

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	St Brendan's Community Nursing Unit
<b>Centre ID:</b>	OSV-0000633
<b>Centre address:</b>	Lake Road, Loughrea, Galway.
<b>Telephone number:</b>	091 871 200
<b>Email address:</b>	bernie.austin@hse.ie
<b>Type of centre:</b>	The Health Service Executive
<b>Registered provider:</b>	Health Service Executive
<b>Provider Nominee:</b>	JJ O'Kane
<b>Lead inspector:</b>	Marie Matthews
<b>Support inspector(s):</b>	Mary McCann
<b>Type of inspection</b>	Announced
<b>Number of residents on the date of inspection:</b>	94
<b>Number of vacancies on the date of inspection:</b>	6

## **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 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 inform a registration renewal decision. This monitoring inspection was announced and took place over 1 day(s).

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

From: 08 May 2017 09:30 To: 08 May 2017 19:00

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

<b>Outcome</b>	<b>Our Judgment</b>
Outcome 02: Governance and Management	Compliant
Outcome 03: Information for residents	Substantially Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Non Compliant - Major
Outcome 07: Safeguarding and Safety	Compliant
Outcome 08: Health and Safety and Risk Management	Substantially Compliant
Outcome 09: Medication Management	Compliant
Outcome 11: Health and Social Care Needs	Substantially Compliant
Outcome 12: Safe and Suitable Premises	Substantially Compliant
Outcome 13: Complaints procedures	Substantially Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Compliant
Outcome 18: Suitable Staffing	Compliant

**Summary of findings from this inspection**

This announced inspection was conducted in response to an application to renew registration. The inspectors also followed up on the actions from the last inspection in January 2016. St Brendan's Community Nursing Unit is a purpose designed building overlooking Loughrea lake in the town of Loughrea, County Galway. It can accommodate 100 residents and includes a dementia unit.

There was an appropriate governance structure in place. The director of nursing who is the person in charge and the assistant director of nursing are responsible for the day to day operation of the centre. They facilitated the inspection and inspectors found that documentation was well organised and appropriate records were maintained. Inspectors found that residents' health care needs were appropriately met. Residents had a choice of General Practitioner (GP) who were employed by the centre or could retain their own GP. There was good support evident from allied

health professionals. The level of detail and personalisation in care plans had improved. Improvements were identified in relation to wound care plans and assessments. Residents said that they felt "safe and well cared for". There was good access to an independent advocacy service and residents were consulted regarding the decisions that affected their day to day lives. There was a range of activities organised weekly that included bingo, music sessions and one to one activities.

The two storey building was purpose built and provided a comfortable living environment for residents. There was a choice of communal areas where residents could relax and spend time together and these were been well used on the day of the inspection. There was a garden area located across the car park to the front of the centre which could be used by resident under supervision. There was also an safe enclosed garden accessed through the day care centre however for residents in the dementia unit the area outside was not suitable for residents due to the sloped uneven surface. An action to address this was included in the previous action plan but it was not addressed. It is repeated in the action plan that accompanies this report.

Additional care staff had been added to the staff rota in the evenings in response to the last inspection. The staff had completed a range of training courses to allow them to meet the needs of residents. The provider stated they had obtained vetting disclosures in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 for all staff. However, the vetting disclosure form was not available in the centre and the provider was relying on a letter from the human resource department as evidence of vetting being in place.

The action plan at the end of the report contains the actions required 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.

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

***Outcome 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):**

No actions were required from the previous inspection.

**Findings:**

The centre is operated by the Health Services Executive (HSE) and it was first registered in 2011. The person in charge is a director of nursing and she is involved in the management of two other HSE centres. The ADON had also been in post for a number of years. Both displayed a good knowledge of the standards and regulatory requirements. The ADON deputised in the absence of the person in charge. The provider representative was not available on the day of inspection however has met with the Authority previously to discuss the governance arrangements. He visits the centre every two months and attends management meetings. There were minutes of these meetings available and of regular management and clinical governance meetings between person in charge and various grades of staff.

The person in charge and assistant director of nursing had completed an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that the care provided was safe and in accordance with the authorities standards. The annual review brought together various audits undertaken during the year and included audits of complaints, the environment, medication, nutrition, catheter care, restraint use, care plans, hand hygiene and venepuncture. Feedback from resident and satisfaction surveys was also reviewed. A quality improvement plan was included in the annual review completed.

The person in charge and ADON regularly received feedback from residents and relatives via the residents' forum and through relatives' meetings. There was also evidence of consultation via residents' satisfaction surveys. The inspectors looked at the recording and management of accidents and incidents that had occurred in the centre and found they were all recorded in line with best practice. Resources were in place to meet the needs of residents and additional staff had been recruited to ensure appropriate resources were in place to meet the needs of residents.

**Judgment:**

Compliant

**Outcome 03: Information for residents**

***A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.***

**Theme:**

Governance, Leadership and Management

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

No actions were required from the previous inspection.

**Findings:**

The residents' guide was reviewed and found to contain all the information as required by the Regulations. A copy of this guide was available to all residents.

Each resident was provided with a contract for the provision of services on admission. Two contracts were reviewed by the inspectors. Both were had been signed by the residents or their representatives. They contained details of the services to be provided and the fees for the service. However, the cost of services not included in the overall fee such as chiropody and hairdressing were not detailed either in the contract or in an appendix to the contract. The contract template contained in the residents guide also differed from the completed contracts reviewed by the inspectors.

The person in charge said that a revised contract was now in use which detailed the costs of any additional services. Residents with older contracts were informed directly in writing of any fee increases.

**Judgment:**

Substantially Compliant

**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:**

The person in charge is a registered general and psychiatric nurse with over 10 years experience in the area of nursing older people. She is a director of nursing based in the centre and works full time. She is also on call out-of-hours and at weekends. She has been interviewed previously by the Authority and demonstrated knowledge of her responsibilities as outlined in the Regulations. She has maintained her clinical skills through continuous professional development. She had a BA (hons) Degree and Masters Degree in Health Care Management and a national cert in business studies. She had also attended various conferences in the area of care and dementia.

**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):**

No actions were required from the previous inspection.

**Findings:**

Most information requested by inspectors was readily available. Records listed in Part 6 of the Regulations were maintained in a manner so as to ensure completeness, accuracy and ease of retrieval as required by the Regulations. The centre was in the process of changing to an electronic care planning system and some records were not yet kept electronically. The centre had copies of the operational policies required by Schedule 5 of the Regulations in place. Insurance cover was in place.

A sample of three personnel files for staff working in the centre were reviewed and these were found to contain information required by Schedule 2 of the regulations, including an employment history. A letter was on file from the Health Service Executive (HSE) human resources department stating that garda vetting had been obtained. However, copies of the National Bureau vetting disclosure confirmations which are required to be kept in the centre under regulation 21 were absent from the staff files reviewed and from the file of a volunteer working in the centre.

**Judgment:**

Non Compliant - Major

***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:**  
The provider and person in charge had taken measures to protect residents from being harmed and from suffering abuse. On the last inspection, it was found that a safeguarding policy based on the new Health Service Executive (HSE) policy on Protection of Vulnerable Adults was available to guide staff but it didn't identify who the designated person was for the centre or include details of the Confidential Recipient. This had been addressed and the person in charge was identified as the designated person. Training records reviewed by the inspector confirmed that all staff had received training on recognising and responding to elder abuse. Staff spoken with were able to explain the different types of abuse, signs to look out for and how to report any concerns. Staff were clear that they would report any suspicions of abuse and identified the person in charge as the person to whom they would report a concern.

17 of the 94 residents had bedrails in situ. Some of these were at the request of the resident to help them to feel safe. The inspectors reviewed a sample of care plans for those who had bedrails. A risk assessment was completed to determine if the restraint was safe or if a less restrictive option might work. Where a bedrail was used at the request of the resident, the enabling function was documented in the sample of restraint records reviewed. This was an action from the last inspection which had been addressed.

Some residents had behaviours and psychological symptoms of dementia (BPSD) and practice was guided by a policy for behaviour that is challenging. Care plans reviewed contained proactive and reactive interventions to help staff to manage such behaviours and alleviate their anxieties. The centre had good links with mental health services which were based on the grounds.

**Judgment:**  
Compliant

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

**Theme:**

Safe care and support

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

No actions were required from the previous inspection.

**Findings:**

The provider had systems in place to protect and promote the health and safety of residents, visitors and staff and the provider had oversight of risk management in the centre. Measures were in place to prevent accidents. Corridors and bathrooms had handrails fitted to support residents with reduced mobility.

There was a policy available on falls prevention and appropriate arrangements for recording and investigating of untoward incidents and accidents. Residents were assessed for their susceptibility to falls on admission and appropriate interventions were put in place to reduce the likely hood of a fall. Residents were observed being encouraged to walk from their rooms to the sitting and dining areas during the inspection. A falls prevention programme had been implemented since the last inspection and those at high risk of falling were identified discretely to alert staff to the risk by the use of a leaf symbol. Residents at high risk and those who sustained a fall were reviewed by the physiotherapist. A falls prevention care plan was developed for those at risk and the inspectors saw that the level of detail recorded had improved since the last inspection and there was better linkage between the falls risk assessments completed and the care plans developed. Moving and handling assessments had been complied for each resident and these were noted to be up to date and reflected resident's dependency and capacity to mobilise.

There were policies in place on infection prevention and control and staff that were interviewed demonstrated knowledge of the correct procedures to be followed. The environment was observed to be very clean and cleaning staff were observed working throughout the day. Personal protective equipment, such as gloves, aprons and hand sanitizers were used by cleaning staff and these were located throughout the premises. Hand-washing facilities had liquid soap and paper towels available. Hand hygiene and infection control training was on-going and staff demonstrated good hand hygiene practice as observed by the inspectors. Arrangements for the disposal of domestic and clinical waste management were appropriate.

Records reviewed confirmed that all staff had attended fire safety training. Fire fighting equipment was available throughout the centre and the inspector saw that this was serviced annually. Fire exits were noted to be clear and unobstructed during the inspection. Staff could describe how they should respond when the fire alarm was activated and said the centre all doors closed automatically in the event of a fire and that they would check the fire panel and evacuate residents away from the direction of the fire. There was suitable fire equipment provided throughout the centre and fire evacuation procedures were prominently displayed. All staff had participated in mandatory annual fire training. The inspector saw that this training incorporated a

simulated evacuation. There were however, no unannounced fire drills completed to test the effectiveness of the fire procedures and provide an assurance that they were fit for purpose.

Daily checks of all fire exits were recorded by a member of staff and the inspector saw that these were unobstructed. Records of weekly, monthly and quarterly checks on the centres fire alarm and fire detection systems were not available on site. These were forwarded the day after the inspection by the person in charge. The inspector noted that a fire register was not used to record all servicing records and all in-house daily , weekly and quarterly fire tests as recommended by HIQA as best practice in, Fire Precautions in Designated Centres, 2016.

Staff had all up-to-date training in movement and handling and in the use of assistive equipment such as hoists. There were non-slip safe floor surfaces throughout and handrails were provided along all corridors to support residents.

An emergency response plan was available which contained instructions for how to respond to major incidents likely to cause death or injury, serious disruption to essential services or damage to property and the inspectors saw that contact numbers for all emergency services was included in the policy as well as alternative accommodation in the event that residents had to be evacuated.

**Judgment:**

Substantially Compliant

***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:**

Inspectors reviewed practice in relation to medication management and found they were processes in place to ensure safe practice. A medication policy was available. Inspectors reviewed a sample of residents' prescriptions and medication administration records.

Photographic identification was available on all drugs charts reviewed to ensure the correct identity of the resident receiving the medication and reduce the risk of medication error. The sample of medication sheets reviewed was clear and legible. The signature of the GP was present for each drug prescribed. The route, dosage and time of administration of medication were indicated on the sample of medication administration records reviewed and the maximum dosage to be administered in a 24 hour period for 'as required' (PRN) medication and the rationale for administering the

medication was stated.

The person in charge confirmed that residents could retain their own pharmacist but in general most medication was supplied by a local pharmacy. Out of date or unwanted medication was returned to the pharmacy. Each resident's medication was supplied in its original packaging. Medication trolleys were secured and the medication keys were kept by a designated nurse at all times. Where medication was being crushed prior to administration for residents with a swallowing difficulty and this was identified on their medication charts.

Medication audits had been completed by the person in charge and the pharmacist also reviewed each residents medication regularly. The inspectors saw that where risks were identified by the pharmacist they were brought to the attention of the GP and corrective actions and /or safety instructions were put in place.

Medication administration sheets were signed by the nurse following administration of medication to the resident and recorded the name of the drug and time of administration. The drugs were administered within the prescribed time-frames.

**Judgment:**

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):**

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

**Findings:**

There were 94 residents accommodated on the day of the inspection in 4 different units. One resident who had sustained a fall was in hospital. There were 43 residents assessed as having maximum care needs, 24 were assessed as having high care needs, 14 had medium care needs and the remaining 13 residents had low care needs. Almost a third of the resident population had dementia diagnosis and some had mental health difficulties.

There were arrangements in place to assess and meet residents' needs. Inspectors saw that evidence-based assessment tools were used to determine the care needs of residents on admission and to assess their level of risk in relation to falls, nutritional, risk

of developing pressure area problems and moving and handling requirements. Arrangements to meet residents' needs were set out in individual care plans that were maintained electronically. On the previous inspection inspectors had found that some care plans were generic and didn't really reflect the residents individual care needs. On this inspection, inspectors found that this area had improved and the care plans reviewed by inspectors were more person centre and comprehensive and linked to the assessments. Reviews and evaluations of care were undertaken at the required intervals. Inspectors saw a narrative note to indicate that the resident was consulted when their care plan was reviewed.

Most residents with dementia were cared for in a dementia specific unit and inspectors saw that the centre had established links with psychiatry for later life and mental health teams which were based on site and that reviews were undertaken promptly to prevent deterioration. A number of care plans had been developed to guide care for residents with dementia in response to the action plan from the last inspection. Those reviewed by inspectors described how the resident might be engaged and encouraged by reference to their likes and interests and their social history.

Four General Practitioners provided medical care to residents in the centre. The person in charge confirmed that residents could choose one of these GPs or could retain their own GP if they preferred. The inspectors saw that residents were reviewed promptly by a GP following admission to the centre and regularly thereafter. An out of hours GP service was provided by Westdoc.

On the previous inspection, inspectors found that there was poor input from physiotherapy services on some care files. This had been addressed and a physiotherapist was allocated to the centre for 2.5 days per week specifically for residents in the centre. There was good access to other support services such as dietician, chiropody and speech and language therapy (SALT) services. Two occupational therapists worked in the centre. They took the lead on activity provision in addition to offering an occupational therapy service. Specialist cutlery had been obtained for some residents to allow them to continue to eat independently. Residents were reviewed regularly by an optician and a dietician and a private chiropodist attended the centre regularly. A reflexologist was also available.

There were 4 residents with pressure ulcers at the time of inspection. Inspectors reviewed a sample of two residents' pressure care plans. While one had evidence of appropriate assessment and care recorded, the other required improvement as the care plan available did not evidence that appropriate pressure relieving measures were in use prior to the wound developing despite a risk assessment indicating that the resident was at high risk of developing a pressure ulcer. While inspectors saw that staff had made efforts to get the advice of a tissue viability specialist, the referral was not timely and the wound had deteriorated. There were regular assessments of the wounds which included photographs but there were no measurements recorded to accurately indicate if the wound was improving or deteriorating. The advice of the tissue viability specialist was obtained and inspectors observed that the treatment recommended was in accordance with the care already being provided by staff.

Residents were very complimentary regarding the choice and quality of meals provided.

A list of special diets was communicated to the kitchen staff and meals were provided in accordance with the recommendations of the dietician and speech and language therapist. Residents were weighed regularly and where weight loss was observed the advice of the GP and dietician was obtained and a nutritional care plan developed.

Systems were in place to prevent unnecessary hospital admissions. Staff were trained in sub-cutaneous fluid administration and administration of intravenous antibiotics and the person in charge said they were well supported by the palliative care team. Systems were in place to prevent unnecessary hospital admissions. Staff had been trained in sub-cutaneous fluid administration and administration of intravenous antibiotics and the centre described good links with the palliative care team. A palliative care suite was available in the centre and the families of residents at end of life could be accommodated in the centre.

**Judgment:**

Substantially Compliant

***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):**

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

**Findings:**

The design and layout of the centre is suitable for its stated purpose, and meets the needs of residents to an adequate standard however one action from the previous inspection was not fully addressed. It is repeated in the action plan that accompanies this report. There was a garden area located across the car park to the front of the centre which could be used by residents under supervision. There was also a safe enclosed garden accessed through the day care centre. However, for residents in the dementia unit the area immediately outside their unit was not suitable due to the sloped uneven surface.

The centre is purpose-built and accommodates a maximum of 100 residents. Inspectors found the centre was clean, bright, well ventilated and warm. It consists of the four units, two on the ground floor either and two on the first floor. A lift serviced the two floors and records were available to show that it was regularly serviced. Residents with a dementia diagnosis were mainly accommodated in a unit on the ground floor. Each unit

had views overlooking Loughrea Lake. There are 21 single bedrooms and 2 double rooms in each unit. All bedrooms have ensuite bathroom facilities. Each resident's room was identified by their name or a picture reference. There were various other visual cues to aid recognition and help orientate residents. The size and layout of the bedrooms was suitable to meet the needs of residents.

There were an adequate number of assisted showers, baths and toilet facilities available for residents. Grab rails were installed in all toilets. The corridors enabled easy access for residents using wheelchairs and those people using frames or other mobility appliances. There was safe flooring provided. Appropriate assistive equipment was provided to meet residents' needs such as hoists, seating, specialised beds and mattresses. Servicing records and maintenance records for equipment were up-to-date. There was a very pleasant visitor's room on the ground floor known as the parlour which had tea and coffee making facilities for residents and their families. Each unit had a smoking room and a dining room. Seating was also provided in the hallway. Furnishings were comfortable and homely.

Each unit had a nurse's station in each area. Appropriate cleaning and disinfection facilities were provided and sluice rooms and cleaning rooms where chemicals were stored were secured by a swipe card system to prevent residents from accessing them. Each unit had a sitting room and a dining room. Improved use of all communal areas was observed on this inspection which eased congestion in the main sitting room. This was an action required from the last inspection.

**Judgment:**

Substantially Compliant

***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):**

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

**Findings:**

Policies and procedures which comply with legislative requirements were in place for the management of complaints. A copy of the complaints procedure was displayed throughout the centre and residents said they would have no hesitation in making a complaint if necessary. A review of the log indicated that complaints were documented and investigated. This was an action from the last inspection.

There was evidence of communication between the centre and those who made complaints. There was one recent complaint recorded where the response by the person

in charge was ambiguous as to whether the complainant could be adversely affected by the complaint. In another complaint reviewed by inspectors, it was not evident that the person who made the complaint was given information about the centres' appeals procedure.

**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):**

No actions were required from the previous inspection.

**Findings:**

Inspectors saw that an assessment of each resident's social care formed part of the admission process. A document called 'a key to me' was completed for and informed the schedule of activities provided. The staff displayed a good knowledge of the resident's interests and were observed to have a good rapport with residents. Group and individual Sonas (a therapeutic activity for residents who are cognitively impaired) were provided for residents and the person in charge said that 4 staff were completing training to enable them to do passive exercises with residents. One to one activities were provided to residents who spent time in their bedrooms which comprised of included hand massage, reminiscence therapy and relaxation sessions.

There was a residents' committee in the centre. Meetings were held every three months and the inspector saw that minutes of the meetings of the meetings were available. A retired staff member had completed advocacy training and chaired the resident committee meetings . Some residents regularly left the centre and attended family celebrations or went shopping or to community events with their families. There were regular visiting groups to the centre from the local community such as school choirs and local musicians.

Residents were facilitated to exercise their political and religious rights. Residents were facilitated to vote in the centre in the recent election. Residents informed the inspector that they could vote in the centre, or externally, if they wished. There was an established prayer group and residents were facilitated to attend. A sitting room know as the parlour was available on the ground floor which had tea and coffee making facilities and both residents and relatives said they valued this room and used it for

family gatherings.

Newspapers were available and televisions and radios were provided in every bedroom. Internet access was also available and some residents said they used 'Skype to communicate with relatives who lived abroad. A phone was available for residents to make or receive phone calls in private and some had their own mobile phones. Large screen televisions were provided in each unit. Relatives spoken with stated that they were happy with their loved one's care and with the communication in the centre.

**Judgment:**

Compliant

***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):**

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

**Findings:**

On the last inspection it was found that staffing levels in the evening were not appropriate to meet the needs of residents as the rota indicated that staffing levels reduced by over 50% without any clear rationale for this reduction. The provider had redeployed the staff and increased staffing levels in the evening to address this issue. A copy of the staffing rota for the previous weeks confirmed that an additional care assistant was added to the rota in each unit between 17.30 pm and 21.30 to help the residents get ready for bed. On the previous inspection the PIC was not included in the staff rota. This had been addressed and working times were recorded using a 24 hour clock. The person in charge told inspectors that there were six additional vacant posts and that funding for these posts had been approved. The sitting areas were well supervised throughout the day and staff ensured that residents were comfortably seated and engaged them in conversation when they were with them. Staff were observed to be very respectful towards residents during the inspection.

Inspectors were provided with copies of the staff rota and saw the number and skill mix on duty reflected the planned rota. Residents told the inspectors that they staff responded quickly when they needed assistance. The training records reviewed by inspectors confirmed that staff had all completed training on the mandatory areas of fire

safety, elder abuse and moving and handling. Additionally training had been provided on a range of topics that included infection control, nutrition, hand hygiene and responsive behaviours and continence management.

A sample of personnel files were reviewed and these were found to contain information required by Schedule 2 of the regulations, including employment history, which was an action of the previous inspection. However, as discussed under outcome 5, a copy of the vetting disclosure from An Garda Síochána was not present on the staff files reviewed or on the file of a volunteer who supported residents. An action requiring the provider to address this has been included under outcome 5 and the provider is required to submit the relevant vetting disclosure for these staff.

Nurses active in the centre had confirmation of their 2017 registration with An Bord Altranais agus Cnáimhseachais na hÉireann (Nursing and Midwifery Board of Ireland).

**Judgment:**

Compliant

## 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:*

Marie Matthews  
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>	St Brendan's Community Nursing Unit
<b>Centre ID:</b>	OSV-0000633
<b>Date of inspection:</b>	08 May 2017
<b>Date of response:</b>	14 June 2017

### Requirements

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

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

### Outcome 03: Information for residents

#### Theme:

Governance, Leadership and Management

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

The cost of services not included in the overall fee such as chiropody and hairdressing, were not detailed either in the contract or in an appendix to the contract. The contract template contained in the residents guide also differed from the completed contracts reviewed by the inspectors.

#### 1. Action Required:

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

Under Regulation 24(2)(b) you are required to: Ensure the agreement referred to in regulation 24 (1) relates to the care and welfare of the resident in the designated centre and includes details of the fees, if any, to be charged for such services.

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

A revision of the contracts indicated that the costs of service not included in the in the overall fee is set out in the residents guide and statement of purpose.

Proposed Timescale: Complete

**Proposed Timescale:** 14/06/2017

**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:**

National Bureau vetting disclosure confirmations were absent from the staff files and volunteer file reviewed.

**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:**

Action plan not agreed with the provider despite affording the provider two attempts to submit a satisfactory response

**Proposed Timescale:**

**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:**

There were no unannounced fire drills completed to test the effectiveness of the fire procedures and provide an assurance that they were fit for purpose.

**3. 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:**

Unannounced fire drills are now scheduled into the fire training programme

Proposed Timescale: Complete

**Proposed Timescale:** 14/06/2017

**Theme:**

Safe care and support

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

Records of weekly, monthly and quarterly checks on the centres fire alarm and fire detection systems were not available on site.

**4. Action Required:**

Under Regulation 28(1)(c)(i) you are required to: Make adequate arrangements for maintaining all fire equipment, means of escape, building fabric and building services.

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

A system has been put in place to record the weekly, monthly and quarterly checks on the centres fire alarm and fire detection systems in the fire safety register and this is now available on site.

Proposed Timescale: Complete.

**Proposed Timescale:** 14/06/2017

**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:**

Wound care was not evidence based. In one care plan there was no reference to any pressure relieving measures despite a risk assessment indicating that the resident was at high risk of developing a pressure ulcer. Measurements were not recorded for the wound to accurately evidence progression or deterioration in the wound.

**5. 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 are individualised based on the assessed need of the individuals where a high risk of developing a pressure ulcer is indicated the care plan is devised in accordance with best practice this includes the use of pressure relieving mattress or the rational for non use of pressure relieving mattress.

Wound measurement is recorded to accurately evidence the progression or deterioration in the wound.

Proposed Timescale: Complete

**Proposed Timescale:** 14/06/2017

**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:**

There was not a secure garden that could be accessed easily and independently used by residents from all four units.

**6. 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:**

A plan is in place to erect a secure area within the garden at dementia unit

**Proposed Timescale:** 31/12/2017

**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:**

It was not always evident that the person who made the complaint was given information about the centres' appeals procedure.

**7. Action Required:**

Under Regulation 34(1)(g) you are required to: Inform the complainant promptly of the outcome of their complaint and details of the appeals process.

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

The centres appeal process is displayed in the unit and this information is also relayed to the complainant throughout the process of complaints management. The PIC will record this in the documentation of any future complaints management process.

Proposed Timescale: Complete. Centres' appeals procedure is part of complaint management & this information is given to complainant.

**Proposed Timescale:** 14/06/2017

**Theme:**

Person-centred care and support

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

The response by the person in charge to one complaint was ambiguous as to whether the complainant could be adversely affected by the complaint.

**8. Action Required:**

Under Regulation 34(4) you are required to: Ensure that any resident who has made a complaint is not adversely affected by reason of the complaint having been made.

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

The PIC is satisfied the no resident is adversely affected as a result of making a complaint. The PIC has amended the wording on the one complaint that appeared ambiguous to clearly note that the complainant is not adversely affected by reason of making a complaint.

Proposed Timescale: In place

**Proposed Timescale:** 14/06/2017