Health Information and Quality Authority
Regulation Directorate

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

Centre name:	Áras Deirbhle Community Nursing Unit
Centre ID:	OSV-0000644
Centre address:	Belmullet, Mayo.
Telephone number:	097 81 301
Email address:	belmullet.hospital@hse.ie
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Lead inspector:	Mary McCann
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	25
Number of vacancies on the date of inspection:	5

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration renewal decision. This monitoring inspection was announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
22 January 2018 10:30	22 January 2018 19:00
23 January 2018 09:00	23 January 2018 13:30

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

Outcome	Our Judgment
Outcome 01: Statement of Purpose	Substantially Compliant
Outcome 02: Governance and Management	Substantially Compliant
Outcome 03: Information for residents	Substantially Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Substantially Compliant
Outcome 06: Absence of the Person in charge	Compliant
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	Substantially Compliant
Outcome 12: Safe and Suitable Premises	Compliant
Outcome 13: Complaints procedures	Compliant
Outcome 14: End of Life Care	Compliant
Outcome 15: Food and Nutrition	Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Non Compliant - Moderate
Outcome 17: Residents' clothing and personal property and possessions	Substantially Compliant
Outcome 18: Suitable Staffing	Compliant

Summary of findings from this inspection

This was an announced monitoring inspection in response to submission of an application by the registered provider to renew registration of this centre. This centre is registered to accommodate a maximum of 30 residents who need long-term/respite care. Twenty five residents were accommodated on the days of inspection.

As part of this inspection the inspector reviewed progress on the nine actions documented post the last inspection carried out in February 2017. All actions were addressed.

Notification of incidents received since the last inspection were reviewed pre this inspection and reviewed and discussed with the person in charge and clinical nurse manager during this inspection. Residents and relatives spoken with during the inspection and from a review of the ten resident questionnaires were very positive in their feedback and expressed satisfaction with regard to the staff and the service provided. They were complimentary of the food, the way they staff were flexible, how they spend time with the chatting about local news and events, were courteous and the provision of meaningful activities. All staff had up to date mandatory training and the environment was clean and well maintained. Catering staff told the inspector that there were always adequate provisions available to meet the nutritional needs of residents and they could order food as required.

The inspector observed practices and reviewed documentation including policies and procedures, risk management records, staff personnel files, accident and incident records care files, medical records, audits, minutes of meetings. The person in charge and the clinical nurse were well prepared for the inspection and all documentation requested was available and information was easily accessible.
Of the 18 outcomes inspected, ten were found to be compliant seven were substantially compliant. And one was moderately non-compliant. A feedback meeting was held with the person in charge and clinical nurse manager. Findings of this inspection were discussed in detail at this meeting.

Areas which require review post this inspection include reviewing the requirement to have a safe accessible smoking room, review and submission of the revised statement of purpose and review of storage space for some residents. Additionally there is a requirement for more detailed recording of fire drills. Actions with regard to these matters that are required to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland are contained in the action plan at the end of this report.

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 01: Statement of Purpose
There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:
Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
The Inspector reviewed the statement of purpose, which had been updated since the last inspection. It outlined the ethos and aims of the centre. While it contained all the matters as per Schedule 1 of the Regulations, it failed to provide adequate detail in some areas for example, a description of each room in the centre, its capacity and function. Additionally further detail was required with regard to procedures in place regarding associated emergency procedures.

Judgment:
Substantially Compliant

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

Findings:
A new provider representative has been in post since 1 December 2017. He has worked in the HSE for many years and was previously a person in charge. In the past he has deputised in the absence of the provider representative. He was unable to attend the feedback meeting, however the inspector spoke to him on the phone regarding the findings of the inspection. He gave a firm commitment to try and address any deficits

addressed. The person in charge stated that she had met the provider representative frequently since he became provide representative and he was actively engaged with any issues identified as requiring his input, for example the provision of an appropriate smoking area for residents. She confirmed he was contactable at any time by phone or email. Minutes were available of formal meetings between the provider representative and the person in charge.

The management structure was suitable to ensure the effective governance of the service. The provider is the Health Service Executive (HSE), represented by the acting general manager for the Mayo/Roscommon area. The provider representative held monthly accountability meetings with the directors of nursing in the Mayo/Roscommon area. In addition to these meetings the directors of nursing for HSE older person's services in Mayo, Galway and Roscommon also met every two months to discuss governance issues, HIQA action plans and review updates with regard to evidence based practice. The person in charge worked full time and had responsibility for the management of both the centre and the community hospital which was situated in the same building. She was supported by two full time clinical nurse managers, who worked one day each week on management duties and also deputised in the absence of the person in charge. The staff team also included nurses, multi-task attendants, catering, activity and administration staff. The provider representative has ensured that there are adequate resources to ensure the effective delivery of care in accordance with the statement of purpose. This was supported by a review of the rosters by the inspector which showed that the staffing levels during the inspection were the usual staffing levels. No relative or residents spoken with or in the completed pre registration questionnaires raised any issue with regard to staffing levels. All accident and incident records were reviewed by the person in charge and reported to the provider representative. Any deficits identified were addressed to try and prevent re-occurrence and decrease the risk of injury to residents.

A quality management system was in place. This included audits with regard to clinical care and hygiene audits with regard to the environment. While the inspector could see that deficits identified had been addressed there was no formal quality improvement plan enacted post audits which showed the timescale from the deficit was identified to when it was addressed and dates for re-auditing to ensure sustainable improvement. An annual satisfaction survey is undertaken; the most recent one indicated a high level of satisfaction with the service provided. An annual review of the quality and safety of care delivered to residents in the designated centre had been completed for 2017. This was an action from the previous inspection. The report was presented in two sections and used the themes from the National Standards for Older People and highlighted areas requiring review. Section one related to quality and safety and section two capacities and capability. This review was carried out in consultation with residents and their families. One area that was identified for review and remained outstanding related to the provision of an appropriate smoking area for residents. This is discussed further under outcome 16 – residents' rights dignity and consultation.

Judgment:
Substantially Compliant

Outcome 03: Information for residents

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

Theme:
Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
The person in charge informed the inspector that a contract of care of care detailing the services to be provided an d the fees payable by residents had been agreed with each resident. The inspector reviewed a sample of these contracts. All services with the exception of the hairdressing fee are covered by the contract fee. The contracts of care did not specify if the room to be occupied by the resident was a single or shared room as required by the 2016 regulations.
A residents' guide was available to residents. This contained all of the information required by the Regulations however it was not accessible to residents with dementia or cognitive impairment as it was in type print only. Consideration should be given to producing an accessible version which would facilitate a better understanding for residents who were cognitively impaired.

Judgment:
Substantially Compliant

Outcome 04: Suitable Person in Charge
The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:
Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
The person in charge was experienced and fulfilled the criteria required by the regulations in terms of qualifications. She is in post since 2013. She qualified as nurse in 1994 and has many years experience of working in elderly care. She works full-time and also manages the 20 bedded District Hospital which is adjoined to the designated centre. She demonstrated good clinical knowledge and was knowledgeable regarding the Regulations, Standards and her statutory responsibilities. She has completed an advanced diploma in health service research, a course in teaching and assessing in clinical practice, a course in principles of palliative care, a certificate in management studies and other various shorts courses in infection control, dementia care and in medication management. Recent training completed included risk management -

investigations where there is an incident and safegfuarding training.
Her mandatory training in safeguarding vulnerable adults and manual handling 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.
The person in charge is supported in her role by a two clinical nurse managers who deputise in her absence.

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

Findings:
Actions from the last inspection with regard to recording accident and incidents, ensuring the full name of staff working was recorded on the roster and policies were reviewed in the previous three years had been addressed since the last inspection.

Records listed in Schedules 2, 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People Regulations 2013 (as amended) were available and were stored and maintained securely. The inspector reviewed a sample of records to include accident and incident records, fire safety, staff personal files and residents' care and medical records. A sample of staff files was reviewed. However the Garda vetting available on staff files was not the original vetting and was a letter of confirmation from the HSE stating that the staff member had Garda vetting completed.

There was a visitors' record to monitor the movement of persons in and out of the building to ensure the safety and security of residents.
The directory of residents' contained all information required by schedule 3 of the regulations and was maintained up to date. Valid insurance was in place.

The inspector also reviewed a sample of policies and procedures as required by Schedule 5 of the regulations. All the required policies were in place.

Judgment:
Substantially Compliant

Outcome 06: Absence of the Person in charge
The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:
Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
The inspector was satisfied that there were appropriate arrangements in place for the safe management of the centre in the absence of the person in charge. Two full time clinical nurse managers deputise in the absence of the person in charge.
Both are registered nurses and their registration with An Bord Altranais was up to date. An on-call management rota was in place.

Judgment:
Compliant

Outcome 07: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe care and support

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

Findings:
A comprehensive policy based on safeguarding vulnerable adults at risk of abuse was in place. Staff spoken with by the inspector confirmed that they had received training on adult protection and were aware of the different forms of abuse and the reporting structure within the designated centre.

The person in charge confirmed that they had enacted the new policy on safeguarding in the centre but staff had not been trained on the new procedures, training was planned for this to occur. The person in charge was familiar with the procedures on how to investigate an allegation, suspicion or disclosure of abuse. A visitor's book was maintained and all visitors were required to sign in and out of the centre. The entrance was secure and required a key pad code to open the doors. Residents spoken with

stated they felt safe in the designated centre and informed the inspector that they were well cared for. Relative spoken with confirmed that they felt their loved ones were safe and well cared for in the centre. This was also confirmed in the residents' questionnaires. Staff had recorded background personal information which would foster good communication with residents and make them feel secure and decrease their anxieties.

A culture of promoting a restraint free environment with evidence of the use of alternatives such as low-low beds and/or alarm mats was in place. The national policy, 'Towards of Restraint Free Environment in Nursing Homes (2011)' was available in the centre. Nine residents had bedrails in place. In discussion with the person in charge on the use of bedrails she described how most were used as enablers to enhance resident functioning. However care plans did not detail the enabling function of the restraint measure. Records indicated that restraint was only used following a risk assessment and restraints were regularly reviewed by staff. There was evidence of discussion with the resident and/or their representative.

A policy on the management of responsive behaviours was in place. A person centred positive behaviour support plan was in place for any resident who displayed responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment), to ensure a consistent approach when working with residents. The inspector observed staff managing a resident with responsive behaviour; the resident was distracted by staff chatting with her about her family. There was very good evidence of access to psychiatry of later life with regular contact from the team to assess and support residents.

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

Findings:
Actions from the previous action plan including review of the risk management policy, completion of regular fire drills, ensuring the shutter between the dining room and the kitchen automatically closes when the fire alarm is activated were addressed. However the completion of fire drills required further work. he action. A fire drill simulating a night duty scenario when the least amount of staff is on duty had been undertaken. Fire drills were carried out regularly by staff and the recording of these had improved since the last inspection however it was still not clear if an evacuation occurred and if so how many were evacuated and where evacuated to.

Currently residents who wish to smoke have to use an out of use toilet that has no door, consequently smoke escapes on to the public corridor causing a hazard to residents staff and visitors. Additionally It is difficult to observe residents in this area as there was poor access each side to view if a cigarette fell onto the residents' lap. this is further discussed under Outcome 16 Residents' rights, dignity and consultation.

There was a health and safety statement, a risk management policy and a risk register which included the management of clinical and environmental risks and included the precautions in place to control risks identified.

The inspector reviewed fire safety procedures and associated records. Fire evacuation notices were prominently displayed and fire exits were unobstructed. Training records showed that all staff had undertaken training in fire safety and evacuation and staff who spoke with the inspector were knowledgeable with regard to the procedures to follow in the event of fire. Personal emergency evacuation plans (PEEPs) were in place for each residenst. These were kept in residents' bedrooms. These identified those who required verbal prompts, physical assistance, or equipment such as a wheelchair or evacuation sheet. The inspector reviewed the servicing records of fire safety equipment which showed that up to date servicing by external consultants of the fire detection and alarm system and of fire fighting equipment had been undertaken.

A documented system of daily checks on fire exits was also in place. A health and safety statement which had been recently reviewed was available. An emergency plan which provided guidance in the event of fire, flood, and power outage to the centre was also available. There was poor evidence available that missing persons drills were occurring regularly.

Measures were in place to help prevent accidents and promote the residents' mobility including staff supervision, wide corridors with supportive handrails and an environment free of obstructions, low entry beds and crash mats. A log of all incidents was maintained by the person in charge and the inspector saw that detailed records were completed for each incident that occurred and where falls were unwitnessed or the resident sustained a head injury neurological observations were completed.

All staff had up to date training in moving and handling and this was confirmed by training records. Manual handling assessments had been carried out for all residents. There was appropriate assistive equipment available such as hoists, pressure relieving mattresses and cushions, wheelchairs and walking frames. Records indicated that hoists and other equipment had been regularly serviced and maintained.

The centre was clean and good infection control procedures were in place. All staff had received training in hand hygiene. Hand sanitising gels and protective equipment were available throughout the centre.

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 medication management policy was comprehensive and evidence based. The policy was made available to staff. Staff spoken with were aware of the contents of the medication management policy. Medications for residents were supplied by a local community pharmacy in original containers. The pharmacist was available to residents should they wish to discuss their prescribed medication.
Medications were stored in a locked medication trolley. A medication fridge was available and the temperature was recorded daily to ensure medication was appropriately stored. Medications that required strict control measures (MDAs) were securely stored and were checked and counted twice daily by nursing staff.
Where medications were to be administered in a modified form such as crushing, this was individually prescribed by the medical practitioner on the prescription chart. Staff confirmed that appropriate and comprehensive information was provided in relation to medication when residents were admitted to the centre. This formed part of the pre admission process.
All staff nurses had completed medication management training. Medication prescription sheets reviewed by the inspector were current. They detailed the weight, an up to date photo of the resident and any known allergies. Maximum daily doses were specified for 'pro re nata' (PRN) medication.
Medication administration record sheets (MARS) identified the medications on the prescription sheet, contained the signature of the nurse administering the medication. Space to record comments on withholding or refusing medications was available. The times of administration matched the prescription sheet.
The inspector observed medication administration practices and found that the nursing staff adhered to professional guidance of An Bord Altranais agus Cnáimhseachais.

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:

The provider representative and the person in charge were aware of the requirements in relation to notifying HIQA of periods of absence of the person in charge, and there were suitable deputising arrangements in place in the event of such an absence.

To date all relevant incidents and quarterly returns had been notified to the Chief Inspector as required.

The inspector reviewed the accident and incident log and saw that all relevant details of each incident were recorded together with actions taken.

Judgment:
Compliant

Outcome 11: Health and Social Care Needs
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

Theme:
Effective care and support

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

Findings:
The action was addressed from the last action plan. There was evidence of consultation with residents and where appropriate their families with regard to the care plans. Files reviewed showed that a pre-admission assessment had been completed in all cases to ensure that the centre could meet the needs of the residents.
Comprehensive assessments and a range of additional risk assessments had been carried out for all residents. Care plans were generally developed based on the risks and care needs identified. One resident with a movement disorder did not have a care plan in place with regard to this identified need. Care plans reviewed contained sufficient detail to guide staff in the delivery of care. Care plans were reviewed every four months or sooner if required. Residents at risk of falling were assessed using a validated falls assessment tool. Falls prevention care plans were in place. These provided guidance to staff in the delivery of safe care and what detailed aids such as sensor mats to mitigate the risk of further falls.
Residents or their relatives were involved in the care plans. This was confirmed by the residents and relatives spoken with during the inspection.
Some staff knew the residents and their families prior to their admission to the centre and staff demonstrated good knowledge and understanding of each resident's background in conversation with the inspector.
There was evidence that appropriate referrals had been made to mental health services and expert recommendations had been implemented with positive outcomes for the residents. Access to allied health professionals to include dietetic service, chiropody and

speech and language therapy (SALT) services, opticians, audiology and physiotherapy. There had recently been deterioration in the availability of occupational therapy services as the occupational therapist was on leave but was soon to return to her post.
Where a resident required assessment by they were referred to the appropriate service. For example when a resident had unintentional weight loss they were referred to the dietician, or a falls risk they were referred to the physiotherapist. Discharge letters for residents who spent time in acute hospital care and letters from consultations detailing findings following out-patient clinic appointments were available.
A daily narrative note was documented for each resident but this was medical in nature and did not detail psychological and social aspects of care. It failed to document what meaningful activities the residents took part in even though residents and relatives informed the inspector of a variety of activities which occurred regularly.
There was evidence in the medical files of good access to the General Practitioner.

Judgment:
Substantially Compliant

Outcome 12: Safe and Suitable Premises
The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:
Effective care and support

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
Aras Deirbhle is a community nursing unit, built in 1975, located half a kilometre from the town of Belmullet on the same site as Belmullet District Hospital under the management of the Health Service Executive (HSE). It is a single-storey purpose built building. It is registered with the Health Information and Quality Authority (HIQA) to provide care to 30 residents. There are four twin ensuite rooms and 22 single rooms. A dining, a large bright day room cum activity/living area with a sea view, visitor's room, oratory, hairdresser's room kitchen and various offices and staff facilities make up the structural layout. In the twin rooms screening curtains are provided around beds for privacy. An individual wardrobe and locker with a lockable drawer is available for each resident in which residents can store their valuables and personal possessions. The building was clean, bright, warm, comfortable and well maintained and there were sufficient toilets and showers to meet residents' needs. Structural improvements have enhanced the living environment and the design and layout of the building now meets the needs of residents.

Older persons who need long term care, people who have dementia care needs and people under the age of 65 requiring residential care who prefer to remain in the local

area are admitted. There is an enclosed garden provided with seating. All entrance and exit doors are ramped ensuring ease of access for residents. There is ample parking to the side of the building.
Prior to the refurbishment the centre had a smoking room for residents use. The issue with regard to the provision of a smoking room is detailed under Outcome 16 - Residents' rights dignity and consultation.

Two refurbished bathrooms were available so that residents have the option of having a bath if they wish. A restrictive condition is contained in the current registration of this centre which states that the physical environment in the designated centre must be reconfigured as outlined in the plans submitted to the Chief Inspector on 1 April 2016. The reconfiguration must be complete by December 2017. This reconfiguration is complete.

A number of residents had personalised their rooms with personal items including photos. There was a functioning call bell system in place within the centre.

Judgment:
Compliant

Outcome 13: Complaints procedures
The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Person-centred care and support

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
There was evidence of good complaints management.

There was a complaints policy in place and the complaints procedure, which outlined the name of the complaints officer and details of the appeals process, was prominently displayed.

The inspector viewed the complaints register and found that the complaints which had been made were recorded, investigated and resolved in a timely manner.

Judgment:
Compliant

Outcome 14: End of Life Care
Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.

Theme:
Person-centred care and support

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
The inspector found that end of life care was managed. The visitors' room was available for relatives to stay over and refreshments were provided.

A comprehensive policy on the provision of care at end of life was in place. The policy provided guidance on meeting the emotional, psychological and physical aspects of end of life care. The inspector reviewed processes around care with members of staff and management. The policy referenced arrangements for the provision of pastoral care according to religious preferences. End of life care plans were in place and the centre demonstrated a proactive approach to the gathering and review of information on residents' expressed wishes in relation to their preferences for care.

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):
No actions were required from the previous inspection.

Findings:
Residents were assessed for nutritional needs on admission and these assessments were reviewed at four monthly intervals or in response to residents' changing needs. Monthly weights were recorded or more regularly where unexplained weight loss was identified. Those with any identified nutritional care needs had a nutritional care plan in place and residents who had unintentional weight loss were referred to a dietician. Food and fluid charts were well completed and gave a good indication of the resident's intake. Likes and dislikes were recorded and residents told the inspector that they got the food they chose or if the menu wasn't to their liking they could get an alternative option. Those on a modified diet could choose from the same menu as those on a normal diet. Catering staff had a clear up to date list as to what was the correct diet for each resident to ensure their safety was protected.
Regular snacks and drinks were available throughout the day. A water dispenser was

available in the day room. The menu was displayed and provided a varied diet of meat, vegetables, fish and fruit. Homemade soups, scones, cakes and deserts were provided daily. The dining room provided adequate space for all residents to eat at the same time if they wished. A small minority of residents chose to eat in their bedrooms. The inspector observed that those who required support at mealtimes were provided with timely assistance from staff.

Judgment:
Compliant

Outcome 16: Residents' Rights, Dignity and Consultation
Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

Theme:
Person-centred care and support

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
Residents were admitted to this centre with full knowledge that they smoked and this would be facilitated and this is now not the case. Prior to the refurbishment the centre had a smoking room for residents use. The centre now has no appropriate smoking facility. Some residents who are currently living in the centre and like to smoke were living in the centre prior to the loss of the smoking room. The person in charge informed the inspector that there are currently no plans in place to provide a suitable safe smoking room.

Currently residents who wish to smoke have to use an out of use toilet that has no door, consequently smoke escapes on to the public corridor causing a hazard to resident staff and visitors. This is a small rectangular area approximately 1 metre x 3 metres. Due to the size of this are only one person could smoke at anytime. The inspector observed a resident in a wheelchair smoking in this area. As a toilet is still located in this area the resident was directly sitting in front of the toilet in a wheelchair. It is difficult to observe residents in this area as there was poor access each side to view if a cigarette fell onto the residents' lap. The centre was using some safety precautions. A smoking apron was available and a risk assessment was in place with regard to the use of this area as a smoking area. The use of a disused toilet with no door on it as a smoking room does not respect the residents' right to dignity and respect. The inspector spoke to the provider representative with regard to this issue. an action with regard to the risk posed by the use of this area as a smoking room is documented under Outcome 8 - Risk Management.

The ethos of the centre is that all staff has a responsibility to provide meaning activity. A

social care assessment was completed on admission. This included collecting information on individual resident backgrounds and interests were used to inform a meaningful, person-centred activity programme. There were good arrangements for the provision of meaningful activities. Staff was appropriately experienced and trained to provide a range of activities including Sonas and activity gym. Information on individual resident backgrounds and interests were used to inform a meaningful, person-centred activity programme. The activity co-ordinator on the days of inspection stated that 'she makes sure there is something for everyone'.

On the days of inspection residents were seen to engage in group, individual and one-to-one activities, including physical exercise and crafts. There was a collection of photographs of residents engaged in a variety of meaningful activities. An artist attended weekly for two hours. Residents had safe access to an outside space and residents confirmed that they assessed this regularly. This was also confirmed form questionnaires. Information on activities was clearly displayed in the centre. The centre ran a fun day in July when lots of families attended. Also the centre partakes in the local agriculture show and was delighted to have won some prizes at this.

Arrangements were in place for advocacy services as provided with contact details displayed. Regular resident meetings took place and minutes of these meetings were recorded. The last meeting was held on the 17 January 2018. Areas discussed included what activities residents enjoyed most, outings furnishing the new visitors room. No quality improvement plan was developed post these meetings but it was obvious from that discussions led to enactment of requests. Annual satisfaction surveys took place and feedback was noted to be positive. Consultation with residents and their significant others was recorded in care plans reviewed. There was an open visiting policy and visitors were seen to be in regular attendance throughout the inspection spending time with residents and chatting freely to staff. One relative told the inspector 'I have booked my place to come in here'.

Local and national newspapers were available. There was access to TV or radio in both communal areas and individual rooms. The inspector met and spoke with a number of residents and visitors who were very positive in their comments about the care they received, stating that the care was "second to none" and this was "a great place to be". The inspector observed interactions between staff and residents and noted that communication was respectful and friendly. Staff assisted residents in a pleasant unhurried way. The activities coordinator was also able to demonstrate how information was maintained about how residents participated in activities in keeping with their abilities and preferences.

Judgment:
Non Compliant - Moderate

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:
Laundry was carried out in the centre and there was a system for the identification of items of clothing to ensure that residents' clothes were not lost or mislaid. No recent complaints were or feedback from residents to suggest that clothing had been misplaced while laundering. However, in two of the resident questionnaires there was a concern expressed at the lack of space for some residents to store their personal belongings.

There were good systems in place with regard to protecting residents' finances. No residents' money was retained for safekeeping on the premises. A system was in place for the safekeeping of residents' money through a request and with funds requested transferred via cheque to the centre and money passed to the residents.

These transactions were clearly recorded and verified with signatures of two staff for all transactions made. Internal and external audits of residents' finances were carried out annually and no discrepancies had been found in the most recent audit.

Judgment:
Substantially Compliant

Outcome 18: Suitable Staffing
There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

Theme:
Workforce

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

Findings:
The inspector reviewed staffing levels and reviewed staff rosters over a three week period. This showed that planned staffing levels reflected the actual staff arrangements in place. The inspector noted that communal areas were supervised at all times and there was always additional staff in the day room in addition to the activity person so that the activity person was not disrupted while completing activities. There were registered nurses on duty at all times and the person in charge or the clinical nurse

manager was available. Generally a clinical nurse manager and two nurses were available up to 16:30 each day, with 2 nurses at all other times. There were four care assistants on duty up to 16:30 with two until 21:00hrs and one on night duty. A porter also worked on night duty and his duties were shared with the district hospital. Additional staff to include an activities co-ordinator, administration staff, cleaning, laundry catering and maintenance staff were available

The inspector reviewed the training matrix and identified that training was regularly delivered in mandatory areas such as safeguarding and manual handling.

Management monitored staff training renewal dates and all staff members had current training as required. Additional training was provided for staff that was in keeping with their role and the profile of residents. Catering staff had received training in the relevant areas of food and environmental hygiene. All staff had received training in dementia care and the management of related responsive behaviours. Training was also regularly provided on infection control and prevention, end of life care and nursing staff had completed training in management of medication.. All staff nurses had up-to-date registration with An Bórd Áltranais agus Cnáimhseachas na hÉireann.

Management systems were in place to ensure that information was communicated effectively with regular staff meetings occurring and a handover twice daily. Management meetings to review learning across centres took place at a regional level. Staff had access to relevant policies as necessary, and information on the standards and regulations was also made available to staff.

Judgment:
Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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 report[1]

Centre name:	Áras Deirbhle Community Nursing Unit
Centre ID:	OSV-0000644
Date of inspection:	22/01/2018
Date of response:	05/03/2018

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 01: Statement of Purpose

Theme:
Governance, Leadership and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The statement of purpose failed to provide adequate detail in some areas for example, a description of each room in the centre, its capacity and function. Additionally further detail was required with regard to procedures in place regarding associated emergency procedures.

1. Action Required:

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

Under Regulation 03(1) you are required to: Prepare a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Please state the actions you have taken or are planning to take:
The statement of purpose now gives a clear description of each room in the centre, its capacity and function as well as giving detail in place regarding associated emergency procedures.

Proposed Timescale: 07/02/2018

Outcome 02: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
A quality management system was in place. This included audits with regard to clinical care and hygiene audits with regard to the environment. While the inspector could see that deficits identified had been addressed there was no formal quality improvement plan enacted post audits which showed the timescale from the deficit was identified to when it was addressed and dates for re-auditing to ensure sustainable improvement.

2. 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 monitored.

Please state the actions you have taken or are planning to take:
All audits to have formal quality improvement plans to address the deficits and dates for re-auditing to ensure sustainable improvement.

Proposed Timescale: 22/06/2018

Outcome 03: Information for residents

Theme:
Governance, Leadership and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The contracts of care did not specify if the room to be occupied by the resident was a single or shared room as required by the 2016 regulations.

3. Action Required:
Under Regulation 24(1) you are required to: Agree in writing with each resident, on the admission of that resident to the designated centre, the terms on which that resident shall reside in the centre.

Please state the actions you have taken or are planning to take:
The contracts of care now specify if the room to be occupied by the resident is a single or shared room.

Proposed Timescale: 23/01/2018

Outcome 05: Documentation to be kept at a designated centre

Theme:
Governance, Leadership and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
A sample of staff files was reviewed. However the Garda vetting available on staff files was not the original vetting and was a letter of confirmation from the HSE stating that the staff member had Garda vetting completed.

4. 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:

Proposed Timescale:

Outcome 07: Safeguarding and Safety

Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The person in charge on the use of bedrails she described how most were used as enablers to enhance resident functioning. However care plans did not detail the enabling function of the restraint measure.

5. 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:
In cases where the use of bedrails is used as enablers to enhance resident functioning the care plans will detail the enabling function of the restraint measure.

Proposed Timescale: 31/05/2018

Outcome 08: Health and Safety and Risk Management

Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
There was poor evidence available that missing persons drills were occurring regularly.

6. 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:
Carry out and document missing person drills with improvement plans where deficits identified.

Proposed Timescale: 31/05/2018

Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Currently residents who wish to smoke have to use an out of use toilet that has no door, consequently smoke escapes on to the public corridor causing a hazard to residents staff and visitors. Additionally It is difficult to observe residents in this area as there was poor access each side to view if a cigarette fell onto the residents' lap.

7. Action Required:
Under Regulation 28(1)(a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.

Please state the actions you have taken or are planning to take:
Provide suitable area for resident who wish to smoke that will provide adequate precautions against risk of fire.

Proposed Timescale: 30/06/2018

Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
While fire drills were carried out regularly by staff and the recording of these had improved since the last inspection it was still not clear if an evacuation occurred and if so how many were evacuated and where to.

8. 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:
Carry out and document fire drills regularly detailing if an evacuation occurred and if so how many were evacuated and where to. Include improvement plan where deficits identified.

Proposed Timescale: 31/05/2018

Outcome 11: Health and Social Care Needs

Theme:
Effective care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
One resident with a movement disorder did not have a care plan in place with regard to this identified need.

9. 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:
Provide specific care plan for resident with movement disorder identifying specific care as a result of the condition.

Proposed Timescale: 22/03/2018

Outcome 16: Residents' Rights, Dignity and Consultation

Theme:
Person-centred care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Residents were admitted to this centre with full knowledge that they smoked and this would be facilitated and this is now not the case. Prior to the refurbishment the centre had a smoking room for residents use. The centre now has no appropriate smoking facility. Some residents who are currently living in the centre and like to smoke were living in the centre prior to the loss of the smoking room. The person in charge informed the inspector that there are currently no plans in place to provide a suitable safe smoking room. Currently residents who do wish to smoke have to use an out of

use toilet that has no door, consequently smoke escapes on to the public corridor causing a hazard to residents' staff and visitors. This is a small rectangular area approximately 1 metre x 3 metres ft. The inspector observed a resident in a wheelchair smoking in this area. As a toilet is still located in this area the resident was directly sitting in front of the toilet in a wheelchair. It is difficult to observe the resident as they self propelled into this area and there was poor access each side to view if a cigarette fell onto the residents' lap. The use of a disused toilet with no door on it as a smoking room does not respect the residents' right to dignity and respect.

10. Action Required:
Under Regulation 09(3)(e) you are required to: Ensure that each resident can exercise their civil, political and religious rights.

Please state the actions you have taken or are planning to take:
Provide suitable area for resident who wish to smoke.

Proposed Timescale: 30/06/2018

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:
In two of the residents questionnaires there was a concern expressed at the lack of space for some residents to store their personal belongings.

11. Action Required:
Under Regulation 12(c) you are required to: Provide adequate space for each resident to store and maintain his or her clothes and other personal possessions.

Please state the actions you have taken or are planning to take:
Provide adequate space for each resident to store and maintain his or her clothes and other personal possessions.

Proposed Timescale: 30/06/2018