

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Raheny Community Nursing Unit
Centre ID:	OSV-0000704
Centre address:	Harmonstown Road, Raheny, Dublin 5.
Telephone number:	01 850 5600
Email address:	rcnu@beaumont.ie
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Beaumont Hospital
Lead inspector:	Nuala Rafferty
Support inspector(s):	PJ Wynne
Type of inspection	Unannounced
Number of residents on the date of inspection:	90
Number of vacancies on the date of inspection:	10

About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

- **Registration:** under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- **Monitoring of compliance:** the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- to carry out thematic inspections in respect of specific outcomes
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or wellbeing of residents.

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.

Please note the definition of the following term used in reports:
responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration renewal decision. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 10 January 2018 07:00 To: 10 January 2018 19:00

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

Outcome	Our Judgment
Outcome 02: Governance and Management	Compliant
Outcome 07: Safeguarding and Safety	Non Compliant - Moderate
Outcome 15: Food and Nutrition	Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Non Compliant - Moderate
Outcome 18: Suitable Staffing	Compliant

Summary of findings from this inspection

This was an unannounced monitoring inspection by the Health Information and Quality Authority (HIQA). The focus of the inspection was to monitor progress on the actions required from the inspection that took place on 09 and 10 October 2017. The inspection also focused on the adequacy of resources available and the standard and safety of care delivered to residents. As part of this inspection, practices were observed and documentation was reviewed such as care plans, accident logs, management meetings and staff files. The views of residents, relatives and staff members in the centre were also sought.

Immediate risks identified on the last inspection were mitigated and inspectors were assured that an improved level of safe care was being provided to residents. Inspectors found there were improvements to governance systems to provide effective leadership and direction to staff. Inspectors also noted that there was a greater awareness by all staff of the importance of safeguarding and promoting a restraint free culture.

Changes to the guidance on managing residents with complex behavioural needs, together with improved interactions with residents, demonstrated that a developing ethos of person-centred and social model of care was emerging.

Some further improvements were required in the area of safeguarding and residents rights, dignity and consultation. However, there was an improved level of compliance with the requirements of the Health Act 2007 (Care and Welfare of Residents in

Designated Centres for Older People) Regulations 2013 (as amended) and the National 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 02: Governance and Management

The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.

Theme:

Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):

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

Findings:

Actions required from the last inspection were being addressed. Inspectors found there were improvements to governance systems to provide effective leadership and direction to staff, monitor staffing levels, skill mix, training, and clinical practice and to ensure that safe suitable and sufficient care was delivered to residents with a more person-centred focus. Inspectors also noted that there was a greater awareness by all staff of the importance of safeguarding and promoting a restraint free culture.

Improvements to the systems of governance included:

- A Quality and Resident Safety Committee was established which included all members of the senior management team in the centre and the senior medical consultant, allied health professional manager and quality and safety representatives. The role of the committee was to ensure appropriate and regular oversight of all risks associated with residents care and to effectively minimize and manage these risks. Inspectors viewed the minutes of the initial meeting of the committee in November 2017, a second meeting had not yet taken place.
- A unit specific risk register was being established.
- A steering group was established to implement national policy and monitor progress on moving towards a restraint free environment. The remit of the group was to promote and develop protocols and guidance for staff and to trend the use of restraint practices. The initial meeting of this group was held on the 3 January 2018 and minutes were viewed.
- Improvements to contingency plans for staff replacement for unexpected absences and planned shifts were in place. Progress on the agency to permanent post conversion process was noted with 50% of the required posts converted since the last inspection.

• In order to enable the establishment of the governance new structures, enable the provision of increased staff training and to minimize the reliance on agency staff, the person in charge took the decision to formalize an agreed admission criteria. Until this criteria has been determined and agreed, the management team have limited the admission of residents to persons with low to medium dependency needs only. Inspectors looked at the assessed dependency of residents admitted since August 2017 and found that no residents with high or maximum dependency needs were admitted to the centre.

Additional governance measures that were also in place included: Increased resources to provide 24 hour clinical nurse management cover to provide supervision and guidance to staff. Increased resources for clinical practice facilitator to provide practice support to staff. Additional training was delivered to staff on safeguarding and restraint free practices.

Inspectors were informed that the investigation into the allegation of abuse was on-going and that all staff implicated in the allegation remained on paid leave pending the outcome. Inspectors were assured that a copy of the full report into the investigation with outcome, learning and measures to be implemented would be forwarded to the Chief Inspector. Inspectors were assured that these additional measures mitigated the risks identified on the last inspection.

However, inspectors were aware that the new governance structures and measures implemented were only recently established and not yet sufficiently embedded to identify or audit trend indicators so that learning can be derived, and improvements enabled in all areas. Inspectors discussed this with the person in charge, provider representative, and the senior clinical nurse manager. Inspectors stressed the need for these improvements to be sustained, in order for changes in culture and practice to become embedded and sustained improvements to the standard of care, restraint free practices, and development of a social model of care and person-centred ethos to be delivered.

Judgment:
Compliant

Outcome 07: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe care and support

Outstanding requirement(s) from previous inspection(s):

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

Findings:

Actions were required from the previous inspection to ensure that restrictive practices were used only in accordance with national policy and that the least restrictive practice was used for the shortest time possible. These actions were partially addressed on this inspection. Improvements were noted in particular to the attitude, awareness and understanding of staff to deliver care within a restraint free culture and in a person-centred manner.

Inspectors observed that there was a low-level of restraint use in the centre, although restraints were still in use, primarily where complex processes were required to manage the behaviour of some residents. Expertise was sought for residents with complex behavioural needs, who were reviewed by clinicians such as, occupational health, psychiatry of old age and medical consultants. Guidance based on these reviews were provided to staff to implement person-centred care practices that protected residents rights and dignity while also meeting their personal care needs.

Inspectors found there was evidence of a change in culture and practice in relation to restraint and protection of residents. This evidence was primarily through talking with staff and observing their interactions with residents. All staff spoken with were very aware of their role and responsibility to safeguard residents and to report any concerns of possible abuse. All were very keen to reduce the use of restraints in the centre.

However, inspectors found that clarity was required for staff on what constituted restraint, and clearer descriptors and definitions were needed on elements of the behaviour management recommendations from expert clinicians. Additionally, the recording and documentation of each incident of restraint required to improve to enable a sustained improvement in the reduction of restraint practices. Examples where these improvements were found to be needed, included where a practice known as 'safe hand-holding', was in use in the centre. This practice related to the hands of a resident being held, to manage behaviour and risks associated with physical aggression during personal care delivery. Guidance based on clinical expert reviews was available and described the use of 'therapeutic hand-holding' to manage the aggressive behaviour (in addition to other positive supports such as music and conversation on past life interests). However, inspectors learned from verbal examples from staff, that how they were interpreting this guidance differed considerably. Inspectors also found that management's interpretation was not fully clear and that instances of hand-holding, by two or more staff were not being recorded or identified as a form of restraint.

Inspectors discussed with the management team the need for clarity on descriptors and definitions to clearly identify the level of force used with hand-holding, whether the hands are open when guiding, or closed if holding. This clarity is required to ensure that the interventions by staff to manage behaviours are always transparent and safe, uphold residents' dignity and rights, and are the least restrictive possible.

Inspectors found that as the improvements identified in Outcome 2 Governance and management were not yet fully established, that further improvements to supervision, documentation, auditing and review of restrictive practices were required to embed a

restraint free culture in the centre.
Judgment: Non Compliant - Moderate

Outcome 15: Food and Nutrition <i>Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.</i>
Theme: Person-centred care and support
Outstanding requirement(s) from previous inspection(s): No actions were required from the previous inspection.
Findings: This Outcome was not reviewed on the last inspection. However, some aspects of the breakfast service were reviewed and the findings are detailed under Outcome 16 rights, dignity and consultation. Actions required, as a result of the findings of this inspection, relevant to the breakfast experience, are included under Outcome 16.
Judgment: Compliant

Outcome 16: Residents' Rights, Dignity and Consultation <i>Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.</i>
Theme: Person-centred care and support
Outstanding requirement(s) from previous inspection(s): Some action(s) required from the previous inspection were not satisfactorily implemented.
Findings: The action required from the October inspection in relation to the provision of advocacy services for residents and relatives was fully addressed. Improvements were also found in relation to actions required to obtain and implement residents feedback on the service

provided in the centre were also found. However, further improvements were required to ensure that residents received their meals in a manner that was not rushed, respected their dignity, and ensured that hot elements of the meal remained at the optimal appropriate temperature.

Inspectors viewed minutes of resident meetings held in November and December 2017. These showed that meetings were held more frequently and residents' views on aspects of the service were considered. The records showed that the meetings were held centrally on one unit, with residents from other units attending. However, inspectors noted that attendance was low and suggested that smaller, individual, informal meetings could be held on each unit to improve participation and seek the views of a wider group of residents to improve care quality. Inspectors also noted that efforts to do this had already commenced with a conversation group set up to meet on a weekly basis by the activity team.

Further improvement to the standard of the breakfast service was required. Inspectors observed the service of breakfast on one unit. There were 24 residents on the unit on the day of the inspection. Breakfast service commenced at 8am. A member of the catering staff brought the breakfast out on a standard trolley. This trolley contained a large flask of tea and two stainless steel pre-heated containers of cooked porridge. A plate containing a fried egg on a slice of fried bread and a boiled egg (sitting on the side of the trolley not in an egg cup) was on this trolley and it also held cutlery, serving bowls and plates as well as milk, sugar and other condiments. The trolley was not heated. A second trolley containing breakfast trays was also used. The inspectors observed that all of the breakfast trays were ready for service and all had either a slice of pre-buttered bread or toast. Heated covers were not available to maintain the hot food elements already plated.

All residents were served their breakfast in their bedroom. As the breakfast was being served, some staff, one nurse and three health care assistants divided into two teams to ensure residents were comfortable and ready to eat, and then give assistance to those who needed it to have their breakfast. The staff were observed working very hard and as fast as they could, but they were not able to reach any residents before the breakfast was served, as all residents required some assistance to enable them to eat their breakfast. This ranged from assistance to sit upright in bed and bringing the bed table containing the breakfast within the residents' reach, to putting residents' dentures in place or toileting. All residents who required full assistance to eat their breakfast had to wait until every other resident had received some or all of these interventions. The breakfast service to all residents took 40 minutes. However, for those residents who required the assistance of staff to eat, some did not receive this assistance until an hour after the breakfast service had commenced. The inspectors checked the temperature of the hot food elements and found that some were cold, including the eggs fried bread and toast. The porridge and tea was lukewarm.

Feedback from some relatives, on this inspection, concurred with these observations. Relatives also said that elements of the breakfasts and teas were not always warm when received by residents.

The inspector observed that while breakfast was being served, the remaining nursing staff, including the senior nurse-in-charge on the day was administering medication.

This meant that there was no supervision of the breakfast service. This is a recurrent finding. During the breakfast service no resident was observed to experience any discomfort or indignity. However, inspectors did not find any evidence of any additional measures, or changes to the breakfast service to prevent a recurrence at any future time.

Judgment:

Non Compliant - Moderate

Outcome 18: Suitable Staffing

There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

Theme:

Workforce

Outstanding requirement(s) from previous inspection(s):

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

Findings:

Actions required from the previous inspection were addressed and included:

- Suitable and sufficient staffing and skill mix were found to be in place to deliver a good standard of care to the current resident profile. The staff rota was checked and found to be maintained with all staff that worked in the centre identified.
- All planned shifts were filled and there was a reduced level of reliance on agency staff to fill unexpected and planned absences. This was partly due to the reduced number of residents who required one-to-one supervision, and also due to the provision of increased resources, by the provider entity to replace staff on a full-time basis.
- A specific staff allocation system was in place that identified the staff for each area on every floor in the centre. All staff were aware of the system which was implemented in full. However, as referenced under Outcome 16, improvements to the supervision and allocation of staff were required, to ensure residents were comfortable, and ready, to receive their breakfast in a timely manner.
- Additional training opportunities were provided to staff on safeguarding and restraint-free practices. Approximately 95% of staff had received this training. Although not all staff on-duty on the day of inspection had attended this training, in conversation with them, inspectors found all staff had an increased awareness of their role in recognizing,

responding to, and reporting abuse. Changes to the guidance on managing residents with complex behavioural needs, together with improved interactions with residents, demonstrated a developing ethos of person-centred and social model of care was emerging.

- As previously referenced under Outcome 2, increased staffing resources, to improve and maintain the level of supervision, guidance and direction provided to staff on each unit in the centre was found. Three whole-time-equivalent (w.t.e.) posts for clinical nurse managers were approved and the recruitment process had commenced. In the interim, these posts were being filled on a full-time basis, in an acting capacity, since the last inspection. Further additional resources including increased hours to a full-time w.t.e were approved for a clinical practice facilitator and one additional w.t.e activity coordinator were approved.

- Good progress was found to be made on the conversion of agency posts to full-time permanent positions. On the last inspection there was a heavy reliance of up to 16 agency staff required to fill planned shifts on a regular basis. Half of these were now converted to full-time with the remainder in progress.

Judgment:
Compliant

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

Nuala Rafferty
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 report¹

Centre name:	Raheny Community Nursing Unit
Centre ID:	OSV-0000704
Date of inspection:	10/01/2018
Date of response:	06/02/2018

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 07: Safeguarding and Safety

Theme:

Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:

Clarity was required for staff on what constituted restraint and clearer descriptors and definitions were needed on elements of the behaviour management recommendations from expert clinicians.

1. Action Required:

Under Regulation 07(3) you are required to: Ensure that, where restraint is used in a

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

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 Restrictive Interventions Policy has been updated with clear guidelines for considering a restrictive procedure. The policy includes clarify on descriptors, the level of force used and whether the hands are opened when guiding or closed if holding.
- Staff training underway on the updated Restrictive Interventions policy with completion by 1st of March 2018.

Proposed Timescale: 01/03/2018

Theme:

Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:

Improvements to the recording and documentation of each incident of restraint were required to enable a sustained improvement in the reduction of restraint practices.

2. 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:

1. The Restrictive Interventions Committee (RIC) co-chaired by the PIC and occupational therapist with agreed terms of reference in place.
2. The RIC is scheduled to convene monthly and has interdisciplinary representation.
3. Restrictive Interventions Policy has been updated with clear guidelines for staff to use when considering a restrictive procedure.
4. All residents requiring the use of restrictive interventions are risk assessed and the application of a new restrictive intervention or the continued use of a restrictive intervention is approved by the RIC and subsequently documented in the resident's medical notes and care plans.
5. Staff training on the revised Restrictive Interventions policy underway with completion by the 1st of March 2018.
6. Weekly audits against policy adherence underway with governance and oversight of audit performance discussed at the RIC with action plans initiated as appropriate to ensure 100% compliance with the policy.
7. Audit results will be presented to the Quality & Resident Safety Committee to ensure trending and appropriate oversight across all units is in place.

Proposed Timescale: 01/03/2018

Outcome 15: Food and Nutrition

Theme:

Person-centred care and support

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

Hot elements of the breakfast were not maintained at an appropriate temperature to ensure safety and enjoyment for residents.

3. Action Required:

Under Regulation 18(1)(c)(i) you are required to: Provide each resident with adequate quantities of food and drink which are properly and safely prepared, cooked and served.

Please state the actions you have taken or are planning to take:

1. Heated covers are in use for all hot breakfasts.
2. Toast is prepared as requested by the residents and served immediately.
3. The NSC has increased the frequency of meal-time audits schedule to ensure the food served is at the appropriate standard inclusive of temperature. The results will be reviewed by the NSC and further quality improvement plan will be initiated as required.
4. Results will be reviewed monthly at the NSC meeting and will be reported to the Quality and Residents Safety Committee

Proposed Timescale: Completed

Proposed Timescale: 06/02/2018

Theme:

Person-centred care and support

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

Evidence that adequate staff were allocated to ensure that all residents received assistance with their meals in a timely manner was not found.

4. Action Required:

Under Regulation 18(3) you are required to: Ensure that an adequate number of staff are available to assist residents at meals and when other refreshments are served.

Please state the actions you have taken or are planning to take:

1. An interdisciplinary Nutritional Steering Committee (NSC) chaired by the PIC and co-chaired by the catering manager is in place
2. Following the inspection the NSC completed an audit of the service of breakfast.
3. The audit results were discussed at the NSC meeting and the following actions are being tested:-

a) Following consultation with the residents breakfast time has changed to 08.20am to

ensure all residents who wish to receive their breakfast at this time are prepared and to ensure all nursing staff, healthcare assistants and catering staff are available to assist residents.

b) The CNM or the nurse in charge will supervise breakfast service to ensure all residents receive their meals in a manner that is not rushed.

c) Medications administration times have been altered to avoid coincidence with breakfast to ensure maximum staff availability for meal time, avoid unnecessary disruptions for safe medication administration and allow for management oversight of both care elements.

d) Feedback will be sought at the Resident's Forum Meeting to ensure residents are satisfied with the breakfast service and discussed at the NSC meeting to ensure a responsive approach to improvement opportunities based on resident feedback.

Proposed Timescale: Complete

Proposed Timescale: 06/02/2018

Outcome 16: 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:

Evidence of improvements to ensure that residents meals were provided in a manner that was not rushed and that upholds their rights to comfort and dignity were not found.

5. Action Required:

Under Regulation 09(3)(e) you are required to: Ensure that each resident can exercise their civil, political and religious rights.

Please state the actions you have taken or are planning to take:

1. Monthly resident Forum meetings take place on each Unit to enhance attendance and participation of residents.
2. Residents have been consulted at the Resident's Forum meeting to ascertain their preference to have their breakfast served in the dining room or their bedroom.
3. A resident and family satisfaction survey regarding meal time experience will be completed. The findings of this survey will be discussed at the NSC and a quality improvement plan will be implemented as required.
4. The CNM or the nurse in charge will supervise breakfast service to ensure all residents receive their meals in a manner that is not rushed.

Proposed Timescale: 01/03/2018