## Health Information and Quality Authority Regulation Directorate

### Compliance Monitoring Inspection report

**Designated Centres under Health Act 2007, as amended**

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Breffni Care Centre for Older Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000489</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Ballyconnell, Cavan.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>049 952 6782</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:Loida.Aragon@hse.ie">Loida.Aragon@hse.ie</a></td>
</tr>
<tr>
<td>Type of centre:</td>
<td>The Health Service Executive</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>Health Service Executive</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Siobhan Kennedy</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>None</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Unannounced Dementia Care Thematic Inspections</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>18</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>0</td>
</tr>
</tbody>
</table>
About Dementia Care Thematic Inspections

The purpose of regulation in relation to residential care of dependent Older Persons is to safeguard and ensure that the health, wellbeing and quality of life of residents is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer and more fulfilling lives. This provides assurances to the public, relatives and residents that a service meets the requirements of quality standards which are underpinned by regulations.

Thematic inspections were developed to drive quality improvement and focus on a specific aspect of care. The dementia care thematic inspection focuses on the quality of life of people with dementia and monitors the level of compliance with the regulations and standards in relation to residents with dementia. The aim of these inspections is to understand the lived experiences of people with dementia in designated centres and to promote best practice in relation to residents receiving meaningful, individualised, person centred care.

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).
This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor compliance with specific outcomes as part of a thematic inspection. This monitoring inspection was un-announced and took place over 2 day(s).

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

From: 28 August 2018 10:30  
To: 28 August 2018 17:00  
29 August 2018 09:00  
29 August 2018 16:30

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

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Provider’s self assessment</th>
<th>Our Judgment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome 01: Health and Social Care Needs</td>
<td>Compliance demonstrated</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 02: Safeguarding and Safety</td>
<td>Substantially Compliant</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 03: Residents' Rights, Dignity and Consultation</td>
<td>Compliance demonstrated</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 04: Complaints procedures</td>
<td>Compliance demonstrated</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 05: Suitable Staffing</td>
<td>Substantially Compliant</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 06: Safe and Suitable Premises</td>
<td>Non Compliant - Moderate</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 07: Health and Safety and Risk Management</td>
<td></td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 08: Governance and Management</td>
<td></td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 09: Statement of Purpose</td>
<td></td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 12: Notification of Incidents</td>
<td></td>
<td>Compliant</td>
</tr>
</tbody>
</table>

**Summary of findings from this inspection**

This inspection was carried out to monitor the care and welfare of residents with dementia. The centre did not have a special dementia care unit but 6 residents had some form of dementia.

The inspector followed up on the actions from the previous inspection on the 23 August 2017 and found they had been satisfactorily actioned. These matters related
to the deputising arrangements in respect of the person in charge being absent, safeguarding procedures, health and safety, notification of incidents, involvement of residents in the operational arrangements of the centre and training of staff in dementia/responsive behaviours.

The methodology for this inspection included gathering the views of residents relatives and staff and assessing how residents with dementia experience life and care in the centre. A validated tool, the quality of interactions schedule (QUIS) was used to observe and analyse care practices and interactions between staff and residents. Documentation such as care plans, medical records and staff files were reviewed.

A self-assessment form and questionnaire completed by the provider in preparation for this inspection was also reviewed. This identified performance against regulations and standards and highlighted ways to improve the service. The self-assessment and inspection findings are stated in the table above.

Improvements identified by the provider included:
• Completion by the person in charge of the safeguarding designated officer training.
• Staff vigilance to protect the safety and well-being of residents and to fully understand the designated centre’s policies and procedures.
• Ensuring that all staff are fully trained to understand what constitutes abuse.
• Risks identified to be managed through a continuous assessment process.
• Care to be delivered in a person centred way to promote the individuality of each resident.
• Treat and investigate allegations of abuse seriously.
• Internal monitoring through audits to continually improve the service.
• More training required for staff.
These matters had been addressed or were in progress with the exception of the physical environment which was not conducive to a lifestyle as close as possible to that experienced by persons being at home.

Since the previous inspection persons participating in management had changed. The deputy person who will manage in the absence of the person in charge was interviewed on 13 March 2018 by the inspector and this was satisfactory.

Governance and management of the centre was effective and the staff team were led by a manager who had good clinical and operational management knowledge.

The health care needs of residents were met and there was evidence to judge that end of life care was of a good standard. Residents were supported to live as independent a life as possible. Allied health professionals provided a service to meet residents’ needs. Medication management was satisfactory and the nutritional needs of residents were met.

Residents were consulted with and participate in the organisation of the centre. Residents’ privacy and dignity was respected, including receiving visitors in private. Residents were enabled to exercise choice and control over their lives, and to
maximise their independence. Residents who participated in group activities were happy to be involved and expressed satisfaction, however, residents who did not wish to participate in group activities had limited opportunities for fulfillment.

There were policies and procedures in place around safeguarding residents from abuse. All staff had completed training, and were knowledgeable about the action to take if they witnessed, suspected or were informed of any abuse taking place.

There were policies and practices in place around managing responsive and psychological behaviours and using methods of restraint.

Other matters in relation to the implementation of the risk management policy were noted during this inspection and the findings forms part of this inspection report.

The Action Plan at the end of this report identifies areas where improvements are required to comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centre’s for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.
Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

Outcome 01: Health and Social Care Needs

Theme:
Safe care and support

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

Findings:
The wellbeing and welfare of residents with a diagnosis of dementia was maintained to a satisfactory standard through the provision of evidence based nursing and medical care.

The inspector reviewed a sample of residents’ nursing and medical records. These records confirmed that residents were assessed prior to admission to the centre. The pre-admission assessment documentation was available in the residents’ files. On admission to the centre each resident’s needs were comprehensively assessed using a number of risk assessment tools, for example, risk associated with factors that included vulnerability to falls, dependency levels, nutritional care, risk of developing pressure area problems and moving and handling requirements.

Each resident had a care plan completed that was maintained. This identified their needs and the care and support interventions that were implemented by staff to meet their assessed needs. Care plans for four residents with dementia and the management of nutrition and wound care were examined. These provided a good overview of residents’ care and how care was delivered. There were good descriptions of the risks presented, the control measures in place and the triggers for further intervention available in the relevant areas of care records. Nursing staff described the procedures/protocols in place to manage wound care including the dressings used to aid healing and how to prevent skin deterioration by ensuring a routine of position changes was implemented and referral if necessary to allied health professionals. An examination of one of the care plans showed that the resident was in hospital at the time of the inspection due to the resident’s deteriorating condition and subsequent fall in the evening when only two staff were rostered on duty. The inspector advised management to review the circumstances leading up to the hospital admission in order to ascertain if there was a need for further learning in respect of this incident. See outcome 8 for action plan. The provider and person in charge assured the inspector that a plan of care would be put in place to meet the resident’s needs on discharge from hospital.

A general practitioner was available in the centre each morning and an out of hours
service was available. There was good access to the psychiatry of later life team. Arrangements were in place to review and update care plans on a regular basis and there was evidence of involvement by the residents or their next of kin.

Systems for monitoring the exchange and receipt of relevant information when residents were transferred to or returned from another healthcare setting were in place. Discharge letters for residents who spent time in acute hospital care and letters from consultants detailing findings following out-patient clinic appointments were available. A letter was completed by staff in the centre for residents requiring in-patient care in the acute hospital care setting.

There were assessment and care procedures in place to ensure residents' nutritional needs were met and that they did not experience dietary or hydration deficits. Residents' weights were checked on a monthly basis or more frequently if necessary. Diet and fluid intake records were used as appropriate. Reference sheets were available to all staff including catering outlining residents’ special diets including diabetic, modified and thickened consistency diets. There was evidence of the involvement of allied health professional's such as speech and language therapists and dieticians. During the meal times staff were observed to offer assistance in a respectful and dignified manner. Staff sat beside the resident they were giving assistance and were seen to patiently and gently encourage the resident throughout their meal. Independence was promoted and residents were encouraged to eat their meal at their own pace by themselves or with minimal assistance to improve and maintain their functional capacity. The quality of interactions was found to be person centred. Staff were familiar with residents' care needs and family background and efforts were continuously made to chat to residents about their family, previous interests or news items.

The inspector found that there were policies and procedures in place to ensure residents received a good standard of end-of-life care which was person centred and respected their preferences. The inspector viewed some residents’ care plans and these detailed the views and wishes of residents regarding their preferences for end-of-life care. At the time of the inspection no residents were receiving end of life care but the palliative care team were available if necessary. The staff team confirmed that relatives were welcome to stay with their relative and they encouraged them to do so and provided drinks and snacks during their stay. A single bedroom was available if any of the residents accommodated in a multi-occupied bedroom wish to avail of it. Nurses were well informed about end of life care and had participated in training to avoid unnecessary hospital admissions. The resuscitation status and medical situation that prevailed were discussed with family members and their views were considered and reflected in care and medical records. Residents’ cultural and religious needs were supported and arrangements were put in place to ensure that residents received the spiritual care they requested.

There were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents. Nursing staff were observed administering medicines to residents by explaining to them what they needed to do to take their medicine. Details of all medicines administered were recorded by nurses. The inspector saw that a medication management audit had been completed. The pharmacist visits and provides support as necessary. Prescription records included all the appropriate
information such as the resident’s name and address, any allergies, and a photo of the resident. The General Practitioner’s signature was present for all medication prescribed and for discontinued medication. The maximum dose of PRN (as required) medication to be given in a 24 hour period was outlined. Medications that required special control measures were safely managed and kept securely in keeping with professional guidelines. There was evidence of auditing the usage of antipsychotic, anti-anxiety medicines and night sedatives.
Nurses maintained a register of controlled drugs. Two nurses signed and dated the register and the stock balance was checked and signed by two nurses at shift changeovers.

Judgment:
Compliant

Outcome 02: Safeguarding and Safety

Theme:
Safe care and support

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

Findings:
The matter arising from the previous inspection related to a notifiable adult protection incident received by HIQA in June 2017 which was appropriately actioned, however, further assurances were sought in relation to safeguarding procedures for all residents and review of system to ensure learning and effective protocols were in place. A further notification was received in March 2018. These were discussed with the person in charge at the time of the incident and were further reviewed on this inspection. These matters were satisfactorily addressed in accordance with the designated centre’s policies and procedures and HSE safeguarding protocols. Staff who communicated with the inspector confirmed that they had received training on safeguarding vulnerable adults and were familiar with the reporting structures in place. There were systems in place to ensure allegations of abuse were fully investigated, and that pending such investigations measures were in place to ensure the safety of residents. Staff confirmed that there were no barriers to raising issues of concern.

There was a policy/procedure in place about behavioural and psychological signs and symptoms of dementia and restrictive practices. These were clear and gave good instructions to guide staff practice.

A review of training records indicated that staff were provided with up-to-date knowledge and skills, appropriate to their role to enable them to manage responsive behaviours. At the time of the inspection there were no residents displaying such behaviours. However, from past experience staff described potential triggers, the use of behaviour charts and interventions that could be adopted such as redirection, distraction...
and diversion and noise reduction.

The inspector saw that expert advice from the relevant professionals was sought where necessary before commencing any psychotropic medication. Staff focused on a proactive and positive approach to residents.

Residents had a section in their care plan that covered communication needs and staff were familiar with this. There was a policy on provision of information to residents. Some residents were seen to be wearing glasses and hearing aids to assist communication.

The centre had a policy on the use of restraint which was in line with "Towards a Restraint Free Environment" to ensure residents were protected from potential harm. The use of any measures that could be considered as restraints such as bed rails (13 in use) was underpinned by an assessment and was reviewed on a regular basis. There was evidence that discussion had taken place with the resident, his/her representatives and in instances where these measures were requested the staff provided information on associated hazards and offered alternative options. One resident was using a lap belt. Staff were clear these measures were a last resort and only considered when less restrictive interventions had not achieved the desired outcome to keep the resident safe.

There were systems in place to safeguard residents’ money. The centre acts as an agent for six residents and this money is held in residents’ accounts separate to the centre’s account. Policies/procedures, systems and practices were in place to manage small amounts of money on behalf of some residents. These were found to be satisfactory with regard to documenting transactions, for example, lodgements, withdrawals and balances. Signatures of two were available on the records.

Judgment:
Compliant

Outcome 03: Residents' Rights, Dignity and Consultation

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 matter arising from the previous inspection related to the provision of regular forums for residents to meet so that they could contribute to the operational management of the centre. This matter was actioned. There was evidence that residents and relatives were involved and included in decisions about the life of the centre. The most recent meeting took place on 16 August 2018. This entailed a review of the talent and entertainment evening by families and friends of the designated centre which took
place on 13 July 2018. External advocacy services were available to residents.

The inspector spent a period of time observing staff interactions with residents. A validated observational tool (the quality of interactions schedule (QUIS) was used to rate and record at five minute intervals the quality of interactions between staff and residents. The scores for the quality of interactions are +2 (positive connective care), +1 (task orientated care), 0 (neutral care), -1 (protective and controlling), -2 (institutional, controlling care).

The observations of two group activities took place in the dining/activity room and sitting room. The sessions were led by an activity staff member and care staff member. The inspector observed that the staff members knew the residents well and connected with each resident therefore scoring +2. Reminiscence, bingo, and hand massages were therapies used to improve and maintain memory function during the observation period. Regular activities included puzzles, arts and crafts and pet therapy. Newspapers and magazines were available.

The hairdresser was in the centre at the time of the inspection. The inspector was informed that residents had outings in the community this year, for example, some residents attended a local fair day. The inspector was informed that the weekly programme included evenings and weekends. Significant calendar dates and birthday parties were celebrated. The local minister was in the centre at the time of inspection and confirmed that residents were facilitated to practice their spiritual or religious beliefs.

However, there were some residents who did not have an opportunity to participate in activities in accordance with their interests and capacities. The inspector observed that some residents were spending time in their own rooms, but in the multi-occupied rooms there was only one television and where it was positioned only one resident could see the screen. The inspector observed residents requesting to lie for a period in the afternoon and return again to the day room or dining room. Staff supported residents' wishes in this regard.

The inspector found that residents were positive about their experiences of living in the centre. They described being able to exercise choice regarding the time they got up and were able to have breakfast at a time that suited them. During the day residents were able to move around the centre freely. They expressed satisfaction with the facilities, services and care provided. They conveyed that they would be able to talk to staff freely about their concerns.

There was evidence of good communication between residents and the staff team. The inspector observed that residents were well dressed and personal hygiene and grooming were attended to by care staff. Staff interacted with residents in a courteous manner and residents' privacy was respected as staff knocked on the bedroom doors prior to entering.

There were no restrictions to visiting in the centre and some residents were observed spending time with family or friends in the bedrooms or communal rooms. Relatives confirmed that they were satisfied with the provision of care to their family member.
Staff were observed to interact with residents in a warm and personal manner, using touch and eye contact appropriately.

**Judgment:**
Non Compliant - Moderate

---

### Outcome 04: Complaints procedures

**Theme:**
Person-centred care and support

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

**Findings:**
A policy/procedures was in place regarding the management of complaints and it met the requirements of the regulations. There was evidence from records and discussions with residents and relatives that complaints were managed in accordance with the policy. Issues recorded were found to be resolved locally or formally by the complaints officer as appropriate. A record of complaints was maintained. This outlined the investigation, action taken, whether the complaint was resolved or otherwise and whether the complainant was satisfied or not. Following a review of complaints an education session was delivered to staff in March 2018. Views expressed by residents and relatives confirmed that management and staff were approachable if they had a complaint or suggestions to improve the service.

**Judgment:**
Compliant

---

### Outcome 05: Suitable Staffing

**Theme:**
Workforce

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

**Findings:**
The matter arising from the previous inspection was that staff were not trained in the management of responsive behaviour. An examination of the training record showed that training was provided in November 2017 and in January and April 2018. There was a rolling training programme and the records showed that staff had participated in up to date mandatory training for example fire safety, moving and handling and safeguarding.
The staff also had access to a range of education appropriate to their roles and responsibilities, including tissue viability, record-keeping and advocacy and capacity. The assistant director of nursing completed the advanced practice in developing person centred dementia care module and was leading the team to implement the focused intervention training and support (FITS) into practice. Some staff completed the dementia champions programme. Staff confirmed that they were supported to carry out their work by the provider and the person in charge. They were confident, well informed and knowledgeable of their roles, responsibilities and the standards regarding residents with dementia living in residential care.

The inspector was informed that there are policies and procedures in relation to the recruitment process and this included maintaining the documents in respect of persons working at the designated centre. The inspector randomly examined from an electronic data documents in accordance with the requirements of Schedule 2 of the legislation. These were found to be satisfactory. Details of professional staff subject to registration were up-to-date.

The numbers and skill mix of staff were sufficient to meet the needs of residents. In general, two nurses were rostered on duty daily. There were three carers on duty from 08:00 hours to 20:00 hours and two carers from 08:00 hours to 17:00 hours. One of the carers was dedicated to providing activities. There were sufficient support staff. One staff nurse and one carer were rostered to work at night.

There was a clear organisational structure and reporting relationships in place.

The inspector saw records of regular meetings at which operational and staffing issues were discussed. Copies of the regulations and standards were available.

Staff confirmed that there were good supports available to them and there was good staff morale.

Judgment:
Compliant

Outcome 06: Safe and Suitable Premises

Theme:
Effective care and support

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

Findings:
The centre was purpose built to provide the service in 2001. It is a single story residential care facility located in a small town.
The layout of the centre consists of two main corridors with a nurse’s station at the intersection. The entrance of the building contains a reception area, offices and a visitor’s room with toilet facilities, tea/coffee making facilities and overnight accommodation for relatives of residents who are unwell. There is a courtyard in the centre, however, at the moment it is being refurbished and therefore not available for residents’ use. Communal accommodation consists of a large sitting and dining room, designated smoking room, a pantry, prayer room, laundry and kitchen facilities. Bedroom accommodation consists of four 3 bedded rooms, one twin room and four single bedrooms. Each room has a wash hand basin. There is a designated single room to provide palliative care. Screening was provided between beds in shared bedrooms. In shared bedrooms furniture was arranged to maximise privacy around each bed space. There was suitable storage space for resident’s clothing and personal possession with shelving available to display photos and personal mementos. Each resident had secure lockable storage.

Originally the three bedded rooms accommodated four residents and then a bed and bedroom furniture were removed, providing more space for residents, however, this space in each of the rooms had not been fully developed for residents’ use. Each resident had a small notice board in their private space, however, some of these did not contain any relevant information for the resident. The two main corridors were primarily decorated in the same colours and there was limited signage or use of objects to orientate residents. The paint on wall surfaces in some bedrooms and on some doors was damaged and a bedroom required redecoration. The palliative care room was clinical in decoration.

There was a call bell system in place at each resident’s bed and when in use it displayed a green light above the entrance to the bedroom indicating that a staff member was in attendance with the resident. This system requires review as the inspector noted that these lights were on when the rooms were vacant. Residents confirmed that their rooms were comfortable. There were three shower rooms, a bathroom and an accessible toilet located close to the sitting room. These were clinical in decoration.

Hallways had handrails and there was a range of specialist equipment available, including overhead hoists.

Although there were identified, storage areas a number of items were stored in residents’ private spaces, for example, tables, chairs and weighing scales. A hoist was being stored in the bathroom.

Some chairs in the sitting room were damaged and needed repair or replacement and a penetration point (open socket with wiring) had not been closed.

Staff facilities were provided. Separate toilets facilities were provided for care and kitchen staff in the interest of infection control.

**Judgment:**
Non Compliant - Moderate
Outcome 07: Health and Safety and Risk 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:
The matter arising from the previous inspection was satisfactorily actioned. New laundry containers were provided for residents.
In general, the risk management policy/procedure was implemented and there was evidence that there were systems and practices in place to identify any, assess and put measures in place to address risks. However, the following risks were identified during this inspection:

- Arrangements for the identification, recording, investigation and learning from an incident involving a resident's deteriorating condition and subsequent admission to hospital had not occurred. This references a care plan reviewed under outcome 1.
- The sluice room was unlocked and contained flammable liquids.
- Linen trolleys containing personal toiletries were left on the corridor and were blocking handrails.
- Refreshment trolleys were left on the corridor and were blocking handrails.
- The pantry containing a hot water geezer was unlocked and the door to this area was left open.
- Household equipment was left unattended on a corridor.
- Room number 40 did not have paper towels and the toilet floor wet.
- A resident's towel was left in the ensuite of a three bedded room.
- Clean laundry was stored on a corridor.
- There was no evidence that fleeces/throws brought in by relatives were fire retardant.
- An evacuation sledge hung on a wall was not easily accessible due to the positioning of furniture.
- The fire exit in the main sitting room was blocked by furniture.

Judgment:
Non Compliant - Moderate

Outcome 08: Governance and Management

Theme:
Governance, Leadership and Management

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

**Findings:**
The matter arising from the previous inspection related to the deputising arrangements in respect of the absence of the person in charge. A staff member was recruited for this position and was interviewed by the inspector and found to be knowledgeable regarding the legislation and standards pertaining to residential care.

**Judgment:**
Compliant

### Outcome 09: Statement of Purpose

**Theme:**
Governance, Leadership and Management

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

**Findings:**
The matter highlighted from the previous inspection related to the deputising arrangements in respect of the absence of the person in charge and this was satisfactorily actioned.

**Judgment:**
Compliant

### Outcome 12: Notification of Incidents

**Theme:**
Effective care and support

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

**Findings:**
In the previous inspection it was found that a statutory notification in relation to a safeguarding matter was not submitted to HIQA within the required three day time frame. This matter had been satisfactorily actioned.

**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:

Siobhan Kennedy
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
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 03: 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:
All residents were not provided with opportunities to participate in activities in accordance with their interests and capacities.

1. Action Required:
Under Regulation 09(2)(b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests and capacities.

---

The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Please state the actions you have taken or are planning to take:
Breffni Care Centre provides opportunities for residents to participate in activities in accordance with their interests and capacities. PAL (Pool Activity Level) checklist is an instrument newly introduced from the FITS (Focused Intervention Training and Support) programme. This assessment is specifically designed for use with residents who have a diagnosis of dementia, a cognitive impairment and residents with communication difficulties to assist staff in establishing resident’s different levels of ability. The outcome of the profile act as a guide to engaging the residents in meaningful activity. Activities provided are Planned, Exploratory, Sensory and Reflex. Staff to provide or encourage residents to engage in an activity depending on their abilities and interests basing on PAL assessment.

We respect the wishes and choice of each individual resident if they prefer not to participate with activities planned for the day but we continue to give them an opportunity and chance by encouraging them participate and engage more even when they're in bed. Diversional Activity Coordinator manages and delivers activities planned for the day and staff participates in the activity programme. In addition, one staff is now assigned or delegated to provide an activity to residents who are not engaging with Diversional Therapist on that day. All activities provided are documented in each resident’s note.

Televisions have been purchased and these will be installed for the multi-occupied rooms where residents could see the screen and enjoy the view.

Proposed Timescale: 04/09/2018

Outcome 06: Safe and Suitable Premises

Theme:
Effective care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The physical environment was not conducive to a lifestyle as close as possible to that experienced by persons being at home.

The space in three bedded rooms had not been fully developed for residents’ use.

The two main corridors were primarily decorated in the same colours and there was limited signage or use of objects to orientate residents.

The palliative care room was clinical in decoration.

The courtyard garden was being refurbished and therefore not available for residents’ use.
The call bell system in place required review

Some chairs in the sitting room were damaged and needed repair or replacement and a penetration point (open socket with wiring) had not been closed.

The paint on wall surfaces in some bedrooms and on some doors was damaged and a bedroom required redecoration.

Each resident had a small notice board in their private space, however, some of these did not contain any relevant information for the resident.

2. **Action Required:**
Under Regulation 17(1) you are required to: Ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.

**Please state the actions you have taken or are planning to take:**
One of our main objectives is to provide a safe therapeutic environment to where resident’s privacy and dignity are respected and health and well-being is promoted.

Prior to the unannounced HIQA inspection, residents have been involved in the planning of further developing the centre with their suggestions of decorating, painting and purchasing murals or piece of artworks to the wall to add more beauty, attraction and stimulation to all residents as discussed with recent Focus Group meetings held in the centre. Since the inspection, initial works have been started to areas and spaces needing development and improvements.

- Purchase furniture, personal items/ lighting, and paintings for each cubicle and the open spaces of these areas will be further developed for residents use.
- Small notice boards have been installed to incorporate family photos or any items meaningful to the resident. This initiative has been communicated to staff and families and a letter sent out to encourage them to bring meaningful objects and photos or any items. Memory boxes will be developed for residents with dementia.
- More appropriate Signage of Toilets/Bathrooms will be sourced to guide residents or another way of effective communication. This will be done following consultation with residents.
- Painting to be done to distinguish between two corridors and develop a pathway difference for our residents with dementia. This be done in consultation with the practice development facilitator and will be research based.
- Painting on bedrooms and doorframes is on-going.
- Bedrooms and doors needing repair has been assessed by Maintenance and a redecoration programme is now on-going.
- Palliative Care room (End of Life room) - a mural and another pieces of artworks to the wall to be installed. Furniture purchased to make more homely and lighting provided. This project will be done following consultation with residents and families.
- Call Bell system reviewed and all staff communicated about the light indicator and the reset button.
- Open Shelves have been removed in the Shower/Bathroom and Toilet.
- Equipment that is not currently in use has been removed and is now stored in a more
appropriate storage area.
- Chairs in the sitting room have been upholstered and repaired.
- Open socket has been closed by electrician safely.
- Courtyard Garden works has been completed. Residents are very happy to see the outcome.

Proposed Timescale: 24/09/2018

**Outcome 07: 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:
The following risks were identified during the inspection:
- Arrangements for the identification, recording, investigation and learning from an incident involving a resident had not occurred. When this is completed a report should be forwarded to The Health Information and Quality Authority (HIQA).
- The sluice room was unlocked and contained flammable liquids.
- Linen trolleys containing personal toiletries were left on corridor and were blocking handrails.
- Refreshment trolleys were left on the corridors blocking hand rails.
- The pantry containing a hot water geezer was unlocked and the door to this area was left open.
- Household equipment was left unattended on a corridor.

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

Please state the actions you have taken or are planning to take:
The PIC and PPIM have linked with the Practice Development Facilitator and the Clinical Nurse Specialist in Infection Control and have developed a clear and comprehensive method of identification, recording, investigation and learning from an adverse event involving a resident.

Each day a staff member is delegated as a Safety Champion.

The Person in Charge and Clinical Nurse Manager support this delegated responsibility with the goal of increasing staff awareness about safety and risks. Staff are rotated to be assigned as The Safety Champion of the day.

Brief education sessions have been provided by Practice Development Coordinator to all staff who will act as the Safety Champion.
The following have been acted accordingly:

- Flammable steel cabinet removed from inside sluice room.
• Linen Trolley no longer used in the Centre.
• Catering staff informed of refreshment trolley not to be left unsupervised blocking handrails.
• Lock installed to pantry door and staff communicated to keep same locked at all times.
• Cleaner staff informed to bring equipment safely on Cleaning trolley as they work and use same throughout centre.
• Cleaner to check paper dispensers and restock and all staff informed to inform Cleaner if paper dispensers require paper and following showers to alert housekeeping to deal with wet floor areas immediately.

All of the above will be monitored each day by the safety Champion.

**Proposed Timescale:** 30/08/2018

**Theme:**
Safe care and support

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
A resident’s towel was left in the ensuite of a three bedded room.
Clean laundry was stored on a corridor.

**4. Action Required:**
Under Regulation 27 you are required to: Ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.

**Please state the actions you have taken or are planning to take:**
Management continues to ensure that all staff should adhere with the policies and procedures about the standards for the prevention and control of healthcare associated infections published by the Authority.

The Safety Champion is responsible in highlighting all risks: Environmental and other risks associated with prevention and control of infection.

Communicated to all staff the importance of proper segregation and storage of linens, personal clothing and of clean/dirty laundry.

**Proposed Timescale:** 30/08/2018

**Theme:**
Safe care and support

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
There was no evidence that fleeces/throws brought in by relatives were fire retardant.
The fire exit in the main sitting room was blocked by furniture. An evacuation sledge was not easily accessible.

**5. 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:
Some residents have chosen to have personal bedspreads, and in order to adhere to fire regulations policy, a letter from Person in Charge has been sent to all Next of Kins to request that any purchased blankets, bedspreads or duvet covers brought in to the centre should be flame retardant and there should be evidence of this produced to the PIC/PPI Ms

Evacuation Sledge removed and repositioned for staff access to same.

Daily Fire checklist maintained to ensure no furniture blocking fire exit.

All of the above will be monitored each day by the Safety Champion

**Proposed Timescale:** 30/08/2018