

**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 High Support Unit
<b>Centre ID:</b>	OSV-0000389
<b>Centre address:</b>	Mulranny, Westport, Mayo.
<b>Telephone number:</b>	098 36027
<b>Email address:</b>	don.stbrendans@hotmail.com
<b>Type of centre:</b>	A Nursing Home as per Health (Nursing Homes) Act 1990
<b>Registered provider:</b>	Mulranny Day Centre Housing Limited
<b>Provider Nominee:</b>	Susan Moran
<b>Lead inspector:</b>	Nan Savage
<b>Support inspector(s):</b>	None
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	28
<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.

**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.**

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

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

From:	To:
15 October 2014 12:00	15 October 2014 17:50
16 October 2014 09:15	16 October 2014 15:30

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

Outcome 02: Governance and Management
Outcome 04: Suitable Person in Charge
Outcome 05: Documentation to be kept at a designated centre
Outcome 07: Safeguarding and Safety
Outcome 08: Health and Safety and Risk Management
Outcome 09: Medication Management
Outcome 11: Health and Social Care Needs
Outcome 12: Safe and Suitable Premises
Outcome 17: Residents' clothing and personal property and possessions
Outcome 18: Suitable Staffing

**Summary of findings from this inspection**

As part of this monitoring inspection the inspector met with residents, the provider, person in charge and staff members. The inspector observed practices and reviewed documentation such as care plans, medical records, incident logs, policies and procedures and staff files. On this inspection, the inspector also followed up on 6 required actions which were identified on the previous thematic inspection in April 2014. These actions related to areas including end-of-life care, nutrition, staff training and aspects of the physical environment. The inspector found that most actions were completed and the remaining action that related to upkeep of the dining room, was in the process of being completed.

There were 28 residents living in the centre, 11 of whom were of maximum dependency, 9 high dependency, 4 medium dependency and 4 low dependency.

On this inspection, there was evidence of good practice in most areas of the service inspected. However, the inspector was concerned that aspects of medication management practice were unsafe and placed residents at potential harm. As a result the provider and person in charge were required to take immediate action. The person in charge responded promptly and addressed the immediate risk posed to

residents. Prior to completion of this inspection, an agreed action plan was put in place to address the non compliances in medication management.

The healthcare needs of residents appeared to be met and residents had good access to general practitioner (GP) services and to other health services. Residents had the opportunity to participate in a variety of recreational opportunities that suited their individual needs. There was an assessment and care planning process although aspects of some residents' care planning documentation required improvement to reflect the current needs of these residents.

During the inspection, staffing arrangements were adequate to meet the needs of residents and were kept under review by the person in charge. Procedures were in place for the recruitment, selection and vetting of staff although some improvement was required. The provider had made resources available for staff to attend additional training pertinent to their role however, some staff required specific training in medication management and management of potential behaviours that challenge. Ongoing mandatory training took place and the person in charge facilitated staff to attend.

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

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

**Outcome 02: Governance and Management**

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

**Theme:**

Governance, Leadership and Management

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

No actions were required from the previous inspection.

**Findings:**

The governance arrangements and the lines of authority and accountability had not changed since previous inspections.

The person in charge had completed audits and reviews of the quality of care and experience of residents although, not all areas of the service had been adequately monitored. For example, the inspector was not satisfied that adequate systems were in place to monitor and review medication management practices. The person in charge had reviewed an aspect of medication management that related to residents' prescriptions in April 2014 but had not reviewed other aspects of medication management. During the inspection, the person in charge showed the inspector a sample of a medication management audit and nursing staff medication management competency assessments that she planned to implement.

Other audits and reviews of the service had taken place and included a quality assurance and continuous improvement review conducted in July 2014. Residents were reviewed regarding clinical areas including pressure care, weight loss and administration of specific vaccinations. Results identified that there were no residents with pressure ulcers and there were high levels of residents' participation in activity provision. The inspector noted that the results of the review were discussed at residents' weekly meetings and a copy was available at reception.

There was evidence that residents and where applicable their representatives had been consulted with regarding service provision. Residents' feedback surveys continued to be completed by the resident or where appropriate the resident's next of kin. Records viewed by the inspector indicated that the majority of the feedback was very positive and suggestions for improvement had been taken into consideration and used to inform practice. For example, the menu had been amended to include specific food requests from residents.

Other systems remained in place to monitor and review food and nutritional management including the completion of resident questionnaires. Residents were facilitated to complete questionnaires and surveys regarding the catering service and the inspector viewed those that had taken place recently. Areas commented on by residents or their representatives included the quality of food, menu choices and times of meals. Residents' meetings continued to take place regularly and were also used as another way to discuss food and other areas including activity provision.

The person in charge had completed an audit of the national standards during 2013 on most areas of the service including residents' rights. In response to the audit findings, the person in charge completed identified actions such as developing and adopting policies on residents' rights and consent.

**Judgment:**

Non Compliant - Minor

***Outcome 04: Suitable Person in Charge***

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

**Theme:**

Governance, Leadership and Management

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

No actions were required from the previous inspection.

**Findings:**

There was no change to the role of person in charge. The inspector found that the person in charge demonstrated a good understanding of her role and responsibilities as required by the legislation. The person in charge was a registered general nurse, had the relevant required experience and worked full-time in the centre.

The person in charge displayed commitment to improving the service for residents. She had undertaken continued professional development and had attended courses in areas such as early detection of memory problems in older persons, percutaneous endoscopic gastrostomy (peg) feeding, medication management and end-of-life care. She had attended a conference on the national care of the older person and was currently completing a wound management course. The person in charge also showed the inspector evidence that she had enrolled on a management development course on person centred practice that was scheduled to take place during early 2015.

**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:**

This outcome is included to ensure that the matters identified under Outcome 8, 9 and 18, are addressed as part of the agreed action plan.

The policy on the prevention, detection and response to abuse did not provide adequate instruction on how to respond in the event of an allegation of abuse made against a member of management and how to investigate an allegation as referred to in Outcome 8. Also, the policy on the management of behaviour that challenges had not been fully implemented.

Medication management policies and procedures did not provide sufficient guidance to support and direct practice in a number of areas of medication management (Outcome 9). Some parts of the procedures relating to areas including the disposal of medication had not been adhered to by staff. The person in charge commenced a review these policies and procedures during the inspection. Prior to completion of the inspection she had devised new procedures for medication administration and the management of as required (PRN) medications. Also identified under outcome 9, staff had not administered all residents' medications in line with professional guidelines. For example, the date on which some medications had been discontinued and the maximum dose of as required (PRN) medication had not been consistently recorded on the residents' prescription sheets. Nurses had signed that MDAs were administered and checked at a specific time, however, this time conflicted with the staff roster. MDAs were not checked at the change of each shift as required by professional guidelines.

There was a policy on the recruitment, selection and vetting of staff but the policy did not adequately reflect all the requirements of the Regulations (Outcome 18). The inspector examined a sample of staff files and found that most were complete. However, a satisfactory history of any gaps in employment had not been attained for one staff member and there was no evidence that some references had been verified.

The person in charge had addressed a required action identified on the previous inspection that related to the centre policy on nutrition. This action had been included under food and nutrition in the previous inspection report.

**Judgment:**

**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):**

No actions were required from the previous inspection.

**Findings:**

The inspector found that measures had been taken to safeguard residents from being harmed and from suffering abuse although some improvement was required.

The policy on the prevention, detection and response to abuse provided clear guidance to staff on recognising and preventing abuse. However, a required action relating to this policy is included under Outcome 5.

Staff spoken with outlined clearly what they would do if they suspected abuse and reported that they had received education from the person in charge. The inspector viewed training material which confirmed that staff had received ongoing education in this area. The inspector also noted that two staff had been scheduled to complete a train the trainer course on abuse on 24 October 2014.

Systems were in place to manage residents' finances, however, some improvement was required to ensure transparency and that residents had full control over their finances. The inspector noted that receipts were not maintained of hairdressing to verify that residents had received this service. Records were kept of transactions that took place regarding residents' monies and were signed by two staff. However, these transactions were not signed by the resident, where possible. A required action relating to this area is included under Outcome 17. The inspector viewed the arrangements for the safekeeping of residents' monies and valuables and found that they were stored in a secure manner and a number of balances checked by the inspector corresponded with records maintained.

Arrangements were in place to manage potential behaviour that challenges although improvements were required to ensure some residents' needs were fully met. There was a policy to instruct staff on how to manage behaviour that challenges, however, this policy had not been fully implemented. For example, the assessment process and review meetings had not been completed in accordance with the policy. The inspector also noted that sufficient care interventions had not been documented to guide staff practice on identifying possible triggers and how to de-escalate an incident. Staff described techniques that they used in response to this behaviour but this had not been clearly



documented in associated care plans. Required actions relating to these areas that require improvement are included under Outcomes 5 and 11. While a number of staff had completed training on the management of behaviour that challenges, not all relevant staff had completed this training.

Some improvement was necessary to the management of the use of restraint and promotion of a restraint free environment. There was a centre policy on the use of restraint and other relevant information was available including the national policy on restraint, however, these policies had not been fully implemented. For example, the policy referenced that the resident could only consent for the use of restraint but in practice some resident's next of kin had signed this consent. Prior to the use of a restraint measure, risk assessments were completed to determine the suitability of the restraint for the specific resident. However, from the sample of assessments reviewed one was incomplete, while another assessment had not been reviewed when required. The inspector also noted that the risk of entrapment had not been assessed. There was evidence that alternatives had been considered but these had not been recorded prior to the use of restraint for all residents. The inspector also found that the use of restraint was monitored but daily checks had not been consistently completed when required. The inspector noted that there was a consultation process regarding the use of restraint measures between the nurse, GP and occupational therapist.

**Judgment:**

Non Compliant - Minor

***Outcome 08: Health and Safety and Risk Management***

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

**Theme:**

Safe care and support

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

**Findings:**

Processes were in place to promote and protect the safety of residents, staff and visitors to the centre although, improvement was required to aspects of risk management and some areas of fire safety.

There was a risk management framework in place that included a risk management policy and health and welfare statement, that had both been updated in October 2014. There was also guidelines on the completion of risk assessments and safety. The inspector noted that formal precautions and arrangements were in place for specific risks identified in the Regulations such as self harm and missing persons.

A risk register was maintained, which included clinical and environmental risk assessments. However, some assessments were generic such as the assessment conducted on the grounds and as a result the inspector identified some risks in this area

that had not been assessed and controlled. For example, a gate leading from the residents' courtyard to an unsafe area had not been kept secure and appropriate railing had not been erected beside some steps at the front of the centre. The inspector also noted that risks associated with disposable gloves, which were easily accessible on an open trolley and also stored along with plastic aprons in dispensing units, had not been risk assessed to ensure that these items did not pose a risk to residents' personal safety.

While measures were in place to promote the safety of residents in the event of fire, an aspect of staff awareness on fire safety precautions required improvement. Some staff did not demonstrate appropriate knowledge of actions to take in the event of a resident's clothes catch fire. The inspector noted that staff had received formal training on fire safety and those spoken with during the inspection demonstrated knowledge of procedures to follow in the event of a fire in other areas. The inspector also found that fire strips attached to some doors had been painted over, which could impact on the effectiveness of the fire doors in the event of a fire.

A servicing programme was implemented and the inspector noted that equipment such as fire extinguishers had been most recently serviced in April 2014 and servicing of fire alarms had been completed in May 2014. The inspector reviewed records, which showed that internal safety checks were completed including a daily inspection of the fire doors, escapes and fire extinguishers. The inspector also noted that fire instructions were prominently displayed throughout the centre. In response to findings from the previous inspection the provider had recently installed appropriate mechanisms on most fire doors to ensure that these doors could be safely kept open and also promote resident's choice and independence. Additional door guards had been ordered and were planned to be fitted on the remaining doors by the end of October 2014. The inspector noted that the person in charge had educated staff on the importance of not wedging any doors open.

There was an emergency plan that identified what to do in the event of emergencies including storm damage and loss of heat and water. The plan also detailed contingency arrangements for staff to follow in the event of an emergency that required full evacuation of the centre.

Staff spoken with and training records reviewed by the inspector confirmed that staff had received adequate training in moving and handling. The inspector noted that the person in charge was a qualified people moving and handling trainer. While staff used appropriate manual handling techniques the inspector noted that an aspect of the physical environment did not promote safe manual handling practices. The inspector saw that the width of the doorway leading to the dining room did not adequately support staff to safely manoeuvre residents in specialised seating through this area. The inspector noted that the parts of the door frame were damaged as result of equipment hitting against the frame. A required action relating to this is included under Outcome 12.

There was a satisfactory standard of cleanliness in the centre and systems in place to control and prevent infection including policies to guide staff practice and an effective staff education programme. Staff spoken with described infection control precautions that had been implemented to prevent and control the spread of infection.

The provider and person in charge had implemented a system to monitor visitors to the centre to ensure the safety of residents. This system included controlled access and the completion of a visitor's book. The inspector also noted that CCTV continued to be operated in the centre. In response to the previous action plan, required signage had been displayed in relevant areas alerting residents and others to the use of CCTV and the policy on the use of CCTV had been updated to include clear guidance on the use of CCTV.

**Judgment:**

Non Compliant - Moderate

**Outcome 09: Medication Management**

*Each resident is protected by the designated centre's policies and procedures for medication management.*

**Theme:**

Safe care and support

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

No actions were required from the previous inspection.

**Findings:**

The inspector found that aspects of medication management practices were unsafe and posed a significant risk to residents' safety. The provider and person in charge were required to take immediate action to address these risks.

The inspector was very concerned that nursing staff had pre-prepared residents' medications and stored these inappropriately in the MDA cupboard. The inspector located these medications on day one of the inspection at approximately 3.30pm and was told by nursing staff that these medications must have been prepared by night staff for the evening medication round. This medication round was due to take place at approximately 8pm. The inspector noted that the medications were stored in uncovered plastic cups that had no labels. The person in charge stated that she was not aware of this practice. The provider and person in charge were required to review this risk immediately and undertake an investigation to safeguard residents from any potential harm. The person in charge confirmed that there was no way of determining which residents the medications had been prescribed for and therefore disposed of the medications promptly.

Prior to completion of the inspection, the person in charge had commenced the investigation and had taken a number of appropriate actions including the completion of a medication error form for the near miss, which outlined remedial measures to be taken and held an emergency meeting with nursing staff. The inspector requested that the person in charge submit the investigation report to the Authority when completed.

Medication management policies and procedures did not provide sufficient guidance to

support and direct practice in a number of areas. For example, the policies and procedures did not include adequate instruction for nursing staff on administration and recording of medications, prescribing, administering and review of PRN medications, disposal of medications and the management of medications that require special controls (MDAs). During the inspection, the person in charge had commenced a comprehensive review of the medication management policies and procedures. Prior to completion of the inspection, procedures had been developed for administration of medications and the prescribing, administration and review of PRN medication.

The inspector noted that nursing staff had not administered all residents' medications in line with professional guidelines. For example, the date on which some medications had been discontinued and the maximum dose of as required (PRN) medication had not been consistently recorded on the residents' prescription sheets.

Medications that required special control measures were stored securely, however, the inspector noted that other medications including medications that were no longer in use were inappropriately stored in the MDA cupboard. This issue was addressed by the person in charge prior to completion of the inspection.

Adequate processes were not in place for the management of MDAs. While the inspector checked a number of balances and found that they tallied with residents' administration records, some issues were identified. For example, the inspector noted that nurses had signed that MDAs were administered and checked at a specific time but the inspector found that this time conflicted with the staff roster. Nursing staff confirmed that the time recorded on the controlled drugs register was incorrect. The inspector also noted that MDAs were not checked at the change of each shift as required by professional guidelines. An action has been included under Outcome 5. The person in charge started to address these issues on inspection and devised a new system for checking residents' MDAs before the end of the inspection.

The inspector found that arrangements in place for the disposal of unused and out of date medications were not adequate. The inspector noted that medications were disposed off into a sealed box. The person in charge confirmed that the box had not been emptied in a number of years and that there was no systems for recording the safe return of unused medications or out of date medications, as required by the centre policy on medication management.

Most nursing staff had completed on-line training on medication management in July 2013. From a review of training records the inspector noted that one nurse had not completed this training. The inspector was concerned that given the poor practices identified on this inspection, nursing staff had not displayed a good standard of evidence-based nursing care in the area of medication management. The person in charge informed the inspector that all nursing staff would be required to complete further training on medication management. A required action relating to this training is included under Outcome 18.

A list of nurses' signatures was not maintained. The person in charge started to address this issue during the inspection.

The person in charge had reviewed an aspect of medication management that related to residents' prescriptions in April 2014 but had not reviewed other aspects of medication management. During the inspection the person in charge showed the inspector a sample of a medication management audit and nursing staff medication management competency assessments that she planned to commence. A required action relating to monitoring and review of the service is included under Outcome 2.

The inspector viewed a sample of residents' medical notes and found that residents' health needs were being monitored by the GP. Residents' medications were reviewed on a regular basis and an out-of-hours GP service was available to residents.

Adequate refrigerated storage was in use for medications that required temperature control and the temperature of the refrigerator was monitored. The inspector noted that the medication trolleys were kept secure and the medication keys were kept by a designated nurse at all times.

**Judgment:**

Non Compliant - Moderate

**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:**

A required action from the previous thematic inspection that related to the assessment and care planning of some residents' nutritional and end of life needs had been addressed.

The health needs of residents appeared to be met and evidence-based nursing care was evident in areas such as pressure ulcer prevention and nutritional management. Residents had access to medical and allied healthcare services. There was an assessment and care planning process, however, aspects of residents' care planning documentation required improvement to accurately reflect the current needs of these residents and ensure continuity of care. There were a range of opportunities for residents to participate in meaningful activities to suit their needs although, some improvement was required to ensure an activity programme was available in the absence of the activity coordinator.

The provider had facilitated residents' access to allied health services including chiropody, dietetics, speech and language therapy (SALT), optical and dental care when required. A physiotherapy service had been available to residents but arrangements had not been put in place when the physiotherapist left the service during 2014. The inspector noted that a new physiotherapist had been recruited and commenced employment in September 2014. Records of referrals and assessments were kept on residents' files.

The inspector reviewed the arrangements in place and management of clinical issues such as falls management, wound care and nutritional care. The inspector examined a sample of residents' files and found that risk assessments had been completed and most were used to develop care plans that were individualised, person centred and reflected the current needs of the resident. While there was evidence that most assessments and care plans were reviewed, some had not been reviewed when required. There was evidence that residents, where possible or their representative, were involved in the development and review of the residents' care plan.

Fall prevention measures were in place but the associated policy had not been fully implemented. The inspector noted that the assessment process had not been consistently completed and updated for residents when required. While mobility care plans were in place some required interventions regarding falls prevention measures had not been captured in some residents' care plans. The inspector found that assessments and care plans had not been consistently reviewed after falls with interventions to minimise the likelihood of re-occurrence. Appropriate arrangements were in place for the supervision and support of residents during the inspection. Staff were rostered and continually present in the day room to attend to residents' needs.

Systems were in place to support a good standard of care in pressure ulcer prevention and wound care management and this had resulted in positive outcomes for residents. At the time of inspection there was no resident with a pressure ulcer or any type of wound. In the event that either would occur, there were processes in place to monitor and manage wound care. The inspector noted that assistive devices were currently in use to promote pressure relief and the person in charge confirmed that when necessary tissue viability services had been used in the past.

Systems remained in place for the management of residents' nutritional requirements and areas that required some improvement on the previous inspection had been addressed. In response to the previous inspection findings, the person in charge had ensured that residents' weights were now consistently monitored on a regular basis. A formal process was implemented to monitor residents' food and fluid intake and the quantities of food consumed by some residents that required close monitoring were now sufficiently documented. Updated information from speech and language therapist's (SALT) regarding residents' specialised diets was kept in the kitchen.

There were opportunities for residents to take part in social care and the inspector noted that a number of activities took place during the inspection including newspaper discussions, imagination therapy, live music sessions and a visit to the local pub. The inspector found that staff interacted with residents in an appropriate and respectful manner. Activities were mainly facilitated by an activities coordinator who described to

the inspector the programme of activities available to residents. However, the inspector noted that suitable alternative arrangements had not been put in place, while the activities coordinator was on planned leave. As a result, there were fewer opportunities for residents to engage in social care during this time. This was confirmed by some staff during the inspection. The inspector noted that while residents' social needs had been assessed this information had not been reviewed when required.

**Judgment:**

Non Compliant - Minor

**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:**

Since the previous inspection the standard of decoration in the dining room had improved. This included repainting and display of wall murals. The person in charge outlined remaining plans that were in place to make the dining room more homely. However, the inspector noted that there was some damage to the doorway leading to the dining room. As detailed under Outcome 7, the width of this doorway did not adequately support staff to safely manoeuvre residents in specialised seating through this area.

Other areas relevant to this outcome were not reviewed on this inspection

**Judgment:**

Non Compliant - Minor

**Outcome 17: Residents' clothing and personal property and possessions**

*Adequate space is provided for residents' personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.*

**Theme:**

Person-centred care and support

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

No actions were required from the previous inspection.

**Findings:**

This outcome is included in this report to ensure that the matters identified under Outcome 8 are addressed as part of an agreed action plan.

Systems were in place to manage residents' finances, however, some improvement was required to ensure transparency and that residents had full control over their finances. The inspector noted that receipts were not maintained of hairdressing to verify that residents had received this service. Records were kept of transactions that took place regarding residents' monies and were signed by two staff. However, these transactions were not signed by the resident, where possible.

**Judgment:**

Non Compliant - Minor

**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:**

The required action from the previous inspection that related to some staff members' insufficient knowledge of the content of the end-of-life care policy, had been addressed.

The inspector found that there was appropriate staff numbers and skill mix to meet the needs of residents during the inspection. While overall there was evidence of safe recruitment practices, some improvement was required to the recruitment policy to reflect the requirements of the Regulations and staff files. Required actions relating to this policy and staff files are included under Outcome 5.

The inspector noted that there was sufficient staff on duty to meet the assessed needs of residents. Residents' numbers and dependency levels had decreased since the previous inspection. The person in charge informed the inspector that staffing levels and skill mix would be kept under review. The inspector noted that there were sufficient staff to cover the current number of residents although there was not enough whole



equivalent nursing staff to cover the staff roster if the centre was at maximum capacity. The person in charge confirmed that a recruitment programme had taken place and reported that some nursing staff were due to return to the service within the next few weeks. The person in charge also confirmed that additional residents would be admitted based on appropriate staffing levels and skill mix.

While professional development of staff had been supported by the provider and person in charge, the inspector identified some gaps in the training programme. As detailed in Outcome 9, there were unsafe nursing practices in relation to medication management. Training records viewed and staff spoken with confirmed that not all nursing staff had received formal training in this area. The person in charge informed the inspector that this training would be prioritised. A number of staff had received training on other areas including dementia care, infection control and behaviour that challenges.

At the time of inspection there were no volunteers attending the centre. The person in charge was aware of the regulatory requirements regarding the recruitment of any volunteers in the future.

**Judgment:**

Non Compliant - Moderate

## Closing the Visit

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

### Acknowledgements

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

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

Nan Savage  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority

## Health Information and Quality Authority Regulation Directorate

### Action Plan



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

<b>Centre name:</b>	St. Brendan's High Support Unit
<b>Centre ID:</b>	OSV-0000389
<b>Date of inspection:</b>	15/10/2014
<b>Date of response:</b>	17 November 2014

### Requirements

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

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

### Outcome 02: Governance and Management

#### Theme:

Governance, Leadership and Management

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

Some areas of the service had not been adequately monitored such as medication management.

#### Action Required:

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

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

monitored.

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

Medication audits to include all aspects of medication management will be carried out at regular intervals to ensure compliance with the new medication management policy implemented and profession guidelines. Medication competencies for all staff nurses will be carried out.

**Proposed Timescale:** 30/11/2014

**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:**

Some aspects of the policies on the management of behaviour that challenges and medication management had not been fully implemented.

**Action Required:**

Under Regulation 04(1) you are required to: Prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.

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

A new medication management policy has been implemented. All aspects of the behaviour that challenges policy is currently under review and all procedures in the policy will be implemented in practice.

**Proposed Timescale:** 30/01/2015

**Theme:**

Governance, Leadership and Management

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

Medication management policies and procedures did not provide sufficient guidance to support and direct practice in some areas of medication management.

The policy on the prevention, detection and response to abuse did not provide adequate instruction on how to respond in the event of an allegation of abuse being made against a member of management and how to investigate an allegation.

The centre policy on recruitment, selection and vetting of staff did not provide sufficient guidelines to ensure compliance with Schedule 2 of the Regulations.

**Action Required:**

Under Regulation 04(3) you are required to: Review the policies and procedures referred to in regulation 4(1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.

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

A new medication policy has been drawn up and implemented to direct practice in all aspects of medication management.

The policy on the prevention, detection and response to abuse has been updated to provide adequate instruction on how to respond in the event of an allegation of abuse being made against a member of management and how to investigate an allegation.

The recruitment policy has been updated to include guidelines to ensure compliance with Schedule 2 of the Regulations.

**Proposed Timescale:** 10/11/2014

**Theme:**

Governance, Leadership and Management

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

Staff had not administered all residents' medications in line with professional guidelines. For example, the date on which some medications had been discontinued and the maximum dose of as required (PRN) medication had not been consistently recorded on the residents' prescription sheets.

Nurses had signed that MDAs were administered and checked at a specific time, however, this time conflicted with the staff roster.

MDAs were not checked at the change of each shift as required by professional guidelines.

**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:**

A new process of administering, recording and checking MDAs has been implemented to ensure clarity, safety and compliance with professional guidelines. All nurses are aware of this new process. New record books for controlled drugs and the disposal of drugs have been ordered. A new signature bank has been implemented for staff nurses. Discussion has taken place between nursing staff and the GP to ensure that all drug prescriptions are consistent. Discontinued drugs will be signed and dated and PRN medication will include maximum dose for all drugs.

**Proposed Timescale:** 20/11/2014

**Theme:**

Governance, Leadership and Management

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

A satisfactory history of any gaps in employment had not been attained for one staff member and there was no evidence that some references had been verified.

**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:**

All written references are verified by telephone, this will be documented on all references in the future. Gaps in employment on all CVs will be explored and documented accordingly.

**Proposed Timescale:** 30/10/2014

**Outcome 07: Safeguarding and Safety**

**Theme:**

Safe care and support

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

Adequate systems had not been implemented to ensure that all staff had up to date knowledge and skills, appropriate to their role, to respond to and manage behaviours that is challenging. While a number of staff had completed training on the management of behaviour that is challenging, not all relevant staff had completed this training.

**Action Required:**

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

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

All staff will be trained in behaviour that challenges.

**Proposed Timescale:** 30/03/2015

**Theme:**

Safe care and support

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

The national policy on the use of restraint had not been fully adopted in staff practice. All risks associated with restraint had not been assessed. The assessment for the use of restraint had not been consistently completed in full and reviewed when required for all residents. There was no evidence that alternatives had been considered prior to the use of restraint for some residents and the monitoring system had not been consistently completed when required.

**Action Required:**

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

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

The assessment for the use of restraint will now include the risk of entrapment for all residents. The alternatives considered prior to the use of restraint will be documented on the assessment sheet. The consent form has been rewritten to state that resident's next of kin are consulted in relation to restraint as next of kin cannot consent to this as was previously stated on the form.

**Proposed Timescale:** 30/10/2014

**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:**

Some assessments were generic and as a result some risks identified by the inspector had not been assessed and controlled.

**Action Required:**

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

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

The health and safety policy has been updated to include specific risks identified both inside and outside the building.

**Proposed Timescale:** 30/10/2014

**Theme:**

Safe care and support

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

Some risks had not been adequately controlled including the gate leading from the residents' courtyard to an unsafe area and an appropriate railing had not been erected beside some steps at the front of the centre. Risks associated with disposable gloves had not been assessed to ensure that these items did not pose a risk to residents' safety.

**Action Required:**

Under Regulation 26(1)(b) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the risks identified.

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

These risks have been included in the risk assessment of the building. The gate in the courtyard is secured with a lock as it leads to an unsafe area. Residents can safely exit the courtyard via the main gate which has controlled access with enables residents to safely come and go where deemed appropriate. New railings have been erected on the ramp at the front of the building.

**Proposed Timescale:** 14/11/2014

**Theme:**

Safe care and support

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

Some staff did not demonstrate adequate knowledge of the procedures to follow in the event that a resident's clothes catches fire.

**Action Required:**

Under Regulation 28(1)(d) you are required to: Make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.

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

The fire safety training now includes procedures to follow in the event that a resident's clothes catches fire. This has been discussed with staff and will be included in all future fire training.

**Proposed Timescale:** 05/11/2014

**Theme:**

Safe care and support

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

Fire strips attached to some doors had been painted over and this could impact on the effectiveness of fire doors in the event of a fire.

Some doors did not have suitable mechanisms fitted to allow these doors to be safely kept open and also promote residents' choice and independence. Additional door guards had been ordered and the person in charge confirmed that they were due to be fitted on the remaining doors by the end of October 2014.

**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:**

Door guards have been fitted to all remaining doors to allow the doors to be safely kept opened.

Fire strips has been ordered for all doors in the building and old ones will be replaced to ensure compliance with fire regulations.

**Proposed Timescale:** 30/12/2014

**Outcome 09: Medication Management**

**Theme:**

Safe care and support

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

Adequate practices were not in place for the safe disposal of unused and out of date medications.

**Action Required:**

Under Regulation 29(6) you are required to: Store any medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident in a secure manner, segregated from other medicinal products and dispose of in accordance with national legislation or guidance in a manner that will not cause danger to public health or risk to the environment and will ensure that the product concerned can no longer be used as a medicinal product.

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

A new medication management policy has been implemented which now includes guidelines on the safe disposal of unused and out of date medications and a new record book has been ordered.



**Proposed Timescale:** 20/11/2014

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

**Theme:**

Effective care and support

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

Some residents' assessments and care plans had not been reviewed when required.

**Action Required:**

Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.

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

Falls assessments are being carried out on all residents and will be reviewed at intervals not exceeding 4 months or sooner if required in response to the changing needs of residents. Post fall assessments will be completed for any resident who suffers a fall.

**Proposed Timescale:** 30/11/2014

### **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:**

Some damage was noted to the doorway leading to the dining room. The width of this doorway did not adequately support staff to safely manoeuvre residents in specialised seating through this area.

**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:**

Due to the design of the current doorway, the wall will need to be cut out to increase its width. Because of the new dimensions a standard fire door will no longer fit. A new door which will meet with fire safety regulations has been ordered and a contractor hired to complete the job.

**Proposed Timescale:** 31/12/2014

**Outcome 17: Residents' clothing and personal property and possessions**

**Theme:**

Person-centred care and support

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

Systems were in place to manage residents' finances but some improvement was required to ensure transparency and that residents had full control over their finances. Receipts were not maintained of hairdressing to verify that residents had received this service and records of transactions were not signed by the resident, where possible.

**Action Required:**

Under Regulation 12 you are required to: Ensure that each resident has access to and retains control over his or her personal property, possessions and finances.

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

Receipts are now obtained from the hairdresser for all payments and residents where possible are asked to sign the transaction sheet.

**Proposed Timescale:** 30/10/2014

**Outcome 18: Suitable Staffing**

**Theme:**

Workforce

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

Not all relevant staff had received appropriate training on medication management.

**Action Required:**

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

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

Medication management training is currently in progress for all staff nurses.

**Proposed Timescale:** 30/11/2014

