentary evidence of what the drill (if any) had entailed, what had gone well and what required improvement. There were no details as to the length of time it would take to evacuate all residents from a specific zone if needed. This was discussed with the person in charge and was an issue identified on the previous inspection.

Judgment:
Non Compliant - Moderate

Outcome 09: Medication Management
Each resident is protected by the designated centre's policies and procedures for medication management.

Theme:
Safe care and support

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

Findings:
There were written operation policies in place relating to medication management.

The process in place for handling medicines, including controlled drugs, were safe and in accordance with current guidelines. A random check of controlled medicines tallied with records. The inspector observed a medication round and found that administration practices were in line with current guidance for nurses and the practice for disposal of unused medication was found to be safe. The nurse was seen to explain the reason for the medication to the resident.

Nursing staff confirmed that the practice of transcribing did not take place in the centre.

The arrangements for the return of discontinued or unwanted medication were safe and transparent. A returns duplicate book was maintained and this contained the name, dose and number of medications being returned. The nurse responsible for returning the medication signed the book as did the collecting person.

Arrangements were in place for the safe prescribing of medications should a resident staying in the centre for respite or convalescence stay longer than anticipated.

Judgment:
Compliant

Outcome 10: Notification of Incidents
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

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:
The quarterly returns submitted to HIQA did not include details of environmental restraint such as keypad locks on doors.

Judgment:
Substantially Compliant

Outcome 11: Health and Social Care Needs
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. 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.

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:
Residents' health care needs were met through timely access to medical treatment. A number of general practitioners (GP) visited the centre and an on call system of regular GPs was in place for residents whose GP was not affiliated with the centre. An out of hours service was available at the weekend.

The average stay for residents was 7-10 days and during this time there was access four days per week to a physiotherapist on site. Onward referrals to allied health professionals were made as part of the discharge plan including communicating with the public health nurse to ensure adequate support was in place upon the residents' discharge. Evidence of organised discharge planning was evident in the sample of files reviewed.

Residents had general health observations undertaken on admission such as vital signs, weight, urinalysis and blood profiles. General health promotion was seen via leaflets regarding flu vaccine available in the foyer and health promotion posters about how to prevent falls were displayed in corridors.

A comprehensive range of assessments were completed on admission, these included matters such as risk of developing pressure sores, risk of falls, malnutrition risk, manual handling and dependency level assessment. These were completed for all residents in the sample of files reviewed and where a resident was discharged from the centre to

hospital and returned to the centre, risk assessments were seen to be reviewed.

Biographical assessments were completed for each resident on assessment and this included information such as the person's preferred name and what time they liked to dine/get up at. Efforts were made to get to know the resident's personal interests and hobbies and these were documented.

Improvements were required in the documentation of care plans. Care plans were prepopulated with generic, non specific information, the person in charge stated that nursing staff added information to the care plans as it became available, however, this was not evident or was inconsistent in the sample of care plans reviewed.

For example, a wound care plan for a resident had been reviewed but it was not evident that it had been done so with the involvement of the wound care specialist who had been attending the resident. There was no record of the wound care specialist's visit or recommendations. It was evident upon review of the wound care assessment that consistent care was delivered to the resident however, the most recently revised care plan did not give adequate guidance regarding the materials to be used nor the frequency of the dressing changes, therefore it was difficult to ascertain as to whether or not wound care was based on evidence based practice.

Personal hygiene care plans required review to ensure that they clearly identified the level of assistance required to ensure that independence was maintained and care was consistent. A care plan was not always in place for each identified need, this had also been identified in the recent documentation audit. For example, a resident who required specific assistance with elimination did not have an associated care plan.

A sample of end-of-life care plans were reviewed and these required further information so as to ensure that the resident received care that was in line with their wishes at the end of their life. For example, there was no information recorded regarding wishes or preferences, no information pertaining to their care after death or no input from next of kin or family documented. Given the centre had three suites dedicated to palliative care, this was an area that required review. The person in charge and other staff spoke of a recently formed committee that was responsibility for reviewing and improving the end of life care delivered in the centre. A questionnaire had been send to relatives of some of those who had received such care in the centre. The responses seen were overall very positive in regards to the care delivered.

A recognised assessment was completed to detect residents who were at risk of malnutrition. Reports from allied health professionals were seen to be available in the kitchen and special dietary requirements, likes & dislikes were also recorded on a white board in the kitchen. Kitchen staff who spoke with the inspector demonstrated good knowledge of residents' needs and said that the kitchen information board was updated daily by nursing or care staff.

Residents were afforded the opportunity to decline or refuse care and this was respected and documented.

Judgment:

Non Compliant - Moderate

Outcome 12: Safe and Suitable Premises
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. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

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:
Non-compliances relating to the premises in previous inspection had not been satisfactorily progressed and are restated in this outcome. It was noted however, that since the last inspection, phase one of the proposed works had been completed. This involved the addition of a dining room, a small dayroom area leading out to the garden and a shower room on the ground floor. The person in charge said that they had had good feedback regarding the dining room but the dayroom was not utilised very much. Residents who spoke with the inspector indicated that they enjoyed having their meals in the dining room as it was a 'break from the bedroom'.

Efforts had been made to include homely touches to the centre. The dayroom had photographs displayed which had been taken by a previous resident. Paintings on the ground floor corridor were also completed by previous residents. A grandfather clock and bookshelves were situated in the day room also.

Otherwise the issues relating to premises were ongoing. The centre is set over three floors, with resident accommodation on the ground and first floor and physiotherapy and administration offices on the second floor. The ground floor comprised three well appointed palliative care suites with facilities for family to stay overnight and a small kitchenette. Each suite had access to the garden and a seating area. One suite was awaiting the delivery of new reclining furniture.

The first floor lacked the homely touches of the ground floor. It comprised two five bedded wards, one twin room and one single room. As discussed in the health & safety outcome, the general décor and upkeep of the centre required review as it was evident that paint was peeling, the corridor floor on the first floor was dull and discoloured, radiators and pipework was rusted and paint was peeling. Skirting boards were scuffed and separating in places. Some furniture was damaged such as torn material in armchairs.

There was inadequate storage in the centre for residents' personal belongings. There were no wardrobes available, only bedside lockers. The space between beds in each ward was very limited which had the potential to impact on residents' privacy and dignity should personal care be required whilst in bed and thus ensuring the privacy screening could be maintained in position. It also posed a restriction on movement for staff delivering care at the bedside.

The provider nominee and the person in charge confirmed that plans to address these issues had not been progressed since the previous inspection in May 2015.

There was a lack of signage in the centre to assist with locating communal areas or bedrooms. There were no door numbers / room names displayed on bedroom doors.

Judgment:
Non Compliant - Major

Outcome 13: Complaints procedures
The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

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:
There was a policy for the management of complaints in place, however, there was no person nominated to oversee that complaints were appropriately responded or that appropriate records maintained.

The complaints process was displayed in the corridors of the centre. There was a person nominated to deal with complaints.

It was evident upon review of the complaints log that residents were facilitated to make a complaint and staff were responsive in dealing with same. Documentation did not always reflect whether or not the resident was satisfied with the outcome as required by the regulations. Learnings weren't always evident or documented as to how practice would change to prevent a reoccurrence of the issue.

Judgment:
Substantially Compliant

Outcome 16: Residents' Rights, Dignity and Consultation

Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

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:
Elements of this outcome were inspected against on this inspection.

As discussed in the governance and management outcome, there were no arrangements in place to consult residents on an ongoing basis in order to elicit feedback as to how the centre was run. This was discussed with the person in charge and the provider nominee at the feedback session.

Residents confirmed that a priest visited the centre at the weekends.

Biographical data completed on admission for each resident confirmed that staff aimed to elicit resident preferences regarding routine.

It was observed on inspection that the evening meal was served at 16:00 hours. The person in charge stated that that had always been the routine in the centre. The resident satisfaction survey in November 2015 asked residents some questions pertaining to meals served, however, satisfaction with the timing of meals was not determined. Staff who spoke with the inspector all said that residents were afforded choice and if they wished to dine at times other than the structured mealtimes this was always accommodated. Residents who spoke with the inspector on the day of inspection said that they were happy with the meal times and that they would never be hungry in the centre. Staff confirmed that snacks were available in the evening such as soup, sandwiches, custard and dessert rice.

The inspector noted that the lunchtime and evening menu was displayed on a notice board in the dining room. For the residents who dined upstairs there were no arrangements in place for informing them of what was on offer until the meal time itself. The chef advised the inspector that there were always sufficient resources in stock to offer an alternative and every effort would be made to accommodate a resident's request.

Board games and cards were available in the day room and staff said that they often encouraged residents to partake in a game but generally residents were disinterested. Activities had been included in the resident survey in November 2015 but as there was

only nine responses it was difficult to determine whether the views elicited were the views of the majority of residents. On the day of inspection, residents who spoke with the inspector said they were happy with what was on offer and that they staff were good to them. There was no formal activities/entertainment schedule in place.

Judgment:
Non Compliant - Moderate

Outcome 18: Suitable Staffing
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. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

Theme:
Workforce

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

Findings:
There was a planned roster in place and this was available for review. Following the previous inspection, the provider and person in charge had undertaken to roster a twilight shift from 17:30hrs to 23:30hrs each evening. While the recruitment of this additional person had been sanctioned and one person recruited to fulfil half of the hours, this staff member was being utilised to cover annual leave and sick leave.

The person in charge confirmed that when available the twilight shift was filled and staff confirmed that having the shift available relieved pressure on them in the evening time. On the day of inspection the breakdown of dependency levels was as follows: maximum x1, high x6, medium x6 and low dependency x2. Staff who spoke with the inspector said that the absence of the twilight shift on that particular day was not an issue due to the mix of needs of residents in the centre but that could change day to day given the turnaround of residents being admitted to and discharged from the centre. The inspector found that it had been assessed that a twilight shift was required seven days per week and based on the rota and conversations with the person in charge, this was not adequately resourced to ensure it was always available. This was discussed with the person in charge and the provider nominee who stated that she would recommence a recruitment drive to fill the outstanding hours.

There was a registered nurse on duty at all times and up to date registration details were held in the centre and were available for review.

The majority of staff were up to date with mandatory training, however, some staff had not received fire safety training or safeguarding training. Staff whose role involved modifying the consistency of foodstuffs for residents with specific dietary needs had not received formal training for same.

The person in charge confirmed that there were no volunteers in the centre at the time of the inspection.

Judgment:
Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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Regulation Directorate

Action Plan

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

Provider's response to inspection report[1]

Centre name:	St. Brigid's Hospital
Centre ID:	OSV-0000672
Date of inspection:	07/11/2016
Date of response:	23/11/2016

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 02: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The audit programme required expansion to ensure it was comprehensive and encompassed all areas of care and safety. For example, the audit programme did not include audit of the use of restraint or the management of complaints.

There was no formal procedure for consulting residents on an ongoing basis about the running of the centre and eliciting feedback to improve the residents' experience.

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

1. Action Required:
Under Regulation 23(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

Please state the actions you have taken or are planning to take:
With immediate effect the Person in Charge will source an audit tool for restraint, and review the complaints policy to be compliant with HIQA standards,
A quarterly meeting will be held with current inpatients in order to gain feedback of their experience during their stay in St Brigids. The first meeting will take place the first week in December 2016.

Proposed Timescale: 09/12/2016

Outcome 05: Documentation to be kept at a designated centre

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Staff files did not hold all the requirements as per schedule 2 of the regulations.

2. 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:
Administration assistance has been approved and staff files will be reorganised to contain all requirements of schedule 2. This work is commencing week beginning 21/11/2016 and be completed by the 31st December 2016.

Proposed Timescale: 31/12/2016

Outcome 07: Safeguarding and Safety

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all staff had received mandatory safeguarding training.

Care plans for residents who had behaviours that were challenging were pre-populated documents that gave general, non person specific guidance to staff and required

development.

3. Action Required:
Under Regulation 07(1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.

Please state the actions you have taken or are planning to take:
Safeguarding training is being sourced and all staff will be updated by year end.

Care plans have been discussed at a staff nurse meeting on 16th November and staff will ensure that care plans are more patient centred.
The CNM2 will be responsible for monitoring the Care Plans on an ongoing basis. The Practice Development Coordinator will continue to complete annual audits.

Proposed Timescale: 31/12/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The use of restraint was not always in line with national policy. For example, there was no evidence of MDT input and alternatives trialled prior to implementation of restraint was not always documented.

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:
With immediate effect the Director of Nursing will ensure there is documentary evidence of MDT input when discussing the use of restraint. Available alternatives will be discussed with the patient and next of kin and trialled where deemed suitable.

Proposed Timescale: 29/11/2016

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The inspector reviewed the complaints log and found that complaints where there was a possibility that abuse may have occurred had not been managed as potential reports of abuse. The preliminary screening was not always implemented to assist in the decision as to whether or not a safeguarding investigation was required. Although

action was taken, records did not adequately set out the reported incident, investigation taken nor the subsequent follow up.

5. Action Required:
Under Regulation 08(3) you are required to: Investigate any incident or allegation of abuse.

Please state the actions you have taken or are planning to take:
With immediate effect all complaints received which could potentially be reports of abuse will be notified and preliminary screening take place. All complaints will be investigated and actioned as required. The complaints policy will be amended to identify the Director of Nursing as complaints administrator and CNM 2 as complaints officer. Information will be relayed to staff through staff meetings.

Proposed Timescale: 23/11/2016

Outcome 08: Health and Safety and Risk Management

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all the risks identified in the regulations had been identified such as self harm.

There was no formal process in place for identifying new or changing hazards prior to annual review of risk assessments taking place, therefore the management of new or changing hazards required review. As identified in the previous inspection, all hazards identified were not consistently responded to with control measures.

6. Action Required:
Under Regulation 26(1)(a) you are required to: Ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.

Please state the actions you have taken or are planning to take:
A new hazard check list has been sourced and implemented. Risks will be reassessed to ensure control measures are in place.

Proposed Timescale: 23/11/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Improvements were required in the overall décor of the premises to ensure effective

cleaning could take place.
For example:
There was damage and rusting to paintwork on pipes and radiators.
Skirting boards had separated in some areas.
The sink in the male ward had a panel of unfinished wood beneath the sink, the surface of which was damaged. Handwashing sinks in the centre's sluice facilities were domestic in design.

The management of indwelling catheters required review as it was seen on inspection, that the tip of a catheter bag was lying on the floor. This contravened the associated care plan instructions and is not in line with good hygiene infection control practices.

7. Action Required:
Under Regulation 27 you are required to: Ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.

Please state the actions you have taken or are planning to take:
Technical Services manager has been advised of the outcome of the report and will undertake redecoration.

All staff will be reminded to ensure adherence to Infection control Policy when caring for patients with indwelling catheters, when receiving daily handover report.

The replacement of the hand washing sinks will take place in conjunction with the phased capital development of St. Brigid's Hospital. Phase 1 is complete and Phase 2 and 3 are dependent on capital allocation.

Proposed Timescale: Infection Control: Immediate
Redecoration: January 2017

Proposed Timescale: 31/01/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Fire drills, that were not part of a structured training session, were not being carried out at suitable intervals.

Documentation of fire drills was insufficient.

8. Action Required:
Under Regulation 28(1)(e) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and residents are aware of the procedure to be followed in the case of fire.

Please state the actions you have taken or are planning to take:
Documentation of fire drills will comply with HIQA guidelines with immediate effect. Fire drills will take place twice yearly in January and August at different times of the day. Results of the fire drills will be documented with actions taken as advised by the outcome of the fire drills.

Proposed Timescale: 31/01/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Personal emergency evacuation plans required review to ensure that they gave sufficient detail and were easily accessible in the event of an emergency evacuation being required.

9. Action Required:
Under Regulation 28(2)(iv) you are required to: Make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and safe placement of residents.

Please state the actions you have taken or are planning to take:
An improved Personal Emergency Evacuation Plan will be sourced and implemented for all current inpatients. These will be in place by December 16th.

Proposed Timescale: 16/12/2016

Outcome 10: Notification of Incidents

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The quarterly returns submitted to HIQA did not include details of environmental restraint such as keypad locks on doors.

10. Action Required:
Under Regulation 31(3) you are required to: Provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of any incident set out in paragraphs 7(2) (k) to (n) of Schedule 4.

Please state the actions you have taken or are planning to take:
Future quarterly returns on restraint will include key pad locks

Proposed Timescale: 31/01/2017

Outcome 11: Health and Social Care Needs

Theme:
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Improvements were required in the documentation of care plans. Care plans were prepopulated with generic, non specific information.
For example:
Wound care
Personal hygiene
End of life care

Care plans were not in place for all identified problems.

11. Action Required:
Under Regulation 05(3) you are required to: Prepare a care plan, based on the assessment referred to in Regulation 5(2), for a resident no later than 48 hours after that resident's admission to the designated centre.

Please state the actions you have taken or are planning to take:
Care plans have been discussed at a staff nurse meeting on 16th November and staff will ensure that care plans are more patient centred. All care plans required to guide patient care will be opened and be patient centred.

Proposed Timescale: 23/11/2016

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
It was not evident that all care plans were evidence based or based on recommendations from the relevant allied health professional, for example, wound care.

12. 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:
Care plans have been discussed at a staff nurse meeting on 16th November and staff will ensure that care plans are more patient centred. All care plans required to guide

patient care will be opened and be patient centred.

Proposed Timescale: 23/11/2016

Outcome 12: Safe and Suitable Premises

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The general décor and upkeep of the centre required review.
For example:
Paint was peeling;
the corridor floor on the first floor was dull and discoloured;
radiators and pipework was rusted and paint was peeling;
Skirting boards were scuffed and separating in places;
Some furniture was damaged such as torn material in arm chairs.

There was inadequate storage in the centre for residents' personal belongings.

The space between beds in each ward was very limited which had the potential to impact on residents' privacy and dignity should personal care be required whilst in bed and thus ensuring the privacy screening could be maintained in position. It also posed a restriction on movement for staff delivering care at the bedside.

There was a lack of signage in the centre to assist with locating communal areas or bedrooms.

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

Please state the actions you have taken or are planning to take:
Technical Services manager has been advised of the outcome of the report and will undertake redecoration.
Capital development at St. Brigid's is dependent on funding being made available. Developments at St. Brigid's will occur on a phased basis. Phase 1 has already been completed.

Proposed Timescale: 31/01/2017

Outcome 13: Complaints procedures

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Documentation did not always reflect whether or not the resident was satisfied with the outcome as required by the regulations.

14. Action Required:
Under Regulation 34(1)(f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.

Please state the actions you have taken or are planning to take:
All complaints will be investigated and actioned as required and learning from the complaint will be documented.
Any complaints received will be discussed at staff meetings to provide further learning.
Patients will be contacted as a follow up to ensure satisfaction

Proposed Timescale: 23/11/2016

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Learnings weren't always evident or documented as to how practice would change to prevent a reoccurrence of the issue.

15. Action Required:
Under Regulation 34(1)(h) you are required to: Put in place any measures required for improvement in response to a complaint.

Please state the actions you have taken or are planning to take:
All complaints will be investigated and actioned as required and learning from the complaint will be documented.

Proposed Timescale: 23/11/2016

Outcome 16: 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:
The process for consultation required review to ensure adequate feedback was obtained regarding the running of the centre. For example, views regarding meal times and activities.

16. Action Required:
Under Regulation 09(3)(d) you are required to: Ensure that each resident is consulted about and participates in the organisation of the designated centre concerned.

Please state the actions you have taken or are planning to take:
A quarterly meeting will be held with current inpatients in order to gain feedback of their experience during their stay in St Brigids. The first meeting will take place the first week in December 2016.

Proposed Timescale: 31/12/2016

Outcome 18: Suitable Staffing

Theme:
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were inadequate resources in place to ensure that the number of staff that had been identified as being required were always available and allocated, e.g. the twilight shift was often unfilled.

17. 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:
Staffing needs vary on a daily basis. If a twilight shift is required but no twighlight staff available, agency carers will be sought.

Proposed Timescale: 23/11/2016

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all staff had received mandatory training.

Not all staff had received training specific to their role, for example, training in modifying the consistency of foodstuffs.

18. 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:
Training around modified diets will be sourced and implemented.

Any areas where mandatory training has not been received will be addressed to ensure all staff are up to date.

Proposed Timescale: 31/01/2017