Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	Bushfield Care Centre
Name of provider:	Bushfield Nursing Home Limited
Address of centre:	Bushfield, Oranmore, Galway
Type of inspection:	Unannounced
Date of inspection:	02 September 2020
Centre ID:	OSV-0005242
Fieldwork ID:	MON-0030288

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

Bushfield care centre is located approximately 2km from Oranmore, Galway. The centre accommodates up to 45 male and female residents with varying levels of dependency. Bushfield Care centre offers general care, dementia care, and palliative care, and care for people with physical disabilities. Residents who are, at all times, treated with dignity and respect and who are supported to live their lives as independently and fully as is possible, with safety our key concern. The centre is a purpose built single storey bungalow style building. Facilities available include a dining room, two sitting rooms, two conservatory areas. An activities' room, oratory, 31 single bedrooms all with en-suite toilet & shower facilities, and seven twin bedrooms, four of which have en-suite toilet facilities. One communal bathroom & shower which includes a toilet and a further two communal toilets are available for residents use. An enclosed garden is also available.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	38

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 2 September 2020	11:00hrs to 19:00hrs	Catherine Sweeney	Lead
Wednesday 2 September 2020	11:00hrs to 19:00hrs	Leanne Crowe	Support

What residents told us and what inspectors observed

Inspectors acknowledge that COVID-19 precautions remained in place on the day of this inspection. Notwithstanding the restrictions in place, residents were observed to be relaxed and comfortable in the centre and in the company of staff.

Resident spoken with told inspectors that they enjoyed living in the centre and that 'there was always plenty going on and plenty to do'.

The dining experience was observed by the inspectors to be a social experience with residents dining in the dining room and in their bedrooms, if this was their preference. Food appeared appetising and nutritious. The residents were complimentary of the food available. Residents confirmed to inspectors that the menus were varied and that they were offered a choice at every meal.

Residents told inspectors that they felt safe in the centre and that they could talk to the management team about any concern or complaint they may have. Residents knew staff by name and told inspectors that staff were always kind and treated the residents with respect. This was observed through staff interacting with residents on the day of inspection.

A resident-centred culture was evident in the centre. Residents were consulted regularly through group meetings and individually about the COVID-19 restrictions, refurbishments to the centre, the menus and food choices and participation in social activities. Residents were seen to mobilise around the centre independently and were observed to use the many communal and private seating areas around the centre. Although there was a safe outdoor area available for the residents, access to it was through an alarmed door. This restricted the residents ability to go outside independently.

Capacity and capability

This report sets out the findings on a unannounced inspection by the Office of the Chief Inspector. The inspection was scheduled to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated centres for Older people) Regulation 2013. Overall, inspectors found good compliance with the regulations. Improvement was required in the areas of fire safety documentation and update training for staff. A review of the management of complaints was also required to ensure compliance with regulation 34. Inspectors also followed up on unsolicited information received by the Chief Inspector. This information was found to be unsubstantiated.

The centre had a clear governance structure. The person in charge was supported by a clinical nurse manager. The management team was supported by the provider representative who attended the centre weekly.

Inspectors found that there were sufficient staffing levels in place on the day of the inspection. There was a planned and actual roster in place, with any changes were documented. A sample of staff files were reviewed and included all of the documentation required by Schedule 2 of the regulations. All staff had An Garda Síochana vetting disclosures in place, and all staff nurses had up-to-date professional registration with An Bord Altranais agus Cnáimhseachais na hÉireann.

Staff spoken with confirmed that regular training in relation to infection control, including hand hygiene and the use of personal protective equipment (PPE) was on-going. Mandatory training in areas such as safeguarding and manual handling was also up to date. However, some improvement was required to ensure staff were adequately trained. Records indicated that 27 of 45 staff did not have up to date training in fire safety. This is actioned under regulation 28, fire precautions. The person in charge confirmed that fire training sessions to update staff had been scheduled for the weeks following the inspection.

The provider had robust systems in place to ensure that the service was safe and well monitored. A scheduled of environmental and clinical audit audit was in place. Clinical audits completed this year included falls management, skin integrity, medication and infection prevention and control. Audits identified areas that required improvement, an action to address non-compliance's and a named person responsible for the actions. All audits were reviewed and discussed in management meetings.

A review of the management of complaints was required. The documentation of complaints, the investigation of the complaint and the learning identified form complaint was not documented in line with regulation 34.

Regulation 14: Persons in charge

The centre has an experienced and suitably qualified person in charge. The person in charge had a strong presence in the centre and was well known to the residents.

Judgment: Compliant

Regulation 15: Staffing

The number and skill mix of the staff was appropriate to meet the needs of the residents and for the size and layout of the building.

Judgment: Compliant

Regulation 16: Training and staff development

The majority of staff had recently completed training in infection prevention and control in response to the COVID-19 pandemic, including hand hygiene and the use of PPE. Other training such as cardiopulmonary resuscitation (CPR), dementia care and nutrition and hydration had been completed by a large proportion of staff. There was evidence that other training had been scheduled in the near future, including falls prevention, restrictive practice and responsive behaviours.

There was evidence that staff were supervised by the nursing management team.

Judgment: Compliant

Regulation 19: Directory of residents

A review of the directory of residents found that the information was in line with the requirements of Regulation 19.

Judgment: Compliant

Regulation 23: Governance and management

The centre was sufficiently resourced with staff and supportive equipment to ensure effective delivery of care. The centre had robust monitoring systems in place to ensure the service was safe and effective. An annual review of the quality and safety of care for 2019 was made available for inspection. The review contained an associated quality improvement action plan.

Judgment: Compliant

Regulation 34: Complaints procedure

The procedure for the management of complaints required review. The policy did not include the details of the complaints officer, but did state that the director of nursing was the second person nominated to ensure that complaints were appropriately responded to and recorded. In practice, the director of nursing

managed some complaints directly and it was not clear who was responsible for overseeing the responses to complaints.

Records of complaints were maintained but of the complaints that had been received since January 2020, each complaint did not contain at least one element of information that is required by the regulations.

Judgment: Not compliant

Regulation 4: Written policies and procedures

A review of the policies and procedures in the centre found that the requirements under Schedule 5 had been met. All policies were up-to-date and most aligned to best practice and national guidelines. A review of the Complaints policy was required to ensure best practice procedures were maintained. This issue is addressed under Regulation 34, Complaints.

Judgment: Compliant

Quality and safety

This inspection took place during the COVID-19 pandemic. The centre had a robust COVID-19 contingency plan and had remained COVID-19 free. Overall, inspectors found good evidence that residents received high quality health and social care. Inspectors found that a review of the fire safety documentation was required to ensure that the system worked effectively.

Resident were observed mobilising independently around the centre, and exercising choice in relation to where and how they spent their day. However, a review of residents access to outside space is required to ensure independence is facilitated where possible.

Staff interaction with residents was respectful and kind. Some staff wore identification badges with their name and photograph. This allowed the residents to identify the staff member when they were wearing personal protective equipment (PPE).

The centre had a robust risk management policy. A review of the risk register found that appropriate hazards were identified and actions to mitigate against risks had been developed and communicated to staff. A review of the incident and accident log found that all incidents were logged in a detailed manner, identifying actions taken which included a comprehensive incident analysis and review. Learning were

identified from incidents and were discussed at follow-up staff meetings.

The centre was visibly clean on the day of inspection. Protocols were in place for the prevention of COVID-19. The centre had remained free from COVID-19. A contingency plan was in place to ensure that the centre was prepared for an outbreak. There was a designated isolation area with four beds which were available for any suspected or positive cases.

Staff spoken with could clearly describe COVID-19 prevention protocols. There was adequate supply of PPE. Staff had received training on the use of PPE, hand hygiene techniques and infection prevention and control, including COVID-19 prevention protocols.

The fire safety systems in the centre were reviewed. The fire system, emergency lighting and fire fighting equipment had been serviced in line with requirements. Staff spoken with were aware of the procedure in the event of the fire alarm sounding. Each resident had a personal emergency evacuation plan that was reviewed and updated every four months, or as required. The centre had recorded evacuation drills, however, the content of the drills require review to ensure that all zones can be safely evacuated with night time staffing levels. The fire system is an L2/3 system which means that it does not identify the exact sensor that triggers the alarm to sound. Rather, it directs the staff to a zone within the centre, and staff then determine the location of the triggered sensor. This increases the time required for a full zone evacuation, and should be factored into the drill times. The centre is divided into five zones. A number of fire safety documentation issues were identified as a risk to the effectiveness of the safety systems. The fire safety drills and documentation required review. Fire safety update training was required for a number of staff. The person in charge confirmed that this training was scheduled for the month following the inspection.

Individual assessments and care plans were in place for each resident. The detail contained within each care plan was well written and respected the individual identity of each residents. For example, an eating and drinking care plan for a resident detailed the time they liked to have their meals, the food they enjoyed and how they liked their food presented.

Care plans for the management of challenging behavioural symptoms were developed in a sensitive and respectful manner. Triggers for challenging behavioural symptoms were identified and de-escalation techniques were described in a person-centred and individualised manner.

A number of residents in the centre had complex health and social care needs. A multi-disciplinary approach was used to develop appropriate and person-centred care plans for each resident. Care plans were found to be guided and developed through nursing, OT and physiotherapy assessments.The person in charge also worked closely with social support agencies facilitating some residents to explore the possibility of independent living.

The centre had a safeguarding policy in place. The centre does not act as a pension agent for any resident. There were robust systems in place to manage residents

personal funds.

Regulation 11: Visits

Following information received by the Chief Inspector, the visiting policy and procedure was reviewed with regard to the restrictions in place for COVID-19 pandemic. The centre was found to be facilitating visits in line with the Health Protection Surveillance Centre (HPSC) *Interim Public Health, Infection Prevention and Control Guidelines on the Prevention and Management of COVID-19 Cases and Outbreaks in Residential Care Facilities.* Window visits had been facilitated and a policy was in place to ensure visiting was arranged on compassionate grounds, when required.

Judgment: Compliant

Regulation 26: Risk management

The risk register contained assessment of both environmental and clinical risk. There was clear evidence of risk assessment and action plans being reviewed and discussed at management meetings.

Judgment: Compliant

Regulation 27: Infection control

The centre had an infection control policy and systems in place to ensure compliance with regulation 27. The centre's COVID-19 contingency plan was robust and included detail in relation to isolation and cohorting of residents in the event of an outbreak.

Judgment: Compliant

Regulation 28: Fire precautions

A number of fire safety issues required review;

- Training records indicated that 27 of 45 staff did not have up to date training in fire safety
- It was not clear if a zone was a fire compartment, designed to inhibit rapid fire spread within the centre .
- Zones were not clearly identified in either the fire safety documentation and on the fire maps displayed beside the fire panel
- Fire safety maps identifying fire escape and fire fighting equipment location were available inside residents bedrooms but not on display in the communal areas of the designated centre. This posed a risk to visitors to the centre.
- The number of residents accommodated within each zone was not identified.
- Fire drills did not identify the evacuation of residents from a compartmentalised zone to an area of safety using night time staffing levels.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

All residents had a comprehensive assessment and care plan in place. Care plans were developed to a high standard and contained person-centred detail which guided care. Care plans were updated in a timely manner.

Judgment: Compliant

Regulation 6: Health care

The residents had access to a general practitioner (GP) of their choice. GP access remained unrestricted throughout the COVID-19 emergency period. Inspectors found evidence of regular GP review. Medical notes were integrated into the nursing notes ensuring a multi-disciplinary approach to care. The centre had an occupational therapist (OT) and a physiotherapist on the roster as part of the care team. Residents also had regular access to dietitians, chiropodist, community palliative care teams and psychiatry of later life.

Judgment: Compliant

Regulation 8: Protection

The centre had robust system in place to protect residents. Staff were appropriately

trained in the safeguarding of residents.

The registered provider did not act as pension agent for any residents, but a small amount of petty cash was managed on the behalf of residents. This was held securely, all transactions were logged and signed off by two staff. Spot checks of records were completed on a monthly basis and a comprehensive audit was completed once annually.

Judgment: Compliant

Regulation 9: Residents' rights

Inspectors observed the residents actively engaging in social activities throughout the day of the inspection. There was an activity schedule in place that incorporated both individual and group activities. A review of the residents meeting notes found that residents were actively involved in the decision making process in relation to activities and social engagement. Changes in the staff, COVID-19 updates and the advocacy and complaints process was also discussed at the resident's meeting.

The centre had a number of residents with complex health and social care needs. The needs of these residents were supported by a multi-disciplinary team and appropriate referral to advocacy groups.

Resident in the centre were facilitated to vote in each election. Newspapers, television and radio were freely available in the communal areas of the centre and in the resident's bedrooms.

Residents had access to outside space. There was an enclosed courtyard for the residents to use. However, access to the outside space was restricted by alarm sensors to alert the staff that the door was opened. An alarm sounded when the door was opened. Staff would deactivate the alarm sensors manually using a key. This system had the potential of limiting the residents choice to go outside independently. A review of this system was required to facilitate residents choice and independence.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 23: Governance and management	Compliant
Regulation 34: Complaints procedure	Not compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Bushfield Care Centre OSV-0005242

Inspection ID: MON-0030288

Date of inspection: 02/09/2020

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 34: Complaints procedure	Not Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: The complaints procedure has been reviewed and revised to specify a nominated person to deal with complaints. The nominated person will maintain all complaint records and investigation details. The Person in Charge will oversee the complaints process. The Provider will complete a final review of all complaints. The complaints document will be revised to include details of the investigation, the outcome and complainant satisfaction, provider review and learning outcomes. Complaint learning outcomes will be communicated to all staff. Complaints will be audited quarterly to ensure the procedure is adhered to and complaints are managed effectively.	
Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: The registered provider has reviewed the Management of Internal Emergencies Policy (Including Fire). The building of Bushfield Care Centre is compartmentalized into zones in order to separate each section from the next for fire safety purposes. Each zone is separated by a fire door. All fire doors are fitted by electronic releases which are activated by the fire alarm, this system affords a phased evacuation to be facilitated where required. A 6 monthly audit of all Fire Safety precautions will be completed by the Person in	

Charge and Maintenance Person.

Updated training for staff has been scheduled for the following dates: 29th & 30th September 2020 and 14th and 15th of October 2020.
The number of residents accommodated within each zone has been identified, this will be displayed in the nurses station for information. Occupancy in each zone will be kept under review and referred to in the event of a new resident admission/ significant change in dependency levels.
Content of fire drills have been reviewed, future drills will identify the evacuation of residents from a zone to a safe area using night time staff levels.
The fire maps and fire safety documentation, displayed beside the fire panel, will be revised to make zones more identifiable.
Fire safety maps will be displayed in the communal areas of the centre. They had been displayed but were removed during refurbishment.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
A review of the existing system is underway, in order to find more appropriate ways to alert staff when a resident enters the enclosed courtyard.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Yellow	30/09/2020
Regulation 28(1)(d)	The registered provider shall 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	Not Compliant	Orange	30/10/2020

	resident catch fire.			
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Orange	30/10/2020
Regulation 34(1)(c)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall nominate a person who is not involved in the matter the subject of the complaint to deal with complaints.	Not Compliant	Yellow	30/09/2020
Regulation 34(1)(f)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall ensure that the nominated person maintains a record of all complaints	Not Compliant	Orange	30/09/2020

	including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.			
Regulation 34(1)(h)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall put in place any measures required for improvement in response to a complaint.	Not Compliant	Orange	30/09/2020
Regulation 34(2)	The registered provider shall ensure that all complaints and the results of any investigations into the matters complained of and any actions taken on foot of a complaint are fully and properly recorded and that such records shall be in addition to and distinct from a resident's individual care plan.	Not Compliant	Orange	30/09/2020
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise	Substantially Compliant	Yellow	31/12/2020

	choice in so far as such exercise does not interfere with the rights of other residents.			