

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	St Anne's Community Nursing Unit
Centre ID:	OSV-0000632
Centre address:	Westport Road, Clifden, Galway.
Telephone number:	095 211 89
Email address:	sandhya.joy@hse.ie
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	JJ O'Kane
Lead inspector:	Mary McCann
Support inspector(s):	Damien Woods (Day 1 only)
Type of inspection	Unannounced
Number of residents on the date of inspection:	23
Number of vacancies on the date of inspection:	1

About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

- Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- to carry out thematic inspections in respect of specific outcomes
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or wellbeing of residents.

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.

Please note the definition of the following term used in reports:
responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to 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:
11 October 2016 14:00	11 October 2016 20:00
12 October 2016 09:00	12 October 2016 14:00

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

Outcome	Our Judgment
Outcome 02: Governance and Management	Non Compliant - Major
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Non Compliant - Moderate
Outcome 07: Safeguarding and Safety	Substantially Compliant
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 09: Medication Management	Compliant
Outcome 10: Notification of Incidents	Compliant
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 12: Safe and Suitable Premises	Non Compliant - Major
Outcome 13: Complaints procedures	Compliant
Outcome 15: Food and Nutrition	Compliant
Outcome 18: Suitable Staffing	Non Compliant - Moderate

Summary of findings from this inspection

This unannounced monitoring inspection was carried out as part of the Health Information and Quality Authority's (HIQA's) regulatory monitoring function to check progress on actions from the previous inspection and to monitor compliance with the Health Act 2007 (Care and Welfare of residents in Designated Centres for Older People) Regulations 2013.

The provider has also applied to remove condition 8 of the current registration with the Health Information and Quality Authority (HIQA). This condition relates to the premises and is discussed further under Outcome 12 - Premises. Four actions were reviewed from the last inspection of the 5 November 2014, two were found to have been completed, these related to medication management and food and nutrition. One was partially completed this related to health care issues and one was not completed, this related to the premises.

St Anne's Community Nursing Unit is a two storey building which is registered with HIQA to accommodate 24 residents. The centre is located in Clifden, Connemara, Co. Galway. The centre consists of three single, six twin, one four bedroom room and one five bedroom area. One single room has an en-suite facility, the four bedded area has a full en-suite facility and the five bedded area had a small en-suite toilet. Overall there are five en suite facilities and one separate toilet on the ground floor. A large day room (64sq m) and small dining room with facilities for a maximum of 10 people to dine is available. A safe accessible courtyard garden is available for residents use. An oratory/church is available on the first floor, this is accessible by a lift.

During the course of this inspection, inspectors met with a number of residents, a relative and staff members. Inspectors observed practices including a medication round and reviewed records such as accidents and incidents, complaints records, audits, medication administration records, directory of residents, nursing care plans, medical records, policies and procedures. Staff members were observed to interact well with residents.

Improvements were required in relation to care planning, review of staffing to ensure effective consistent care for residents and ensuring priority is given to the completion of a new centre. Many of the non compliances in this report are due from the lack of oversight by the provider nominee. Thirteen actions are detailed in the action plan at the end of this report, eleven of which are the responsibility of the provider and 2 are the responsibility of the person in charge.

Matters requiring review are discussed throughout the report and the action plan at the end of the report contains actions that are required to be completed to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

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

Outcome 02: Governance and Management

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

Staff informed the inspectors that the provider representative rarely attends the centre but the manager of older person's services visits occasionally. The Person in Charge attends accountability meetings quarterly with other Person's in Charge in the Galway area and the manager of older person's services.

Inspectors found there were insufficient resources to ensure the effective delivery of care in accordance with the statement of purpose. The person in Charge stated that although she had found deficits on auditing the care plans she did not have sufficient time to enact a quality improvement plan. Staff members spoken with stated that they did not have adequate staff to meet the needs of residents, in particular there was a significant decrease in staffing levels after 18:30 hrs. when there is one nurse and two care assistants to meet the needs of 17 maximum dependency residents and six high dependency residents. This is discussed further under Staffing - Outcome 18.

The Person in Charge informed the inspectors that she informed the provider by email on the 6 October 2016 of her intention to step back from the position of person in charge but to continue working in the centre. She has worked in the centre as Person in Charge since October 2015. She stated on some occasions she had to work as the nurse on the floor and the clinical nurse manager always had to work as the nurse as they did not have adequate nursing staff available. Consequently she found it difficult to have adequate time for the management and governance of the centre.

The provider representative has failed to provide an appropriate comprehensive response to the queries from the inspector. One of the inspectors emailed the provider representative on two occasions, on the 14 October 2016 and again on the 24 October 2016, to seek clarity on this and to request that the provider provide information by way of notification to HIQA of what arrangements will be put in place to ensure

compliance with Regulation 14 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. The inspector rang the providers office on the 27 October to check if the emails had been received and administration staff confirmed they had. No response was received until 28 October 2016. The provider representative emailed stating that the person in charge issue has been resolved. The inspector requested by return email on the 28 October 2016 further information regarding the person in charge position but no response has been received. Post further communication a satisfactory response was received on the 24 January 2017.

The inspector had requested further information regarding the proposed new build, to include dates of commencement, position on planning, confirmation of funding and any plans regarding refurbishment of St Anne's to enhance the environment for current residents.

Some systems were in place to review the service delivered. For example staff had access to ongoing training and fire safety was found to be of a good standard. However, there was poor evidence available to show improvements were brought about as a result of auditing. For example care plans had been audited and some deficits had been identified but as detailed above no plan was enacted to rectify these deficits

An annual review of the quality and safety of care delivered to residents in the designated centre was available however there was poor evidence that this was carried out in consultation with residents and their families. A copy of this review was available to residents in the information folder but there was no evidence that it was discussed with residents.

Judgment:
Non Compliant - Major

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:

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The person in charge fulfilled the criteria required by the Regulations in terms of qualifications and experience. She held a full-time post. Inspectors found that she was actively engaged in the governance, operational management and administration of the designated centre on a days of inspection, however she told the inspectors that she did

not have adequate time to fulfil her management duties and had worked as the only nurse on duty in the centre on regular occasions. On the days of inspection an additional nurse was on duty who took a lead on residents care. Although an experienced clinical nurse manager was in post she was not available to assist the person in charge with governance tasks as she was usually allocated as a nurse to work on the floor. This is discussed further under Outcome 2.

The Person in Charge had good knowledge of each resident's specific care needs. Her mandatory training in Adult protection, manual handling and fire safety and her registration was up to date with an Bord Altranais agus Cnáimhseachais na hÉireann (Nursing and Midwifery Board of Ireland) (ABA) were all in date.

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:
Inspectors found that the directory of residents did not comply with current legislation. Where a resident died at the designated centre the time and cause of death was not documented. Inspectors also noted the use of a deleting substance on the directory.

Some records were incomplete and did not include a full date for example August but no date or year

Judgment:
Non Compliant - Moderate

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:

Measures were in place to protect residents from being harmed or suffering abuse. Staff had been provided with training in recognising and responding to elder abuse. All staff spoken with were clear on their role and responsibilities in relation to reporting abuse.

A culture of promoting a restraint free environment with an increase in the use of alternative safety measures such as chair alarms and low- low beds was in place. Evidence of alternatives considered or trialed was available. In discussion with the person in charge on the use of bedrails she described how most were used as an enabling function and were in place for the purpose of positioning or enhancing the residents' function. However care plans were not in place detailing the rationale for use of bed rails. Laps straps were in use mainly as a safety measure when moving residents in chairs. Records indicated that restraint was only used following a risk assessment and there was evidence of discussion with the resident and/or their representative. There was evidence of ongoing review of the need for restraint

There was a policy on the management of responsive behaviour. Some residents presented with responsive behaviour. Inspectors found that clear concise behaviour management care plans were not in place to provide direction to staff as to how to manage responsive behaviour and the plans failed to identify what triggers had been identified in the completed ABC (assessment, behaviour and consequences) charts. However, the interventions described by the staff reflected the needs of the residents even though they were not always documented in the behaviour support plans.

Judgment:

Substantially Compliant

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):

No actions were required from the previous inspection.

Findings:

All staff did not have up to date manual handling training An action with regard to this is contained under outcome 18 - Staffing.

A risk management policy which complied with the regulations was in place. An emergency plan was in place that identified what to do and who to contact in the event of an emergency such as fire, flooding, loss of water, power outage and disruption to gas supply. There was a comprehensive policy in place on infection prevention and control. Hand washing sinks were available in each bedroom and hand hygiene gel dispensers were located throughout the premises. Staff were seen to use them appropriately. There was adequate personal protective equipment such as aprons and gloves available for staff. The centre was clean.

Clinical risk assessments were undertaken, including falls risk assessment, nutritional care assessments and neurological observations were completed post un-witnessed falls to monitor neurological function. Records were maintained of accidents and incidents which indicated the immediate response and follow up to the incident.

Fire safety was well managed. One of the health care assistants took a lead on fire safety. The local fire services had attended the centre and were familiar with the layout including access points. Review of the fire training records showed that all staff had undertaken training in fire safety. This was confirmed by staff. All staff spoken with knew what to do in the event of a fire and were confident they would be able to safely evacuate including night time.

Fire drills were completed regularly, however records did not provide a comprehensive record as to whether a full or partial evacuation had been completed, what time it took to evacuate and whether there were any impediments to safe evacuation identified. Fire records showed that fire equipment had been regularly serviced and the fire alarm had been serviced quarterly. The inspector found that all internal fire exits were clear and unobstructed during the inspection.

Contracts were in place for the regular servicing of all equipment. Equipment such as specialist beds, wheelchairs and mattresses were provided in accordance with residents' needs. There were moving and handling assessments available for all residents.

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):

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

Findings:

At the time of the last inspection there was insufficient evidence to confirm that residents medications were being administered as required. On some of the charts nurses had not signed to confirm that the prescribed medication had been administered and there was no information to indicate that the medication had been withheld. This had been addressed.

The inspector observed one of the nursing staff on part of their medication round and found that medication was administered in accordance with the policy and An Bord Altranais agus Cnáimhseachais Na hÉireann (Nursing and Midwifery Board of Ireland) guidelines. Medicines were stored in individual locked cabinets in each resident's bedroom.

Inspectors reviewed a sample of medication records and found that the prescription sheets were regularly reviewed. For residents who were deemed unable to swallow tablets, tablets were prescribed by the general practitioner as safe to crush.

Judgment:

Compliant

Outcome 10: 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

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

No actions were required from the previous inspection.

Findings:

A record of all incidents occurring in the designated centre was maintained. Notifications had been submitted to HIQA as required and the person in charge was aware of her responsibilities in relation to submission of notifications.

Incidents that had been reported to HIQA that required investigation were actioned and evidence was available of learning from these incidents for example, staff training completed, introduction of template forms. An allegation of abuse was under investigation at the time of the inspection. This was being appropriately managed by the person in charge.

Judgment:

Compliant

Outcome 11: Health and Social Care Needs

Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

Theme:

Effective care and support

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

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

Findings:

Residents had assessments of daily living and other assessments completed on admission which included; dependency level, moving and handling, falls risk, pressure sore risk assessment and nutritional risk. Allied health/specialist services such as speech and language therapy, dietetics, and physiotherapy was available and there was evidence of referral and review. Occupational therapy services were available as required. Residents had access to the psychiatry of later life team who visited the centre as required. Inspectors reviewed a sample of the resident's care plans to include the files of residents with nutritional issues, residents with wound care issue and residents at high risk of falls. Overall, inspectors found that care plans for residents required review to ensure they are person centred. For example, nutritional care plans did not detail if the resident was on a fortified diet or their likes and dislikes regarding food and fluids. In some care plans reviewed where a resident was seen by a specialist service the advice of the specialist was not incorporated into the care plan.

Inspectors observed that some plans were not specific enough to guide staff and manage the needs identified as the individual needs were not linked to the assessments. Similar findings were found at the time of the last inspection.

At the time of the last inspection, the size of a wound had not been consistently recorded at each dressing change to assess the healing process. Inspectors noted that there had been improvements post the last inspection regarding documentation of wounds but this had not been maintained, consequently this action had not been addressed. Where residents were deemed to be at risk of developing wounds preventative measures were identified including regular position changes, supportive equipment such as specialist cushions, mattresses and dietary supplements also formed part of the care package. A review of residents' medical notes showed that residents had good access to their general practitioner.

Staff demonstrated good knowledge and understanding of each resident's background in conversation with the inspectors. Inspectors found from talking with the staff and residents that residents' overall health care needs were met. Staff could describe changes to the identified needs of residents and delivery of care. The interventions

described by the staff reflected the needs of the residents even though not always documented in the care plans. Assessments and care plans were updated at four monthly intervals.

A narrative record was recorded for residents each day, and while this gave an overall clinical picture of the resident but did not convey the full range of care provided on a daily basis such as the social and psychological support provided to ensure residents well-being. Personal calendars were sparse and not person centred. There was some evidence of resident/ relative involvement in their care planning by way of a signature however no narrative note was recorded to ensure the residents' and or their family had input into the care plan.

Judgment:

Non Compliant - Moderate

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):

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

Findings:

The provider has submitted an application to vary a condition of registration, Condition 8 which states 'No new residents may be admitted to the four bedded room (Bedroom No. 8) or the five bedded room (Bedroom No. 9 & 12) until a plan to reconfigure the physical environment to improve the privacy, dignity and quality of life of residents has been submitted to and accepted by the Chief Inspector'.

The provider has informed HIQA that a new centre is to be built "We have plans in place and funding to construct a new 50 bedded unit of the grounds of St Anne's. This is to replace the local Community Hospital and St Anne's. It will be completed by 2021".

The premises have been the subject of documented on-going non compliances with the (Care and Welfare of Residents in Designated Centre for Older People) Regulations 2013 regarding the provision of multi occupancy bedrooms and the negative impact that this layout has on residents residing in the centre including their privacy, dignity and independence. No renovations have taken place to date to improve facilities to enhance the environment for residents who reside in multi-occupancy bedrooms.

The person in charge informed the inspectors that there are five en suite facilities and

one separate toilet on the ground floor. While there are three additional toilets upstairs, these are not easily accessible to residents. Due to the fact that there is an en-suite in both the multi occupancy rooms and in one single room and two twin rooms with en-suite facilities, consequently 10 residents have access to one toilet. (Toilet facilities on the first floor are disregarded as they are not easily accessible)

A large day room (64sq m) and small dining room with facilities for a maximum of 10 people to dine is available.

The inspectors viewed both multi occupancy rooms and found that, while privacy and dignity could reasonably be provided in room 8, it was not the case in room 9/12. Room 9/12 is a series of 3 interconnecting spaces with a single small en-suite consisting of a toilet and wash hand basin. Five residents are accommodated therein, four in one area and a single bed adjacent to the en-suite.

At the poorly lit entrance space is the personal storage for the residents and individual medication lockers. Residents residing in the five bedded room do not have access to a toilet/en suite within the environs of their own bedroom space. As a consequence the use of commodes/ continence wear does not promote residents' independence, privacy or dignity in line with the National Standards. In order for a current resident to access a toilet/ shower they have to be assisted by hoist out onto the corridor to access a shower/bathroom/toilet. While there is a small toilet in the upper corner of the five bedded room is only accessible to mobile residents due to its size. To use this facility you have to pass through the private space of the resident in the corner area of the room.

At times during the inspection, this area was found to be cramped and unsuitable for the number of people accommodated therein and the activities ongoing. There was little room to use a hoist or sit by a bed. As the wardrobes are located on entry to the room it is difficult for residents to access personal items. It is impossible to personalise your own personal space as there was no space to do this.

The centre uses a single en suite bedroom for end of life care. However to do this, the resident who is generally occupying this room has to be relocated to another bedroom area. This does not protect the rights of the resident who has to be moved from her usual bedroom space.

Other bedrooms in the centre, though small in the case of single rooms, were suitable for residents and offered reasonable privacy and dignity. Communal areas on the ground floor were clean and well maintained. The chapel area on the first floor was accessible by lift.

As documented under Outcome 2 further information has been requested from the provider regarding the new build.

Judgment:
Non Compliant - Major

Outcome 13: Complaints procedures

The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

A centre specific complaints policy was available.

The inspectors reviewed the complaints procedure and noted this was displayed. The policy detailed timelines to be adhered to, the requirement to carry out a thorough investigation and to inform the complainant of the outcome of the investigation. An independent appeals process was also detailed so that if the complainant was not satisfied with the outcome of their complaint they could utilise this procedure.

No complaints were being investigated at the time of inspection. A complaints log was in place which contained a record all relevant information about complaints. There was evidence that where complaints were made, the policy was enacted and complaints reviewed were resolved to the satisfaction of the complainant. Complaints were recorded in a communal book, consideration should be given to recording complaints individually.

Judgment:

Compliant

Outcome 15: Food and Nutrition

Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.

Theme:

Person-centred care and support

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

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

Findings:

At the time of the last inspection information regarding modified consistency diets had not been clearly supplied to the catering staff. Additionally the terminology used in the documentation supplied by the speech and language therapists differed from the terminology used by catering staff to describe various food consistencies. This action had been addressed. Inspectors met with the chef on duty who displayed a good knowledge of residents specific needs and had a list of residents and their specific

dietetic requirements. Terminology was the same as the advice given by speech and language therapy services.

Inspectors viewed the menu that demonstrated the provision of a varied and nutritious diet. Inspectors observed, and records indicated, that specific diets, incorporating therapeutic and modified consistency foods, were facilitated and served in an attractive manner. Hot/cold drinks and snacks were readily available. Residents spoken with by the inspector stated that they were happy with the choice of food and alternatives were available on request.

Judgment:

Compliant

Outcome 18: Suitable Staffing

There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

Theme:

Workforce

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

No actions were required from the previous inspection.

Findings:

Inspectors reviewed the actual and planned staff roster and the staff numbers on the day correlated with the roster. Inspectors discussed the staff allocation with the person in charge and staff. Staff stated that they did not have adequate staff to meet the needs of residents, in particular they was a significant decrease of staff in the evening. While there are six care staff and one nurse in the morning, after 18:30hrs there is one nurse and two care staff. At the time of inspection there were 17 residents who were assessed as maximum dependency and 6 as high dependency.

In order to assure HIQA that there is adequate staffing to meet the needs of the residents and ensure appropriate governance and management of the centre a staffing needs analysis taking all variables into consideration that could have an influence on staffing levels, including the dependency of residents, the size and layout of the centre, accident and incident records, safe evacuation of residents, staff training, leave and staff breaks is required.

Training records available conveyed that staff had access to ongoing education and a range of training was provided. The inspector found that in addition to mandatory training required by the Regulations staff had attended training on caring for residents

with dementia, infection control, behaviours that challenge and nutritional care. as detailed under Outcome 8 all staff did not have mandatory training in safe manual handling.

A daily communication system was established to ensure an exchange of information between shifts which included updates on the residents' condition.

Evidence of professional registration for nurses was available and current. Garda vetting was in place on the selection of staff files reviewed and the person in charge informed the inspectors that all staff employed had Garda Vetting in place. There were no volunteers working in the service at the time of inspection.

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:

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 Anne's Community Nursing Unit
Centre ID:	OSV-0000632
Date of inspection:	11/10/2016
Date of response:	24/01/2017

Requirements

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

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

Outcome 02: Governance and Management

Theme:

Governance, Leadership and Management

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

There was poor evidence available to show improvements were brought about as a result of auditing. For example care plans had been audited and some deficits had been identified but no plan was enacted to rectify these deficits.

1. Action Required:

Under Regulation 23(c) you are required to: Put in place management systems to

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

ensure that the service provided is safe, appropriate, consistent and effectively monitored.

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

1. CNM 3 and CNM 1 together audited one care record using a new documentation Audit tool aligned to DML-MDS care records. A plan has been devised for CNM1 to re audit all care plan folders using this audit tool.
2. The complete DML recording system was reviewed and a few changes were done, based on which a new index sheet has been devised. Certain document sheets example weight recording sheets, vital sign recording sheets were reviewed and sheets with duplication were reviewed.
3. A small guideline is also being prepared with the observations made from the audit, which also incorporates the changes made for the key nurses to keep all information in a specific format in the folder.
4. 16 care plans have been already audited (as of 17/11/16) and the results of the audit have been relayed to staff nurses individually by the CNM 1.
5. CNM1 will also organise a care plan work shop for all nurses.
6. CNM1 and CNM3 will meet with each staff nurse and review the findings of the audit.
7. To maintain the standard of care plans and service, specific champions will be selected to monitor certain categories in the careplan, e.g. wound management, falls management, restraint management, nutritional management, etc.

Proposed Timescale: 31/07/2017

Theme:

Governance, Leadership and Management

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

An annual review of the quality and safety of care delivered to residents in the designated centre was available however there was poor evidence that this was carried out in consultation with residents and their families to ensure that such care was in accordance with relevant standards set by the HIQA under Section 8 of the Health Act.

2. Action Required:

Under Regulation 23(e) you are required to: Prepare the review referred to in regulation 23(1)(d) in consultation with residents and their families.

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

The next annual review of quality and safety care for the designated centre will be prepared in consultation with residents and their families. The consultation process will consist of Residents meeting, Resident Family meeting and Annual Quality Feedback questionnaire. The data from these sources will be incorporated into the annual review.

Proposed Timescale: 30/04/2017

Theme:

Governance, Leadership and Management

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

A copy of the annual review is required to be made available to residents.

3. Action Required:

Under Regulation 23(f) you are required to: Make available a copy of the review referred to in regulation 23(d) to residents and, if requested, to the chief inspector.

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

The annual review of the quality and safety of care delivered is available to residents via the resident's information folder which is kept along with other resident reading materials near the day room. A separate copy of the upcoming annual review will be provided to each individual resident.

Proposed Timescale: 30/05/2017

Theme:

Governance, Leadership and Management

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

The Person in charge stated on some occasions she had to work as the nurse on the floor and the clinical nurse manager always has to work as the nurse as they did not have adequate nursing staff available. Consequently she found it difficult to have adequate time for the management and governance of the centre.

4. Action Required:

Under Regulation 23(a) you are required to: Ensure the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.

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

The Person In Charge/Clinical Nurse Manager occasionally works on the floor. We are also introducing Epicare Electronic Care Planning system which will make a far more effective and efficient use of the Nurses time on the floor, freeing up the Person In Charge to concentrate more on management duties. An IT upgrade is required to facilitate this system.

The CNM role demands that they work 0.5 on the floor with direct patient care and 0.5 in a managerial capacity. I can confirm that the CNM 1 works on the floor up to 75% of the time due to nursing staff shortages which we are endeavouring to fill. We have been involved in three separate recruitment drives facilitated through the HSE at the National Offices in Manorhamilton but regrettably we were unsuccessful in recruiting any Nursing Staff for St. Anne's. With that knowledge we contacted the services of a Private Agency who were successful in recruiting Nursing Staff for us in other remote locations where we had experienced similar problems. They are actively working on

recruiting staff for St. Anne's, Clifden.

Proposed Timescale: 30/04/2017

Theme:

Governance, Leadership and Management

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

The Person in Charge informed the inspectors that she informed the provider by email on the 6 October 2016 of her intention to step back from the position of person in charge but to continue working in the centre. She has worked in the centre as Person in Charge since October 2015. She stated on some occasions she had to work as the nurse on the floor and the clinical nurse manager always had to work as the nurse as they did not have adequate nursing staff available. Consequently she found it difficult to have adequate time for the management and governance of the centre.

The provider representative has failed to provide an appropriate comprehensive response to the queries from the inspector. One of the inspectors emailed the provider representative on two occasions, on the 14 October 2016 and again on the 24 October 2016, to seek clarity on this and to request that the provider provide information by way of notification to HIQA of what arrangements will be put in place to ensure compliance with Regulation 14 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. The inspector rang the providers office on the 27 October to check if the emails had been received and administration staff confirmed they had. No response was received until 28 October 2016. The provider representative emailed stating that the person in charge issue has been resolved. The inspector requested by return email on the 28 October 2016 further information regarding the person in charge position but no response has been received.

5. Action Required:

Under Regulation 23(b) you are required to: Put in place a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

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

We recognise there is a major challenge in Nurse recruitment at St. Anne's. We have engaged the services of a Recruitment Agency who specialise in Nurse Recruitment and have successfully found us Nurses for another rural centre. They are currently advertising for staff for St. Anne's. We are hopeful for a successful outcome on this.

I can confirm that the CNM 3 is the Person In Charge at St. Anne's and since the Director of Nursing retired in October 2016, another staff member has taken over the responsibility as Director of Nursing. We are currently in the process of recruiting a Director of Nursing for the Clifden area. This is work in progress and we hope to have this completed by May 2017.

Proposed Timescale: 28/02/2017

Outcome 05: Documentation to be kept at a designated centre

Theme:

Governance, Leadership and Management

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

Inspectors found that the directory of residents did not comply with current legislation. Where a resident died at the at the designated centre the time and cause of death was not documented. Inspectors also noted the use of a deleting substance on the directory.

6. Action Required:

Under Regulation 19(3) you are required to: Ensure the directory includes the information specified in paragraph (3) of Schedule 3.

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

A new directory of residents has been ordered. Once this directory is received all relevant resident information will be entered. The data from these sources will be incorporated into the annual review.

Staffs have been advised to refrain from using any deleting substances. In the event of an error it is advised to put single line through the entry.

Proposed Timescale: 31/03/2017

Theme:

Governance, Leadership and Management

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

Some records were incomplete and did not include a full date for example August but no date or year

7. Action Required:

Under Regulation 21(6) you are required to: Maintain the records specified in paragraph (1) in such manner as to be safe and accessible.

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

All Staff have been advised to include the full date format in all documentation. The present directory has been reviewed to ensure proper date formats.

Proposed Timescale: 31/03/2017

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:

Inspectors found that clear concise behaviour management care plans were not in place to provide direction to staff as to how to manage responsive behaviour and the plans failed to identify what triggers had been identified in the completed ABC (assessment, behaviour and consequences) charts.

8. Action Required:

Under Regulation 07(2) you are required to: Manage and respond to behaviour that is challenging or poses a risk to the resident concerned or to other persons, in so far as possible, in a manner that is not restrictive.

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

1. All care plans are being reviewed and special emphasis will be given to incorporate the triggers identified from the Assessment, Behaviour and Consequences (ABC) chart into the care plans.
2. Care plans will also include the rationale for the use of bed rails.

Proposed Timescale: 30/06/2017

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:

Fire drills records did not provide a comprehensive record as to whether a full or partial evacuation had been completed, what time it took to evacuate and whether there were any impediments to safe evacuation identified.

9. 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:

CNM 3 spoke with the care staff who is also a fire officer regarding developing a detailed record of each fire drill conducted. A template has been prepared to record the details of every fire drill. Details such as date, time and type of evacuation, number of residents and the staff involved in the evacuation will be recorded. And these fire drill records will be saved in a separate bound folder. Fire drills will be performed once every quarter at different times of the day at different locations in the unit. All fire trainings will also incorporate fire fighting equipment and fire control techniques.

Proposed Timescale: 31/03/2017

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:

There was some evidence of resident/ relative involvement in their care planning by way of a signature however no narrative note was recorded to ensure the residents' and or their family had input into the care plan.

10. Action Required:

Under Regulation 05(5) you are required to: Make the care plan, or revised care plan, prepared under Regulation 5 available to the resident concerned and, with the consent of that resident or where the person-in-charge considers it appropriate, to his or her family.

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

As outlined in Action No 3 All care plans are being reviewed and adapted.

The template used to record relative or resident involvement in their care plan has been adjusted to facilitate input from the resident/family with a narrative note.

Work is also in progress to migrate to an electronic care plan system.

Proposed Timescale: 31/07/2017

Theme:

Effective care and support

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

Care plans for residents required review to ensure they are person centred. For example, nutritional care plans did not detail if the resident was on a fortified diet or their likes and dislikes regarding food and fluids. In some care plans reviewed where a resident was seen by a specialist service the advice of the specialist was not incorporated into the care plan.

Inspectors observed that some plans were not specific enough to guide staff and manage the needs identified as the individual needs were not linked to the assessments.

The size of a wound had not been consistently recorded to show evidence of progression or regression.

A narrative record was recorded for residents each day, and while this gave an overall clinical picture of the resident but did not convey the full range of care provided on a daily basis such as the social and psychological support provided to ensure residents well-being.

Personal calendars were sparse and not person centred.

11. Action Required:

Under Regulation 05(1) you are required to: Arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2).

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

As detailed in Action Number 3. All care plans will be reviewed. Nutritional care plans will incorporate details of resident's likes and dislikes. Dietician's advice will also be included.

Care plans will be prepared in a person centred manner. Wound care plans are in place where necessary. Wounds are photographed periodically. Wound sizes are also recorded frequently. Wound care champions will also be devised

Daily narrative records will also incorporate social and physiological support provided to residents.

Personal calendars are also being reviewed.

Proposed Timescale: 31/07/2017

Outcome 12: Safe and Suitable Premises

Theme:

Effective care and support

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

The provision of multi occupancy bedrooms has a negative impact on residents residing in these rooms compromising their in privacy, dignity and independence.

The centre uses a single en suite bedroom for end of life care. However to do this, the resident who is generally occupying this room has to be relocated to another bedroom area. This does not protect the rights of the resident who has to be moved from her usual bedroom space.

The person in charge informed the inspectors that there are five en suite facilities and one separate toilet on the ground floor. While there are three additional toilets upstairs these are not easily accessible to residents. Due to the fact that there is an en-suite in both the multi occupancy rooms and in one single room and two twin rooms with en-suite facilities, consequently 10 residents have access to one toilet. (Toilet facilities on the first floor are disregarded as they are not easily accessible)

12. 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:

There is a plan for a modular 50 bedded unit to incorporate St. Anne's plus the District Hospital on the grounds of St. Anne's. This will be completed in 2021.

I have spoken with the Estates Department in Merlin Park regarding the construction and consolidation of a 50 bedded Community Hospital on the grounds of St. Anne's, consolidating current St. Anne's and The District Hospital and they informed me they have difficulty in relation to plan, timescale and funding as they are in negotiations with National Estates as to whether this project will be funded by direct HSE Capital Funding or through Public/Private Partnership. Dependent on which route they take this will reflect differently on both timescale and funding. I have forwarded this request on the Chief Officer seeking current update and likely development plans which I will forward to you separately on receipt of same.

Proposed Timescale: 31/12/2021

Outcome 18: Suitable Staffing

Theme:

Workforce

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

Staff stated that they did not have adequate staff to meet the needs of residents, in particular they was a significant decrease of staff in the evening. While there are six care staff and one nurse in the morning, after 18:30hrs there is one nurse and two care staff. At the time of inspection there were 17 residents who were assessed as maximum dependency and 6 as high dependency.

In order to assure the Authority that there is adequate staffing to meet the needs of the residents and ensure appropriate governance and management of the centre a staffing needs analysis taking all variables into consideration that could have an influence on staffing levels, including the dependency of residents, the size and layout of the centre, accident and incident records, safe evacuation of residents, staff training, leave and staff breaks is required.

13. Action Required:

Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

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

Action 2 refers

We have calculated as requiring 19 staff at care for 24 beds, Nursing Staff x 7, Care Assistants x 12. We currently have 5 Nurses plus two Agency to make up a complement of 7. We have 14 Care Assistants.

Proposed Timescale: 28/02/2017

Theme:
Workforce

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

All staff did not have up to date manual handling training

14. 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:

Two Staff whose manual handling training was out of date are waiting to under go training on the 28 of November 2016.

Proposed Timescale: 31/03/2017