

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Ballinderry Nursing Home
<b>Centre ID:</b>	ORG-0000318
<b>Centre address:</b>	Kilconnell, Ballinasloe, Galway.
<b>Telephone number:</b>	090 968 6890
<b>Email address:</b>	ballinderrynursinghome@eircom.net
<b>Type of centre:</b>	A Nursing Home as per Health (Nursing Homes) Act 1990
<b>Registered provider:</b>	Mary Noone
<b>Provider Nominee:</b>	Mary Noone
<b>Person in charge:</b>	Katherine McGinty
<b>Lead inspector:</b>	Nan Savage
<b>Support inspector(s):</b>	None
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	41
<b>Number of vacancies on the date of inspection:</b>	9

## 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.

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 2 day(s).

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

From:	To:
17 October 2013 11:30	17 October 2013 16:30
18 October 2013 08:00	18 October 2013 16:30

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

Outcome 01: Statement of Purpose
Outcome 03: Suitable Person in Charge
Outcome 04: Records and documentation to be kept at a designated centre
Outcome 06: Safeguarding and Safety
Outcome 07: Health and Safety and Risk Management
Outcome 08: Medication Management
Outcome 09: Notification of Incidents
Outcome 10: Reviewing and improving the quality and safety of care
Outcome 11: Health and Social Care Needs
Outcome 13: Complaints procedures
Outcome 16: Residents Rights, Dignity and Consultation
Outcome 18: Suitable Staffing

**Summary of findings from this inspection**

During this follow-up inspection, the inspector met with residents and staff members. The inspector observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files.

Since the previous inspection, the provider appointed Adrian Ahern as operations manager. The inspector interviewed Adrian Ahern as a person participating in the management of this centre.

There were 41 residents living in the centre, 15 of whom were maximum dependency, 12 high dependency, 10 medium dependency and 4 low dependency. These dependency levels were not available on the first day of inspection for twelve residents. This raised concerns that the method used in determining appropriate staffing levels and skill mix was not based on the current assessed needs of residents.

This inspection focused on the 20 required actions in the previous action plan. Three actions were completed and the remaining actions were partly completed and

ongoing. While some improvement had been noted the inspector was not satisfied that sufficient progress had been made and that these actions had not been completed within the timeframes agreed with the Authority. There continued to be non-compliances with the Regulations in care planning documentation, areas of health care that related to aspects of restraint management, falls management and medication management, risk management and staffing.

Other required actions that remain outstanding from the previous inspection included the establishment of an effective system for reviewing and improving the quality and safety of care and quality of life for residents. Also, some residents did not have regular opportunity to attend in activation suitable to their capabilities and interests.

The inspector identified two additional significant risks on this inspection that related to an area of risk management and fire safety. These risks were brought to the immediate attention of the operations manager who responded promptly and addressed these during the inspection.

On this inspection some issues were noted under Outcome 3 and Outcome 9. The inspector found that the person in charge was covering sick leave on night duty and was not therefore full time person in charge as required by the Regulations. The inspector requested an updated staff roster for the following week which confirmed that the person in charge was no longer covering staff shortages on nights. The inspector also noted that improvements were required in the recording of some incidents and submission of notifiable events to the Chief Inspector.

The inspector noted improvements had been made in wound care management. The provider had continued to make available resources for staff training although additional education had not been provided on the management of the use of restraint. While the provider, person in charge and operations manager had attended some training on health and safety, issues identified on this inspection demonstrated that they did not have sufficient knowledge in the area of risk management.

The findings are discussed further in the report and improvements required are included in the Action Plan at the end of the report.

**Section 41(1)(c) of the Health Act 2007 Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.**

**Outcome 01: Statement of Purpose**

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

**Theme:**

Leadership, Governance and Management

**Judgement:**

Non Compliant - Moderate

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

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

**Findings:**

The actions from the previous inspections had been partially completed.

The inspector reviewed the most up-to-date statement of purpose and found that while improvements had been made, it still did not fully comply with the Regulation and associated schedule. For example, fire precautions and associated emergency procedures had not been included and the size of all communal rooms had not been documented. The number of whole time equivalent (WTE) nurses included did not reflect the actual number of WTE nurses working in the centre.

The inspector also found that aspects of the service outlined in statement of purpose did not adequately inform practice and did not accurately reflect the service provided. For example, the provider stated that residents' care plans would be reviewed every three months or more frequently if required. However, as detailed further in Outcome 11, this had not happened in practice for a number of residents. The inspector also noted that the centre accepted emergency admissions but there was no reference in the statement of purpose to this type of admission and how it would be managed.

**Outcome 03: Suitable Person in Charge**

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

**Theme:**

Leadership, Governance and Management

**Judgement:**

Non Compliant - Moderate

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

No actions were required from the previous inspection.

**Findings:**

The person in charge had not changed since the previous inspection.

However, the inspector was concerned that the person in charge had been recently rostered on night duty and was not adequately performing her operational and management functions. The inspector found that she was unable to provide sufficient clinical governance in the centre during the day as she formed part of the staffing complement on night duty. The person in charge confirmed that she was covering sick leave. The operations manager was in charge of the centre during the day and provided support to staff.

In response to a request by the inspector the provider submitted to the Authority the staff roster for week commencing 21 October 2013 which confirmed that the person in charge had been taken off front-line nursing duties.

Since the previous inspection the person in charge had engaged in continuous professional development in areas including dementia care, dysphasia and tools for safe practice.

As part of this inspection the inspector met with and interviewed the operations manager appointed in August 2013. The inspector found that he had relevant experience and had completed additional training since commencing work in the centre. He had initially worked in the centre as a relief nurse prior to taking up his current position.

**Outcome 04: Records and documentation to be kept at a designated centre**

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

**Theme:**

Leadership, Governance and Management

**Judgement:**

Non Compliant - Moderate

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

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

**Findings:**

The actions from the previous inspection had been partially completed. The inspector was concerned that all current policies were not readily available to staff and that staff were therefore not familiar with the content of some of these policies. For example, the operations manager and staff could not locate the policy on falls prevention.

The person in charge had begun the process of reviewing the policies. However, the inspector was not satisfied that sufficient process had been made. The inspector noted that the policy on behaviour that challenges was still not implemented which had been identified on previous inspection.

These issues are discussed in more detail in Outcomes 7, 8, 11 and 13.

**Outcome 06: 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.*

**Theme:**

Safe Care and Support

**Judgement:**

Compliant

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

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

**Findings:**

The specific action that related to the policy on the preventing, detecting and responding to allegations or suspicions of abuse had been completed.

The inspector reviewed the updated policy and found that sufficient guidance was provided to staff on how to respond to and investigate all suspicions of abuse.

**Outcome 07: Health and Safety and Risk Management**

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

**Theme:**

Safe Care and Support

**Judgement:**

Non Compliant - Major

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

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

implemented.

**Findings:**

The inspector was not satisfied that the provider had made sufficient progress in completing the required actions from the previous inspection even though the provider had stated in her response to the action plan that these action would be addressed by the end of August 2013.

Some risks that were identified at the inspection in March 2013 had not been fully addressed and an additional risk was also noted which placed some residents at potential harm. For example, the inspector saw that some bedroom doors were wedged open during part of the inspection and that the surface temperature of a radiator was very hot and posed a risk to some residents. These risks were brought to the attention of the operations manager and were addressed immediately. The inspector also found that the floor covering was sticky in some areas of the communal rooms and lifting in some parts including a section in a resident's bedroom and circulation area. This posed a potential trip hazard.

The inspector found that the following issues remained outstanding and had not been completed within the timeframes set by the provider:

- the risk management policy had not been updated to reflect the current risk management arrangements in the centre,
- precautions were not in place for specific risks identified in the Regulations including assault
- arrangements had not been documented for the identification, recording, investigation and learning from incidents. There was no formal review of incidents/ accidents such as falls to inform learning and reduce the likelihood of recurrence. During the inspection, the operations manager started to gather data on these incidents
- the risk register did not reflect all risks in the centre. Risk assessments were not available on areas including the dining room, medication room and day rooms
- all residents identified at risk of absconsion had not been formally assessed for this risk. The inspector noted from records viewed that since the previous inspection a resident at risk of absconsion had left the building. The inspector was informed that this was for a very short period of time
- a ramp which formed part of an external fire escape had not yet been completed to a safe standard. The interim safety measure that had been implemented during the previous inspection was partly in place and the risk register had not been updated to include this risk. The operational manager informed the inspector that a safety gate had been ordered for this area
- since the previous inspection the provider, person in charge and operations manager had attended a half day course on health and safety. However, from the lack of improvement made in risk management and additional risks noted on this inspection, the inspector was concerned that there was an insufficient understanding of risk management. The operations manager informed the inspector that as part of his new role he had now responsibility for non-clinical areas.

Since the last inspection the provider and the person in charge had addressed the following specific issues:

- a window restrictor had been put in place on the large outward opening window in the



dining room

- unsafe assistive seating devices that were used in residents' toilets had been removed.

## **Outcome 08: Medication Management**

*Each resident is protected by the designated centres policies and procedures for medication management.*

### **Theme:**

Safe Care and Support

### **Judgement:**

Non Compliant - Moderate

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

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

### **Findings:**

This action had not been completed within the timeframe stated by the provider.

While work had begun on the development of a new medication policy, the current policy in use was inadequate. For example it did not include centre-specific procedures on areas including medication administration, recording, disposal of medications and procedures for crushed medications. In addition the inspector observed nurses administering some medications in crush formats that had not been prescribed for.

An issue that had been identified on a previous inspection in March 2013 had not been addressed. On day one, the nurse signed that she had administered some residents' medications to indicate that the medications had been administered prior to actually doing so, before the resident had taken the medication. This had been identified as an issue on a previous inspection. The inspector brought this matter to the attention of the operations manager and person in charge who was on night duty. The inspector found that medications were administered contemporaneously on day two of the inspection. Following the inspection, the person in charge confirmed to the inspector that she had fully reviewed and followed up on this medication error.

The inspector read that in response to the previous action plan, residents' prescription sheet and medication administration sheet had been amended to include the times for administration of medications.

**Outcome 09: 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

**Judgement:**

Non Compliant - Minor

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

No actions were required from the previous inspection.

**Findings:**

On this inspection, the inspector found that some improvement was required in relation to the recording and notification of incidents.

From the sample of records reviewed not all incidents that had occurred were maintained and, where required, one was not notified to the Chief Inspector. The person in charge submitted this notification to the Authority after the inspection. The inspector also read that all relevant details relating to some incidents had not been documented.

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

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

**Theme:**

Effective Care and Support

**Judgement:**

Non Compliant - Moderate

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

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

**Findings:**

The provider had made limited progress in addressing this action.

A system for reviewing and improving the quality and safety of care and quality of life for residents had not been established.

Since the last inspection, the operations manager had gathered some data on medication management. During the inspection, he also supplied some data on incidents and accidents from the partly implemented computerised system. However, this information had not been reviewed to inform learning and improve service provision.

## **Outcome 11: Health and Social Care Needs**

*Each residents wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each residents 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

### **Judgement:**

Non Compliant - Moderate

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

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

### **Findings:**

The inspector was not satisfied that sufficient progress had been made in addressing the issues identified on the previous inspection. The provider and person in charge had indicated in the previous action plan response that all required actions would be completed by 30 September 2013 but this had not happened.

Care planning documentation was disjointed and some residents did not have required assessments and care plans in place to guide staff practice. Further improvement was required in falls management, the management of the use of restraint and activity provision to ensure all residents' needs were met.

#### **Care Planning**

The inspector reviewed a number of residents' files and found that the staff were in the process of changing from a paper based system to an electronic system of care planning. The inspector was concerned that this change process was not being managed safely and effectively to ensure timely accurate information was available for all residents. Areas of concern included:

- two care planning systems in place both of which were incomplete
- some assessments and care plans were not up-to-date on either system
- some assessment and care plans were not in place for residents on either system
- staff identified a need for additional training on the new electronic system.

In response to an immediate request from the inspector the provider submitted a plan on 23 October 2013 on how these issues would be addressed.

In addition there was insufficient evidence to demonstrate that residents were involved in the development and review of the care plans.

### Falls Management

While some good practice was noted in the management of falls during the inspection, nursing documentation was still inadequate and did not promote the safety of some residents. As outlined in Outcome 4, the policy on falls prevention and management could not be located by staff or the operations manager during the inspection. The inspector was concerned that care plans were not developed for two residents assessed at high risk of falls and who had recorded incidents of falls. The inspector requested that these residents were assessed and appropriate care plans developed as a matter of urgency. The person in charge submitted this requested information shortly after the inspection.

In some cases residents' associated care plans were not updated with interventions where appropriate to reduce the likelihood of re-occurrence after residents had a fall. The inspector also noted that following one incident there was limited evidence available that sufficient monitoring had been completed for a resident post fall.

### Restraint Management

While some improvement had been noted since the previous inspection the provider and person in charge had not taken adequate measures to ensure restraint was appropriately managed in the centre. The inspector saw that one resident had a restraint measure in place which was maintained in an unsafe condition in that the bedrails rails in use were very loose. The operations manager submitted confirmation that this risk had been addressed shortly after the inspection.

The centre's policy on restraint had not reviewed since the last inspection and did not provide adequate guidance to staff. The inspector noted that:

- a new assessment for the use of restraint had not been completed for all relevant residents
- the alternative interventions tried prior to using the restraint measure were not consistently documented
- there were no care interventions in place for some residents with restraint in situ
- evidence of consultation on the use of restraint with residents and/or their representatives was not available
- not all staff had received training on the management of restraint.

### Behaviour that Challenges

Specific issues identified on the previous inspection had not been addressed. The inspector found that associated care plans for residents with potential behaviours that challenge were inadequate to provide appropriate guidance to staff and in some cases there were no care plans in place. The policy on behaviour that challenges did not adequately inform practice and had not been fully implemented.

### Wound Care Management

Wound care practices and care plans had improved since the last inspection. However, the inspector found that some residents did not have up to date assessments and associated care plans on the promotion of skin integrity. The inspector saw evidence that the person in charge and some nursing staff had attended training on wound care management and described to the inspector new learning that they had applied in practice. There were policies and guidelines on the prevention of pressure ulcers and

wound care. However, the policy updated in August 2013 was not readily available to staff and was not maintained in the policy folder.

#### Activity Provision

While progress had been made in this area, further improvements were required. The inspector saw staff interacting with residents in a respectful manner as they performed their duties. Planned activities took place as well as one to one chats with residents. The inspector observed residents participating in exercises and music therapy. However, the inspector noted that there were still limited opportunities for residents with communication and other sensory difficulties to engage in appropriate activities based on their capabilities. This included those residents that spent most of their time in their bedrooms. Individual assessment had not been completed to inform a resident's care plan in order for the resident to engage in meaningful social interaction and activities appropriate to their interests and capabilities.

#### Supervision Arrangements

The inspector noted that supervision arrangements had improved. In addition to staff the operations manager also provided additional supervision and support to dependent residents during the inspection.

### 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

#### Judgement:

Non Compliant - Minor

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

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

#### Findings:

The provider had partially completed the required actions from the previous inspection. The provider had stated in the previous action plan that these required actions would be completed by 16 August 2013.

The complaints policy and procedure did not comply with all the requirements of the Regulations. The complaints policy had not been reviewed since the last inspection and still did not contain details of the nominated person to ensure that all complaints were appropriately responded to and records maintained. The inspector also noted that the complaints procedure attached to the complaints policy was different from the procedure displayed in the centre and did not fully reflect the current arrangements that were in place for the investigating of complaints. In addition, the policy had not been updated to reflect the current procedure for documenting complaints.

Practice in relation to the recording of complaints had improved. The inspector was informed by staff that all complaints were recorded and this was referenced in the complaints procedure displayed in the centre. The inspector also noted that the complainant's satisfaction level to the outcome of the complaint was now consistently documented.

### **Outcome 16: Residents Rights, Dignity and Consultation**

*Residents are consulted with and participate in the organisation of the centre. Each residents 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.*

**Theme:**

Person-centred care and support

**Judgement:**

Non Compliant - Minor

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

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

**Findings:**

The required action from the previous inspection that related to the promotion of residents' privacy and dignity had been partially completed.

The inspector noted that the provider had erected signage in the centre to alert residents and visitors to the location of CCTV monitors and documented procedures had been implemented on the use of CCTV in the centre.

However, the inspector found that the provider had failed to address the inadequate screening to ensure privacy for residents in some shared rooms.

### **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.*

**Theme:**

Workforce

**Judgement:**

Non Compliant - Moderate

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

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

**Findings:**

While the provider had made progress in the completion of required actions they had not been completed within the agreed timeframe. The inspector found that since the last inspection two WTE equivalent nursing staff had since left the service and one WTE nurse was on long-term leave of absence. As a result, on some occasions staffing levels and skill mix were not sufficient to meet the needs of all residents. Some further improvement was also required in the provision of training and staff files.

The inspector was not satisfied that there was a system in place to inform staffing levels and skill mix. The inspector found that twelve residents' dependency levels were not available on day one of the inspection which included residents of higher dependency. The person in charge completed these during the inspection. The provider and person in charge continued to utilise agency staff to support staffing levels while the provider was actively recruiting new nursing staff. Staffing levels and skill mix had improved since the previous inspection but were not adequate on some shifts and consequently the needs of all residents were not consistently met.

The person in charge had rostered an extra nurse on day shifts and night shifts. However, the inspector found that one nurse had been on duty on some shifts which could impact on the provision of care to residents. On these occasions when this happened the person in charge continued to roster an extra care assistant and/or nursing staff worked extra hours to reduce the timeframe that one nurse was on duty. Since the previous inspection a second cleaner had been rostered on duty most days from 10:00 hrs to 14:00 hrs. The person in charge informed the inspector that an additional cleaner was starting in November 2013.

While some staff had attended additional training in areas relevant to their role and the needs of residents the inspector noted that training on the management of restraint had not taken place. Staff and training records confirmed that some staff had received training in areas including dementia care, anaphylaxis and infection control. Mandatory training in moving and handling of residents had been provided as planned in July 2013. A training plan had been developed for the remainder of 2013 and some staff were booked to attend training on areas including nutritional assessment, diabetic care and venipuncture.

The inspector reviewed the recruitment, selection and vetting process. Since the previous inspection the policy on recruitment, selection and vetting of staff had been updated to include details on the procedure for employing agency staff. However, this policy had not adequately informed practice. Confirmation was not available that an agency nurse working in the centre had the necessary information required in the Regulations including Garda Síochána vetting, three written references and sufficient evidence of mental and physical fitness.

A sample of other staff files that were viewed by the inspector contained all required

information with the exception of Garda Síochána vetting for one staff member. The inspector read that Garda Síochána vetting had been applied for and a self declaration had been obtained as an interim measures from this staff member. The inspector noted that staff files now contained three written references.

## **Closing the Visit**

At the close of the inspection a feedback meeting was held to report on the inspection findings, which highlighted both good practice and where improvements were required.

### **Acknowledgements**

The inspector wishes to acknowledge the cooperation and assistance of the residents, relatives, and staff during the inspection.

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

Nan Savage  
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>	Ballinderry Nursing Home
<b>Centre ID:</b>	ORG-0000318
<b>Date of inspection:</b>	17/10/2013
<b>Date of response:</b>	20/12/2013

#### Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure Compliance with Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.

#### Outcome 01: Statement of Purpose

**Theme:** Leadership, Governance and Management

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

Information included in the statement of purpose was not reflected in practice.

**Action Required:**

Under Regulation 5 (1) (b) you are required to: Compile a Statement of purpose that describes the facilities and services which are provided for residents.

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

1) The statement of purpose has been reviewed to include all the requirements of schedule 1 of the regulations and reflects the services provided in the centre. Facilities and dimensions of rooms not previously included have been added to the current table. Completed 25th November and submitted with Action Plan.

**Proposed Timescale:** 25/11/2013

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

**Theme:** Leadership, Governance and Management

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

The statement of purpose did not contain all the required information listed in Schedule 1 of the Regulations.

**Action Required:**

Under Regulation 5 (1) (c) you are required to: Compile a Statement of purpose that consists of all matters listed in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

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

1) The statement of purpose has been reviewed and amended to fully comply with Schedule 1 of the Health Act 2007 Regulations 2009. Emergency admissions, complaints, and room dimensions have been included. Completed 25th November and submitted with Action Plan.

2) An Audit of the statement of purpose has been performed against regulations and adjusted according. Completed 20th November.

**Proposed Timescale:** 25/11/2013

**Outcome 07: 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:**

Some risk assessments were generic and areas including the day rooms, dining room and medication room had not been adequately risk assessed.

**Action Required:**

Under Regulation 31 (1) you are required to: Put in place a comprehensive written risk management policy and implement this throughout the designated centre.

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

1. Residents who wish to have their bedroom door kept open while they are in their rooms have been identified and a suitable approved mechanism fitted. 11 doors have had the mechanism fitted by 6th November. A further 8 have been ordered following risk assessment review. We are currently awaiting confirmation from the supplier on completion date. There is currently only 1 resident who remains in her room without the mechanism on the door. Safety checks are maintained routinely throughout the day and this resident is encouraged to participate in the daily activities. Wedges have been removed from doors. It is regularly impressed on staff not to have doors held open with anything other than the approved devices. Partially completed 6th December. Completion date for remainder awaited from supplier.

2. Tenders had been sought during September for the replacement of floor covering and this work has been completed 13th of November.

3. The issue regarding the sticky floor has been addressed by the introduction of a new cleaning regime, staff training and closer monitoring by the household supervisor has led to an improvement in the floor surfaces of those areas not requiring replacement. A colour coded cleaning system has been introduced to reduce the risk of cross contamination. An additional staff member has been assigned 18hrs per week for cleaning duties, this staff member is specifically assigned tasks and revised safe practice sheets introduced during November. It has been stressed to all staff by the Person in Charge and the Operations manager the need to minimise the risk of slips, trips and falls as identified in the updated risk register by careful attention to the cleaning regimen, the wearing of suitable footwear as outlined in the Dress Code Policy. Good housekeeping and daily review have also contributed. Completed 1st November.
4. The draft risk management policy shown to the inspector during the inspection is now a live document. Completed 25th November
5. Policies are now in place in accordance with Section 31 of the Regulations. Completed 25th November.
6. The recently installed I.T. system supports the identification, recording, investigation and learning from incidents. Formal reviews are conducted on quarterly basis in addition a weekly review of the open incidents is also performed. Incidents can only be "closed" when all fields have been completed including "learning outcomes" by the Person in Charge and the Operations Manager. Attachment in point 4 above sets out the procedure on how to complete the incident report. Completed 6th December.
7. The register has been updated and hazards identified and controlled measures put in place and risks managed. These risks are then reviewed and discussed at the monthly Health and Safety committee meeting. Completed 25th December, Hazard Analysis, risk rating, control measures and impact ongoing for all areas.
8. The following rooms have been risk assessed, the treatment room, the day rooms, the smoking room, the sluice room together with and overall hazard risk analysis of the building has been completed during October and November. The catering risk assessment has been commenced and will be completed by 20th December. These assessments have been carried out in conjunction with the staff and the elected safety representative. Completed 4th December.
9. Resident Risk Assessment are currently in progress and related care plans are being devised including specified risks such as absconscion. Additional control measures have been installed at the entrance door, including changing the PIN regularly. Completed 30th November.
10. Further discussions have been held with an appropriate qualified person regarding the provision of appropriate safety measures at the ramp. The control measure of the gate was installed on the 9th of December.
11. The Health and Safety Course was provided by a recognised training agency on the 19th of September, work had commenced on risk management e.g. establishment of a Health and Safety committee and review of existing risk register had commenced. Completed 25th November.
12. The safety statement has been reviewed and amended to reflect current practice in the Home, this is in place since 25th November.
13. A review of the existing safe work practice sheets has commenced in co-operation with the elected staff safety representative, sheets reviewed to date are catering and housekeeping. Other departments will be reviewed in the coming weeks. Risk assessment and hazard analysis being organic processes will be continually updated and work will be ongoing. It is intended to review at the monthly health and safety

meetings. Resident risk assessments will be reviewed on a continually basis and adjusted accordingly. Completed 4th December.

14. A current fire compliance certificate was issued on 25th November.

**Proposed Timescale:** 25/12/2013

**Theme:** Safe Care and Support

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

Some hazards had not been adequately assessed and controlled.

**Action Required:**

Under Regulation 31 (2) (a) and (b) you are required to: Ensure that the risk management policy covers, but is not limited to, the identification and assessment of risks throughout the designated centre and the precautions in place to control the risks identified.

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

1. A comprehensive risk assessment has been undertaken and a scoring of risks has taken place and controls identified and impact/likelihood scored Completed 25th November.
2. The smoking room has had extractors fitted, door modified and nurse call system upgraded as a consequence of the hazard analysis process. Evidence of fire retardancy for the furniture and fittings including the smoking apron has been obtained. Completed 2nd December.
3. A number of doors were identified as requiring fire upgrading, have been rectified. Completed 2nd December.
4. Fire alarm testing continues each Monday morning and fire exits are checked on a daily basis and signed off. Any obstructions noted and are removed immediately. The fire system has been serviced on 26th November. Contact has been made with the local authority fire service to arrange an evacuation exercise involving nursing home staff and fire service personnel. Weekly on a Monday.
5. The current policies are now in place in compliance with Regulation 31 (2) (a) and (b), these are attached with the action plan. Completed 25th November.

**Proposed Timescale:** 02/12/2013

**Theme:** Safe Care and Support

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

There were no formal precautions in place for specific risks identified in the Regulations including assault.

**Action Required:**

Under Regulation 31 (2) (c) you are required to: Ensure that the risk management policy covers the precautions in place to control the following specified risks: the unexplained absence of a resident; assault; accidental injury to residents or staff;

aggression and violence; and self-harm.

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

1) Policies are now in place and available to staff in compliance with Regulation 31 (2) (c) (i), (ii) (iii), (iv) and (v). These are included in our Health and Safety statement and available in the policies folder.

**Proposed Timescale:** 25/11/2013

**Theme:** Safe Care and Support

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

There were no formal arrangements in place for the recording, investigating and learning from serious or untoward incidents.

**Action Required:**

Under Regulation 31 (2) (d) you are required to: Ensure that the risk management policy covers the arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents.

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

1. An accident and incident log is maintained which record all relevant details of all each incident, action taken and outcomes. A review of incidents takes place and discussed at the monthly Health and Safety committee meeting, staff meetings and trends in incidents identified, in compliance with our policy. The Person in Charge reports incidents and accidents to the Chief Inspector as per Regulation 36.
2. An Audit of incidents will take place every quarter, with weekly review of any open incidents. Completed 9th December.
3. Any trends identified and learning will be shared with staff to improve practice and thus quality of service. Completed 9th December.

**Proposed Timescale:** 09/12/2013

**Outcome 08: Medication Management**

**Theme:** Safe Care and Support

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

The medication management policy did not provide sufficient guidance.

During part of the inspection residents' medications were not administered contemporaneously.

Medications that required crushing were not consistently prescribed that way.

**Action Required:**

Under Regulation 33 (1) you are required to: Put in place appropriate and suitable

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

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

1. A revision of the medication policy has taken place in consultation with the Pharmacist, GP and staff which guides practices as per Regulation 33 (1). Completed 19th November and Submitted with Action plan.
2. A review is currently in progress with the GP and Pharmacist in relation to residents requiring crushed medication, including alternative forms of medication. Completed 28th November.
3. The pharmacist is due to visit the centre to complete an external audit on medication management on 12th December.
4. The incident regarding the administration and signing of medication has been reviewed. An incident form was completed. Completed 20th October.
5. All Nursing staff are reminded of the policy and the need for compliance, the Person in Charge and the Operations Manager have monitored performance and no further episode of this type has occurred. All new staff have received comprehensive induction, working in a supernumery capacity and mentored by a nominated nurse. All nursing staff have provided evidence of completed Medication Management module provided by NMBI. Completed 9th December.
6. Recruitment Policy reviewed to highlight/identify nursing competencies. Completed 6th December.

**Proposed Timescale:** 09/12/2013

**Theme:** Safe Care and Support

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

The medication management policy did not include a centre-specific procedure on disposal.

**Action Required:**

Under Regulation 33 (2) you are required to: Put in place suitable arrangements and appropriate procedures and written policies in accordance with current regulations, guidelines and legislation for the handling and disposal of unused or out of date medicines and ensure staff are familiar with such procedures and policies.

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

The revised policy includes the following specific details on the disposal of medication: Any medicinal product that has expired, has a short date or is no longer required by the resident shall be returned to pharmacy. Returned medication will be recorded in a duplicate book, to be signed by the Nurse returning the medication and the pharmacy staff, the following information will be recorded

- Name of the Resident
- Name of the Medication
- Amount of Medication
- Date of return

- Signatures of Nurse and Pharmacy Staff. The pharmacist has provided a container for the safe disposal of medication.

This has been circulated to all staff. In accordance with Regulation 33 (2).

**Proposed Timescale:** 19/11/2013

#### **Outcome 09: 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:**

A record of all incidents that had occurred were not maintained and all relevant details relating to some incidents had not been documented.

**Action Required:**

Under Regulation 36 (1) you are required to: Maintain a record of all incidents occurring in the designated centre.

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

1. A manual register was in place prior to the installation of the I.T. system. All incidents are now recorded on the I.T. A review of all open incidents will take place on a weekly basis. System and incidents can only be closed by the Person in Charge and the Operations Manager, all fields must be completed including Outcomes and Lesson Learned. Completed 25th November and as incidents occur going forward.

2. All incidents are discussed at the staff monthly meetings. If any incident is considered to be of greater importance/significance, high risk of recurrence or serious injury then staff are briefed immediately. Monthly and when deemed necessary.

**Proposed Timescale:** 25/11/2013

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

**Theme:** Effective Care and Support

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

Systems were not in place to review and improve the quality and safety of care.

**Action Required:**

Under Regulation 35 (1) (a) you are required to: Establish and maintain a system for reviewing the quality and safety of care provided to, and the quality of life of, residents in the designated centre at appropriate intervals.

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

1. In addition to the audits mentioned above, we are currently devising a audit programme to measure the quality and safety of care for the residents. To be fully in

place by 10th January 2014.

2. A resident forum is active and has monthly meetings with 2 nominated staff members to share resident experiences. Family members are also welcome and have attended these meetings. These will be ongoing on a monthly basis.

3. An independent advocate for residents meets with residents on a weekly basis and reports back to the Person in Charge.

4. We implement and address the actions identified in the report back from the advocate.

**Proposed Timescale:** 10/01/2014

## **Outcome 11: Health and Social Care Needs**

**Theme:** Effective Care and Support

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

Some issues were identified in care provision in aspects of falls management and the management of the use of restraint.

**Action Required:**

Under Regulation 6 (3) (a) you are required to: Put in place suitable and sufficient care to maintain each residents welfare and wellbeing, having regard to the nature and extent of each residents dependency and needs.

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

Falls Management:

1. The falls policy had been misfiled on the days of inspection and has since been located. This is available to all staff. Completed 21st October.

2. Staff are regularly reminded of the requirement to update care plans following identification of any resident with high falls risk. Daily at handover.

3. Staff are reminded of the post falls policy. Daily at handover.

4. Audits on the implementation of the provisions of the falls policy, including implementation of appropriate control measures e.g. bedrails, low low beds and involvement of any Health Care professionals will be done by the Person in Charge. Next falls Audit is due 30th January.

5. Nurses had been using the Glasgow Coma Scale in the event head injury being suspected. As part of the falls management policy all unwitnessed falls as well as evident head injury must use the Glasgow Coma Scale. Completed 21st October and review of same to take place in the audit cycle next due 30th January.

6. Each resident has the Cannard falls risk assessment completed and an organisational hazard analysis, risk assessment has also been completed. Completed 25th November and these will be reviewed at reassessment date or if an incident occurs whichever is the soonest.

7. Appropriate assistive equipment is provided to meet resident needs such as hoists, specialised beds and mattresses following appropriate risk assessment. Each resident will be risk assessed as required and no later than 3 monthly.

Restraint Management:



1. The restraint policy was under review at the time of inspection and has since been completed. Completed 21st October.
2. Audits are conducted by the Person in Charge in relation to the assessment, care-planning and implementation of the restraint policy in the Home. To be completed by the 31st December.
3. Each resident has a risk assessment as described in the restraint management policy as appropriate. Completed 21st October and will be reviewed at reassessment date or if an incident occurs sooner.

**Proposed Timescale:** 30/01/2014

**Theme:** Effective Care and Support

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

Aspects of the care planning documentation were poor and this did not ensure that continuity of care was provided to residents.

**Action Required:**

Under Regulation 8 (1) you are required to: Set out each resident's needs in an individual care plan developed and agreed with the resident.

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

1. Training for all Health care staff is currently in progress in relation to the care planning process. All staff will have had refresher training by the 12th December and all new staff have training completed on 29th November.
2. We continue to monitor and highlight identified deficiencies with the particular staff. Audits will be completed on a monthly basis, next one due week beginning 16th December.
3. The recent recruitment of additional staff will have a positive impact on the development of the nursing assessments and care plans, all residents have been allocated a Named Nurse and carer, this has been communicated to residents and their families. This nurse is responsible for the individual assessment and care planning of residents allocated to them. Completed 6th December.
4. Training is being made available paid for by the proprietor to meet service needs, the competencies and personal preference of staff. This is having a positive impact on the care planning process. Agreed by the Proprietor 25th September.

**Proposed Timescale:** 16/12/2013

**Theme:** Effective Care and Support

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

Some assessments were not maintained up-to-date and residents' current needs were not sufficiently captured in some care planning documentation.

**Action Required:**

Under Regulation 8 (2) (b) you are required to: Keep each residents care plan under

formal review as required by the residents changing needs or circumstances and no less frequent than at 3-monthly intervals.

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

1. An Audit of Assessments and care plans has been conducted by the PIC, actions identified have been discussed with the nominated staff. A further review of same will take place in January. Completed 21st November.
2. Protected time has been made available to staff to complete assessments and care plans. All residents have assessments and care plans completed 6th December.
3. Visiting health care providers which include the G.P, the Physio, the O.T., and the P.O.L.L. team have been given access to the I.T. system to record their entries directly, this allows them to input directly into the assessment and care planning process and view progress notes. Completed 25th November and any new visiting professionals will be given access as required.

**Proposed Timescale:** 06/12/2013

**Theme:** Effective Care and Support

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

There was limited evidence that residents and/or their representatives were consistently involved in the care planning process.

**Action Required:**

Under Regulation 8 (2) (c) you are required to: Revise each residents care plan, after consultation with him/her.

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

1. A new proforma record has been devised to assist the staff in the confirmation of meetings with Residents and/or their representatives to discuss the care planning process. Implementation of record – Completed 22nd November.
2. Due to family commitments for residents representatives scheduling of meetings with them to discuss assessment and care plans has been delayed, however several meetings have been arranged. To be completed by 16th December.

**Proposed Timescale:** 16/12/2013

**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:**

The complaints policy and complaints procedure did not comply with all the requirements of the Regulations and reflect an aspect of current practice.

**Action Required:**

Under Regulation 39 (1) you are required to: Provide written operational policies and procedures relating to the making, handling and investigation of complaints from any person about any aspects of service, care and treatment provided in, or on behalf of a designated centre.

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

- 1) We have reviewed this policy and procedure in accordance with Regulation 39 and are now fully compliant. Completed 25th November.
- 2) The revised complaints regimen is included in the residents guide as a addendum and the revision given to all residents and on display at the main entrance. Completed 25th November.

**Proposed Timescale:** 25/11/2013

**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:**

Adequate screening had not been put in place at some beds in shared rooms.

**Action Required:**

Under Regulation 10 (c) you are required to: Provide residents with privacy to the extent that each resident is able to undertake personal activities in private.

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

- 1) Confirmation has been received from the contractor that the privacy curtains will be in place for identified areas by the 13th of December.

**Proposed Timescale:** 13/12/2013

**Outcome 18: Suitable Staffing**

**Theme:** Workforce

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

Staffing levels and skill mix did not consistently meet the needs of residents.

**Action Required:**

Under Regulation 16 (1) you are required to: Ensure that the numbers and skill mix of staff are appropriate to the assessed needs of residents, and the size and layout of the designated centre.

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

1. Staffing levels have been reviewed using a recognised tool and staff adjusted accordingly in conjunction with dependency levels. Completed 22nd November and

reviewed on a weekly basis.

2. We have recruited 4 new staff nurses, the most recent commenced duty on 7th November, with a range of experience and skills. Further advertising is taking place to invite Registered Nurses to join our organisation. Completed 7th November.
3. In addition to nursing and care staff a number of external service providers are engaged which have a positive effect on the overall staffing requirements, e.g. Physiotherapy, Siel Bleu – Dementia Group and Extend Ireland – Exercise class for older people. We also have members of staff who have completed training in Sonas – Reminiscence Therapy for Dementia residents and Imagination GYM – relaxation therapy for dementia residents. These sessions generally take 2 hours and are organised across the week. Currently operational and due review in January.
4. In the event that there is an increased dependency, based on above assessment tool, additional staff are rostered on duty to respond to this need. Currently operational and due review in January.
5. Care staff have access to care plans and assist nurses in implementation and review. Completed 1st September.
6. An overview of the proposed weekly schedule is submitted with this action plan. Completed 11th December.

**Proposed Timescale:** 11/12/2013

**Theme:** Workforce

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

Some staff did not have sufficient knowledge of the relevant policies and procedures as the policy folder had not been maintained up to date with all relevant and updated policies.

**Action Required:**

Under Regulation 17 (3) you are required to: Make staff members aware, commensurate with their role, of the provisions of the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 as amended, the statement of purpose and any policies and procedures dealing with the general welfare and protection of residents.

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

1. Information sessions on the policies and procedures are planned for staff. To be completed by the 13th December.
2. All policies are available for staff to read, and use as a reference document for completing their duties. Completed 25th November.

**Proposed Timescale:** 13/12/2013

**Theme:** Workforce

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

Confirmation was not available that an agency nurse working in the centre had the

necessary information required in the Regulations including Garda Síochána vetting, three written references and sufficient evidence of mental and physical fitness.

Garda Síochána vetting had not been obtained for all staff.

**Action Required:**

Under Regulation 18 (2) (a) and (b) you are required to: Put in place recruitment procedures to ensure no staff member is employed unless the person is fit to work at the designated centre and full and satisfactory information and documents specified in Schedule 2 have been obtained in respect of each person.

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

1. Written references have been sought for all new members of staff and agency staff, in the meantime telephone confirmation has been obtained. To have completed by the 20th December.
2. A self-declaration has been obtained for all new staff, we are currently waiting on confirmed Garda Vetting to be returned. To have completed by the 20th December.
3. All allied Health professionals have supplied the necessary information in compliance with Regulation 18 (2). Completed 6th December.
4. The existing recruitment policy/procedures has been revised and amended to more truly reflect the regulations. Completed 1st December.

**Proposed Timescale:** 20/12/2013