Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	Bishopscourt Residential Care
Centre ID:	OSV-0000200
Centre address:	Liskillea, Waterfall, Cork.
Telephone number:	021 488 5833
Email address:	info@bishopscourt.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Bishopscourt Residential Care Limited
Provider Nominee:	Paul Vassallo
Lead inspector:	John Greaney
Support inspector(s):	Caroline Connelly
Type of inspection	Unannounced Dementia Care Thematic Inspections
Number of residents on the date of inspection:	60
Number of vacancies on the date of inspection:	0

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.

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 Quality 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 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:	To:
28 June 2016 09:00	28 June 2016 18:15
29 June 2016 08:30	29 June 2016 17:30

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

Outcome	Provider's self assessment	Our Judgment
Outcome 01: Health and Social Care Needs	Substantially Compliant	Non Compliant - Major
Outcome 02: Safeguarding and Safety	Substantially Compliant	Non Compliant - Major
Outcome 03: Residents' Rights, Dignity and Consultation	Substantially Compliant	Compliant
Outcome 04: Complaints procedures	Substantially Compliant	Compliant
Outcome 05: Suitable Staffing	Substantially Compliant	Non Compliant - Moderate
Outcome 06: Safe and Suitable Premises	Substantially Compliant	Substantially Compliant
Outcome 07: Health and Safety and Risk Management		Non Compliant - Moderate
Outcome 12: Notification of Incidents		Non Compliant - Moderate

Summary of findings from this inspection

Bishopscourt Residential Care is a purpose-built single storey residential centre with accommodation for 60 residents. The centre is situated on large, well maintained grounds with ample parking facilities.

The purpose of this inspection was to focus on the care and quality of life for residents with dementia living in the centre. This inspection report sets out the findings of a thematic inspection which focused on six specific outcomes relevant to dementia care. During the inspection, some required improvements were identified in

two additional outcomes and they are included in this inspection report.

Forty six of the sixty residents who were living in the centre on the days of the inspection had a formal diagnosis of dementia and another two residents were suspected of having dementia. The provider had submitted a completed self assessment on dementia care to HIQA with relevant policies and procedures prior to the inspection. The judgments from the self assessment and inspection findings are set out in the table above.

Overall, residents' healthcare and nursing needs were met to a good standard. Residents had access to medical, allied health and psychiatry of later life services. The management of complaints was fully compliant with regulations. Most residents had their meals in the dining room and dining tables were nicely set out with table cloths and cutlery. While the dining rooms were quite crowded at mealtimes, it provided for a social occasion.

As part of the inspection, inspectors spent a period of time observing staff interactions with residents. Inspectors used 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 two communal areas. Overall, inspectors observed staff interacting with residents in a positive and caring manner. There was a wide variety of activities available to residents. Activities were scheduled seven days a week and there was usually an activity scheduled for 7pm each evening.

Some improvements, however, were required, particularly in relation to safeguarding practices. For example, suspicions or allegations of abuse were not always reported to HIQA in a timely manner. In addition, adequate supervision arrangements had not been put in place to safeguard other residents from the risk of abuse at the earliest possible opportunity. Significant improvements were also required in relation to medication management. Similar to the finding of the last inspection, there were discrepancies between the medication administration record (MAR) sheet and the doctors' prescriptions and therefore it was not clear if the correct dosage was being administered. Improvements were also required in relation to the assessment and care plan process. For example, residents were not always reassessed at suitable intervals and care plans were not always developed for issues identified on assessment.

Additional required improvements included:
• some areas of the centre were in need of redecoration and painting
• there was minimal use of contrasting colours and visual cues to support navigation of the centre
• fire safety signage and evacuations plans lacked adequate detail
• staff training
• inadequate assessment for specialty chairs
• personnel records did not always contain required information

The action plan at the end of this report identifies where improvements are needed to meet the requirements of 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 Quality 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):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
This outcome sets out the inspection findings relating to healthcare, nursing assessments and care planning. The social care of residents with dementia is comprehensively covered in Outcome 3.

Inspectors focused on the experience of residents with dementia and they tracked the journey of a number of residents with dementia.

A pre-admission assessment was carried out on all residents prior to admission to the centre to determine if their needs could be met. There were adequate systems in place to optimise communication between the resident/families, the acute hospital and the centre.

Residents' records were mostly electronic, however, some records such as those of medical/allied health/specialist services were paper based. Residents' files held a copy of their hospital discharge letter and some of the files of residents admitted under 'Fair Deal' also held the Common Summary Assessment Report (CSAR), which detailed a comprehensive nursing assessment and, where relevant, assessments by other healthcare professionals. Inspectors examined a sample of records 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. There was also adequate information shared by the hospital with staff of the centre when the resident was discharged from acute care.

Residents' records contained comprehensive biographical details. A section entitled "Key to Me" contained personal information such as what name the resident was usually addressed by, their previous living arrangements, hobbies, personal care needs and likes/dislikes.

Residents had access to a GP of their choice, and to allied healthcare services including dietetics, physiotherapy, speech and language, psychiatry of later life, and chiropody.

GPs visited the centre regularly and records indicated that residents were reviewed on a regular basis. Out-of-hours GP services were also available. An organisation that provided physiotherapy services visited the centre on two afternoons each week providing group activity sessions and also provided one-to-one assessments, when required. Dieticians and speech and language therapists from a nutritional company visited the centre regularly and reviewed residents on a referral basis. A consultant psychiatrist visited the centre to review residents that could not attend outpatient services, particularly residents with responsive behaviour. Dental and optician services were available from local providers and residents requiring ophthalmologist services, such as residents with diabetes, were seen in Cork University Hospital. A chiropodist visited the centre regularly.

Comprehensive nursing assessments were carried out that incorporated the use of validated assessment tools for issues such as risk of falling, risk of developing pressure sores, mental status and for the risk of malnutrition. Improvements, however, were required in the assessment process. For example, a comprehensive assessment used to guide the development of care plans was not completed for one resident. Other assessments were also overdue for renewal in some residents.

Care plans were developed for issues identified on assessment and these were personalised to individual residents. Some care plans, however, did not provide adequate guidance on the care to be delivered and did not always incorporate advice from specialist services. For example, the care plan of one resident that had diabetes did not include advice from endocrinology in relation to the monitoring of blood sugar levels or the care of the resident's feet. Additionally, care plans were not developed for all issues, such as end of life care, when residents were deemed to be approaching end of life. Care plans did not always adequately address issues identified on assessment such as responsive behaviours and there was not always evidence of the use of validated tools for recording episodes of responsive behaviour. While staff members spoken with were knowledgeable of the communication needs of individual residents that had communication deficits, this was not always reflected in care plans.

There were written policies and procedures in place for end-of-life care and for the management of residents' resuscitation status. Staff provided end of life care to residents with the support of their GP and the community palliative care team, to which there was good access. Religious preferences were documented and there was evidence that they were facilitated. Most residents were catholic and a priest visited the centre each Tuesday to celebrate mass. The needs of other denominations were respected and supported. 36 of the 48 bedrooms were single rooms, so the option of a single room was usually available. Family and friends were facilitated to remain with the resident and there were adequate facilities for relatives to remain overnight.

There were policies and procedures to guide practice in relation to the management of nutrition. There were systems in place to ensure residents' nutritional needs were met, and that they did not experience poor hydration. Residents were assessed for the risk of malnutrition on admission and at regular intervals thereafter using a validated tool. Residents' were weighed regularly. There was an effective system of communication between nursing and catering staff to support residents with special dietary requirements. Inspectors found that residents on weight reducing, diabetic, high protein

and fortified diets, and also residents who required modified consistency diets and thickened fluids received the correct diet and modified meals were attractively served.

All residents had breakfasts in their bedrooms but had their lunch and supper in the dining rooms, with the exception of one or two residents. There was one large dining room that was partitioned and a smaller adjacent dining room. Breakfast was served for most residents from 08:00hrs, lunch was served from 12:15hrs and supper was served from 17:00hrs. Dining tables were nicely set out with table cloths and cutlery, and while they were quite crowded at mealtimes, it provided for a social occasion. Residents were seen to interact with each other during meals and were supported to be as independent as possible with their meals. Residents that required assistance with their meals were assisted by staff in a respectful and dignified manner. Choice of food was available at mealtimes with a meat or poultry and a fish dish on offer each day. Meals appeared to be nutritious and were attractively presented.

There was a centre-specific medication policy with procedures for safe ordering, prescribing, storing and administration of medicines. All residents had photographic identification in place in the medication administration record book. The supply and administration of scheduled controlled drugs was checked and was correct against the drug register, in line with legislation. Two nurses checked the quantity of these medications at the start of each shift. The nurse, spoken with by the inspector, displayed a good knowledge of the requirements in the area of controlled drugs and the responsibilities of the registered nurse to maintain careful records.

On the previous inspection there were a number of issues identified with medication management in the centre which included discrepancies between the medication administration record (MAR) and the doctors' prescriptions. This led to a dose of medication being administered which was not supported by a prescription. Other issues identified included

- a prescription was not signed.
- drugs were signed as given on the wrong date.
- discontinued drugs were not signed off as discontinued.
- medical products which were not prescribed were administered.
- the crushing of medications was not authorised by a GP's signature on the resident's prescription.
- 24 hour maximum dose of medications was not specified.

The person in charge responded to the action plan saying they had introduced controls to mitigate the errors as detailed above in conjunction with nurses, pharmacy and GPs through more frequent pharmacy and internal audits. On this inspection inspectors found that many of these issues had not been rectified and although internal and pharmacy audits were taking place on a regular basis, they did not identify the findings of this inspection. There continued to be discrepancies between the MAR and the doctors' prescriptions. An example of this was that medication was prescribed by the GP as one tablet to be given three times a day and the pharmacy sheet said two tablets to be given three times per day which was what was seen to be administered by nursing staff. Therefore, as identified on the previous inspection, nurses continued to administer from the MAR instead of the doctor's prescription. This is not in line with regulations or relevant professional guidance. One prescription had paracetamol containing

medications prescribed on a regular basis and on as required basis which could lead to paracetamol being administered in excess of recommended daily dosage. Other issues identified included:
• prescription medications were not all signed for by the GP on medication charts viewed and some medication charts just included a bracket around 10 medications with one signature.
• medications that required crushing were not individually prescribed as such by the GP.
• discontinued drugs were not signed off as discontinued.
• prescription times of one medication was administration on a different time on a regular basis
• the medication fridge was stored in the nurses' office which contained a number of medications. This was not locked and although the office door to the office generally locked it was accessed regularly by care and other staff to complete resident records.

Medications in the centre were supplied in a monitored dosage system. Inspectors saw that incident reports completed identified a number of issues with missing medications, extra medications in pouches, missing pouches and torn pouches. These incidents have been ongoing for a number of years and although some controls had been put in place the whole system of medication management in the centre required review to be compliant with legislation and best practice guidelines.

This outcome was judged to be substantially compliant in the self assessment, and inspectors judged it as major non-compliant.

Judgment:
Non Compliant - Major

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:
There was an up-to-date policy in place that addressed prevention, detection, reporting and investigating allegations or suspicions of abuse. While there were records available to demonstrate attendance at safeguarding training by staff, not all staff had attended this training. A sample of staff spoken with by inspectors were knowledgeable of what action to take if they witnessed, suspected or had abuse disclosed to them. They also clearly explained what they would do if they were concerned about a colleagues behaviour.

Prior to this inspection HIQA received a notification alleging peer on peer abuse. Following this notification, the provider was requested to conduct an investigation of the allegation and to submit supporting documentation. The inspector reviewed this

documentation and was not satisfied that the allegation was managed appropriately. For example, incidents of peer on peer abuse had occurred previously, but had not been reported to HIQA as required by the regulations. Inadequate safeguarding arrangements had been put in place following the first incident, to safeguard residents from further abuse. Safeguarding measures were eventually put in place following notification of the behaviour to HIQA.

All residents spoken with said they felt safe and secure in the centre, and felt the staff were supportive. Relatives of residents spoke highly of the care provided by the staff and their caring attitude.

There were policies in place about meeting the needs of residents with responsive behaviour (also known as behavioural and psychological signs and symptoms of dementia) and restrictive practices. Policies were seen to give clear instruction to guide staff practice. These policies, however, were not always implemented in practice. For example, records were not always maintained of triggers for particular behaviours, how the behaviour presented and consequences of the behaviour. There were care plans in place identifying how to support residents with responsive behaviour, however, they contained inadequate detail. This action is addressed under Outcome 1. Staff spoken with were knowledgeable of individual residents behaviour including how to avoid the situation escalating.

Records indicated that restraint in the form of bedrails was used following a risk assessment. There were records of safety checks while restraint was in place. However, there was a form of restraint being used on one resident at the time of the inspection that required immediate review. Inspectors were informed that this was used for positioning support purposes. A review by a physiotherapist indicated that the resident required a speciality chair and a support belt. There was, however, no evidence to indicate that the resident had been assessed for the chair and support belt that was currently in use. Inspectors were not satisfied that all other avenues had been explored they were using the least restrictive alternative for this resident.

Inspectors reviewed incident reports in relation to resident's behaviour and records confirmed the information given to inspectors that there were no recent significant behavioural related incidents. There were adequate records in place on the management of residents finances. However, in instances where small amounts of money was held for safekeeping on behalf of residents, records of transactions were not always supported by resident/relative/staff signatures.

This outcome was judged to be compliant in the self assessment, however, inspectors judged it as major non-compliant.

Judgment:
Non Compliant - Major

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:
Residents confirmed that their religious and civil rights were supported. The preferences of all religious denominations were respected and facilitated. Religious ceremonies were celebrated in the centre that included a weekly mass for Catholic residents, usually on Tuesdays.

Residents were facilitated to vote in local and national elections and the returning officer visits the centre to facilitate residents to vote.

Previously, two independent advocates were available to residents in the centre, however, these were no longer available. The general manager had maintained contact with the advocacy service and should residents require the services of an advocate, this would be supported.

Residents meetings were held in the centre on a monthly basis since January 2016 and less frequently during 2015. Records of residents meetings were reviewed by inspectors and issues discussed included meals, activities and the environment. There was an action plan associated with each meeting identifying how issues raised would be addressed.

Inspectors observed staff interacting with residents in an appropriate and respectful manner. Residents chose what they liked to wear and inspectors saw residents looking well dressed, including jewellery and makeup. A number of residents were observed having their hair done in the hairdressing salon on both days of inspection.

Residents had access to a number of private areas and rooms whereby they could meet with family and friends in private, or they could meet with them in their bedrooms. Twelve of the bedrooms were shared and these were adequate in size with sufficient screening between beds to support privacy.

As part of the inspection, inspectors spent a period of time observing staff interactions with residents. Inspectors used 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 two 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). An overview of these observation periods is detailed below

Observations were recorded in the sitting rooms and in the dining room. The total observation period was 90 minutes, which comprised three 30 minute periods. For rating purposes, there were 18 five minute observation periods. 15 scores of +2 were given predominantly when staff were seen to facilitate activities and to assist residents with their meals in the dining room. Staff were seen to sit with residents and chat with them

while making good eye contact. Three scores of +1 were given.

Each resident had a "Key to Me" completed which detailed residents interests. Activities coordinators were available in the centre each day, seven days a week. A range of activities were available throughout the day, including evenings and residents were seen to enthusiastically participate in the activity programme. The programme of activities included various musical events, arts and crafts, throwing games such as darts and rings, seat exercises, and board games. There were also one-to-one activities for residents that do not participate in group activities.

Residents were seen to be wearing glasses and hearing aids, to meet their communication needs.

This outcome was judged to be compliant in the self assessment, and inspectors judged it as compliant.

Judgment:
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:
There was a system in place to ensure that the complaints of residents or their representatives were listened to and acted upon. There was a complaints policy that identified the person responsible for managing complaints and also included an appeals process. The complaints procedure was on prominent display in the centre, and summarised in the residents guide.

Throughout the inspection it was clear that residents were familiar with all members of staff and management. It was apparent to inspectors that residents would find staff easy to approach with any concerns or complaints.

Inspectors viewed the complaints log that contained details of complaints, the investigation of each complaint, the outcome of the investigation and whether or not the complainant was satisfied with the outcome of the complaint.

This outcome was judged to be substantially compliant in the self assessment, and inspectors judged it as compliant.

Judgment:
Compliant

Outcome 05: Suitable Staffing

Theme:
Workforce

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

Findings:
Inspectors observed staff providing care in a respectful and caring manner. Residents appeared to be familiar with staff. Residents' independence was supported and promoted. For example, most residents ate their meals with only supervision and were allowed ample opportunity to finish their meals.

An actual and planned roster was maintained in the centre, with any changes clearly indicated. The person in charge was supported in her role by an assistant director of nursing. Inspectors reviewed staff rosters, which showed there was a nurse on duty at all times. There was a regular pattern of rostered care staff. The staffing complement included activities coordinators, a chef and kitchen assistant, housekeeping, administration and maintenance staff.

Residents and staff spoken with felt there were adequate levels of staff on duty. However, the provider and person in charge were requested to keep staffing under review as the needs of residents change. This was particularly relevant in the morning when there were two nurses and seven healthcare assistants on duty from 08:00hrs to 14:00hrs. An additional healthcare assistant was available from 08:30hrs to 11:30hrs each day prior to commencing duty in the laundry.

There was a varied programme of training for staff. The training programme included training on issues such as end of life care, food safety, continence training and dysphagia. Some improvements, however, were required in relation to training as not all members of staff had up-to-date training in fire safety, and a small number of staff did not have training in safeguarding or manual handling. Additionally, only a small number of staff had attended training on responsive behaviour and on dementia care.

Inspectors reviewed a sample of staff files and found that some improvements were required. For example, there was not always a full employment history for all staff with satisfactory explanations for any gaps in employment, required references were not available for all staff and vetting disclosure in accordance with National Vetting Bureau Act 2012 was not available for all staff. Additionally, a record of current registration was not available in the centre for all nurses, however, this was provided prior to the end of the inspection.

This outcome was judged to be substantially compliant in the self assessment, and inspectors judged it as moderate non-compliant.

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:
Bishopscourt Residential Care is a purpose-built single storey residential centre with accommodation for 60 residents. The location, layout and design of the centre was suitable for its stated purpose and met the needs of the resident in a comfortable way. The centre is situated on large, well maintained grounds with ample parking facilities.

The centre was bright, clean and spacious. All areas were bright and well lit, with lots of natural light in the day, and electric lighting when dark. Corridors had grab rails, and were seen to be clear of any obstructions. Residents were seen to be moving as they chose within the centre. There was a long corridor called ''Flower Walk'', in which residents could walk, uninhibited. The corridor was bright with lots of natural light and had lots of potted plants on each side of the corridor. Residents could access a secure garden from the corridor. The garden had raised flower beds and garden furniture.

Resident' accommodation comprised 36 single and 12 twin-bedded rooms, all of which were en suite with shower, toilet and wash-hand basin. For operational purposes the centre was divided into two sections, Fuschia which contained bedrooms one to 30 and Heather, which contained bedrooms 31 to 48. There were 30 residents in each section.

All bedrooms were adequate in size and some were seen to be personalised. It was observed that there was adequate room in the bedrooms for furniture including a bed, a chair and storage. The rooms also had enough space for equipment such as hoists to be used, with sufficient space to access the beds from either side.

While the centre was bright and clean, some areas were in need of redecoration. The corridors in particular had evidence of scuff marks on walls and doors and paintwork was chipped, particularly on wooden doorframes. Some work was required to make the centre homely and suitable for residents with dementia. As already stated, 46 of the 60 residents had a formal diagnosis of dementia and an additional two residents were suspected of having dementia. While there was signage to direct residents to various areas in the centre, such as sitting rooms and dining room, it could be enhanced to provide additional visual cues to support residents with dementia navigate to the various areas within the centre. There was minimal use of contrasting colours and there was an absence of memorabilia or furniture throughout the centre to create a home like environment.

Communal space comprised one large sitting room and two smaller sitting rooms. There was also a visitors' room with tea and coffee making facilities. There were adequate sanitary facilities such as communal toilets and bathrooms and adequate sluicing facilities.

There was a large well-equipped kitchen with adequate hand hygiene and changing facilities for staff. There was evidence of good practice in relation to the management of clinical and domestic waste.

There were up-to-date records of the maintenance of equipment such as beds, clinical equipment, speciality chairs and hoists.

This outcome was judged to be substantially compliant in the self assessment, and inspectors judged it as substantially compliant.

Judgment:
Substantially Compliant

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:
A number of issues were identified for improvement at the last inspection and these were reviewed on this inspection. The emergency plan had not identified safe placement of residents in the event of a prolonged evacuation. A premises was now identified and detailed in the emergency plan. Offices and storerooms were now locked in order to prevent access by residents to areas that may contain items of risk, such as sharps disposal containers. Window restrictors were in place on all windows to prevent residents at risk from absconding. Electronic doors were checked daily as part of fire safety procedures to ensure they were working.

At the last inspection it was found that the procedure to be followed in the event of a fire was not prominently displayed. On this inspection signage had been put in place. However, the signage could be enhanced to support residents, visitors and staff identify the nearest emergency exit. Inspectors saw that personal emergency evacuation plans (PEEPs) were in place for each resident. The PEEPs identified the current mobility status of each resident. They did not, however, identify the most appropriate means of evacuation, for example, the use of ski sheets under the mattress of certain residents when they were in their beds. Additionally, the PEEPs did not identify the possible psychological response of a resident to the fire alarm and the need to evacuate

promptly.

Not all staff members had up-to-date training in fire safety. Some staff members, when asked by inspectors, were unclear of their response to discovering a fire. Management were requested to review fire safety training to ensure that all staff, particularly staff that worked in high-risk areas such as the kitchen and laundry, had up-to-date training in fire safety.

Judgment:
Non Compliant - Moderate

Outcome 12: Notification of Incidents

Theme:
Effective care and support

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

Findings:
Notifications were not always submitted as required. For example, incidents of peer on peer abuse had occurred, but not all had been reported to HIQA as required by the regulations.

Judgment:
Non Compliant - Moderate

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:

John Greaney
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

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Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	Bishopscourt Residential Care
Centre ID:	OSV-0000200
Date of inspection:	28/06/2016
Date of response:	05/08/2016

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:
A comprehensive assessment used to guide the development of care plans was not completed for one resident and where comprehensive assessments were completed, they were not always regularly reviewed. Other assessments were also overdue for renewal in some residents.

1. Action Required:

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

Under Regulation 05(2) you are required to: Arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to the designated centre.

Please state the actions you have taken or are planning to take:
The Provider will arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to the designated centre.

Proposed Timescale: 31/07/2016

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 did not provide adequate guidance on the care to be delivered, did not always adequately address issues identified on assessment and did not always incorporate advice from specialist services. For example:
• the care plan of one resident that had diabetes did not include advice from endocrinology in relation to the monitoring of blood sugar levels or the care of the resident's feet
• care plans were not developed for all issues, such as end of life care, when residents were deemed to be approaching end of life. the care plan of one resident did not address responsive behaviours and there was not always evidence of the use of validated tools for recording episodes of responsive behaviour
• communication needs of individual residents that had communication deficits was not always reflected in care plans.

2. 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 that resident's admission to the designated centre.

Please state the actions you have taken or are planning to take:
Training will be provided. Assessment and Care Plans will be completed in line with Regulations.

Proposed Timescale: 31/08/2016

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Significant improvements were required in relation to medication management. For example:
• there were discrepancies between the MAR and the doctors' prescriptions
• as identified on the previous inspection nurses continued to administer from the MAR instead of the doctor's prescription
• a prescription had paracetamol containing medications prescribed on a regular basis and on as required basis which could lead to paracetamol being administered in excess of recommended daily dosage
• prescription medications were not all signed for by the GP on medication charts viewed and some medication charts just included a bracket around 10 medications with one signature.
• medications that required crushing were not individually prescribed as such by the GP.
• discontinued drugs were not signed off as discontinued.
• prescription times of one medication was administration on a different time on a regular basis
• the medication fridge was stored in the nurses' office which contained a number of medications. This was not locked and although the office door to the office generally locked it was accessed regularly by care and other staff to complete resident records.
• incident reports completed identified a number of issues with missing medications, extra medications in pouches, missing pouches and torn pouches. These incidents have been ongoing for a number of years and although some controls had been put in place the whole system of medication management in the centre required review to be compliant with legislation and best practice guidelines.

3. Action Required:
Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.

Please state the actions you have taken or are planning to take:
Medication Management Process is currently being reviewed so as to insure compliance with legislation and best practice.

Proposed Timescale: 31/07/2016

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:
Records were not always maintained of triggers for particular behaviours, how the behaviour presented and consequences of the behaviour.

4. 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:
ABC Behavioural Chart that documents possible triggers and the responses to behaviour in place. Care Plans have been updated with same

Proposed Timescale: 31/07/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no evidence to indicate that the all other avenues had been explored prior to the use of restraint and that the centre was using the least restrictive alternative for all residents.

5. Action Required:
Under Regulation 07(3) you are required to: Ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.

Please state the actions you have taken or are planning to take:
The centre will document all avenues explored. Where a restraint is assessed to be used it will be in line with National Policy.

Proposed Timescale: 31/07/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were adequate records in place on the management of residents finances. However, in instances where small amounts of money was held for safekeeping on behalf of residents, records of transactions were not always supported by resident/relative/staff signatures.

6. Action Required:
Under Regulation 08(1) you are required to: Take all reasonable measures to protect residents from abuse.

Please state the actions you have taken or are planning to take:
Two members of staff will sign for transactions where a resident / relative are unable to do so.

Proposed Timescale: 31/07/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
While there were records available to demonstrate attendance at safeguarding training by staff, not all staff had attended this training.

7. Action Required:
Under Regulation 08(2) you are required to: Ensure staff are trained in the detection and prevention of and responses to abuse.

Please state the actions you have taken or are planning to take:
Training will be completed for current staff by 31st August 2016. Training reviewed on a continuous basis.

Proposed Timescale: 31/08/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inadequate safeguarding arrangements had been put in place at the earliest opportunity following an allegation of peer on peer abuse to safeguard residents from further incidents.

8. Action Required:
Under Regulation 08(1) you are required to: Take all reasonable measures to protect residents from abuse.

Please state the actions you have taken or are planning to take:
Safeguarding Plan will be put in place immediately following any allegation of peer on peer abuse.

Proposed Timescale: 31/07/2016

Outcome 05: Suitable Staffing

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Only a small number of staff had attended training on responsive behaviour and on dementia care.

9. 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:
Training will be completed for current staff by 31st August 2016. Training reviewed on a continuous basis.

Proposed Timescale: 31/08/2016

Theme:
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was not always a full employment history for all staff with satisfactory explanations for any gaps in employment, required references were not available for all staff and vetting disclosure in accordance with National Vetting Bureau Act 2012 was not available for all staff. Additionally, a record of current registration was not available in the centre for all nurses, however, this was provided prior to the end of the inspection.

10. Action Required:
Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

Please state the actions you have taken or are planning to take:
Staff files will be completed in line with schedules 2, 3 and 4.

Proposed Timescale: 31/08/2016

Outcome 06: Safe and Suitable Premises

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
While the centre was bright and clean, some areas were in need of redecoration. The corridors in particular had evidence of scuff marks on walls and doors and paintwork was chipped, particularly on wooden doorframes.

11. 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:
Areas for redecoration included as part of annual maintenance

Proposed Timescale: 30/09/2016

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some work was required to make the centre homely and suitable for residents with dementia. As already stated, 46 of the 60 residents had a formal diagnosis of dementia and an additional two residents were suspected of having dementia. While there was signage to direct residents to various areas in the centre, such as sitting rooms and dining room, it could be enhanced to provide additional visual cues to support residents with dementia navigate to the various areas within the centre. There was minimal use of contrasting colours and there was an absence of memorabilia or furniture throughout the centre to create a home like environment.

12. 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:
Decoration of the nursing home will be reviewed.

Proposed Timescale: 30/09/2016

Outcome 07: Health and Safety and Risk Management

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all staff members had up-to-date training in fire safety. Some staff members, when asked by inspectors, were unclear of their response to discovering a fire. Management were requested to review fire safety training to ensure that all staff, particularly staff that worked in high-risk areas such as the kitchen and laundry, had up-to-date training in fire safety.

13. Action Required:

Under Regulation 28(1)(d) you are required to: Make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.

Please state the actions you have taken or are planning to take:
Fire Training will be provided to current staff by 30th September 2016. Training reviewed on a continuous basis.

Proposed Timescale: 30/09/2016

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
At the last inspection it was found that the procedure to be followed in the event of a fire was not prominently displayed. On this inspection signage had been put in place. However, the signage could be enhanced to support residents, visitors and staff identify the nearest emergency exit.

14. Action Required:
Under Regulation 28(3) you are required to: Display the procedures to be followed in the event of fire in a prominent place in the designated centre.

Please state the actions you have taken or are planning to take:
Signage will be put in place to identify the nearest fire exit.

Proposed Timescale: 30/08/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors saw that personal emergency evacuation plans (PEEPs) were in place for each resident. The PEEPs identified the current mobility status of each resident. They did not, however, identify the most appropriate means of evacuation, for example, the use of ski sheets under the mattress of certain residents when they were in their beds. Additionally, the PEEPs did not identify the possible psychological response of a resident to the fire alarm and the need to evacuate promptly.

15. Action Required:
Under Regulation 28(2)(iv) you are required to: Make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and safe placement of residents.

Please state the actions you have taken or are planning to take:
PEEPs will be updated to reflect the method of evacuation and responsive behaviour.

Proposed Timescale: 31/08/2016

Outcome 12: Notification of Incidents

Theme:
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Notifications were not always submitted as required. For example, incidents of peer on peer abuse had occurred, but not all had been reported to HIQA as required by the regulations.

16. Action Required:
Under Regulation 31(1) you are required to: Give notice to the chief inspector in writing of the occurrence of any incident set out in paragraphs 7(1)(a) to (j) of Schedule 4 within 3 working days of its occurrence.

Please state the actions you have taken or are planning to take:
Notifiable events will be submitted to the chief inspector in writing within 3 working days.

Proposed Timescale: 31/07/2016