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Bushfield Care Centre, OSV-0005242, 17 January 2018

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**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Bushfield Care Centre
Centre ID:	OSV-0005242
Centre address:	Bushfield, Oranmore, Galway.
Telephone number:	091 792 301
Email address:	bushfieldcarecentre@gmail.com
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Bushfield Care Centre Limited
Lead inspector:	Mary McCann
Support inspector(s):	Marie Matthews
Type of inspection	Announced
Number of residents on the date of inspection:	33
Number of vacancies on the date of inspection:	12

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 announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 17 January 2018 10:00 To: 17 January 2018 17:00

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

Outcome	Our Judgment
Outcome 01: Statement of Purpose	Substantially Compliant
Outcome 02: Governance and Management	Substantially Compliant
Outcome 03: Information for residents	Non Compliant - Moderate
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Compliant
Outcome 06: Absence of the Person in charge	Compliant
Outcome 07: Safeguarding and Safety	Compliant
Outcome 08: Health and Safety and Risk Management	Substantially Compliant
Outcome 09: Medication Management	Compliant
Outcome 10: Notification of Incidents	Compliant
Outcome 11: Health and Social Care Needs	
Outcome 12: Safe and Suitable Premises	Substantially Compliant
Outcome 13: Complaints procedures	Substantially Compliant
Outcome 14: End of Life Care	Compliant
Outcome 15: Food and Nutrition	Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Compliant
Outcome 17: Residents' clothing and personal property and possessions	Compliant
Outcome 18: Suitable Staffing	Compliant

Summary of findings from this inspection

This report sets out the findings of an announced registration renewal inspection, carried out by the Health Information and Quality Authority (HIQA). The current registration of this centre is due to expire on the 25 June 2018. The last inspection of the centre by the Health Information and Quality Authority (HIQA) was an unannounced monitoring inspection completed on 13 April 2017. This inspection identified the requirement for improvements in four areas, governance and management, ensuring all staff have verified d garda vetting, documentation

regarding fire drills and ensuring that a drill is completed simulating night time staff levels and night time scenario and completion of food and fluid charts to ensure they are of therapeutic value.

The provider and person in charge had ensured there had been significant work done in these areas and all actions were addressed. Monitoring systems were in place to ensure the quality and safety of the service. A good level of compliance was found on this inspection. Residents healthcare needs were met to a good standard. Staff had access to training and knew the residents and their care needs well. The Inspector observed that staff delivered care in a kind and unhurried way and were courteous to the residents.

Bushfield Care Centre is a purpose built single storey bungalow style building which is registered with HIQA to accommodate 45 residents. It is situated approximately 2 kilometres from Oranmore, Galway. On entry there is a large reception area with seating available. A receptionist is on duty 9:00 - 17:00hrs Monday to Friday. Facilities available include a dining room, two sitting rooms, two conservatory areas. An activities' room, oratory, 31 single bedrooms all with en-suite toilet & shower facilities, seven twin bedrooms, four of which have en-suite toilet facilities. One communal bathroom & shower which includes a toilet and a further two communal toilets are available for residents use. An enclosed garden is also available. An outdoor smoking area is available.

Documentation submitted by the centre since the last inspection was reviewed by the inspectors prior to and during the inspection. Inspectors also met with residents, a relative and staff members, observed practices and reviewed documentation such as care files, medical records, staff personnel files, risk and fire documentation, the complaints log, medical records and medication charts. Two resident pre-inspection questionnaires were received. On review of these, the inspector found that these residents and relatives were generally positive in their feedback with regard to the staff, management, the overall service and care provided. Comments included 'the staff couldn't do no more, this place is getting better and better, the food is lovely, I am well looked after, if I had a worry I would tell staff'. Two comments were made one by a resident and one by a staff member that staff were busy. This was communicated to the provider and person in charge at the feedback meeting.

Post this inspection, areas which require review include completion of a risk assessment with regard to the portable heaters and outdoor areas to ensure safe for use by residents, installation of a call bell in the main sitting room, review of the statement of purpose to ensure it reflected the current layout of the centre, quality improvement plans to be enacted where any deficits are identified post audits and or reviews, review of contracts of care to enhance clarity and comply with current legislation. Actions with regard to these areas are contained in the action plan at the end of the report.

Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

Outcome 01: Statement of Purpose

There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

Inspectors reviewed the statement of purpose, which had been updated since the last inspection. It outlined the ethos and aims of the centre. While it contained all the matters as per Schedule 1 of the Regulations, there was inadequate detail in some areas for example, a description of each room in the centre, its capacity and function, associated emergency procedures. There was also conflictual information as to whether Mass was weekly or monthly.

Judgment:

Substantially Compliant

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:

Systems were in place to ensure that the service provided was safe and effectively monitored. Inspectors discussed the organisational management system and quality management system which was in place to ensure the provider complied with their responsibility according to the Health Act 2007. An auditing system was in use.

Statistical information was collected in relation to various areas including falls, care documentation, restraint and medication management. Deficits identified were addressed in practice and further audits were completed to ensure sustainable improvement.

Clear lines of accountability and authority were evident in the centre. Staff were aware of the reporting structure and support systems available to them. A weekly meeting was held between the provider representative and the person in charge. These detailed a general discussion with regard to the running of the centre to include staffing levels, refurbishment, accident and incidents and any residents concerns. Minutes were available of these meetings and items were reviewed at subsequent meetings. Systems were in place to ensure the safety of residents was maintained. Fire safety was found to be of a good standard, staff had received training in infection control and the centre was well maintained.

An annual review of the quality and safety of care delivered to residents was available. There was evidence of consultation with residents. A robust quality improvement plan which identified the actions to be taken, who was responsible and a timescale was not in place.

Adequate resources were available to meet the needs of residents. Sufficient assistive equipment was available to meet the needs of residents. The centre was well maintained and adequate staffing were available to meet resident's needs on the day of inspection.

Judgment:

Substantially Compliant

Outcome 03: Information for residents

A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

A contact of care was in place for each resident, however these did not outline clearly the fees payable and a minority were not signed. They detailed the services provided but were not clear as to what was included in the fee.

While the contracts of care outlined the terms of residency, they did not specify if the room to be occupied was a single or shared room.

A resident's guide was available in each residents bedroom however on review this was not in a format which was accessible to residents with cognitive impairment.

Judgment:

Non Compliant - Moderate

Outcome 04: Suitable Person in Charge

The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The person in charge was experienced and fulfilled the criteria required by the regulations in terms of qualifications. She demonstrated that she was familiar with residents' care requirements and was known by name by residents. She is a registered nurse with the required experience in the area of nursing older persons. She demonstrated good clinical knowledge and was knowledgeable regarding the Regulations, Standards and her statutory responsibilities. She had maintained her continuous professional development and had recently completed a course in end of life care, medication management and management of falls. She had completed her mandatory training in adult protection, fire training, and manual handling. She had completed a diploma course in managing people.

The person in charge informed the inspectors that she has dedicated time allocated to manage the clinical governance and administration duties required by the post of person in charge. The person in charge is supported in her role by a clinical nurse manager who deputises in her absence.

Judgment:

Compliant

Outcome 05: Documentation to be kept at a designated centre

The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:

Governance, Leadership and Management

<p>Outstanding requirement(s) from previous inspection(s): The action(s) required from the previous inspection were satisfactorily implemented.</p> <p>Findings: Records listed in Schedules 2, 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People Regulations 2013 (as amended) were available and were stored and maintained securely. Inspectors reviewed a sample of records to include accident and incident records, fire safety, staff personal files and residents' care and medical records. An action from the last inspection related to verified garda vetting for all staff. The provider representative and the person in charge confirmed that all staff working in the centre have verified garda vetting in place. There was a visitors' record to monitor the movement of persons in and out of the building to ensure the safety and security of residents. This was up to date and located in close proximity to the reception desk which was manned by a receptionist. The directory of residents' contained all information required by schedule 3 of the regulations and was maintained up to date. Inspectors also reviewed a sample of policies and procedures as required by Schedule 5 of the regulations. All the required policies were in place. A sample of staff files was reviewed and found to be compliant with the regulations.</p>
<p>Judgment: Compliant</p>

<p><i>Outcome 06: Absence of the Person in charge</i> <i>The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.</i></p>
<p>Theme: Governance, Leadership and Management</p>
<p>Outstanding requirement(s) from previous inspection(s): No actions were required from the previous inspection.</p> <p>Findings: Inspectors were satisfied that there were appropriate arrangements in place for the safe management of the centre in the absence of the person in charge. A full time clinical nurse manager who is identified as the person participating in the management of the centre on the application for renewal of registration deputises in the absence of the person in charge. She is a registered nurse and her registration with An Bord Altranais was up to date. An on-call management rota was in place. In the absence of this clinical nurse manager and the person in charge a senior staff nurse deputises.</p>
<p>Judgment: Compliant</p>

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):

No actions were required from the previous inspection.

Findings:

A comprehensive policy on protecting residents from abuse was in place. Staff spoken with by the inspectors confirmed that they had received training on adult protection and were aware of the different forms of abuse and the reporting structure within the designated centre. Residents spoken with stated they felt safe in the designated centre and informed the inspector that they were well cared for. Where allegations of abuse had been notified to HIQA, inspectors found that a robust investigation with appropriate management by the provider representative and the person in charge had been completed.

Inspectors reviewed the management of residents' finances. Where residents were able to manage their own finances this was supported and residents had a lockable drawer in their bed side lockers. The centre operated a safe keeping system for small amounts of money for residents and systems were in place to ensure residents' monies were safe. All transactions were checked and signed by two members of staff.

The provider representative confirmed that he did not act as an agent for any resident.

The records viewed confirmed that responsive behaviours were assessed and well managed in the centre. Behaviour management plans were in place for residents who had responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). Assessments and care plans for these residents were comprehensive. ABC charts (assessment forms) were completed on an ongoing basis, and they were formally analysed and used to create an individual care plan for each resident. Inspectors read a sample of care plans and saw that they identified potential triggers and contained sufficient detail about appropriate interventions to guide staff to provide consistent person-centred approaches to care. Residents had a varied meaningful activity schedule which assisted to distract residents and engage them thereby decreasing the likelihood of responsive behaviour.

Files examined showed that a pre-admission assessment had been completed in all cases to ensure that the centre could meet the needs of the residents. There was evidence that appropriate referrals had been made to mental health services and expert

recommendations had been implemented with positive outcomes for the residents. Inspectors read the restraint register and found that 15 of the 33 residents used bed rails at night; the majority were used to prevent the resident from rolling out of bed or to assist residents with turning or allay anxiety.

There was evidence that less restrictive alternatives had been trialled before bed rails were used, for example sensor mats or enhanced supervision. Access to less restrictive equipment was available. This included sensor alarms and low low beds. In the cases reviewed, all the residents had been risk assessed prior to using bedrails and care plans were in place for these residents which detailed the frequency of safety checks and the enabling function of the bedrail.

A visitor's book was maintained and all visitors were required to sign in and out of the centre. The entrance was secure and required a security code to open the doors.

Judgment:

Compliant

Outcome 08: Health and Safety and Risk Management

The health and safety of residents, visitors and staff is promoted and protected.

Theme:

Safe care and support

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

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

Findings:

An action from the last inspection related to fire drills had been addressed. Inspectors found that fire evacuation drills were completed regularly and records were maintained as to the duration of the drill, the staff who took part and any impediments to timely evacuation. A fire drill had been completed simulating a night duty scenario when the least amount of staff is on duty.

Staff had received training in fire safety and evacuation and this was confirmed by speaking with staff and from the training records reviewed. Staff spoken with by the inspectors were clear on fire safety practices and knew what to do in the event of a fire. A procedure was in place for the daily inspections of all emergency exits. At the time of inspection all fire exit doors were free from obstruction. The fire evacuation plans showing the layout and nearest evacuation route required review as they were displayed in small print and difficult to read.

The inspector viewed up to date fire records which showed that equipment, including fire extinguishers, fire alarms and emergency lighting had been serviced within the last year.

Some measures were in place to help prevent accidents and promote the residents' mobility including staff supervision, wide corridors with supportive handrails and an environment free of obstructions, low entry beds and crash mats. However there were some areas of the centre including the flooring in the sitting room, the gravel in the garden area and the use of a portable heater in one resident's bedroom that required

review.

A log of all incidents was maintained by the person in charge and inspectors saw that detailed records were completed for each incident that occurred and where falls were unwitnessed or the resident sustained a head injury neurological observations were completed

Personal emergency evacuation plans (PEEPs) were in place for each resident. These were kept in residents' bedrooms. These identified those who required verbal prompts, physical assistance, or equipment such as a wheelchair or evacuation sheet.

A centre-specific health and safety statement which had been recently reviewed was available. An emergency plan which provided guidance in the event of fire, flood, power outage or structural damage to the centre was also available.

The centre was clean and good infection control procedures were in place. All staff had received training in hand hygiene. Hand sanitising gels and protective equipment were available throughout the centre.

Judgment:

Substantially Compliant

Outcome 09: Medication Management

Each resident is protected by the designated centre's policies and procedures for medication management.

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

The medication management policy was comprehensive and evidence based. The policy was made available to staff who demonstrated adequate knowledge of this document.

Medications for residents were supplied by a local community pharmacy. There was evidence of appropriate involvement by the pharmacist in accordance with good practice, including being available to residents should they wish to discuss their prescribed medication. Medications were stored in a locked medication trolley. The temperature of the medication fridge was monitored and recorded daily and medications requiring refrigeration were stored appropriately. Handling and storage of controlled drugs was safe and in accordance with current guidelines and legislation.

Where medications were to be administered in a modified form such as crushing, this was individually prescribed by the medical practitioner on the prescription chart. Staff confirmed that appropriate and comprehensive information was provided in relation to medication when residents were admitted to the centre. This formed part of the pre admission assessment and staff informed Inspectors that the pharmacist worked very closely with the centre to ensure the required medication was available. All staff nurses had completed medication management training. Medication prescription sheets reviewed by inspectors were current. They detailed the weight, an up to date photo of the resident and any known allergies. Maximum daily doses were specified for 'pro re

nata' (PRN) medication.

Medication administration record sheets (MARS) identified the medications on the prescription sheet, contained the signature of the nurse administering the medication. Space to record comments on withholding or refusing medications was available. The times of administration matched the prescription sheet.

One of the inspectors observed medication administration practices and found that the nursing staff adhered to professional guidance of An Bord Altranais agus Cnáimhseachais.

Judgment:

Compliant

Outcome 10: Notification of Incidents

A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

Inspectors noted that a record of all incidents was maintained. Notifications to Health Information and Quality Authority were made in line with the requirements of the Regulations.

Judgment:

Compliant

Outcome 11: Health and Social Care Needs

Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

Theme:

Effective care and support

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

No actions were required from the previous inspection.

Findings:

An admission policy was available and inspectors found that this was reflected in practice. Discharge letters for residents who spent time in acute hospital care and letters from consultations detailing findings following out-patient clinic appointments were

available.

Comprehensive assessments and a range of additional risk assessments had been carried out for all residents and staff had developed care plans based on the risks and care needs identified. Care plans reviewed contained sufficient detail to guide staff in the delivery of care. Dementia care plans were in place detailing the functional ability and ways in which the independence of the resident could be maintained.

Access to allied health professionals to include dietetic service, chiropody and speech and language therapy (SALT) services, opticians, audiology physiotherapy and psychiatry of later life was available. Inspectors saw that where resident's needs changed they were referred to the appropriate service. For example when a resident was had difficulty swallowing they were referred to and assessed by the speech and language therapist who attended the centre. A new care plan was drawn up with the revised advice that had been provided.

Care plans were reviewed every four months or sooner if required. Residents or their relatives were involved in the care plans. This was confirmed by the residents and relatives spoken with during the inspection. Evidence was available that residents had been reviewed by the physiotherapist who was employed by the provider. All residents at risk of falling were reviewed by the physiotherapist. Low-low beds and sensor mats were provided to assist residents and reduce the risk of a fall.

There was evidence in the medical files of good access to the resident assigned General Practitioner.

Arrangements were in place to review accidents and incidents. Residents at risk of falling were assessed using a validated falls assessment tool. Falls prevention care plans were in place. These provided guidance to staff in the delivery of safe care and what detailed aids such as sensor mats to mitigate the risk of further falls for the resident. Evidence was available that post-fall observations including neurological observations were undertaken to monitor neurological function after a possible head injury as a result of a fall.

Systems were in place to prevent unnecessary hospital admissions. Staff had been trained in sub-cutaneous fluid administration and the centre described good links with the palliative care team. Observations such as blood pressure, pulse and weight were assessed on admission and according to assessed need thereafter.

Judgment:

Outcome 12: Safe and Suitable Premises

The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:

Effective care and support

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

No actions were required from the previous inspection.

Findings:

The centre is a purpose built single-storey 45 bedded nursing home. It is situated approximately 2 miles from Oranmore in a rural location in Galway. Inspectors found that it was clean warm and odour free. However the decor was dated and some maintenance issues for example new flooring in the day room was required.

Entry to the centre was secure and a receptionist was on duty Monday to Friday. Handrails were provided and the layout allowed for circular movement for residents with dementia who like to actively walk around.

Accommodation comprised of 31 single rooms, 30 of which have a full ensuite facility. There are seven twin rooms, four of which have a full ensuite. Some bedrooms had decreased occupancy from four to two to enhance the privacy and dignity of residents however the curtain rails were not removed from the ceilings where the beds were removed. While some bedrooms were very large they were poorly laid out which did not give a homely ambience to the room.

Emergency call bells were provided in each room. Rooms were numbered and some had pictures to assist residents to recognise their rooms and aid independence and enhance choice as they could freely go back to their bedrooms when they wished. Most rooms were personalised according to the choice of the resident. An armchair was available to assist residents maintain their independence with dressing as they could sit in the chair to put on their socks and shoes.

Other facilities included a day room, activities room/dining room, two conservatories, a dining room oratory, storerooms and offices. Cleaning and sluicing facilities and a laundry were provided which were secured to prevent residents with a cognitive impairment entering. A range of assistive equipment was available including pressure relieving mattresses and sit-to-stand hoists. Records were available to support to verify that these were regularly serviced.

Judgment:

Substantially Compliant

Outcome 13: Complaints procedures

The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

The person in charge explained issues of concern are addressed immediately at local level without recourse to the formal complaints procedure. A designated individual was nominated with overall responsibility to investigate complaints. A summary of the complaints procedure was displayed prominently and was included in the statement of purpose.

A comprehensive complaints policy was in place. This detailed the process for dealing with a complaint which complied with the regulations. A complaints log was in place. Inspectors noted on reviewing this log that any complaint detailed had been investigated and resolved. However there was no evidence of whether the complaint initiator was satisfied with the outcome of the complaint and whether they were informed of the appeal procedure. The contact details of the office of the Ombudsman were recorded in the policy.

Judgment:

Substantially Compliant

Outcome 14: End of Life Care

Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.

Theme:

Person-centred care and support

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

This was the centre's first inspection by the Authority.

Findings:

Staff had attended training in End of Life Care. End of life care was provided to residents with the support of the palliative care team if required and the General Practitioner. Each resident had their end of life preferences recorded and an end of life care plan was in place. These care plans addressed the resident's physical, emotional, social and spiritual needs. They reflected each resident's wishes and preferred pathway at end of life care. Where specific instructions with regard to wishes regarding resuscitation had been discussed with the resident and or their relatives, these were documented.

Judgment:

Compliant

Outcome 15: Food and Nutrition

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.

Theme:

Person-centred care and support

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

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

Findings:

The action from the last inspection was appropriately addressed. Food and fluid charts were well completed and gave a good indication of the resident's intake. Residents were assessed for nutritional needs on admission and these were reviewed at four monthly intervals or in response to residents' changing needs. Likes and dislike were recorded and residents told inspectors that they got the food they chose or if the menu wasn't to their liking they could get an alternative option.

Regular snacks and drinks were available throughout the day. The menu was displayed and provided a varied diet of meat, vegetables, fish and fruit. Homemade soups, breads, cakes and deserts were provided daily. Those on a modified diet could choose from the same menu as those on a normal diet. Residents were weighed monthly or more regularly where unexplained weight loss was identified. Those with any identified nutritional care needs had a nutritional care plan in place and residents who had unintentional loss were referred to a dietician. Two dining rooms were available, these provided adequate space for all residents to eat at the same time if they wished. A small minority of residents chose to eat in their bedrooms. Inspectors observed that those who required support at were provided with timely assistance from

Judgment:

Compliant

Outcome 16: Residents' Rights, Dignity and Consultation

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.

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

Staff were observed to engage well with residents and had good knowledge of residents which promoted person centred care. A weekly activities programme timetable was on display in the centre. An activity co-ordinator is in post. Dedicated time is provided by the activities co-ordinator to provide Sonas regularly. Residents told the inspector that there were lots of activities for them to partake in. Inspectors observed residents actively engaged in activities during the inspection. Activities observed included baking, singing, hand massage. The chef took a lead on the baking activity where buns and cakes were baked for consumption at the afternoon tea. The activity coordinator runs short frequent activities which enhance the engagement of residents. Residents had access to a small outdoor area, however, there were larger outdoor areas that could be

assessable if they were better maintained. This is actioned under Outcome 8. The provider representative explained at the feedback meeting that a refurbishment plan to include the courtyard areas and external surround of the building was planned. Newspapers were provided and residents had access to television and the radio.

There was evidence that residents had choice about their daily routines such as getting up or participating in activities. Residents had access to religious services, Mass was celebrated monthly and was viewed on the television on a Sunday. Voting arrangements were in place and residents were facilitated to vote. Staff were observed to protect the privacy and dignity by knocking on bedroom doors before entering and ensuring that curtains were drawn around the beds. Residents were consulted on the organisation of the centre. Resident meetings were held quarterly. Minutes were available of these meetings. The inspector reviewed the minutes of these meetings and found that the meetings were managed in a manner to elicit feedback or suggestions from the residents. An action plan arising from any areas that required review or planning was completed post the meeting.

Group activities were organised such as exercise classes, Bingo and music sessions and hand massage. One-to-one activities, for residents who were unable or chose not to participate in group activities were observed to be occurring. Social care assessments were completed for each resident. These captured information on the resident's life prior to coming to live in the centre and detailed their hobbies, interests, likes and dislikes. Information from this assessment was used to inform the care plans and planning of activities. A record was maintained of the social engagements and various activities that each resident participated in. There were no restrictions on visiting times, there were facilities to allow residents to receive visitors in private. Relatives who spoke with the inspector confirmed that they were always made to feel welcome.

Judgment:

Compliant

Outcome 17: Residents' clothing and personal property and possessions
Adequate space is provided for residents' personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.

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 policy on the management of residents clothing and possessions. Each resident had an individual wardrobe and locker and access to a secure area where they could store personal valuables. Residents clothing was laundered on the premises and residents expressed satisfaction with the service provided and the safe return of their

clothes to them. A record was kept of each resident's personal property and this was updated regularly by laundry staff.

Judgment:

Compliant

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):

No actions were required from the previous inspection.

Findings:

The person in charge worked full time and was actively engaged in the governance of the centre. There were 33 residents living in the centre at the time of inspection, the centre is registered to provide care to 45. Inspectors reviewed duties rotas over a three week period and found that a twilight shift from 19:00hrs to midnight was only covered 4 days per week. This was discussed with staff who stated while they managed when this shift was not covered they did find that it was helpful when this shift was covered and they had more time to spend caring and interacting with residents.

This was discussed with the provider representative and the person in charge at feedback who stated that they were trying to recruit a carer for the other three days but had been unsuccessful in doing so but gave a commitment to continue to try to recruit into this post.

All residents and staff spoken with expressed no concerns with regard to staffing levels. Staff was available to assist residents as required and residents were supervised at all times. There was adequate staff available at meal times to assist residents.

The person in charge confirmed that staffing levels and skill mix are reviewed regularly and adjusted in response to residents' needs. The person in charge and staff spoken with demonstrated their knowledge, skills and experience necessary to fulfil their role and responsibilities regarding care of older persons. The person in charge always worked in a supernumery capacity and when she was not on duty there are always two staff nurses or one staff nurse and the clinical nurse manager on duty from 08:00 to 20:00hrs.

In addition to nursing staff there were six health care assistants rostered to care for residents up until 15:00hrs and five up to 20:00 hrs. Two care assistants and one staff nurse are on duty from 20:00hrs to 08:00. Four days per week there is a carer on a twilight shift from 19:00hrs to midnight. Additionally, a full-time activity coordinator and maintenance man and a physiotherapist worked one day per week in the centre.

Catering kitchen, housekeeping and administration staff are also employed. The provider representative attends the centre one day per week.

The person in charge confirmed that all staff had been appropriately vetted prior to commencing work. There was a training matrix available to ensure that mandatory training requirements were met. A review of training records showed that all staff had up to date mandatory training in place. When new staff were employed they completed an induction programme. Additional training and education relevant to the needs of the residents profile had been provided for example hand hygiene, responsive behaviour, end of life care, dysphagia, falls prevention and basic life support had been undertaken. A training plan was in place for 2018 which included dementia care and infection control. There was a policy on confidentiality and staff signed a confidentiality agreement prior to commencement of work.

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:

Mary McCann
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Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	Bushfield Care Centre
Centre ID:	OSV-0005242
Date of inspection:	17/01/2018
Date of response:	22/02/2018

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 01: Statement of Purpose

Theme:

Governance, Leadership and Management

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

While the statement of purpose contained all the matters as per Schedule 1 of the Regulations, there was inadequate detail in some areas for example, a description of each room in the centre, its capacity and function, associated emergency procedures. There was also conflictual information as to whether Mass was weekly or monthly.

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 03(1) you are required to: Prepare a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

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

The statement of purpose and function has been revised to include the emergency procedure. It includes an accurate and detailed description of resident facilities and activities provided.

Proposed Timescale: 23/02/2018

Outcome 02: Governance and Management

Theme:

Governance, Leadership and Management

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

A robust quality improvement plan which identified the actions to be taken, who was responsible and a timescale was not in place.

2. Action Required:

Under Regulation 23(b) you are required to: Put in place a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

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

A robust quality improvement plan has been developed based on the findings of the annual review. This plan identifies actions, persons responsible and a timescale has been implemented for completion.

Proposed Timescale: 23/02/2018

Outcome 03: Information for residents

Theme:

Governance, Leadership and Management

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

A resident's guide was available in each residents bedroom however on review this was not in a format which was accessible to residents with cognitive impairment.

3. Action Required:

Under Regulation 20(1) you are required to: Prepare and make available to residents a guide in respect of the designated centre.

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

The residents guide has been revised and is now in a format which is accessible to residents with cognitive impairment.

Proposed Timescale: 23/02/2018

Theme:

Governance, Leadership and Management

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

A contract of care was in place for each resident, however these did not outline clearly the fees payable and a minority were not signed. They detailed the services provided but were not clear as to what was included in the fee.

4. Action Required:

Under Regulation 24(2)(b) you are required to: Ensure the agreement referred to in regulation 24 (1) relates to the care and welfare of the resident in the designated centre and includes details of the fees, if any, to be charged for such services.

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

The contract of care has been revised to ensure accurate information is in place regarding fees and services provided. The Person in Charge will ensure that all contracts of care are signed and returned to the centre in a timely fashion.

Proposed Timescale: 23/03/2018

Outcome 08: Health and Safety and Risk Management

Theme:

Safe care and support

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

There were some areas of the centre including the flooring in the sitting room, the gravel in the garden area and the use of a portable heater in one resident's bedroom that required review.

5. Action Required:

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

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

Flooring in communal areas will be replaced as part of a refurbishment plan due to commence later this year. The external grounds are included in this plan also. A risk assessment of portable heaters on site has been carried out and these will only be used

where safe to do so.

Proposed Timescale: 30/09/2018

Outcome 12: Safe and Suitable Premises

Theme:

Effective care and support

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

The decor was dated and some maintenance issues for example new flooring in the day room was required.

Some bedrooms had decreased occupancy from four to two to enhance the privacy and dignity of residents however the curtain rails were not removed from the ceilings where the beds were removed. While some bedrooms were very large they were poorly laid out which did not give a homely ambience to the room.

6. 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:

Refurbishment of the centre is due to commence later in the year; this will include new décor and flooring and the division of larger bedrooms. In the interim, the larger bedrooms will be re arranged to create a more homely ambience.

Proposed Timescale: 30/09/2018

Outcome 13: Complaints procedures

Theme:

Person-centred care and support

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

There was no evidence of whether the complaint initiator was satisfied with the outcome of the complaint and whether they were informed of the appeal procedure.

7. Action Required:

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

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

The complaints document will be revised to monitor complainant initiator satisfaction

with the outcome of the complaint. The person in charge will also record all discussions of the appeal procedure as they occur.

Proposed Timescale: 23/02/2018