**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>Arus Breffni</th>
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<tr>
<td>Centre ID:</td>
<td>OSV-0000659</td>
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<tr>
<td>Centre address:</td>
<td>Manorhamilton, Leitrim.</td>
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<tr>
<td>Telephone number:</td>
<td>071 985 5161</td>
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<td>Email address:</td>
<td><a href="mailto:geraldine.mullarkey@hse.ie">geraldine.mullarkey@hse.ie</a></td>
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<tr>
<td>Type of centre:</td>
<td>The Health Service Executive</td>
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<tr>
<td>Registered provider:</td>
<td>Health Service Executive</td>
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<tr>
<td>Provider Nominee:</td>
<td>Geraldine Mullarkey</td>
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<tr>
<td>Lead inspector:</td>
<td>Marie Matthews</td>
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<td>Support inspector(s):</td>
<td>None</td>
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<tr>
<td>Type of inspection</td>
<td>Announced Dementia Care Thematic Inspections</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>25</td>
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<td>Number of vacancies on the date of inspection:</td>
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**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).
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: 29 November 2017 10:30  
To: 29 November 2017 18:00  
From: 30 November 2017 09:30  
To: 30 November 2017 20:00

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

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Summary of findings from this inspection

This report sets out the findings of an unannounced thematic inspection. The purpose of this inspection was to determine what life was like for residents with dementia living in the centre. The inspector focused on specific outcomes relevant to dementia care and followed up on the actions from the previous inspection completed in December 2016. Some of the actions were fully addressed. The Person in Charge and a Clinical Nurse Manager were on duty and facilitated the inspection.

As part of the thematic inspection process, providers were invited to attend information seminars given by HIQA. In addition, evidence-based guidance was developed to guide the providers on best practice in dementia care and the inspection process.
The person in charge completed the provider self-assessment and scored the service against the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland. Aras Breffni Community nursing unit is registered to accommodate 25 residents. The building is owned and run by the Health Services Executive (HSE). On the day of inspection there were no vacancies.

In total eight residents were suspected to have dementia but only two had been formally diagnosed. There is no dementia care unit in the centre. The inspector found the provider and person in charge were very committed to providing a high quality service for all residents including residents with dementia. The inspector met with residents, relatives and staff members during the inspection and tracked the journey of residents with dementia within the service. They observed care practices and interactions between staff and residents who had dementia using a validated observation tool. The inspector also reviewed documentation such as care plans, medical records and staff rosters and training records.

The centre is a single storey building located in the town of Manorhamilton in County Leitrim. It is configured around a central enclosed garden. Residents admitted were from the local area and were well known by staff. There was a relaxed atmosphere in the centre and residents told the inspector that they felt safe and were well cared for. Staffing levels had been reviewed since the last inspection to ensure residents’ needs were met and there was evidence of improved supervision of communal areas and a reduction in the number of falls sustained. Residents were assessed prior to admission and comprehensive assessments were completed. There was evidence of regular review by a General Practitioner (GP) and referrals to allied support services. There was an improvement in the level of detail recorded in residents care plans however further work was required to ensure that guidance contained in each care plan was linked to the assessments and was person centred.

The inspector tracked the journey of a number of residents with dementia within the service. An observational tool (QUIS) in which social interactions between residents and care staff are coded as positive social, positive connective care, task orientated care, neutral, protective and controlling or institutional care/controlling care was used by the inspector. The results of this were very positive with the inspector observing very positive connective care. (This is discussed under the Outcome on Rights, Dignity and Consultation). There was an active residents’ forum chaired by an independent advocate and residents complaints were responded to.

Improvements were identified regarding the coordination of social care and the deployment of staff to ensure that residents social care needs were met. The staff had completed a range of training courses to allow them to meet the needs of residents however three staff were overdue training in mandatory areas. Dates were scheduled for this to take place. The provider had obtained vetting disclosures in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 for all staff. There were policies and practices in place around managing responsive and psychological behaviour, and the use of restraint in the service.
Residents were safeguarded by staff completing risk assessments and reviewing their needs in relation to any plans of care that were in place to support them to live as independent a life as possible however some staff had not completed training on the management of responsive behaviours and 3 staff were overdue training on safeguarding.

There was a programme in place to repaint the centre and all corridors, doors and skirting boards had been repainted. Residents had been involved in choosing fabric and paints for bedrooms and communal areas. There was a range of communal areas available in the centre but residents were not supported to use all of the available space. New signage had been purchased but this was not yet displayed. Further adaptations such as the use of visual cues and contrasting colours were required to give the centre a more home-like appearance.

At the feedback meeting at the end of the inspection, the findings were discussed with the Person in Charge and the Clinical Nurse Manager. The centre was substantially compliant in six out of the eight outcomes monitored. Areas of non-compliances were communicated to the management team and are discussed in the main body of the report and set out in the action plan at the end of this report in order to comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.
Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

### Outcome 01: Health and Social Care Needs

**Theme:**
Safe care and support

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

**Findings:**
This outcome sets out the inspection findings relating to healthcare, nursing assessments and care planning. The inspector focused on the experience of the eight residents identified as having some element of cognitive impairment and tracked their journey. The inspector also reviewed aspects of care such as nutrition, wound care and restrictive practices in relation to other residents. The social care of residents with dementia is covered in Outcome 3. The centre was full at the time of the inspection and there were 25 residents in receipt of long-term care. No respite services are provided in the centre. Eight residents were identified as having dementia. Two had a formal diagnosis. There was no specific dementia unit in the centre.

An admission policy was available and the inspector found that this was reflected in practice. A pre-admission assessment was completed for each resident to ensure that the service could meet their needs. The person in charge said that she reviews and assesses all prospective residents prior to making a decision regarding admission. Residents had a comprehensive nursing assessment completed on admission. Clinical observations such as blood pressure, pulse and weight and manual handling assessments were recorded as part of the admission process and were assessed on a monthly basis thereafter. Each resident’s assessment included: physical ability, psychological wellbeing, social care needs, emotional wellbeing, spiritual and communication needs.

An assessment of cognition using a validated tool also formed part of the admission, follow up and review process. The inspector saw that a care plan for dementia was developed which described the stage of the residents’ dementia and the level of recognition the resident had retained.

A care plan was developed following admission based on the residents assessed needs. The inspector reviewed a sample of four care plans and medical notes. There was evidence that residents were reviewed promptly following admission by one of two local General Practitioners (GPs) who provided care to residents in the centre. Residents had received their flu vaccination and the medical notes reviewed confirmed on-going
reviews by GPs in response to residents needs. Residents had access to psychiatry of later life services on the referral basis. Physiotherapy, Occupational Therapy, Dietetics, Speech and language therapy, Chiropody, dental and optical services were all available to residents as required and multidisciplinary notes available for each resident indicated regular input from all allied support services.

The inspector reviewed notifications of any serious accidents reported to the Authority since the last inspection. A system was in place whereby each resident was reviewed and assessed following a fall. A system known as ‘the safety pause’ was in place whereby all new and identified risks to residents were highlighted to staff twice a day. Residents were regularly assessed for risk of falls and arrangements were in place to review any accidents and incidents that occurred. There were systems in place to check on residents hourly and where a resident with dementia was identified as been at risk of absconding there were 15-minute checks in place.

Arrangements to meet each resident’s assessed needs were set out in an individual care plan. A paper-based care planning system was used to provide guidance to staff on the residents care needs. In general those reviewed reflected significant work by staff to ensure that they reflected accurately the care needs, interests and capacity of the residents. However some of those reviewed lacked clear specific details and instead included a list of criteria for staff to check against rather than individual person centred guidance.

Clinical assessments were completed on an on-going basis on continence, tissue viability, sensory deficits, nutrition and hydration, risk of falls and pain. Summary information about residents' history, daily routine, their families and significant risks were recorded in a summary document found at the front of their care notes.

The inspector examined the files of residents who were transferred to hospital from the centre and found that appropriate information about their health, medications and their specific communication needs were included with the transfer letter.

Most residents were up and about on the days of the inspection. Three residents had remained in bed. One resident was ill and the other two residents told the inspector that they were tired and had requested to stay in bed. The residents were generally from the local area and were well known to the staff and the inspector observed that the staff members on duty had a good knowledge of the residents’ needs and preferences.

The care plans reviewed had been developed with the involvement of the resident or their representatives. There was good evidence of ongoing communication with residents and their families recorded in the care notes and this was confirmed by those residents who spoke with the inspector.

Most residents were the single occupant of their bedroom on this inspection. Staff told the inspector they provided end of life care to residents with the support of and in consultation with their general practitioner (GP) and the community palliative care services, if required. The inspector spoke with the family of a resident in receipt of palliative care who were very complementary regarding the care and support provided.
and they confirmed that their loved one had been given the opportunity to discuss their end of life needs and wishes. The inspector reviewed a sample of end of life care plans. Two separate documents had recorded information about end of life care. Information was not found however in either document regarding the residents’ wishes to remain in the centre or be transferred to hospital and there was no information recorded on the family members the residents wished to have present.

There were a number of residents with a do not attempt resuscitation (DNR) status in place. This decision was reviewed by the GP periodically as required by the action plan of the last inspection. There was a quick reference system in place to allow prompt identification by staff of residents with a DNR status.

There were systems in place to ensure residents' nutritional and hydration needs were met. Residents were screened for nutritional risk on admission and reviewed on a monthly basis thereafter. Residents' weights were checked on a monthly basis or more frequently if required. Nutritional care plans were developed which included the residents' individual food preferences and the recommendations of dieticians and speech and language therapists where appropriate. Some care plans were not written in a manner which gave clear guidance to staff on the residents care needs. For example a care plan reviewed for a resident who was on a protein supplement to ensure a healed wound did not reoccur did not refer to the fact that the resident was prescribed a high protein diet. Medical records reviewed indicated that nutritional supplements recommended by the dietician were prescribed by the GP and were administered appropriately.

The majority of residents attended the dining room for both their dinner and evening meal. The menu was displayed on a white board in the dining room and residents chose each morning their meal preference from a menu prepared in the main hospital kitchen which was on site. Staff supported residents to remain as independent as possible sometimes just prompting the resident or providing assistance where required. There was sufficient staff on duty to support residents that did require help. The inspector saw that meals were attractively served and gravy was offered separately according to the residents taste. Those requiring a pureed constituency diet were offered choice and these meals were served in individual portions so they retained the appearance of a normal constituency meal.

**Judgment:**
Substantially Compliant

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**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 self assessment tool (SAT) completed by the provider for this outcome was rated non compliant and an action plan was in progress to address the areas of non compliance identified including for all staff to attend training on safeguarding and the management of responsive behaviours.

Measures were in place to protect residents from being harmed or suffering abuse however some areas for improvement were identified.

The person in charge was identified as a designated officer and has attended designated officer training.
A HSE policy was available which provided guidance for staff to help them to identify and manage any incidents of abuse that occurred. The policy contained information on the various types of abuse, assessment, reporting and investigation of incidences was available. The policies and procedures were well known by the staff who spoke with the inspector and they were aware of the signs of abuse, the reporting procedures and what to do in the event of a disclosure about actual, alleged, or suspected abuse. The training records identified that staff had opportunities to participate in training in the protection of residents from abuse but three staff were overdue this training. The inspector saw that dates were scheduled in the coming weeks to address this.

Several residents spoken with said they felt very safe and secure in the centre due to the measures taken, such as the secured entrance and support and care provided by the staff team. The design of the centre around a central courtyard meant that all parts of the centre or communal areas were within view. There was a policy on missing persons available and a resident who was identified as being at high risk of absconding was appropriately supervised and wore an alarm bracelet to alert staff if he left the centre unknown to them. A system was in place to check that the wandering device was in good working order each day, however only one missing person drill had been completed to test the procedures in place.

The inspector reviewed the arrangements for ensuring that residents' finances were safeguarded and found it was robust and protected the residents. The centre maintained small amounts of monies for day-to-day expenses for a small number of residents and the inspector saw evidence that financial records were maintained which were clear and transparent. Money was stored securely and all transactions were clearly recorded in a ledger. A running balance was maintained. All entries were signed and checked by two staff. The system was found to be sufficiently robust to protect residents and staff. The provider acted as an agent for six residents. Individual property accounts were in place for each resident and printed statements were available. Residents' accounts were audited by an external registered auditor.

A HSE policy on restraint was available and in line with the policy the centre aimed to promote a restraint free environment. Bedrails were only used by one resident. Risk assessments had been completed and records of decisions regarding the use of bedrails were available to show that the decision was made in consultation with the resident or representative, staff member and general practitioner (GP). Daily” reviews were undertaken and recorded in a restraint register. Records reviewed indicated that regular
checks of bedrails as a restraint were included in the plan of care.

The inspector saw that where possible less restrictive options were always considered and a restraint was considered as a last resort where necessary to keep the resident safe. Low entry beds, floor and bed sensory alarms and crash mats were in use. Two residents displayed responsive behaviours associated with their dementia. Staff spoken with were familiar with the interventions to respond to or prevent escalations in behaviour. Behaviour logs were maintained and the staff recorded where possible the antecedents and/or triggers of behaviours and to minimise the consequences or impact on others. The inspector saw during the inspection that staff approached residents in a sensitive and appropriate manner, and the residents responded positively to techniques used by staff. PRN or as required medication was prescribed for some residents however the inspector saw that this was not regularly administered and support and distraction techniques were used by staff to reduce the number of incidents.

The policy on responsive behaviours referred to education and training however the inspector found that all of the staff had not yet completed this training. While there were detailed notes of the proactive and reactive strategies used to prevent escalations in the residents behaviour in multidisciplinary team records, these were not always transferred into the residents care plan to provide easy reference for staff.

**Judgment:**
Substantially Compliant

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**Outcome 03: Residents' Rights, Dignity and Consultation**

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

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

**Findings:**
The inspector found that the centres’ approach to ensuring that each resident had sufficient opportunities for meaningful engagement was unstructured and residents consequently could not choose to participate in the activities of interest to them. The self-assessment tool (SAT) completed by the provider also rated this area as non-compliant and an action plan was in progress to help develop a more structured approach to the provision of meaningful social activity for residents by developing activity plans to reflect resident choices and have individual or group activities provided daily.

There was a good relationship between the staff and the residents and staff worked to ensure that each resident received care in a dignified way that respected their privacy. It was evident during the inspection that staff knew the residents well, including their backgrounds and personal history. A life story had been completed for each resident and this was included at the front of their care records for easy reference. It contained a good level of detail about the residents’ life before coming to the centre and the significant events and people who were important to the resident however, this
information did not appear to form part of a person centred social care plan for residents.

Residents had some opportunities to participate in social activities as a group however it was not evident that there was any link between the social assessments completed for residents and the activity scheduled in place.

Local musicians provided weekly entertainment and there were arts and crafts and card games organised. There was no staff member employed however to coordinate social care and staff on supervision duty were tasked with also engaging the residents in activities. The activity been provided was therefore subject to interruption when any resident required assistance. Most social activities were organised in the main sitting room where residents congregated and some residents told the inspector they had little interested in some of what was organised. Some residents also said they would welcome more social activities.

Residents spoken with confirmed that their religious and civil rights were supported. There was an oratory located in the centre which provided a quiet space for residents to pray and reflect and there were daily prayers and weekly Mass for Catholic residents. Church of Ireland residents were supported by a local minister.

There were appropriate systems in place to ensure all new residents were included on the electoral register.

A record of visitors to the designated centre was maintained and there were private areas available where residents could meet with visitors in private. Family members told the inspector that they were always made feel welcomed when they visited. Daily national newspapers and regional papers were provided.

Residents' families were encouraged to bring in pictures and ornaments belonging to the resident to personalise their bedrooms and photographs and pictures were observed in several bedrooms. Residents said they were able to exercise choice regarding the time they got up and went to bed and they were able to have breakfast at a time that suited them. Most residents opted to have all meals in the dining room.

The Inspector found that residents' privacy and dignity was respected. The staff were observed knocking on bedroom and bathroom doors and waited for permission before they entered. They were heard explaining why they were coming into their room, e.g. to give medications or to assist the resident with care.

Screens were provided in the shared bedrooms and they were observed to be in use when personal care was been provided. However some bathroom doors didn’t have a lock fitted to ensure the residents privacy.

Residents had access to an independent advocacy service and there was an established resident’s forum which met every two months. The group was chaired by a member of the local community who supported residents to raise issues and represented the views of the residents who were not in attendance. Minutes of the meetings were available and the inspector saw that they included a plan for the actions required to address the
issues raised and these were reported on at subsequent meetings. The residents' feedback was generally positive. The person in charge told the inspector about a new companionship programme which was planned where two members of the local community will spend 19 hours a week in the centre to support and engage residents and provide companionship.

As part of the inspection, the inspector spent a period of time observing staff interactions with residents with a dementia using a validated observational tool (the quality of interactions schedule, or QUIS) to rate and record at five-minute intervals the quality of interactions between staff and residents in the three communal areas. 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 took place in the main sitting room. The Inspector found most of the observation period (total observation period of 60 minutes) the quality of interaction score was positive connective care. The staff knew the residents well and connected with them on personal level. They greeted each resident by name when they came into the room and it was evident that they knew the resident’s personally and could talk about their families and local events important to them.

**Judgment:**
Substantially Compliant

### 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 copy of the HSE Complaints Policy was displayed in the foyer centre and residents said they felt comfortable making a complaint if necessary. A log of informal complaints was recorded manually and formal complaints were recorded electronically. A review of both logs indicated that complaints were clearly documented and were investigated promptly and there was evidence of communication with the complainants. It was not always evident that the person who made the complaint was satisfied with the outcome or if they were given information about the centres’ appeals procedure.

**Judgment:**
Substantially Compliant

### Outcome 05: Suitable Staffing

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

Findings:
Staff members demonstrated a clear understanding of their role and responsibilities. They knew the residents well and were knowledgeable regarding their individual needs. The residents spoken with were very complementary regarding the care provided by staff and described them as caring and attentive to their needs. They confirmed that all staff members treated them courteously and with respect and dignity. This was observed by the inspector throughout the inspection. Residents with dementia were observed to be well supported by staff in a dignified and caring manner.

There were appropriate communication systems in place to ensure that staff were kept up to date with changes to policies and procedures and any changes to the residents' needs. The inspector saw that there were regular staff meetings with all grades of staff. There were handover meetings before each work shift to ensure continuity of care. The inspector noted that the day room was supervised at all times and there was adequate staff on duty to assist residents at meal times.

A recruitment policy was in place in line with the HSE national policy. The inspector reviewed a sample of staff files which included information required by Schedule 2 of the Regulations. There was evidence that Garda vetting had been obtained for all of those working in the centre.

The inspector reviewed the planned and actual staff rosters for the current and previous week. The roster reflected the staffing levels on the day of inspection but it was not recorded in a 24-hour format and codes were used to indicate some shifts without any key to explain their meaning. The normal allocation of staff on duty in addition to the person in charge and a clinical nurse manager was one nurse who worked from 08.00 to 20.00 and five multi-task attendants in the morning. This reduced to four MTAs from 12pm until 20.00hrs. At night there was one nurse and two MTAs on duty until 23.00 and then one nurse and one MTA until 8am. As stated under outcome 3, there was no designated staff member employed to ensure that each resident could engage in some form of meaningful activity and as a result the social care provided was not focused or person centred. A staff member was assigned to the main sitting room to supervise residents and this staff member was tasked also with the provision of activities for residents but this was subject to regular interruptions as the staff member also assisted residents with toileting and other care needs. The inspector saw that the person in charge had reviewed staffing levels since the last inspection and working times had been altered to ensure that residents' needs are met. The staffing was supplemented by agency staff. The person in charge stated that regular staff was used to ensure continuity of care.

A training plan was available which included all mandatory training courses required under the regulations as well as training on clinical areas such as cardio pulmonary resuscitation, infection control, the management of responsive behaviours and the management of medication. However on review the inspector saw that 3 staff members were overdue training on fire safety and safeguarding. The person in charge confirmed that refresher training was scheduled to take place within a month of the inspection.
Evidence of this was requested to be forwarded to the Authority once completed.

**Judgment:**  
Non Compliant - Moderate

### Outcome 06: Safe and Suitable Premises

**Theme:**  
Effective care and support

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

**Findings:**  
The centre is located in the centre of the town and provided a comfortable warm, environment. Access to the centre was secured by a keypad lock in the interest of safety to residents with dementia. The design and layout of the centre was seen to be suitable for residents with dementia. For example, the centre was configured around a central courtyard garden and the continuous corridor surrounding the courtyard provided a pleasant outlook and a safe environment for residents who mobilised continuously as a result of their dementia.

The inspector observed that all of the available communal space was not well used to afford residents a choice of communal areas to relax. On the day of the inspection all of the residents were observed to sit in the main sitting room together. This impacted on their ability to choose the television programmes they wished to watch and to spend quiet time away from other residents. Two additional spacious rooms were available in the centre which were used occasionally for staff training and visitors but residents were not encouraged to use these areas as an alternative to the main sitting room.

The centres dining room was centrally located and overlooked the enclosed garden. It was bright and well laid out. Other facilities in the centre included a visitors' room, a small oratory and a newly refurbished room which was used to provide therapies for residents with dementia and a hair salon.

Bedrooms accommodation comprised of 19 single and three twin bedrooms two which had an ensuite bathroom shared. The centre had been recently painted and efforts were made to help orientate residents with dementia around the building. For example each bedroom door was painted a different colour to help aid recognition and all bathroom doors were painted the same colour. Most bedrooms had been personalised with the residents’ pictures and personal effects. Appropriate privacy curtains were provided in shared bedrooms. Lockable safes were provided for residents who wished and there was suitable personal storage in all bedrooms for residents' belongings. Clocks were provided in all bedrooms and in the main sitting room to help orientate residents’ regards time. A notice board was used in the sitting room to communicate information on activities, day of week, date and weather conditions.

There were a sufficient number of accessible bathrooms provided for use by residents.
however the inspector saw that locks were not fitted to all bathroom doors to ensure privacy. Toilets were located close to the main sitting room for the residents’ convenience. Raised toilet seats were provided in some bathrooms however these were not suitable as they were not securely fixed toilet. Handrails were provided in all bathrooms to assist residents.

Some of the signage had been removed and not replaced when corridors were repainted and in general, improved pictorial signage was required to help direct residents towards the dining room and other communal areas.

**Judgment:**
Substantially Compliant

### Outcome 08: Governance and Management

**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 with clearly identifiable lines of authority and accountability. The person in charge is an experienced qualified nurse with a good knowledge of her responsibilities under the regulations. She is employed as a clinical manager (CNM) level 2. She is supported by a CNM level 1. Appropriate deputising arrangements were in place to cover any periods of absence.

The person in charge reports to a Director of Nursing based in another centre run by the provider. There was evidence of monthly management meetings available. The person in charge and the CNM1 had worked to address the actions identified on the previous inspection. A review of each residents care plans had been completed and improvements were evident. Further work was required however to make care plans more person centred.

There was an audit schedule in place and audits had been completed of the accidents and incidents, care plans, restraint use, medication and where areas of improvement were highlighted, a quality improvement plan was developed to address the areas required and improvements were undertaken. For example, the review of accidents and incidents had resulted in increased staffing and better deployment of staff to ensure supervision of residents. This had resulted in a reduction in the number of falls sustained.

An annual report on the quality and safety of care had been completed for the previous year however information was not presented in an accessible meaningful format that could be easily shared with residents.

Management Systems were in place to continuously review the staffing levels however
these required review to ensure the deployment of staff to meet residents social care needs. As discussed under outcome 5, there was no staff member deployed to ensure that residents were facilitated to engage in meaningful activities appropriate to their interest and ability.

The management of training also required review. For example, the inspector identified that training was not provided in accordance with the regulations or with the centres training policy and consequently three staff were found not to have completed up to date mandatory training in fire safety or safeguarding. Although a training matrix was used to schedule training yearly, measures were not in place to ensure that staff who did not attend this training in mandatory areas completed this training on an alternative date.

There were good systems in place to ensure that any change to the residents care needs was clearly communicated to all staff. All staff members attended the handover between shifts and an additional safety pause system was in place to highlight any to residents who were at increased risks for example those at risk of abscondion or at risk of sustaining a fall.

Each resident had a signed contract of care in place which set out the cost of care and the services which incurred an additional cost. However, those reviewed did not clearly indicate whether the resident would occupy a single or shared bedroom

Judgment:
Substantially 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:

Marie Matthews
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Arus Breffni</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000659</td>
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<tr>
<td>Date of inspection:</td>
<td>29/11/2017</td>
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<tr>
<td>Date of response:</td>
<td>19/01/2018</td>
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</tbody>
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Requirements

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

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

Outcome 01: Health and Social Care Needs

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some care plans reviewed lacked clear specific details and instead included a list of criteria for staff to check against rather than individual person centred guidance.

1. Action Required:
Under Regulation 05(3) you are required to: Prepare a care plan, based on the assessment referred to in Regulation 5(2), for a resident no later than 48 hours after

1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
that resident’s admission to the designated centre.

**Please state the actions you have taken or are planning to take:**
The person in charge is currently reviewing all care plans to ensure compliance under Regulation 05(3). All care plans will provide clear specific details of the care needs required by the residents while also ensuring that care plans are person centred and reflect the needs and wishes of each resident.

**Proposed Timescale:** 31/03/2018

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**Outcome 02: Safeguarding and Safety**

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
All staff had not completed training on responding to responsive behaviour in line with the centres policy.

2. **Action Required:**
Under Regulation 07(1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.

**Please state the actions you have taken or are planning to take:**
To comply with Regulation 07(1) the person in charge has developed a training schedule that has been put in place to ensure that all staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.

**Proposed Timescale:** 30/04/2018

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**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There were detailed notes of the proactive and reactive strategies in place to prevent escalations in behaviour recorded in the multidisciplinary notes but these were not always transferred into the residents care plan to provide easy reference for staff.

3. **Action Required:**
Under Regulation 07(2) you are required to: Manage and respond to behaviour that is challenging or poses a risk to the resident concerned or to other persons, in so far as possible, in a manner that is not restrictive.
Please state the actions you have taken or are planning to take:
The person in charge will ensure that Regulation 07(2) is complied with by ensuring multidisciplinary notes and comments in relation to responsive behaviour are reflected in the residents care plans promoting a person centred individual approach to care.

Proposed Timescale: 28/02/2018

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:
There was not a structured approach to ensuring that each resident had sufficient opportunities for meaningful engagement and residents consequently could not chose to participate in activities of interest to them.

4. 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.

Please state the actions you have taken or are planning to take:
To comply with Regulation 09(2)(b) and ensure a more structured approach to opportunities to meaningful activities is implemented the registered provider and the person in charge have reviewed staffing allocations. A staff member has been assigned as a Social Activities Co ordinator. In addition two TUS workers have been engaged through Leitrim Development Company to co ordinate social activities based on resident’s choice and preference.

Proposed Timescale: 20/12/2017

Outcome 04: Complaints procedures

Theme:
Person-centred care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
It was not always evident that the person who made the complaint was satisfied with the outcome or if they were given information about the centres’ appeals procedure.

5. Action Required:
Under Regulation 34(1)(g) you are required to: Inform the complainant promptly of the outcome of their complaint and details of the appeals process.

Please state the actions you have taken or are planning to take:
To comply with Regulation 34(1)(g) the registered provider and the person in charge have reviewed the complaints log and have included a further column to capture the complainant’s satisfaction of the outcome. All Complainants are provided with information on the Appeals process.

**Proposed Timescale:** 21/12/2018

### Outcome 05: Suitable Staffing

**Theme:**
Workforce

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
There was no designated staff member deployed to ensure that each resident could engage in some form of meaningful activity and as a result the social care provided was not focused or person centred.

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

**Please state the actions you have taken or are planning to take:**
To comply with Regulation 15(1) and ensure a more structured approach to opportunities to meaningful activities the registered provider and the person in charge have reviewed staffing allocations. A staff member has been designated to provide greater opportunities for residents to participate in activities in accordance with their interests and capacities.

**Proposed Timescale:** 20/12/2018

**Theme:**
Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Three staff members were overdue training on fire safety and on safeguarding.

7. **Action Required:**
Under Regulation 16(1)(a) you are required to: Ensure that staff have access to appropriate training.

**Please state the actions you have taken or are planning to take:**
All staff members have completed mandatory fire safety training as per the 08/12/2017.

All Staff who have not been trained in Safeguarding Vulnerable Adults have been
allocated places on Safe Guarding training as per the training schedule and will have completed training by 24/1/2018.

**Proposed Timescale:** 24/01/2018

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### 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:**
Communal space was not well used to afford residents a choice of communal areas to relax.

Some of the signage had been removed and not replaced when corridors were repainted and in general, improved pictorial signage was required to help direct residents towards the dining room and other communal areas.

**8. 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:**
To comply with Regulation 17(1) The Registered Provider ensured the Dementia Specific Visual Signage was refitted following the painting works.
A review of all communal spaces has been carried out by the person in charge and all communal area are now available to residents to include the sitting room, the “parlour” and the new “sonas/quiet room”.

**Proposed Timescale:** 20/12/2017

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**Theme:**
Effective care and support

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
Some toilets had raised toilet seats provided to support residents which were not securely fixed to the toilet.

**9. 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:**
To Comply with Regulation 17(2) An Occupational Therapy Assessment and a Risk Assessment was carried out to determine the appropriate safe use of the raised toilet seat. The assessments outcome recommended the safest and most suitable raised toilet seat to be the T87 which is a product that is adjustable and fits over the toilet and is supported by four legs. The product also contains a toilet seat within the raised area. T87 has been ordered and awaits delivery to unit.

**Proposed Timescale:** 31/01/2018

### Outcome 08: Governance and Management

**Theme:**
Governance, Leadership and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Management Systems required review to ensure that appropriate staff were deployed to the provision of activities and that all mandatory training was attended by all staff.

10. **Action Required:**
Under Regulation 23(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

Please state the actions you have taken or are planning to take:
To ensure Regulation 23(c) is complied with the Registered Provider will put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored. A staff review has been carried out and a staff member redeployed to co ordinate social activities. A training needs analysis has been carried out by the Person In Charge and a training log developed to clearly identify training received and outstanding training.

**Proposed Timescale:** 31/12/2017

**Theme:**
Governance, Leadership and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
An annual report on the quality and safety of care had been completed for the previous year however it did not provide information in an accessible format that could be easily shared with residents.

11. **Action Required:**
Under Regulation 23(e) you are required to: Prepare the review referred to in regulation 23(1)(d) in consultation with residents and their families.
Please state the actions you have taken or are planning to take:
To comply with Regulation 23(e) the Registered Provider will make the annual report available to residents in an accessible A3 Age Friendly Georgia 14 font.

**Proposed Timescale:** 31/01/2018

**Theme:**
Governance, Leadership and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The contracts of care reviewed did not specify clearly whether the resident would occupy a single or shared bedroom.

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

Please state the actions you have taken or are planning to take:
To comply with Regulation 24(1) the Registered Provider and Person in Charge have reviewed all contracts of care and these will be amended to clearly outline if the residents is being cared for in a single or double occupancy room.

**Proposed Timescale:** 31/01/2018