



**Health
Information
and Quality
Authority**

An tÚdarás Um Fhaisnéis
agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	Ballinasloe Community Nursing Unit
Name of provider:	Health Service Executive
Address of centre:	Creagh Road, Ballinasloe, Galway
Type of inspection:	Unannounced
Date of inspection:	09 March 2021
Centre ID:	OSV-0005270
Fieldwork ID:	MON-0032221

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

Ballinasloe community nursing unit (CNU) is a purpose-built designated centre. The centre is situated on the grounds of the St. Brigit's Campus, Creagh in Ballinasloe. The centre consists of fifty beds, located between two care areas called the Clontuskert and Clonfert suites. The centre has four twin rooms and forty two single rooms. the overall objectives of Ballinasloe CNU is to provide a person-centred approach to care, empowering and supporting residents to be as independent as possible and to live meaningful and fulfilling lives.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	34
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This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 9 March 2021	11:30hrs to 17:30hrs	Catherine Sweeney	Lead

What residents told us and what inspectors observed

The inspector spoke with a number of small groups of residents in the communal areas of the centre throughout the day of inspection. The overall feedback from the residents was overwhelmingly positive. Residents told the inspector that they felt happy to be living in the centre.

The inspection took place during the COVID-19 pandemic. Residents spoken with told the inspector that they were fed up with the restrictions and looked forward to the day when their families could come in to see them. A number of residents told the inspector that they had been facilitated with window visits and compassionate visits when they were needed. The residents were very grateful that this had been facilitated by staff. They explained how staff went 'out of their way to make sure they had contact' with their families.

Resident spoke of the kindness of staff. One resident stated that 'each of the staff is nicer than the other'. One resident told the inspector that she missed her home, but that the staff in the centre made them feel like they were in 'a second home'.

Residents told the inspector that they felt 'very safe and well looked after'. Resident explained that they rarely had anything to complain about, but if they did, they would be comfortable talking to any of the staff.

There was a relaxed and comfortable atmosphere in each communal area observed by the inspector. Residents were observed to be at ease in the company of staff. Staff spoke to resident in a respectful and kind manner. Staff were observed to chat and laugh with residents about local events and people who they might have known. The inspector observed residents having their hair and nails done by the care staff. They explained to the inspector that it was nice to feel 'a little glamorous'. Supervision of residents in the communal areas was discrete and respectful.

The inspector observed the lunch time meal being served on the day of inspection. The meals appeared to be appetising and nutritious. Some residents had their meals in the dining room, while others preferred to dine in their bedrooms. The residents confirmed to the inspector that they were offered choice in where they had their meals.

Overall, the centre was in a good state of repair. The day rooms were comfortably furnished. Residents bedrooms were seen to be personalised in line with the residents wishes. Bedrooms were observed to be decorated with family photographs and personal items.

Residents had access to an activities room where structured therapy sessions and scheduled activities took place. There was also a physiotherapy and occupational therapy room available for resident assessment and treatments.

Residents had access to television, radio and newspapers. A computer was available for resident use. Residents could also use the computer to contact their families through video calling.

Residents were facilitated to complete surveys in relation to their care and living environment. A review of these surveys found the feedback from residents was generally positive.

Capacity and capability

This was a risk inspection conducted by an inspector of social services to follow up on the actions of a previous inspection in February 2019. All actions from the last inspection had been completed.

This inspection also followed up on unsolicited information received by the Chief Inspector since the last inspection in relation to the visiting arrangements during the national restrictions in place during the COVID-19 pandemic. The information was found to unsubstantiated.

Overall, the inspector found that the person in charge, an assistant director of nursing, supported by a director of nursing, demonstrated positive clinical leadership. They were a strong presence in the centre. The director of nursing and the person in charge were in attendance on the day of inspection. The person in charge facilitated the inspection and all information requested by the inspector was made available to review in a timely and efficient manner.

The provider of this centre is the Health Service Executive (HSE). The organisation structure within the centre is clear, with roles and responsibilities understood by the management team, residents and staff. The person in charge, an assistant director of nursing, is supported by a director of nursing who is shared between 12 HSE designated centres.

Due to a historical arrangement with the HSE, the designated centre accommodated the offices of the community mental health services. The building was previously used by the mental health services. The maintenance and kitchen staff previously employed by the mental health service have retained their employment contracts and continue to work on-site in the centre but they are not employed by the designated centre. The person in charge confirmed that they are not involved in the management of these staff. They further confirmed that the staff do not have contact with the residents. As there is no arrangement in place to provide assurance in relation to the Garda (police) vetting and the training and supervision arrangement for these staff, this arrangement could pose a potential risk to residents in relation to the management of safe recruitment, training and supervision of all staff working within the centre.

There were adequate resources to meet the assessed needs of the residents.

Staffing levels were adequate as a result of occupancy being reduced to 34. The statement of purpose had been updated to reflect this change of occupancy.

The centre is registered for 50 beds. However, the occupancy of the centre on the day of inspection was 34. An assessment to determine the dependency of each resident had been completed. On the day of inspection, 14 residents were assessed as requiring maximum levels of care, eight high, eight medium, and four residents were assessed as having low dependency needs or independent. Admissions to the centre had been ceased due to a drop in the number of available staff nurses. A number of nurses were on long term leave on the day of inspection leaving significant gaps in the nursing roster. The availability of agency nurses had been reduced due to the COVID-19 pandemic. For this reason, the provider had made the decision to reduce the occupancy of the centre from 50 to 34 until the availability of nurses had improved. The changes in the occupancy and the number of nurses available was reflected in the statement of purpose of the centre.

The support staff in the centre consisted of multi-task attendants (MTA). MTAs were rostered as care assistants, activity coordinator, or kitchen assistants. The roster review clearly identified the role of the MTA on particular days. The centre had eight agency multi-task assistants who have worked exclusively in the centre over the past 18 months. Cleaning staff were contracted from a cleaning agency. All agency staff are included in the centres' training schedule and supervision arrangements.

A review of the training records for staff found that staff had received training appropriate to the health and social care needs of the residents. All staff had received safeguarding, infection control, fire safety and manual handling training. Some gaps were identified in the training on the management of responsive behaviours. The person in charge had recognised this gap in training and had a plan in place to address the issue.

Regular management and staff meetings were scheduled. Issues such as staffing, risk management and infection control issues were discussed and documented. A daily safety pause meeting was held on each wing to communicate any on-going risks or care issues.

A review of the documentation of management systems such as audits, complaints, and incident reports was required to ensure that learning could be identified and a quality improvement plan developed.

Regulation 15: Staffing

A review of the rosters found that staffing levels were adequate to meet both the number of residents accommodated in the centre and the assessed needs of the residents on the day of inspection.

Staffing levels require review prior to further admissions to the centre. This is

reflected in the statement of purpose in the centre.

A review of staff files found that they contained all the requirements under Schedule 2 of the regulations and each member of staff employed by the centre had a Garda (police) vetting record on file.

Judgment: Compliant

Regulation 16: Training and staff development

There were some gaps found in the training records in relation to the management of responsive behaviours. Training in dementia care and responsive behaviours had been sourced and was scheduled.

Judgment: Substantially compliant

Regulation 23: Governance and management

The centre had systems of management in place to ensure the service provided was safe, consistent and effectively monitored. However, a review of the schedule of audit and incident documentation was required to ensure that areas in need of quality improvement were identified. For example,

- audits had been completed on areas such as infection control, care plans and medication, were found to be mostly compliant and no areas of improvement had been identified. Other care areas, such as falls management, had not been audited although there had been a number of falls recorded in the centre.
- there was a system in place to document incidents and accidents. While all incidents were documented, the quality of the documentation was inconsistent. The system in use did not allow for a detailed report of the incident to be documented nor did it include an area for information investigation and analysis, or for learning to be identified.
- Incidents relating to residents and staff members were filed together. This made it difficult to review resident incidents and to identify trends and possible quality improvement measures.

The centre building accommodated personnel from different departments in the HSE. An overall review of the personnel working within the designated centre was required to provide assurance that issues relating to staff training and safeguarding was managed within the requirements of the regulations. .

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The centre had a complaints policy that was in line with the requirements under regulation 34. The complaints procedure was displayed in a prominent and accessible area of the centre. A review of the complaints log found that complaints were documented and investigated in line with the centres policy. However, the quality of the detail documented was inconsistent. For example, it was not always clear if the complainant had been informed and was satisfied with the outcome of the investigation. A review of the documentation system in relation to complaints was required to ensure that complaints were consistently documented to a high standard.

Judgment: Substantially compliant

Quality and safety

Overall, the health and social care of residents was observed to be met to a high standard. Resident told the inspector that they were very well cared for.

There was an electronic nursing documentation system in place. A review of this system found that all residents had a comprehensive assessment completed and that a care plan was developed to reflect the assessed physical needs of the residents. Some improvement was required to the documentation of care plans to ensure they reflected the high quality of care received by residents.

This inspection took place during the COVID-19 pandemic. The centre had a comprehensive COVID-19 contingency plan in place. All staff had received up-to-date training in infection control, including, breaking the cycle of infection, hand hygiene and the safe use of personal protective equipment (PPE). Staff were seen to use PPE effectively. There were systems in place to screen the temperature and symptoms of all staff and visitors to the centre. The centre had remained free from COVID-19 since the start of the pandemic.

A review of the risk register found that appropriate risk assessments had been completed, hazards had been identified and action had been taken to control the identified risks. The safety statement in the centre had been recently reviewed. Identified risks were discussed at management and staff meetings with actions communicated and delegated to staff.

Residents had unrestricted access to their doctors. They were also supported by a team of allied health care professionals including dietitians, physiotherapists,

occupational therapists, speech and language, psychiatry of later life and palliative care. Recommendations made by allied health care professionals were found to be incorporated into the residents care plan.

There was an activity schedule in place that was appropriate and respectful to the needs of the residents. Residents told the inspector that there was plenty to do to fill their days. A daily on-line religious service and prayer time was included in the activity schedule and was observed to be popular with residents. A member of the multi-task attendant team was allocated to activities daily. Staff members with a special interest in activity therapy received training appropriate to their role.

information relating to how to access to advocacy services was displayed prominently on the communal areas of each unit in the centre.

Residents had access to telephone and video calls during the period of visiting restrictions in the centre. Window visits and visits on compassionate grounds were facilitated in line with the Health Protection Surveillance Centre (HPSC) visiting guidelines.

Regulation 26: Risk management

The risk management policy and register for the centre was reviewed and found to contain all the detail required under regulation 26, risk management.

Judgment: Compliant

Regulation 27: Infection control

The centre was visibly clean on the day of inspection. A team of contract cleaners were employed to clean the centre. The team were allocated specifically to the centre to ensure continuity of service. The cleaning staff spoken with demonstrated a robust knowledge of the cleaning systems in the centre, the covid contingency plan for the centre including the isolation arrangements for suspected and positive COVID-19 cases.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

While care plans were detailed and did reflect the physical needs of the resident in a person-centred way, a review of the quality of care plans was required to ensure

that the care plan detail was reflective of residents physical, psychological and social needs. Some residents had numerous care plans some of which had not been kept up-to-date. A review of the detail and quality of care plans was required to ensure that they reflected the high quality of care both observed by the inspector on the day of inspection, and documented in the residents daily progress notes, which were maintained to a high standard and facilitated effective communication.

Judgment: Substantially compliant

Regulation 6: Health care

Residents in the centre had access to a general practitioner (GP) of their choice. Residents told the inspector that they were very content with their access to their doctor. A doctor attends the centre daily. Resident access to their GP and other allied health care professionals had remained unrestricted throughout the pandemic.

Judgment: Compliant

Regulation 9: Residents' rights

Residents told the inspector that their rights were respected in the centre. Staff were observed to speak with residents in a kind and respectful manner and to ask for consent prior to any care interventions. Residents told the inspector that they were offered choice in how and where they spent their day. An appropriate activity schedule was in place to meet the social needs of residents. This schedule included both group and individual opportunities for social engagement.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Ballinasloe Community Nursing Unit OSV-0005270

Inspection ID: MON-0032221

Date of inspection: 09/03/2021

Introduction and instruction

This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant 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 document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non-compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant** - A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.
- **Not compliant** - A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 16: Training and staff development	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 16: Training and staff development:</p> <p>In House dementia Training for all staff has been facilitated by the Person in charge who is a train the trainer.</p> <p>To overcome the challenges of face to face training as a result of Covid, online induction to behaviors that challenge has commenced (completion date 30/04/2021)</p> <p>A train the trainer programme for behaviors that challenge is also to commence. (Expected date of commencement August 2021)</p>	
Regulation 23: Governance and management	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 23: Governance and management:</p> <p>A review of the Audit Programme has been carried out with compliant areas to be rescheduled to an annual basis. New areas of audit have been identified and included in the Audit Scheme.</p> <p>Falls Analysis / Audit has been carried out.</p> <p>Multidisciplinary team meetings have recommenced.</p> <p>All staff have completed online Falls assessment training</p>	

Additional in house Falls prevention Training, with Occupational Therapist, Physiotherapist and The Frailty trainer to commence. (Completion date 31/07/2021).

Residents and staff incident forms have been relocated to separate folders.

The electronic care plan system used in the CNU has facilitated access to the online training hub. Staff are now using the online incident reporting document in conjunction with the NIMS form for more concise incident documentation.

There is controlled access to the 2 resident Ward areas within the CNU, with a sign in register at each ward reception desk.

All therapists providing services are within the governance of the cnu and receive all mandatory training and are garda vetted.

All residents attending services outside the ward are accompanied at all times.

There is a sign in register at the main reception for personnel from different departments working within the center.

Catering Staff have received all Mandatory training.

The Risk register has been updated to include other services within the HSE utilizing the building.

Regulation 34: Complaints procedure

Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:

The local complaints document has been adapted to capture where the complainant has been informed of actions taken to address a complaint as well as an area to identify satisfaction with the outcome of the investigation. This document is now in use.

All Staff have read, understood and signed the complaints policy document

An audit of the complaints compliance will be carried out in 2 months.

Regulation 5: Individual assessment and care plan	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan: All care plans have been updated to include individual Activities and social interests of residents.</p> <p>The activities coordinator is currently completing the key to me with all residents and their Families.</p> <p>Maintenance of Care Plans will be an Agenda item for the next staff meeting.</p> <p>Auditing of Care Plans will be included in the Schedule of Audits.</p>	

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	30/06/2021
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Substantially Compliant	Yellow	01/04/2021
Regulation 34(1)(f)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall ensure that the nominated person maintains a record of all complaints	Substantially Compliant	Yellow	12/06/2021

	including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.			
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Substantially Compliant	Yellow	30/04/2021