Health Information and Quality Authority
Regulation Directorate

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	Bushmount Nursing Home
Centre ID:	OSV-0000292
Centre address:	Bushmount, Clonakilty, Cork.
Telephone number:	023 883 3991
Email address:	bushmountnursinghome@eircom.net
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Bushmount Nursing Home Limited
Provider Nominee:	Seán Collins
Lead inspector:	Caroline Connelly
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	76
Number of vacancies on the date of inspection:	3

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 2 day(s).

The inspection took place over the following dates and times

From:	To:
20 April 2017 09:50	20 April 2017 18:20
21 April 2017 08:50	21 April 2017 16:50

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

Outcome	Our Judgment
Outcome 01: Statement of Purpose	Compliant
Outcome 02: Governance and Management	Non Compliant - Moderate
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	Compliant
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 09: Medication Management	Compliant
Outcome 11: Health and Social Care Needs	Substantially Compliant
Outcome 12: Safe and Suitable Premises	Non Compliant - Moderate
Outcome 13: Complaints procedures	Substantially Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Compliant
Outcome 18: Suitable Staffing	Compliant

Summary of findings from this inspection

This report sets out the findings of an announced registration renewal inspection. The provider had applied to renew their registration which is due to expire on 01 September 2017. As part of the inspection the inspector met with the residents, the acting person in charge, relatives, a General Practitioner (GP), Assistant Director Of Nursing (ADON), the Clinical Nurse Manager (CNM), the administrator, the chef, maintenance personnel and numerous nursing, care and household staff members. The inspector observed practices, the physical environment and reviewed all governance, clinical and operational documentation such as policies, procedures, risk

assessments, reports, residents' files and training records to inform this application. The person in charge and the staff team displayed good knowledge of the regulatory requirements and they were found to be committed to providing person-centred evidence-based care for the residents.

The person in charge was on long term leave and the acting person in charge had been in post approximately 11 months and an interview was conducted with her at the previous inspection. For the purpose of this report the acting person in charge will be referred to as the person in charge. The ADON deputised in the absence of the person in charge and the provider visited the centre regularly. The inspector was satisfied that there was a clearly defined management structure in place. The management team were proactive in response to the actions required from the previous inspection and the inspector viewed a number of improvements throughout the centre which are discussed throughout the report.

A number of quality questionnaires were received from 16 from residents and eight from relatives and the inspector spoke to many residents and relatives throughout the inspection. The collective feedback from residents and relatives was one of general satisfaction with the service and care provided. One relative commented that "the staff go over and above to care for and accommodate the needs of my relative". Another complimented "the warm welcome and friendly atmosphere in the centre". Residents stated that "we are getting good care here everyone is very good to us". " I feel safe amongst the people living and working here" Two residents stated that they would like better smoking facilities and a number of relatives stated they would like to have a quiet area/ visitors room where they could visit in private. These issues were looked into and discussed further in the body of the report. Family involvement was encouraged with relatives and residents stating they are welcomed at any time. The inspector saw numerous visitors in and out of the centre during the two day inspection. There was an residents committee which facilitated the residents' voice to be heard and this was run by the activity staff and management team.

There was evidence of individual residents' needs being met and the staff supported residents to maintain their independence where possible. Resident's health and social care needs were met. Residents had comprehensive access to (GP) services, to a range of other health services, and the nursing care provided was found to be evidence-based. Residents could exercise choice in their daily life and were consulted on an ongoing basis. Residents could practice their religious beliefs. In summary, the inspector was satisfied that the centre was generally operating in compliance with the current conditions of registration granted to the centre.

The inspector identified aspects of the service requiring improvement to enhance the findings of good practice on this inspection. These included the completion of an annual review, review of a number of policies and procedures, updating contracts of care, making care plans available to residents and relatives and replacement of floor covering that remained an issue since the previous inspection. These are discussed under the outcome statements. The related actions are set out in the Action Plan under the relevant outcome.
These improvements are required to comply 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 2016. The provider was required to complete an action plan to address these areas.

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 statement of purpose and function was viewed by the inspector, and it clearly described the service and facilities provided in the centre. It identified the staffing structures and numbers of staff in whole time equivalents. It also described the aims, objectives and ethos of the centre. This ethos was reflected in day-to-day life, through the manner in which staff interacted, communicated and provided care.

The statement of purpose included the registration date, expiry date and the conditions attached by the Chief Inspector to the designated centre's registration under Section 50 of the Health Act 2007. However the arrangements for the management of the centre in the absence of the person in charge was not included. This was identified to the management team by the inspector during the inspection and was rectified. Following the amendment the updated statement of purpose was found to meet the requirements of legislation.

Judgment:
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):
No actions were required from the previous inspection.

Findings:
There was a clearly defined management structure in place. The provider was in the centre on a weekly basis and more frequently as required. There were fortnightly management meetings held attended by the management team and heads of departments the inspector viewed minutes of these meetings. The person in charge and the staff team displayed good knowledge of the regulatory requirements and they were found to be committed to providing person-centred evidence-based care for the residents. They were proactive in response to the actions required from the previous inspection and the inspector viewed a number of improvements throughout the centre.

The management team and staff demonstrated a commitment to continual improvement and quality assurance. The person in charge had introduced a quality management system and was recording weekly collection of data on quality of care issues such as falls, pressure areas, restraint, responsive behaviours and numerous other areas. There was evidence of quality improvement strategies and monitoring of the services. The inspector reviewed audits completed by the person in charge and staff in areas such as medication management, documentation, restraint, care plans, smoking audit, psychotropic medication audit and falls audit. However some of these audits could be further developed such as the enhancement of the psychotropic medication audit to identify PRN (as required medicines) usage. There was evidence of actions taken as the result the audits to improve the quality of care for the residents. The person in charge and ADON regularly received feedback from residents and relatives via the residents forum and through individual consultation and the inspector was informed that issues identified were actioned and resulted in improvements to the service provision. There was currently no resident/relative survey undertaken but the person in charge informed the inspector they were currently developing a survey to be implemented this year.

Although the provider and person in charge had introduced a quality management system and had completed a comprehensive audit against the standards. They had not completed an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by HIQA under section 8 of the Act for 2015 and therefore had not made this available to the residents and relatives.

Judgment:
Non Compliant - Moderate

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:
A Residents' Guide was available which included a summary of the services and facilities provided, terms and conditions relating to residence, procedure respecting complaints and the arrangements for visits. This guide was found to meet the requirements of legislation.

A sample of residents' contracts of care were viewed by the inspector. There were new contracts from 2016 and older contracts before then. The inspector found that contracts had been signed by the residents/relatives and found that the contract was clear, user-friendly and generally outlined all of the services and responsibilities of the provider to the resident and the fees to be paid. The newer contracts also detailed what was included and not included in the fee in a schedule of additional charges. However there were a number of older contracts seen where there was no evidence of the costs for extra services to be provided and some of these contracts had out of date fees included.

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 on long term leave and the acting person in charge had been in post approximately 11 months and an interview was conducted with her at the previous inspection. For the purpose of this report the acting person in charge will be referred to as the person in charge. The person in charge displayed a good knowledge of the standards and regulatory requirements and was found to be committed to providing quality person-centred care to the residents.

The inspector interacted with the person in charge throughout the inspection process. There was evidence that the person in charge was engaged in the governance, operational management and administration of the centre on a day-to-day basis. The inspector was satisfied that she was a registered nurse, was suitably qualified and had a minimum of three years experience in nursing of the older person within the previous six years, as required by the regulations. There was evidence that the person in charge had

a commitment to her own continued professional development and had undertaken relevant education and on-going training.

Staff, residents and relatives all identified her as the person who had responsibility and accountability for the service and said she was very approachable and were confident that all issues raised would be managed effectively. They confirmed she made herself available to them whenever they needed to discuss anything with her.

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:
Residents' records were reviewed by the inspector who found that they complied with Schedule 3 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. The records listed in Schedule 4 to be kept in a designated centre were all maintained and made available to the inspector.

The designated centre had 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 and these are reviewed and updated at intervals not exceeding three years as required by Regulation 4. However some of the policies including the safeguarding policy required updating to reference more updated legislation and best practice guidelines. The inspector viewed the insurance policy and saw that the centre is adequately insured against accidents or injury to residents, staff and visitors.

The person in charge informed the inspector that they had really tightened up on their recruitment process and no staff commenced employment until satisfactory Gardaí vetting, references and all the requirements of schedule 2 of the regulations had been attained. The inspector reviewed a sample of staff files and found that they contained all of the information required under Schedule 2 of the Regulations.

The inspector was satisfied that the records listed in Part 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 were maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. Overall records were seen to be maintained and stored in line with best practice and legislative requirements.

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 person in charge was on long term leave and HIQA was notified of her proposed absence. Satisfactory acting up arrangements were in place. There were suitable arrangements in place should the current person in charge be absent from the centre. There was an Assistant Director of Nursing (ADON) and a Clinical Nurse Manager (CNM). The ADON was appointed to deputise for the person in charge in her absence

The ADON and CNM were interviewed by the inspector during the inspection and were found to have the relevant experience in nursing the older adult. They demonstrated adequate knowledge of the legislation and the standards and were part of the management team.

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):
No actions were required from the previous inspection.

Findings:
The inspector reviewed the centre's policy on suspected or actual abuse and as outlined under outcome 2 documentation it required review to ensure it contained up to date best practice guidelines and legislation. The inspector reviewed staff training records and saw evidence that staff had received up to date mandatory training on detection and prevention of elder abuse. Staff interviewed were familiar with the policy and knew what to do in the event of an allegation, suspicion or disclosure of abuse, including whom to report incidents to. There was evidence that all allegations of abuse in the centre had been documented, investigated, appropriate action taken and notified in accordance with regulatory requirements.

The centre maintained day to day expenses for a number of residents and on the previous inspection the inspector saw evidence that complete financial records were maintained. The inspector reviewed the systems in place to safeguard residents' finances which included a review of a sample of records of monies handed in for safekeeping. Money was kept in a locked safe, all lodgements and withdrawals were documented and a running balance was maintained. All entries were signed and checked and there were regular audits of accounts and receipts. The system was found to be sufficiently robust to protect residents and staff.

A policy on managing responsive behaviours was in place. On the previous inspection not all staff had received responsive behaviour training. On this inspection the inspector saw training records and staff had undertaken recent dementia training and training in responsive behaviours by an external trainer, with the exception of four new staff who had received training from the person in charge. There was evidence that efforts were made to identify and alleviate the underlying causes of behaviour that posed a challenge. The support of the community psychiatry service was availed of as appropriate to residents needs as further outlined under Outcome 11. From discussion with the person in charge and staff and observations of inspectors there was evidence that residents who presented with responsive behaviours were responded to by staff in a very dignified and person-centred way by the staff using effective de-escalation methods. The inspector saw that there were now detailed responsive behaviour care plans which directed care to ensure a consistent approach to responsive behaviours is undertaken by all staff. These had been fully implemented since the previous inspection.

There was a centre-specific restraint policy which aimed for a restraint free environment and included a direction for staff to consider all other options prior to its use. The inspector saw that the person in charge and staff had promoted a reduction in the use of bedrails, at the time of the inspection there were eight residents out of 76 residents using bedrails and three using lap belts for transportation in specialist chairs. The inspector saw that alternatives such as low profiling beds, crash mats, and bed alarms were in use for a number of residents. Assessments and regular checks of all residents were being completed and documented. There had also been a substantial reduction in the use of chemical restraint over the last number of months and regular monitoring of same was taking place. The inspector saw that regular checks of all residents were

being completed and documented.

Judgment:
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:
The inspector saw that the fire policies and procedures were centre-specific. The fire safety plan was viewed and found to be comprehensive. There were notices for residents and staff on "what to do in the case of a fire" appropriately placed throughout the building. Staff demonstrated an appropriate knowledge and understanding of what to do in the event of fire. The inspector saw that fire training was provided to staff on a number of dates in 2016 and 2017 and staff had up to date fire training. The maintenance personnel provided fire training induction training with all new staff and also held regular fire drills. The person in charge told the inspector and records showed that fire drills were undertaken regularly with different staff in attendance the actions taken and outcome of the fire drill was documented and an evaluation form completed. The last fire drill took place on the 30 January 2017. The inspector examined the fire safety register with details of all services and tests carried out. All fire door exits were unobstructed and fire fighting and safety equipment had been tested in October 2016 and the fire alarm and emergency lighting was last tested in April 2017. The centre had received regular visits from Cork County Council fire officer and the fire brigade had also been in to familiarise themselves with the centre.

The smoking area for residents was in the garden, it was a glass canopy erected against the wall. A number of residents who smoked said that this was only suitable when the weather was good. There were no side panels so when it was raining or windy there was no protection for residents in this area. This was discussed with the person in charge at the feedback meeting and she said she would look into the matter. The smoking area was in a highly visible area. A fire blanket was located inside the door in close proximity to the smoking area, Fire extinguishers were also inside the building. There was no call bell outside to alert staff if a resident was having difficulty. The inspector recommended a further review of the smoking area to ensure the safety of all residents using same.

Accidents and incidents were recorded on incident forms and were submitted to the person in charge and there was evidence of action in response to individual incidents. There were reasonable measures in place to prevent accidents such grab-rails in toilets

and handrails on corridors. There was a centre-specific emergency plan that took into account major emergency situations and detailed where residents could be relocated to in the event of being unable to return to the centre. However it did not outline what to do when there was serious disruption to essential services like loss of water, kitchen or laundry facilities. Clinical risk assessments were undertaken, including falls risk assessment, assessments for dependency, assessments for malnutrition and assessments for pressure ulcer formation. The provider has contracts in place for the regular servicing of all equipment and the inspector viewed records of equipment serviced which were all up-to-date.

The environment was observed to be very clean and well maintained. Personal protective equipment, such as gloves, aprons and hand sanitizers were located throughout the premises. All hand-washing facilities had liquid soap and paper towels available. There were policies in place on infection prevention and control and staff that were interviewed demonstrated knowledge of the correct procedures to be followed. Infection control training was on-going and staff demonstrated good hand hygiene practice as observed by the inspector. Arrangements for the disposal of domestic and clinical waste management were appropriate.

The health and safety of residents, visitors and staff were promoted and protected. The health and safety statement seen by the inspector was centre-specific. The risk management policy as set out in Schedule 5 was seen by the inspector. The policy covered, the identification and assessment of risks and the precautions in place to control the risks identified. It included the measures and actions in place to control the following specified risks, 1) the unexplained absence of a resident, 2) accidental injury to residents or staff, 3) aggression and violence, and 4) self-harm. However it did not include the measures and actions in place to control abuse and therefore was found not to meet the requirements of legislation. The risk register was up to date and it identified and outlined the management of clinical and environmental risks. Corrective action reports were completed for any deviation and risks identified.

Records viewed by the inspector indicated that staff had received up to date moving and handling training. Hoists were serviced on a regular basis as required by legislation and records of same were seen by the inspector.

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:
There were written operational policies advising on the ordering, prescribing, storing and administration of medicines to residents. There was evidence on the medication prescription sheets of regular review of medications by the GP's. The inspector observed nurses administering the lunch and morning medications, and this was generally carried out in line with best practice. Medications were prescribed and disposed of appropriately in line with An Bord Altranais and Cnáimhseachais na hÉireann Guidance to Nurses and Midwives on Medication Management (2007).

Controlled drugs were stored in accordance to best practice guidelines and nurses were checking the quantity of medications at the start of each shift. The inspector did a count of controlled medications with one of the nursing staff which accorded with the documented records. Photographic identification was in place for all residents as part of their prescription/drug administration record chart. Medication trolleys were securely maintained within the secure treatment rooms.

Since the previous inspection there had been a number of changes and improvements to medication practices. There was a care plan in place for each resident which was kept with their administration chart identifying how the resident liked to take their medications. this included a photo of the resident and any special precautions required including allergies. Medications that required crushing were now seen to be prescribed as such for each individual medication that required crushing. There was a list available of medications that cannot be crushed. As required medications stated the frequency of dose to ensure there was a maximum dose in 24 hours that could not be exceeded. There were appropriate procedures for the handling and disposal for unused and out of date medicines and the documenting of same. A new medication trolley had been implemented into the new unit which the staff there said was safer than the previous practice of storing all the residents medications in their bedrooms. Medication competency assessments were undertaken with all nursing staff and there was evidence of nurses undertaking regular medication training.

Medication audits were undertaken on a regular basis and actions taken as a result of finding. Medication errors were recorded and investigated accordingly. The pharmacist provided a comprehensive service to the centre and was available to speak to residents as required.

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:
There was evidence that residents had frequent review by general medical practitioners and if required they also had access to specialist medical care. Residents had a choice of General Practitioner (GP) and some residents continued to have their medical care needs met by their GP prior to their admission to the centre. The inspector met one of the GP's during the inspection and he expressed satisfaction with the care his residents were receiving in the centre. Medical notes viewed by the inspector confirmed regular review of the residents and their medications. Residents also had access to allied healthcare professionals including physiotherapy, occupational therapy, dietetic, speech and language therapy, dental, podiatry and ophthalmology services. Residents in the centre also had access to the specialist mental health of later life services and were reviewed and followed up as required.

The inspector saw that there were suitable arrangements in place to meet the health and nursing needs of residents. Residents had a comprehensive nursing assessment completed on admission. The assessment process involved the use of a variety of validated tools to assess each resident's risk of deterioration. For example, risk of malnutrition, falls, level of cognitive impairment and pressure related skin injury among others. Residents generally had a care plan developed within 48 hours of their admission based on their assessed needs. There were care plans in place that detailed the interventions necessary by staff to meet residents' assessed healthcare needs. Improvements were seen in the care planning process since the previous inspection, care plans viewed by the inspector were found to be very personalised and they contained the required information to guide the care. Care plans were regularly reviewed and updated to reflect residents' changing needs and were person centred and individualised. However there was no evidence that the care plans were discussed with residents and relatives and the person in charge said they were looking to implement same.

Nursing staff told the inspector that a detailed hospital transfer letter was completed when a resident was transferred to hospital. Residents at risk of developing pressure ulcers had care plans and pressure relieving mattresses and cushions to prevent ulcers developing. Wound care charts reviewed showed scientific measurements and assessments of wounds and the use of evidenced based practices. Staff had access to support from the tissue viability nurse if required.

There were systems in place to ensure residents' nutritional needs were met, and that they residents received adequate hydration. Residents were screened for nutritional risk on admission and reviewed regularly thereafter. Residents' weights were checked on a monthly basis and more frequently if evidence of unintentional weight loss was observed. Residents were provided with a choice of nutritious meals at mealtimes and all residents spoken to were very complimentary about the food provided. There was an

effective system of communication between nursing and catering staff to support residents with special dietary requirements. Mealtimes in the dining rooms was observed by the inspector to be a social occasion. Staff sat with residents while providing encouragement or assistance with their meal. There were a number of dining rooms residents could eat in and in one unit mealtimes were later at the request of residents and other residents could go there for meals if they choose. Nursing staff told the inspector that if there was a change in a resident's weight, nursing staff would reassess the resident, inform the GP and referrals would be made to the dietician and speech and language therapy (SALT). Files reviewed by the inspector confirmed this to be the case. Nutritional supplements were administered as prescribed. All staff were aware of residents who required specialised diets or modified diets and were knowledgeable regarding the recommendations of the dietician and SALT.

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

Findings:
The premises was generally suitable for its stated purpose and met the residents' individual and collective needs in a homely and comfortable way. The centre was owned and managed by the provider since 2009 and previously consisted of 54 single bedrooms, 29 of which each have en suite facilities including a toilet, wash-hand basin and shower. In addition, one room had an en suite toilet and wash–hand basin and the remaining 24 rooms have a wash–hand basin. There were appropriate beds and mattresses to meet residents' needs and the design and layout provided sufficient space for each resident. There were a sufficient number of communal toilets and washing facilities for residents who did not have an en suite toilet and/or shower and the communal facilities were located within close proximity of bedrooms as well as seating and living spaces. In 2015 an extensive high quality extension had been completed on both the ground and first floor levels. The extension comprising of additional 26 new single bedrooms each with en-suite facilities including a toilet, wash-hand basin and shower. There was also suitable sitting and dining rooms provided on each floor with visitors/quite rooms, sluice and rooms for equipment storage. The centre was divided

into three units one unit was over two floors and the centre can now accommodate 79 residents all in single bedrooms.

Overall, the inspector found the premises promoted dignity and wellbeing. There was adequate lighting and ventilation and an appropriate heating system was in place in the centre. The centre was decorated in a very homely manner with sufficient furnishings, fixtures and fittings. On the day of the inspection, the centre was clean and generally suitably decorated. There was a variety of communal day space, with cosy sitting rooms, dining rooms and recreation rooms. Colour, lighting and cues were used to assist residents with perceptual difficulties and orient residents. For example, colour and signage was used to assist residents to locate toilet and bathroom facilities independently these doors were painted bright red. The corridors were wide and bright and allowed for freedom of movement. Colourful art work was seen on the walls that had been created by residents and staff. There were areas of interest seen along the corridors including textured craft work and rummage boxes. Particular attention had been paid to ensure residents had choice in dining areas with a formal dining room available for residents who wished to dine there but also smaller dining rooms on each unit/floor. Private accommodation was sufficient and there were adequate facilities for residents to meet visitors in private.

Residents' bedrooms were individually decorated with suitable storage facilities for personal possessions. A number had pictures and life stories displayed in a picture frame outside their door. There was a functioning call bell system in place. A lift was provided between floors and records of servicing were up to date. Handrails were provided in circulation areas and on stairways and grab rails were provided in bath, shower and toilet areas. Residents had access to equipment that promoted their independence and comfort. There was a maintenance man who worked full time in the centre. Equipment seen by inspector was found to be fit for purpose and was properly installed, used, maintained, tested and serviced.

The centre had a large church /oratory which was enjoyed by all. Also there was a hairdressing room and quiet room. There was easy access to the extensive and mature gardens both front and back. The inspector noted that there was also access to a large enclosed garden and patio area with raised flower beds to the rear of the building. Skype and Broadband facilities were also available. The centre provided designated car parking facilities and was located adjacent to the town of Clonakility on five acres of mature gardens.

However, there were some improvements required in relation to the premises which had been identified on the previous inspection in relation to the flooring in the centre. The inspector saw that some of the floor covering in bedrooms and in corridor areas required repair and carpets were seen to be torn and stained on the stairways. The inspector noted that any areas that posed a potential trip hazard had been taped to secure the surface but this tape only provided a temporary solution and a more permanent solution was required. The provider had committed to the upgrading of the floor by the 31 October 2017 and there was evidence of contacts made but the work had not stated to date so this remained non-compliant.

Judgment:

Non Compliant - Moderate

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

Findings:
The inspector found there was a complaints process in place to ensure the complaints of residents, their families or next of kin including those with dementia were listened to and acted upon. The process included an appeals procedure. The complaints procedure was prominently displayed. Residents and relatives all said that they had easy access to the person in charge who was identified as the named complaints officer to whom they could openly report any concerns and were assured issues would be dealt with. The person in charge stated that she monitored complaints or any issues raised by being readily available and regularly speaking to residents, visitors and staff. Records showed that complaints made to date were dealt with promptly and the outcome and satisfaction of the complainant was recorded. Staff interviewed conveyed an understanding of the process involved in receiving and handling a complaint.

There was an independent appeals person nominated and the policy had been updated to include the facility to refer to the Ombudsman if required. However the complaints policy did not identify who is the nominated person available in the centre to ensure that all complaints are appropriately responded to and that the complaints officer maintains the records as required by legislation.

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

Findings:
The inspector found that the management style of the centre maximised residents' capacity to exercise personal autonomy and choice. There was an ethos of delivery of person centred care to residents in the centre. This was evidenced by staff knowing the residents and in the compiling of residents life stories, interests and likes and dislikes. The inspector observed that residents were free to join in an activity or to spend quiet time in their room and being encouraged and supported to follow their own routines. Residents were supported to eat their meals at their preferred times in their preferred location. Inspectors observed this happening in practice.

The inspector was satisfied that residents were consulted in the organisation of the centre, and that their privacy and dignity was respected. All residents had single bedrooms and bedroom and bathroom doors were closed when personal care was being delivered. Staff were observed to knock and wait before entering bedrooms.
Residents were treated with respect. The inspector heard staff addressing residents by their preferred names and speaking in a clear, respectful and courteous manner. Staff paid particular attention to residents' appearance, dress and personal hygiene and were observed to be caring towards the residents. Residents choose what they liked to wear. The hairdresser visited regularly and staff also were seen to wash and style residents hair as required. Relatives complimented staff on ensuring their mother was always dressed well and had her make up on.

Residents' religious and political rights were facilitated. The local priests visited and resident priests celebrated Mass twice weekly in the centres' chapel. Staff stated that many of the residents enjoyed attending mass and reciting the rosary. Ceremonies from the church were available by TV link and some residents told inspectors that they enjoyed listening to the mass if they could not get to the church. The person in charge told inspectors that residents of varying religious beliefs were facilitated by ministers of their choosing as required. She also told the inspector that residents were facilitated to vote and explained that residents had been facilitated to vote in-house as required.

There was an open visiting policy in place. A number of relatives stated they would like a private area where residents could meet with family and friends in private if they wished. The inspector saw that a staff office had been just been converted to a visitors room with comfortable seating and tea and coffee making facilities and this was to be made available to visitors. The inspector saw that residents had many visitors during the inspection and relatives spoken with were very complimentary of the service provided.

The recreational and social interests of each resident were well known as assessment of each resident's actual capacity to undertake specific activities had been completed and personalised social and recreational plans were in place for residents. There were staff employed to facilitate an activities programme and there was evidence that residents were provided with a variety of group and/or one-to-one activities many of which were dementia specific to meet the particular needs of residents. The inspector observed that provision of meaningful activities was central to daily life in the centre and both

residents and relatives confirmed that there was always something available to do throughout the day and there was a lot of enjoyment from the activities programme. The inspector observed interactive card games, arts and crafts, exercise group, outdoor activities and music ongoing during the inspection.

Advocacy services were available for residents and a photo and contact details of the advocate was on the notice boards. Residents were consulted with and participated in the organisation of the centre as they were offered opportunities to attend a quarterly residents' meeting that was facilitated by the activity coordinator and person in charge. Items discussed included laundry, housekeeping, meals, activities and staff. Improvements were seen in the residents meetings since the last inspection with the pharmacist and chef having attended the residents meetings and the feedback from this was very positive and residents felt empowered to identify issues.

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

Findings:
The inspector found that staff delivered care in a respectful, timely and safe manner. The centre was person orientated and not task focused as all staff provided care to the residents. Residents and relatives spoke very positively of staff and indicated that staff were caring, responsive to their needs and treated them with respect and dignity. This was seen by the inspector throughout the inspection in the dignified and caring manner in which staff interacted and responded to the residents.

Systems of communication were in place to support staff with providing safe and appropriate care. There were handover meetings each day to ensure good communication and continuity of care from one shift to the next. The inspector saw records of staff and management meetings at which operational and staffing issues were discussed. The inspector saw that staff had available to them copies of the Regulations and standards. In discussions with staff, they confirmed that they were

supported to carry out their work by the person in charge. The inspector found staff to be well informed and knowledgeable regarding their roles, responsibilities and the residents' needs and life histories and particularly knowledgeable about dementia care. There was evidence that residents knew staff well and engaged easily with them in personal conversations.

Staff had embraced a non-uniform policy during 2016. The person in charge informed the inspector this had normalised care and helped prevent any possible power imbalance between residents and staff. Residents confirmed that they liked to see staff not wearing uniform and many staff wore colourful tunics which were a source of conversation and admiration. However some relatives and residents said they would like to see staff wearing name badges so they could identify staff by name and also to know who the nurses were.

Mandatory training was in place and staff had received up to date training in fire safety and safe moving and handling, safeguarding vulnerable persons and the management of responsive behaviours and a lot of this training had taken place since the last inspection. Dementia specific training had been provided to a large number of staff and one of the staff nurses was currently attending a train the trainer course in the UK on dementia specific care and "Butterfly Moments" and plans to roll out training to all staff and implement further dementia specific person centred care to all. This initiative was funded and promoted by the provider and management team. Other on-going training included infection control, end of life, continence promotion, food and nutrition, hydration and the management of dysphagia. Nursing staff confirmed they had also attended clinical training including medication management and wound care. The inspector saw that other formal training courses had been booked and were scheduled for the coming months with a comprehensive training schedule in place.

The inspector found there was an appropriate number and skill mix of staff on duty to meet the holistic and assessed needs of the residents on the days of inspection but requested that this was kept under review with the changing dependencies of residents. The inspector was satisfied that there was a comprehensive induction programme for all new and pre-registration nursing staff.

An actual and planned roster was maintained in the centre with any changes clearly indicated. There were robust recruitment procedures in place. Staff files reviewed were found to contain all the required documentation as required by the Regulations. Garda Síochána vetting was in place for all staff. Nursing registration numbers were available for all staff nurses. Details of induction/orientation received, training certificates and appraisals were noted on staff files.

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:

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Health Information and Quality Authority

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Action Plan

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Provider's response to inspection report[1]

Centre name:	Bushmount Nursing Home
Centre ID:	OSV-0000292
Date of inspection:	20/04/2017
Date of response:	12/05/2017

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 not an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.

1. Action Required:
Under Regulation 23(d) you are required to: Ensure there is an annual review of the

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

quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.

Please state the actions you have taken or are planning to take:
We have begun to create an annual review of the quality and safety delivered to our residents. This is an analysis of the past year and will forecast our plans for the year ahead.

Proposed Timescale: 30/06/2017

Outcome 03: Information for residents

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A sample of residents' contracts of care were viewed by the inspector and there were a number of older contracts seen where there was no evidence of the costs for extra services to be provided and these contracts generally had out of date fees included.

2. Action Required:
Under Regulation 24(2)(d) you are required to: Ensure the agreement referred to in regulation 24 (1) includes details of any other service which the resident may choose to avail of but which is not included in the Nursing Homes Support Scheme or which the resident is not entitled to under any other health entitlement.

Please state the actions you have taken or are planning to take:
An addendum will be attached to the older contracts to state the change in fees and to state the additional services available at Bushmount where charges are incurred

Proposed Timescale: 30/06/2017

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:
Some of the policies including the safeguarding policy required updating to reference more updated legislation and best practice guidelines

3. Action Required:
Under Regulation 04(3) you are required to: Review the policies and procedures referred to in regulation 4(1) as often as the Chief Inspector may require but in any

event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.

Please state the actions you have taken or are planning to take:
All our policies will be reviewed and where appropriate re written in order to ensure they are in accordance with best practice and up to date legislation

Proposed Timescale: 31/10/2017

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:
There was a centre-specific emergency plan that took into account major emergency situations and detailed where residents could be relocated to in the event of being unable to return to the centre. However it did not outline what to do when there was serious disruption to essential services like loss of water, kitchen or laundry facilities.

4. Action Required:
Under Regulation 26(2) you are required to: Ensure that there is a plan in place for responding to major incidents likely to cause death or injury, serious disruption to essential services or damage to property.

Please state the actions you have taken or are planning to take:
The emergency plan will be updated to incorporate all eventualities.

Proposed Timescale: 31/05/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risk management policy set out in Schedule 5 did not include the measures and actions in place to control abuse.

5. Action Required:
Under Regulation 26(1)(c)(i) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control abuse.

Please state the actions you have taken or are planning to take:
The risk management policy will be updated to include the measures and actions in place to control abuse

Proposed Timescale: 31/05/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The inspector required a further review of the smoking area to ensure the safety of all residents using same.

6. 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:
A call bell to be installed at the smoking area as well as a fire blanket, extinguisher and sides to be fitted to the smoking shelter.

Proposed Timescale: 31/05/2017

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 no evidence that the care plans were discussed with residents and relatives and made available to them as required by the regulations.

7. 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:
Our ongoing plan includes the incorporation and inclusion of residents and their family/friends/representative in the care planning and assessment process.

Proposed Timescale: 31/10/2017

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:
Floor covering in corridor areas required repair and carpets were seen to be torn and stained on the stairways. The inspector noted that any areas that posed a potential trip hazard had been taped to secure the surface but this tape only provided a temporary solution and a more permanent solution was required.

8. 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:
Discussions are on-going with the relevant people to advise the most appropriate coverings for both the stairs and corridors.

Proposed Timescale: 31/10/2017

Outcome 13: Complaints procedures

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The complaints policy did not identify who is the nominated person available in the centre to ensure that all complaints are appropriately responded to and that the complaints officer maintains the records as required by legislation.

9. Action Required:
Under Regulation 34(3) you are required to: Nominate a person, other than the person nominated in Regulation 34 (1)(c), to be available in a designated centre to ensure that all complaints are appropriately responded to and that the person nominated under Regulation 34 (1)(c) maintains the records specified under in Regulation 34 (1)(f).

Please state the actions you have taken or are planning to take:
A complaints officer has been nominated and policy rewritten to reflect same

Proposed Timescale: 12/05/2017