

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	St. Fionnan's Community Nursing Unit
Centre ID:	ORG-0000650
Centre address:	Achill Sound, Mayo.
Telephone number:	098 45043
Email address:	michael.fahey@hse.ie
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Micahel Fahey
Person in charge:	Ena Poelenjee
Lead inspector:	Mary McCann
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	23
Number of vacancies on the date of inspection:	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 judgements 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 1 day(s).

The inspection took place over the following dates and times

From:	To:
18 November 2013 10:00	18 November 2013 17:00

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

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 12: Safe and Suitable Premises
Outcome 14: End of Life Care
Outcome 18: Suitable Staffing

Summary of findings from this inspection

This monitoring inspection was carried out as part of the Health Information and Quality Authority's (the Authority) regulatory monitoring function to check progress on any outstanding actions from previous inspections and to monitor compliance with the Health Act 2007 (Care and Welfare of residents in Designated Centres for Older People) Regulations 2009 (as amended). It was unannounced and took place over one day.

This was the seventh inspection of this centre. Previous inspection reports are available on www.hiqa.ie. The previous person in charge had resigned from her post in June 2013 and a temporary acting Director of Nursing was in place as the Person in Charge.

The last inspection was carried out on 4 February 2013. The inspector found that while some progress was made by the provider in implementing the required improvements identified in past inspections, many recurrent breaches of the regulations remained. In particular with regard to governance, the provision of care in line with contemporary evidence-based practice, provision of meaningful activity, person centred care plans, access to specialist services for residents with challenging behaviour, provision of a safe accessible outdoor space, documentation by medical

staff post reviewing a resident and medication administration was not in compliance with an Bord Altranais agus Cnáimhseachais na hÉireann (Nursing and Midwifery Board of Ireland).

On this inspection the inspector was concerned on observing poor manual handling practices, and issues with regard to inadequate investigation and management of unexplained bruising.

The inspector met with the temporary Person in Charge, residents and staff members during the inspection. The inspector observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and the audit file. Residents who were able to express their opinion were complimentary in relation to care provided and the food, they stated they were "well cared for" and "the food was good".

The inspector reviewed the eight actions which comprised of 15 requirements from the previous inspection. Of the eight actions, one was complete, three were partially complete and four were not completed. Under current legislation six of these actions are the responsibility of the provider, one had joint responsibility of the person in charge and provider and one was the responsibility of the person in charge. One of these actions related to training in moving and handling for all staff and the provider had responded that this would be completed by 31 March 2013. However, the inspector found on this occasion that 27 out of 32 staff did not have up to date manual handling training.

The provider's response in the action plan submitted on the 6 March 2013 stated that one action was complete, three actions would be completed by end of April and work had commenced and was ongoing with regard to the outstanding four actions. The following improvements are mandatory and need to be completed in a timely manner in order to comply with the Regulations and provide safe quality care to residents:

- Investigation of all untoward incidents.
- Mandatory training in fire safety, identification and responding to Elder abuse and safe moving and handling for all staff to be continuously compliant with current legislation.
- Competency assessments of staff with regard to the provision of care to residents.
- Supervision of staff pertinent to their role.
- Review of care planning process.
- Review of completion of documentation to ensure completeness and accuracy.
- Training for staff in evidence-based practice with regard to all aspects of care of the elderly.
- Review of the auditing process and reviews of service provision.
- Further amendment to the risk management policy.

There were aspects of the physical environment which did not meet the Authority's Standards in that the centre has multiple-occupancy rooms and residents did not have access to a safe accessible outdoor space. This is discussed further under Outcome 12.

The areas for improvement are discussed further in the body of the report.

The Action Plan at the end of this report identifies areas where mandatory improvements are required to comply 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.

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 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:

Compliant

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

The person in charge commenced working in the centre on the 17 June 2013. She is working in the centre as a temporary measure until a Director of Nursing is appointed. (This post has been advertised). She qualified as a Registered General Nurse in 1979 and as a Public Health Nurse in 1999. She completed a Diploma in Management in 2006 and a Masters in Primary care in 2007. She has worked in Public Health Nursing where a significant proportion of her case load related to care of the elderly since 1999. She was knowledgeable about residents' assessed needs, and was observed by the inspector to engage well with residents.

The duty rosters supported that a minimum of three registered nurses were on duty in addition to the person in charge. The person in charge informed the inspector that she had spent considerable time on staffing issues since her appointment to the centre. She had continued to keep her skills up to date by undertaking ongoing professional development. Courses undertaken recently included challenging behaviour. All her mandatory training was up to date. Her registration was up to date with a Bord Altranais agus Cnáimhseachais Na hÉireann (Nursing and Midwifery Board of Ireland).

Deputising arrangements for the person in charge were in place. One of the staff nurses deputised in her absence and this was noted on the duty roster.

Although the previous person in charge was a planned resignation the provider did not ensure that there was an appropriate induction planned and undertaken with the person in charge on appointment.

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:

Records were not maintained sufficiently to give a clinical picture of the condition or of previous treatment of the residents by nursing and medical staff. There were inadequate care plans and some records were not accurately completed. A comprehensive record of the treatment provided to the resident following an accident and the documentation with regard to incident/accident recording required review to ensure all incidents are recorded contemporaneously.

The person in charge had commenced reviewing operational policies and guidance documents. The elder abuse policy had been reviewed since the last inspection and provided staff with guidance as to how to respond to an allegation of abuse. How staff comply with the policies requires ongoing review.

Review of the risk management policy was required post the last inspection and this is discussed under Outcome 7.

Medical Records

The provider had not ensured that evidence based practice with regard to healthcare was provided to residents. Three medical files were reviewed by the inspector, none of which provided an up-to-date record of review by the general practitioner (GP). Where some care plans stated reviewed by the GP - see narrative notes in medical records, the inspector found on inspecting the medical records, there was no documentation to support that this resident had been reviewed by a GP. In one file reviewed there was an entry where the resident was seen at home prior to admission to the local acute hospital but no further entry, even though the resident was in the centre over two months. None of the files reviewed had evidence of regular medication reviews. Similar issues to these were documented in the registration inspection report of July 2011 as detailed below:

"While staff informed the inspectors that residents had access to general practitioner

(GP) services there was poor recorded evidence of this made available to inspectors. Some residents had no hard copy of medical case files. When inspectors requested confirmation of medical review of residents, they were informed by staff that this was done electronically by the GP. However, when staff tried to retrieve information electronically there was no recent evidence available or it was very sparse. For example, one gentleman who was admitted three months ago had one line recorded 'all well, in great form. No problems'. Staff was unable to inform the inspectors of any medical history in relation to this man. Inspectors were concerned that this did not provide a good overall clinical picture of the resident and could be prejudicial to their care and welfare. This was not an isolated case. Inspectors noted that there is a need for a comprehensive medical history to be available for all residents with regular medical reviews. Where this is absent it poses a risk to residents, is in breach of the Regulations and contrary to good practice".

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:

Non Compliant - Major

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

Appropriate measures were not in place to protect residents from being harmed or abused.

The inspector was concerned with regard to the management of three incidents of extensive unexplained bruising to residents. One incident had occurred in March, one in August and one two days previous to the inspection. While the incident in March was recorded in the narrative notes of the care file, there was no incident report completed, no investigation occurred and the incident was not reported as unexplained bruising to the Authority or the elder abuse social worker. There was no evidence made available to the inspector that any further investigations had occurred at this time.

The second incident was observed in August 2013. No incident form was completed on initial discovery of the bruising and no base line assessment was completed by way of photographic or tracing or marking of the bruise to monitor progress. The senior staff nurse who was deputising for the person in charge did not notify the Authority. When the person in charge was informed of the incident of unexplained bruising on her return from leave, she put procedures in place to monitor the bruising. The resident was reviewed on various occasions and was sent to the acute general hospital for x-ray and treatment. While the person in charge investigated the cause of the bruising to seek to

ask why staff on duty were not following good clinical care practices and to try and find out an explanation for the bruising, no cause or attributing factor was uncovered. The incident was not reported to the elder abuse social worker and no staff were interviewed. Staff did not follow the policy and procedure in place.

The third incident of unexplained bruising occurred on 15 November 2013. Nursing staff informed the inspector that a resident had been reviewed by a medical practitioner but there was no record of this consultation available at the time of inspection.

Documentation with regard to the exact location of the bruising by way of a diagram completed by nursing staff was confusing. The inspector spoke with nursing staff and reminded them of their individual responsibilities as registered nurses with regard to the care of residents and record keeping.

None of these three incidents have been the subject of a robust investigation to ensure the care and welfare of the residents is protected and to try and find any causative factors to prevent re-occurrences or uncover any causative factors, to inform reflective practice and to review arrangements for investigation and learning from serious or untoward incidents. Clinical evidence reviewed by the inspector supports that an urgent independent review of all three incidents is required.

A policy was available which gave guidance to staff on the assessment, reporting and investigation of any allegation of abuse. While staff spoken with displayed some knowledge of elder abuse and were clear on reporting procedures should they receive an allegation of abuse, no staff member who observed the unexplained bruising in March or August 2013 reported this as possible allegation of abuse. The person in charge was clear that unexplained bruising was an allegation of suspected abuse and should be reported, but this had not been reported to the Authority or to the elder abuse social worker. The training records showed that 25 staff had undertaken updated elder abuse training during 2013 and training for the remaining seven staff is scheduled for 19 November and 17 December 2013. Staff had received training in 2008.

The inspector spoke with the person in charge with regard to the systems in place for safeguarding residents' money who confirmed that this was dealt with by administration staff and two staff always signed for resident financial transactions.

She informed the inspector that there were transparent procedures in place with regard to resident finances. These were not checked by the inspector on this inspection. The centre did not act as an agent for any resident. The person in charge confirmed that the centre adhered to the national HSE policies on managing residents' finances.

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:**Moving and Handling Training**

At the time of the last inspection not all staff had up to date moving and handling training. The centre employs 32 staff - 27 of these staff do not have up to date moving and handling training according to the training records provided to the inspector. This was confirmed by the person in charge. The inspector observed inappropriate moving and handling practices. This action is the responsibility of the provider.

Risk Management

The risk management policy required review to ensure it addressed all the risks specified in the Regulations such as self harm, violence and aggression and the arrangements for the identification, recording, investigation and learning from serious incidents. This was an action at the time of the last inspection and had not been addressed.

The inspector saw that since the last inspection risk assessments had been carried out. Some additional control measures were identified by the person in charge and these have been brought to the attention of the provider but have not been addressed. These related mainly to staffing issues and the delivery of safe quality care.

Fire Safety

All staff with the exception of one had up to date fire safety training. The person in charge confirmed that the fire training officer was aware of this. Fire drills had been carried out and the person in charge confirmed that all staff had participated in one to date. A fire drill with minimum staffing levels had not been completed. The inspector reviewed the fire records which showed that all fire equipment had been regularly serviced. There was also a documented in-house daily check of all escape routes. The inspector found on speaking with staff that all were able to describe the correct procedure to follow in the event of activation of the fire alarm.

The fire alarm was tested weekly. A record of all fire alarm tests carried out at the designated centre was available in a fire safety folder. Fire procedures were prominently displayed throughout the centre. Staff spoken with were clear about the procedure to follow in the event of a fire.

Falls Management

Some measures were in place to prevent accidents and facilitate residents' mobility. The inspector noted that staff encouraged residents to mobilise independently thereby promoting their independence. Handrails were provided on both sides of the corridor to assist residents. Falls prevention strategies were in place to protect residents from injury. Although the records did not detail as to the assessment measures that staff utilised before, for example where a resident had fallen, whether it was safe to mobilise the resident staff were able to tell the inspector of safe assessment procedures to prevent further injury. Where the incident related to a fall, the falls risk assessment for the resident was reviewed and all residents who had fallen had up to date falls

prevention care plans in place. The care plans reviewed detailed if the resident had been referred or seen by the physiotherapist or any other specific preventative strategy to minimise the risk of reoccurrence. The person in charge informed the inspector that preventative measures were being taken to prevent reoccurrence, such as review to physiotherapy, provision of a tactile alarm and/or a low-low bed. All residents who sustained an un-witnessed fall were subject to neurological observation to ensure they did not sustain a head injury.

Emergency Plan

An emergency plan was in place. Alternative accommodation for residents was available if evacuation was necessary.

Visitors' Log

A visitors' log was in place to monitor the movement of persons in and out of the building to ensure the safety and security of residents and to inform staff of persons in the premises should evacuation be required.

Missing Person's Policy

A missing person policy was in place to instruct staff as to the procedure to follow should a resident be reported as missing. Recent photographic identification was available for each resident.

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:

A medication policy was in place which guided staff on medication management. The inspector observed both nurses administering the evening medication on the day of inspection, neither administered medication in line with professional guidelines. One signed the medication administration record prior to offering the medication to the residents and the other nurse left the medication trolley unattended while she administered the medication to a resident.

There are two separate medication dispensing trolleys. The inspector spoke with the person in charge with regard to the supply of medication to the centre. She informed the inspector that she had identified a risk with regard to the timing of dispensing of

medication by the pharmacist and this had been documented in the risk register and reported to the provider.

Photographic identification was available on the medication prescription chart for each resident to ensure the correct identity of the resident receiving the medication and reduce the risk of medication error. A dedicated fridge was used to maintain a cold chain and ensure those medications which required cold storage was stored appropriately.

The prescription sheets and medication records for four residents were inspected. The following omissions were noted:

- no signature for discontinuation of medication
- maximum dose of prn medication over a 24 hour period was not recorded in all instances.

These issues were identified in the previous action plan. The provider responded stating that these issues were addressed and were ongoing. The provider had also responded in the previous action plan of March 2012 stating that a monthly medication audit was scheduled on all aspects of medication. However, when this was requested it was not available for inspection.

Medications that required strict control measures (MDAs) were not inspected on this inspection.

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 - Major

Outstanding requirement(s) from previous inspection:

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

Findings:

The inspector reviewed records of accidents and incidents that had occurred in the designated centre and found that the first incident with regard to significant unexplained bruising had not been notified to the Authority as per the Regulations.

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:

At the time of the last inspection the inspector found that there was no clear system in place to capture the reviews planned or undertaken of the quality and safety of care provided to residents and the quality of life of residents in the designated centre and improving the quality of care provided at, and the quality of life of residents in, the designated centre. This action remained live and required input to comply with the Regulations and ensure positive outcomes for residents. An informal system was in place by way of daily communication with residents and/or their family members on visiting.

The person in charge had completed an environmental hygiene audit on 14 November 2013. She explained that as a result of her findings hand hygiene was going to be organised. While information with regard to accident and incidents was available to complete the notifications to the Authority, there was no meaningful analysis of this information in order to identify how to achieve a higher compliance rate or identify possible areas where improvements could be made. There was no evidence that clinical data was reviewed with regard to falls management, wound care, accident and incidents or other clinical areas.

Further work is required to ensure a system is put in place to collect and review data and use it to identify possible trends and areas for improvement and ensure that the review results in improvements in the quality and safety of the service for residents.

The person in charge informed the inspector that staff from the centre for nurse education had recently completed an audit of care plans. However, there was no documentation available in the centre with regard to this audit.

The provider had responded in his response of the action plan of 6 March 2012 stating that "Arrangements are being put in place for a system for reviewing the quality of care provided and quality of life of the resident through weekly and monthly audits, for areas such as, restraint use falls, nutrition, hygiene standards, medication management. A schedule is now in place for the audits.

Findings by way of a report on any actions required will be made available and shared with the residents and the staff."

No evidence was made available to the inspector that this had occurred. A report on reviews conducted for the purpose of Regulation 35 was not available.

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:

There were four requirements with regard to care planning in the previous action plan. The inspector reviewed three care files and comment is made below regarding the findings of files reviewed. The inspector found that while all residents had care plans improvements were required in this area. On admission, a comprehensive nursing assessment and additional risk assessments were carried out for all residents. For example, a nutritional assessment tool was used to identify risk of nutritional deficit, a falls risk assessment to risk rate propensity to falling. The inspector noted that while assessments were completed they did not consistently inform the care plans.

While nursing staff had received training in care planning, this was an area that required further review. Care plans were confusing and it was difficult to find what assessed need the care plan was related to. For example some care plans contained information regarding past infections, nutritional issues and medical care. Additionally under interventions care plans documented 'review by dietician, speech and language therapy services and general practitioner', but the care plan failed to detail whether these consultations had occurred and if so what influence they had in the delivery of care to the resident. The inspector found that care plans were reviewed at three-monthly intervals or as required in response to changing needs. However, there was poor evidence of consultation with the resident with regard to the review of the care plan. Hence there was no evidence available of compliance with Regulation 8 with regard to consulting with residents in most cases. Also as a result of this approach there was a lack of information as to whether the resident agreed, disagreed or wished to make any comment with regard to the care plan.

Care plans were not person centred and did not reflect the individual aspects of the residents assessed needs. Consequently, this did not take account of individual residents' choices and preferences in all aspects of their care. Where person-centred care wishes are recorded and incorporated into care plans, this gives guidance in daily routines and management plans for staff to follow with the aim of ensuring residents are involved in their care and care is delivered in a consistent manner. In the absence of clear care plans it is not possible for the provider to ensure that suitable and sufficient care to maintain the resident's welfare and wellbeing, having regard to the nature and extent of the resident's dependency and needs as set out in their care plan is delivered.

Care plans were not linked together to give a global view of the residents care. For example, skin integrity, nutrition, mobility and pressure area care were not linked. Care plans were not in place for all identified needs. Where a resident developed an acute problem, for example, a chest infection, there was no care plan in place to facilitate and guide the delivery of care. A narrative record was recorded for each individual care plan that was enacted each day but it was difficult to obtain an overall clinical picture of the resident. The records generally described care as planned or aspects of physical care only and did not convey the full range of care provided on a daily basis such as the social and psychological support provided to ensure residents wellbeing. Nurses' entries were not consistently timed which is contrary to best practice guidelines from An Bord Altranais.

Pain Assessment and Monitoring

While residents were being prescribed pain medication and this was being administered, there was some evidence that pain assessments and monitoring of pain post administration of medication was being completed but this was in isolated circumstances.

Healthcare/Provision of Allied Health Services

Residents had good access to a range of allied health services which included physiotherapy, speech and language therapy (SALT), dietetic services and occupational therapist (OT). Chiropody, dental and optical services were also provided. Audiology services were arranged as required. There was access to the local palliative care team. One area that was not accessible to residents was the services of psychiatry of later life. The person in charge informed the inspector that they currently did not accommodate any residents who exhibited challenging behaviour but did have a substantial component of residents who had cognitive impairment.

Restraint Management

The inspector found that progress had been made since the last inspection with regard to the use of restraint. The centre's policy on restraint was based on national policy on promoting a restraint free environment and the person in charge voiced a firm commitment to this view. Risk assessments for the use of restraint were carried out and reviewed but they did not demonstrate that the use of alternatives had been fully addressed. Care plans had not been developed to guide the care of residents who used restraint.

Pressure Area Care

There were no residents with pressure ulcers on the day of inspection.

Nutritional Care

The inspector noted those residents' weights were stable on file reviewed. The person in charge informed the inspector that there were no resident who had had significant unintentional weight loss. Residents had access to the dietician and speech and language therapy services and supplements were prescribed where indicated.

Meaningful Activities

While some meaningful activities were observed taking place the inspector noted that a comprehensive activity plan was not in place and activities were not linked to the residents' social care assessments.

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. There is appropriate equipment for use by residents or staff which is maintained in good working order.

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 layout and design of the multi-occupancy rooms continues to pose difficulties to provide for residents' individual and collective needs in a comfortable and homely way on a daily basis. The residents' personal space is not designed or laid out in a manner to ensure their safety, encourage and aid their independence and assure their comfort, privacy and dignity. There were four multi-occupancy rooms which accommodated three residents.

Safe Accessible Outdoor Space

The residents do not have free access to a safe accessible outdoor space. This was originally brought to the attention of the provider at the first inspection of this centre in 2009. Currently residents are accompanied and supervised by a staff member when in the garden but access to the garden is dependent on staff availability.

The physical environment does not comply with the Regulations 2009 and the Authority's Standards.

Outcome 14: End of Life Care

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

Theme:

Person-centred care and support

Judgement:

Non Compliant - Minor

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

There were no residents receiving end-of-life care at the time of this inspection. The person in charge explained that they accessed the services of the local palliative care team. The centre facilitates relatives/friends to stay overnight should they wish to remain with their loved ones. Where a multi-occupancy room is in use, the person in charge stated that they always try to accommodate the provision of a single room and they have had no issues with this to date.

An end-of-life policy was available to inform and guide staff. An oratory was available for quiet prayer and reflection and Mass was celebrated when a priest was available. Sunday mass was watched on the television.

In the sample of the end-of-life care plans reviewed, they did not detail whether or not there was anything the centre had responsibility to enact should the need arise.

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:

The staff rota contained each staff member's full name and position. The provider had ensured a good level of staffing in order to meet the assessed needs of the residents. On the day of inspection, there were four nurses and four carers on duty on the morning of inspection engaged in the delivery of care to 23 residents - 12 of these residents were assessed as high dependency, four as medium dependency and seven as low dependency. One carer was allocated to supervision in the day room and encouragement and assistance with nutritional intake. In addition there was the person in charge, two catering staff, one cleaner, and one person responsible for laundry, two administration staff and a general operative. The inspector reviewed the rosters and saw that generally three staff nurses were on duty in addition to the person in charge. One nurse and two carers were allocated to the delivery of care during the night.

There was a lack of contemporary evidence-based practice with regard to the delivery of safe quality care to elderly residents. Staff members require supervision on an ongoing basis to ensure they follow policies and procedures, record documentation and administer medication in line with best practice and use safe practices with regard to moving and handling of residents. Training and competency assessments are required to ensure staff are competent to deliver safe care to residents.

Where issues with regard to the management of staff are detailed in risk assessments by the person in charge, appropriate additional control measures need to be put in place by the provider to support and assist the person in charge and ensure residents care and welfare is protected.

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:

Mary McCann
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 report¹

Centre name:	St. Fionnan's Community Nursing Unit
Centre ID:	ORG-0000650
Date of inspection:	18/11/2013
Date of response:	12/12/2013

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

Theme: Leadership, Governance and Management

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

Records were not maintained sufficiently to give a clinical picture of the condition or of previous treatment of the residents by nursing and medical staff. There were inadequate care plans and some records were not accurately completed. A comprehensive record of the treatment provided to the resident following an accident and the documentation with regard to incident/accident recording required review to ensure all incidents are recorded contemporaneously.

Action Required:

Under Regulation 25 (1) (b) you are required to: Complete, and maintain in a safe and accessible place, an adequate nursing record of each residents health and condition and treatment given, on a daily basis, signed and dated by the nurse on duty in accordance with any relevant professional guidelines.

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

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

A full audit by the Designated auditor is planned for the first week in January. In the interim each residents care record has been augmented with a self audit tool for each staff nurse to self assess. We will issue a further update to you in January 2014.

Proposed Timescale: 30/06/2014

Theme: Leadership, Governance and Management

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

Review of the risk management policy was required after the last inspection and this had not been completed.

Action Required:

Under Regulation 27 (2) you are required to: Review all the written operational policies and procedures of the designated centre on the recommendation of the Chief Inspector and at least every three years.

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

Risk register has been updated with hard copies of electronic risk assessments carried out in 2013. Policy as per HSE National Guidelines (Doc Ref No. OQR012) incorporated into the Risk register folder for reference purposes at DoN and also provided at Nurses Station. Alongside this is HSE document OQR010, Developing and Populating a Risk Register for reference. All assessments will be copied on an on-going basis to hard copy folder. The Risk Management Policy has been reviewed, adapted and distributed to personnel.

Proposed Timescale: 12/12/2013

Outcome 06: Safeguarding and Safety

Theme: Safe Care and Support

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

Appropriate measures were not in place to protect residents from being harmed or abused.

The inspector was concerned with regard to the management of three incidents of extensive unexplained bruising to residents. None of these three incidents have been the subject of a robust investigation to ensure the care and welfare of the residents is protected and to try and find any causative factors to prevent reoccurrences or uncover any causative factors, to inform reflective practice and to review arrangements for investigation and learning from serious or untoward incidents. Clinical evidence reviewed by the inspector supports that an urgent independent review of all three incidents is required.

Action Required:

Under Regulation 6 (2) (b) part 2 you are required to: Take appropriate action where a resident is harmed or suffers abuse.

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

An independent review will be carried out by two senior Directors of Nursing into the unexplained bruising, to be completed by January 2014.

Proposed Timescale: 31/03/2014

Theme: Safe Care and Support

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

Appropriate measures were not in place to protect residents from being harmed or abused.

While the incident in March was recorded in the narrative notes of the care file, there was no incident report completed, no investigation occurred and the incident was not reported as unexplained bruising to the Authority or the elder abuse social worker.

Action Required:

Under Regulation 6 (1) (a) you are required to: Put in place all reasonable measures to protect each resident from all forms of abuse.

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

Elder Abuse training will be complete by December 17th 2013. A St Fionnan's Guidelines for PIC when the DoN is away has been written and distributed to each staff nurse. A copy is at the Nurses Station. This supplements the Risk Management Policy. The document comprises the actions to take when a Notifiable event occurs and which document applies. NF06 includes unexplained bruising. It states that each suspected incident of suspected or confirmed abuse, including unexplained bruising must be referred to the social worker with responsibility for the Protection of Older People. The patient concerned has been interviewed by the Elder Abuse social worker and a copy of her report was handed to HIQA by the Provider at meeting on November 27th 2013. Elder abuse social worker will meet with all compus mentus patients on the 12th December 2013 in St Fionnan's CNU.

Proposed Timescale: 12/12/2013

Theme: Safe Care and Support

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

The training records showed that 25 staff had undertaken updated elder abuse training during 2013 and training for the remaining seven staff is scheduled for 19 November and 9 December 2013. Staff had received training in 2008.

Action Required:

Under Regulation 6 (2) (a) you are required to: Make all necessary arrangements, by training staff or by other measures, aimed at preventing residents being harmed or suffering abuse or being placed at risk of harm or abuse.

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

The final training date is December 17th 2013. All personnel will have completed the training then. Personnel files reflect the training undertaken by each person and an overview matrix is on file with the A/DoN

Proposed Timescale: 18/12/2013

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:

The centre employs 32 staff - 27 of these staff do not have up to date moving and handling training according to the training records provided to the inspector. This was confirmed by the person in charge. The inspector observed inappropriate moving and handling practices.

Action Required:

Under Regulation 31 (4) (f) you are required to: Provide training for staff in the moving and handling of residents.

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

Manual handling training has been arranged for December 18th and 19th 2013 on site.

Proposed Timescale: 15/02/2014

Theme: Safe Care and Support

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

The risk management policy required review to ensure it addressed all the risks specified in the Regulations such as self harm, violence and aggression and the arrangements for the identification, recording, investigation and learning from serious incidents.

The inspector saw that since the last inspection risk assessments had been carried out. Some additional control measures were identified by the person in charge and these have been brought to the attention of the provider but have not been addressed. These related mainly to staffing issues and the delivery of safe quality care.

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:

Staffing levels are now regarded as adequate by the Provider and the PIC. Duty allocation and staff management have since been reviewed. The vacant post of CNM 2 is outstanding but falls under the recruitment embargo.

Proposed Timescale: 12/12/2013

Theme: Safe Care and Support

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

One member of staff did not have up to date fire safety training.

Action Required:

Under Regulation 32 (1) (d) you are required to: Provide suitable training for staff in fire prevention.

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

Fire training arranged for December 10th 2013. All fire training includes a practice of evacuation with minimal staffing.

Proposed Timescale: 12/12/2013

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 inspector observed both nurses administering the evening medication on the day of inspection, neither administered medication in line with professional guidelines.

The inspector spoke with the person in charge with regard to the supply of medication to the centre. She informed the inspector that she had identified a risk with regard to the timing of dispensing of medication by the pharmacist and this had been documented in the risk register and reported to the provider.

The prescription sheets and medication records for four residents were inspected. The following omissions were noted:

- no signature for discontinuation of medication
- maximum dose of prn medication over a 24 hour period was not recorded in all instances.

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:

The medication management policies have been updated and distributed to personnel as per national guidelines and regular audits will be carried out. The issues raised by the Inspector on the day have been addressed with HSE personnel. A meeting will be taking place with the General Practitioners who have responsibility for the residents in St Fionnan's CNU in the New year.

Proposed Timescale: 30/06/2014

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:

The inspector reviewed records of accidents and incidents that had occurred in the designated centre and found that the first two incidents with regard to unexplained bruising had not been notified to the Authority as per the Regulations.

Action Required:

Under Regulation 36 (2) (e) you are required to: Give notice to the Chief Inspector without delay of the occurrence in the designated centre of any allegation, suspected or confirmed abuse of any resident.

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

A guide for staff nurses who are nominated to be the Person in Charge when the A/DoN is away has been developed by the A/DoN. Each staff nurse has been given a copy and a copy is available at the nurse's station. This supplements the Risk Management Policy and Standard Operation Procedures. A general meeting with all staff will be held with the provider and the PIC on December 13th, to re emphasise these matters.

Proposed Timescale: 12/12/2013

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:

At the time of the last inspection the inspector found that there was no clear system in place to capture the reviews planned or undertaken of the quality and safety of care provided to residents and the quality of life of residents in the designated centre and improving the quality of care provided at, and the quality of life of residents in, the designated centre.

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:

The audits needed to address care delivered, how it is assessed and recorded as well as actioned is underway. Currently audits on the use of bed rails, appropriate bed use for each resident, the use of nutritional supplements, Moving and Handling aids audit as well as a hygiene audit have all been completed.

Proposed Timescale: 30/06/2014

Theme: Effective Care and Support

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

Further work is required to ensure a system is put in place to collect data and review what data is collected and use it to identify possible trends and areas for improvement and ensure that the review results in improvements in the quality and safety of the service for residents.

A report on reviews conducted for the purpose of Regulation 35.

Action Required:

Under Regulation 35 (2) you are required to: Make a report in respect of any review conducted by the registered provider for the purposes of Regulation 35(1), and make a copy of the report available to residents and, if requested, to the Chief Inspector.

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

The use of trending to analyse data on incidents, accidents and serious will be implemented in regards to each month's events into the future. Retrospective analysis will also be undertaken by the A/DoN.

Proposed Timescale: 30/06/2014

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:

While some meaningful activities were observed taking place, the inspector noted that a comprehensive activity plan was not in place and activities were not linked to the residents' social care assessments.

Action Required:

Under Regulation 6 (3) (d) you are required to: Provide opportunities for each resident to participate in activities appropriate to his/her interests and capacities.

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

The A/DoN has met with the activities leader to regenerate the activities post diluted due to sick leave in September/October. Activities will be recorded daily in the Activities book in the day room. Currently the Transition year students are assisting residents in preparing the crib and other decorating activities with the activities leader.

Proposed Timescale: 30/06/2014

Theme: Effective Care and Support

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

There was poor evidence of consultation with the resident with regard to the review of the care plan.

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:

An audit tool has been issued to each nurse for care plan review. The A/DoN has advised nursing personnel that the residents or their next of kin must be consulted. The A/DoN will review the care plans with staff on an ongoing basis. The staff must record all interactions with the resident or their next of kin in the forms, assessment tools and narrative notes when recording care. See also outcome number 04.

Proposed Timescale: 30/06/2014

Theme: Effective Care and Support

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

Care plans were not person centred and did not reflect the individual aspects of the residents assessed needs.

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:

The A/DoN will be reviewing the care plans with the staff nurse allocated to each client to clarify with them how to be inclusive, non paternalistic and resident focused. See also outcome number 04.

Proposed Timescale: 30/06/2014

Theme: Effective Care and Support

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

The person in charge informed the inspector that they currently did not accommodate any residents who exhibited challenging behaviour but did have a substantial component of residents who had cognitive impairment.

Action Required:

Under Regulation 9 (1) you are required to: Facilitate all appropriate health care and support each resident on an individual basis to achieve and enjoy the best possible health.

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

Arrangements are being made to ensure that access to the services of a Psychiatrist of Old Age will be available when required at St Fionnan's CNU. The Provider will be made aware of any resident who requires such care in advance of that date by the A/DoN

Proposed Timescale: 30/04/2014

Outcome 12: Safe and Suitable Premises

Theme: Effective Care and Support

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

The residents do not have free access to a safe accessible outdoor space.

Action Required:

Under Regulation 19 (3) (o) you are required to: Provide and maintain external grounds which are suitable for, and safe for use by residents.

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

The Provider has again written to the Estates department requesting evaluation of the work required and provision of the necessary funding for same.

Proposed Timescale: 31/12/2014

Theme: Effective Care and Support

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

The residents' personal space is not designed or laid out in a manner to ensure their safety, encourage and aid their independence and assure their comfort, privacy and dignity. There were four multi-occupancy rooms which accommodated three residents.

Action Required:

Under Regulation 19 (3) (a) you are required to: Ensure the physical design and layout of the premises meets the needs of each resident, having regard to the number and needs of the residents.

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

The patients currently in the 3 bed wards will be re allocated to the existing vacant beds in the unit. New accommodation evaluation will commence in 2014 in order to comply with registration requirements in June 2015.

Proposed Timescale: 31/12/2014

Outcome 14: End of Life Care

Theme: Person-centred care and support

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

In the sample of the end-of-life care plans reviewed, they did not detail whether or not there was anything the centre had responsibility to enact should the need arise.

Action Required:

Under Regulation 14 (2) (b) you are required to: Facilitate the religious and cultural practices of each resident approaching end of life.

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

The A/DoN will be reviewing the care plans with the staff nurse allocated to each client to clarify with them how to be inclusive, non paternalistic and resident focused. The next of kin may need to be involved in some cases.

Role play sessions will be used to assist personnel in being sensitive but clear in the use of the end of life care plans and address issues as they pertain to each resident

Proposed Timescale: 30/06/2014

Outcome 18: Suitable Staffing

Theme: Workforce

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

There was a lack of contemporary evidence-based practice with regard to the delivery of safe quality care to elderly residents. Staff members require supervision on an ongoing basis to ensure they follow policies and procedures, record documentation and administer medication in line with best practice and use safe practices with regard to moving and handling of residents. Training and competency assessments are required to ensure staff are competent to deliver safe care to residents.

Action Required:

Under Regulation 17 (1) you are required to: Provide staff members with access to education and training to enable them to provide care in accordance with contemporary evidence based practice.

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

Provide immediate access to HSELand for all care staff who wishes to access it. Previously NICE guidelines on matters relevant to the care of residents here have been provided to Staff nurses for evidence based, peer reviewed information. Personnel who are currently accessing education will be asked to provide a feed back session to colleagues and notify administrative staff to update their training and education matrix on their personnel file. This matter will be kept under continuous review by the A/DoN

Proposed Timescale: 30/06/2014

Theme: Workforce

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

Staff members require supervision on an ongoing basis to ensure they follow policies and procedures, record documentation, report all incidents and administer medication in line with best practice and use safe practices with regard to moving and handling of residents. Training and competency assessments are required to ensure staff are competent to deliver safe care to residents and deliver care in line with contemporary evidence-based practice.

Action Required:

Under Regulation 17 (2) you are required to: Supervise all staff members on an appropriate basis pertinent to their role.

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

It is the intention of the A/DoN to supplement current practice of attending report times by supporting personnel to reflect on their clinical practice, critically analyse their practice and focus on the individual they are providing care for in the context of clear, timely and specific care to each residents needs. This must then be accurately be recorded so that all following staff can see what has been agreed with the resident.

Proposed Timescale: 30/06/2014