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:	Boyne View House
Centre ID:	OSV-0000532
Centre address:	Dublin Road, Drogheda, Louth.
Telephone number:	041 989 3288
Email address:	seamus.mccaul@hse.ie
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Maura Ward
Lead inspector:	Mary O'Donnell
Support inspector(s):	None
Type of inspection	Unannounced Dementia Care Thematic Inspections
Number of residents on the date of inspection:	19
Number of vacancies on the date of inspection:	7

About Dementia Care Thematic Inspections

The purpose of regulation in relation to residential care of dependent Older Persons is to safeguard and ensure that the health, wellbeing and quality of life of residents is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer and more fulfilling lives. This provides assurances to the public, relatives and residents that a service meets the requirements of quality standards which are underpinned by regulations.

Thematic inspections were developed to drive quality improvement and focus on a specific aspect of care. The dementia care thematic inspection focuses on the quality of life of people with dementia and monitors the level of compliance with the regulations and standards in relation to residents with dementia. The aim of these inspections is to understand the lived experiences of people with dementia in designated centres and to promote best practice in relation to residents receiving meaningful, individualised, person centred care.

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

Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National 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 1 day(s).

The inspection took place over the following dates and times

From:	To:
15 November 2016 09:30	15 November 2016 17:00

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	Compliance demonstrated	Non Compliant - Moderate
Outcome 02: Safeguarding and Safety	Compliance demonstrated	Non Compliant - Major
Outcome 03: Residents' Rights, Dignity and Consultation	Non Compliant - Moderate	Substantially Compliant
Outcome 04: Complaints procedures	Compliance demonstrated	Compliant
Outcome 05: Suitable Staffing	Substantially Compliant	Compliant
Outcome 06: Safe and Suitable Premises	Non Compliant - Moderate	Non Compliant - Moderate
Outcome 07: Health and Safety and Risk Management		Substantially Compliant

Summary of findings from this inspection

This inspection report sets out the findings of a thematic inspection which focused on specific outcomes relevant to dementia care. As part of the thematic inspection process, providers were invited to attend information seminars given by the Authority. In addition, evidence-based guidance was developed to guide the providers on best practice in dementia care and the inspection process.

Prior to the inspection, the person in charge completed the provider self-assessment and scored the service against the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland. The table above compares the self-assessment and inspector's judgment for

each outcome.

This HSE centre provides residential and respite services. Fourteen residents were living fulltime in the centre and five were on respite. On the day of inspection 18 of the 19 residents had a diagnosis of dementia. The inspector met with residents and staff members and tracked the journey of four residents with dementia within the service. Care practices were observed and interactions between staff and residents who had dementia were rated using a validated observation tool. Documentation such as care plans, medical records and staff training records were reviewed.

The inspector also followed up on the areas of non-compliance found on the previous inspection on 19 March 2015. Twenty one of the 22 action plans developed to bring the service into compliance had been completed. The provider had yet to submit a costed, time-bound plan to bring the premises into compliance by 2021. A project team was working to progress plans to build a new facility on the grounds, close to the centre. In the interim, improvements had been made to the existing premises to enhance the environment for residents. However some of the single rooms were in a poor state of decorative repair and there were no shelves to display residents' personal items. The flooring in some of the rooms was not suitable for residents who were at risk of falling. Residents did not have access to a call bell, as the call bell unit was fixed to the wall and could not be readily accessed from the bed.

The provider and staff had worked to adapt the service to meet the needs of residents with dementia. Residents had access to a variety of communal rooms and a secure, landscaped garden. They had space for walking both indoors and outside. Noise was controlled to create a calm environment for residents. Respect for residents was evident and the daily routine and pace of life was organised to meet the needs of individual residents. Staff were available in the correct numbers and with the necessary skills to provide care for residents with dementia. Positive connective care was observed during the formal observation periods.

The healthcare and nursing needs of residents were met to a high standard. Residents had access to medical services and a range of other health services and evidence-based nursing care was provided. The provider was working towards creating a restraint free environment but the use of bedrails was high. There was evidence of good interdisciplinary approaches in the assessment and management of residents with behavioural and psychological symptoms of dementia also known as responsive behaviours. However the centre did not have a separate unit for residents with responsive behaviours and although one to one supervision was provided, vulnerable residents could not be protected from residents who exhibited violence or aggressive behaviours. Although residents were assessed prior to admission in order to determine the suitability of the placement, there was no alternative accommodation available if a resident's condition changed and their behaviours impacted on the safety and wellbeing of other residents.

These issues are discussed further in the body of the report and the actions required are included in the action plan at the end.

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):

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.

There were suitable arrangements in place to meet the health and nursing needs of residents with dementia. Comprehensive assessments were carried out and care plans developed and reviewed accordingly. All the care plans examined held an end of life care plans which reflected the wishes of residents' family. Systems were in place to prevent unnecessary hospital admissions. The nutritional and hydration needs of residents with dementia were met. Residents were protected by safe medication policies and procedures.

Residents could retain the services of their own general practitioner (GP) and they had timely access to community and acute medical services. They had access to allied healthcare professionals including occupational therapy, dietetic, speech and language, ophthalmology and podiatry services. The centre also had access to psychiatry of old age and palliative care services. Although residents had access to dental services the waiting times varied and dental services were not always accessible when required. One resident waited for over three weeks before accessing dental services privately. Residents with natural teeth did not have routine dental check-ups.

The inspector tracked the journey of four residents with dementia and also reviewed specific aspects of care such as nutrition, diabetes, wound care and end of life care in relation to other residents.

There were systems in place to optimise communications between the resident/families, the acute hospital and the centre. The Clinical Nurse Manager visited prospective residents in hospital prior to admission. This gave the resident and their family information about the centre and also established that the service could adequately meet the needs of the resident.

Residents' files held a copy of their hospital discharge letter and/or the Common

Summary Assessment Form (CSARS) with relevant information. CSARs held comprehensive information to support residents moving to the centre. Residents who were transferred to hospital from the centre had appropriate information about their health, medications and their specific needs included with the transfer letter. However when residents were readmitted to hospital and then returned to the centre the discharge letters held very little information and the GP said he often had to contact the hospital in order to access the required information.

Residents had a comprehensive nursing assessment on admission. The assessment process involved the use of validated tools to assess each resident's dependency level, cognitive status, risk of malnutrition, falls, and skin integrity. A care plan was developed within 48 hours of admission based on the resident's assessed needs. Care plans contained the required information to guide the care of residents, and were updated routinely on a three monthly basis or to reflect the resident's changing care needs. Family members confirmed that they participated in the three monthly care plan reviews. However not all care plans were comprehensively reviewed. In the case of a resident who had fallen a number of times, their falls history was not analysed to inform the care plan.

Staff provided end of life care to residents with the support of their medical practitioner and the community palliative care services if required. Single rooms were available for end of life care and relatives were accommodated to stay with residents who were very ill. From the sample of files reviewed and conversations with staff it was evident that staff did not discuss future care needs or end of life wishes with residents in order to develop care plans which reflected the residents' preferences and wishes. Family members were consulted to determine the resident's wishes for future care, including end of life care. Initiating conversations with residents to determine their wishes for their future care needs and their preferences for end of life care was an area for improvement.

Staff had access to a tissue viability nurse and the inspector tracked wound care for one resident and found the wound was assessed the care plan directed care provided. Residents at risk of developing pressure ulcers had care plans and pressure relieving mattresses and cushions to prevent ulcers developing.

Residents with diabetes were appropriately monitored and managed. The inspector found the staff who undertook the procedure adhered to the Health Information and Quality Authority (HIQA) guidance of blood glucose monitoring.

There were systems in place to ensure residents' nutritional needs were met, and that they did not experience poor hydration. Residents were screened for nutritional risk on admission and reviewed regularly thereafter. Residents' weights were checked on a monthly basis, and more frequently when indicated. Nutritional care plans were in place that detailed residents' individual food preferences, and outlined the recommendations of dieticians and speech and language therapists where appropriate. Improvements were required in relation to daily intake records. Two of the charts viewed for the previous day had no entries after 5pm. Staff confirmed that these residents had taken food and drink after 5pm which was not recorded.

The inspector joined residents for lunch in the dining room and found that residents on diabetic, and fortified diets had their dietary needs met. Residents who required modified consistency diets and thickened fluids received the correct diet and modified meals were attractively served. Two sittings were offered to overcome the problem of limited space in the dining room. Staff sat with residents and offered support in a considered way. Staff interacted with residents in a way that supported social interaction and also gave residents the space to concentrate on eating their meals. Staff interviewed were conscious of the impact of noise on residents and the inspector noted that the noise of crockery and cutlery was controlled with clearing the tables. Meals were paced appropriately and choices offered to all residents for each course. One resident who preferred not to eat in company was facilitated to dine in a separate quiet room.

There were arrangements in place to review accidents and incidents within the centre, and residents were regularly assessed for risk of falls. Care plans were in place and following a fall, the risk assessments were revised and medications reviewed. Arrangements were in place to replace the flooring for a resident who had fallen in their room. A non–slip mat was provided as an interim measure. Some residents wore hip savers to mitigate the risk of injury from a fall.

There were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents which were implemented for the residents who were case tracked. The inspector found that practices in relation to prescribing and medication reviews met with regulatory requirements and staff were observed to follow appropriate administration practices. Residents had access to the pharmacist. The inspector noted that residents had recently received flu and pneumonia vaccinations.

Judgment:
Non Compliant - Moderate

Outcome 02: Safeguarding and Safety

Theme:
Safe care and support

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
Training records indicated that staff had attended training on the prevention, detection and response to abuse. The person in charge was a designated officer and staff who spoke with inspector were knowledgeable about the various types of abuse, recognising abuse, and were familiar with the reporting structures in place. There were systems in place to ensure that allegations of abuse were fully investigated, and that pending such investigations measures were in place to ensure the safety of residents. The policy had been updated to reference the National Policy 'Safeguarding Vulnerable Persons at risk

of Abuse (2014).

There was a policy and procedures for the use of restraint and the service was working to reduce the use of restraint. However the use of bedrails remained high and less restrictive alternatives were not trialled before bedrails were used. Records showed that 13 residents used bedrails to enable them to move in bed or to promote safety. Twelve of the 13 bedrails in use were restrictive devices. Risk assessments were completed for the use of bedrails and care plans were in place. However there was no documentary evidence that the two hourly checks on these residents were carried out. Five residents who had exit seeking behaviours used security bracelets which activated an alarm should they attempt to leave the facility. The inspector was satisfied that this device allowed residents to move about freely within the centre and their use was reviewed regularly in line with the policy. Chemical restraint was rarely used and all incidents of physical and chemical restraint were recorded in the restraint register and appropriately notified to the Authority.

There was evidence of good interdisciplinary approaches in the management of responsive behaviours. The person in charge had a MSc in Dementia and all staff were trained to work with residents who had dementia and had attended training to equip them to work with residents with responsive behaviours. Residents had access to consultant led mental health and psychology services. Appropriate assessments and care plans were in place for residents with responsive behaviours. However the centre could not meet the needs of a resident who exhibited aggressive behaviours and the inspector found that arrangements in place for one to one supervision did not sufficiently protect other vulnerable residents from the risk of violence and aggression. The incident log showed that in the previous six months there were six incidents of aggression towards other residents and staff members. Four of these incidents occurred while the one to one supervision was in place.
Members of the management team and staff acknowledged that the centre was unsuitable for residents who exhibited violence and aggression and they could not always protect other vulnerable residents. The person in charge told the inspector that they had tried to find more suitable accommodation but could not do so.

Given that the service was developing to accommodate residents with dementia, many of whom were mobile and whose safety awareness was compromised, the risk to these residents merited a judgement of major non compliance.

Judgment:
Non Compliant - Major

Outcome 03: Residents' Rights, Dignity and Consultation

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:
There was a good relationship between staff and residents in the centre. A culture of person centred care was evident and staff worked to ensure that each resident with dementia received care in a dignified way that respected their privacy. The inspector observed staff interacting with residents in an appropriate and respectful manner, and it was clear that staff knew the residents well, including their backgrounds and personal history.

The design and layout of the centre was structured to maximise the independence of residents. Residents could move around the centre as they wished and they had free access to a secure, well maintained outdoor area. Care plans included information about what residents could do for themselves as well as aspects of care where they required support.

A named independent/SAGE advocate was available to residents. Although none of the residents were availing of the service at the time of inspection. There was evidence that a resident had found the service useful to facilitate their discharge back into the community.

Systems for consultation with relatives were good but consultation with residents who had dementia was proving to be a challenge. The person in charge acknowledged that this was an area for development and spoke of plans to set up a 'Rights Forum' in consultation with residents and relatives in 2017.

Records of residents meetings showed that they were poorly attended and the most recent meeting did not have any residents in attendance. Two residents attended the recent information session about the planned new building and the future of the centre. Relatives represented the views of residents on the new build consultation committee.

Relatives and staff confirmed that residents of all denominations were supported to practice their religion. The inspector observed that staff sought the permission of the resident before undertaking any care task and they were consulted about what they wished to wear, how they wished to spend their day and care issues. Residents who wished to vote were facilitated to do so in the centre or at a local polling station.

There were no restrictions on visitors and there were a number of areas where residents could meet visitors in private, apart from their bedroom. Residents had access to national and local newspapers and staff supported residents to discuss relevant news items. There was a computer available but staff confirmed that none of the residents used it to send or receive emails or to Skype family and friends.

Activity staff organised a variety of activities including exercise classes, music, art and religious activities. Residents with dementia were supported to engage in these activities and they were also benefitted from relaxation periods in the quiet room. One to one time was scheduled for residents with more severe dementia who could not or preferred not to participate in the group activities. Aromatherapy and hand massage were some of the 1:1 activities provided. The ‘Key to me’ provided useful information about residents’ life stories, their daily routines, interests and hobbies which were used to inform the care plans and activity plan.

The inspector observed the quality of interactions between staff and residents using a validated observational tool to rate and record at five minute intervals, the quality of interactions between staff and residents. The observations were done in the dining room and the sitting room. Staff passing through the day room created interest for residents and staff greeted and chatted with residents. All the interactions observed were positive, positive connective care was evident as staff availed of opportunities to connect with residents. Staff interacted as equal partners with residents and offered choice wherever possible. They knew the residents well and their communication skills, eye contact, their tone and humour used was appropriate and respectful.

Staff worked to ensure that each resident with dementia received care in a dignified way that respected their privacy. Staff were observed knocking on bedroom and bathroom doors, and privacy locks were in place on bedroom, bathroom and toilet doors.
Aspects of the environment which impacted on the privacy and dignity of residents were addressed. Suitable screening had been installed in twin room and additional wardrobes provided where required. Signage was used to indicate that a shared en suite was in use.

Judgment:
Substantially Compliant

Outcome 04: Complaints procedures

Theme:
Person-centred care and support

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

Findings:
There was a system in place to ensure that the complaints of residents with dementia or their representative were listened to and acted upon, and they had access to an appeals procedure.

There was a complaints policy in place, and the complaints procedure was displayed prominently in the centre, and summarised in the residents guide book. The inspector reviewed the complaints records and saw that details were maintained about each complaint, details of any investigation into the complaint and whether or not the complainant was satisfied with the outcome. There was a nominated person from outside the unit appointed to ensure that complaints were appropriately managed in line with the policy.
There was evidence that complaints were taken seriously and used to inform quality improvement initiatives.

Judgment:
Compliant

Outcome 05: Suitable Staffing

Theme:
Workforce

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

Findings:
The inspector found there were sufficient staff on duty to meet the holistic needs or residents. Residents' dependencies were determined using a validated tool. 10 residents were maximum dependency. Six were high dependency and three were medium dependency. Residents, relatives and staff agreed that there were adequate staff on duty both day and night. Planned and unplanned leave were covered by staff who knew the residents and sometimes by staff from an external agency. There was a planned staff roster in place, with any changes clearly indicated. The staffing in place on the day of inspection was reflected in this roster.

There was an effective system to ensure that all staff attended mandatory training and refresher training. Interviews and training records confirmed that staff had up to date mandatory training. Staff also had training on dementia care and the management of responsive behaviours. Training was also provided on other aspects relevant to dementia care, including infection control and nutrition. A number of staff who spoke with the inspector had begun a training programme to improve skin integrity for residents with incontinence. The implementation of training was consistently monitored and the inspector observed staff using good practices in relation to communication, de-escalation and safe manual handling techniques.

Staff who spoke with the inspector had knowledge of all the residents and the staffing arrangements provided for the supervision of residents in communal rooms and meeting the holistic needs of residents. The inspector found a culture where staff took pride in their work and created a positive environment for residents with dementia. The person in charge told the inspector that staff appraisals had just begun and there were plans to roll it out for all staff. The inspector met a household staff member who explained that she undertook household duties such as making beds and tidying residents' bedrooms in order to enable care staff to spend more time with residents. Two staff were officially engaged in activity provision and maintained a record of the activities that each resident engaged in. The inspector noted that many of the residents benefitted from one-to-one interaction with staff and meeting the social and emotional needs of residents was an integral part of the health care attendants' role. Relatives spoke highly of staff and provided examples of staff who went beyond the call of duty to support residents and their families.

The person in charge confirmed that all staff and volunteers were Garda Vetted. Two staff files were examined and they contained all the documentation required under schedule 2.
There is a policy on volunteers and an agreed work agenda for anyone who wished to

Volunteer. They had a job description and an agreement which set out where they can visit, who must be present and they only undertake activities in public areas.

Judgment:
Compliant

Outcome 06: Safe and Suitable Premises

Theme:
Effective care and support

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

Findings:
Previous inspections had found that the dining space was too limited to accommodate 26 resident and some residents had to take their meals in their bedrooms. There were now two sittings for meals and the inspector found that this arrangement met the needs of all the residents. Residents could also dine in the activity sitting room or in a quiet room allocated for residents who preferred to eat alone. The dining room and the activity room were attractively decorated and furnished. The small quiet dining room was quite bleak and would benefit from some refurbishment.

Previous inspections identified that 15 single bedrooms, with floor areas ranging from 7.5 m^2 to 9 m^2 could not safely accommodate residents who required the assistance of 2 staff or a hoist for transfers. The provider had allocated these rooms to mobile residents who did not require the assistance of two staff or a hoist for transfers. Residents with higher dependency needs were accommodated in twin bedrooms or more spacious single rooms. New screening had been installed in the twin rooms to provide privacy when using the ceiling hoist. The inspector found that the bedrooms were adequate to meet the needs of the residents on the day of inspection. There was adequate wardrobe space and a locked storage unit in each room. However the call bells were fixed to the wall and not accessible to residents when they were in bed. Some rooms had been refurbished but others were in a poor state of repair and required redecoration and the installation of shelving for personal possessions. The flooring in the bedrooms was not suitable for mobile residents who were at risk of slips and falls. The furniture and bed tables in some bedrooms was chipped and worn.

Communal toilet, bath and shower facilities were located throughout the centre and were close to all the bedroom and communal areas. The "cubicle style" toilets adjacent to the dining room which were not suitable for residents who required assistance had been removed and replaced by two single toilets. Other bathrooms and shower rooms had been refurbished but the call bell system installed did not have a hand held piece required for residents use. The inspector noted that a programme of refurbishment was ongoing but would not be completed by January 2017, the timeline identified in the

action plan.

The design and layout of the centre meant that circulation through the building required walking through the living or dining spaces to access resident's bedrooms and the visitors' facilities. This did not impact on the dining experience for residents, however the space available in the day room did not allow for seating to be arranged in clusters to support social interaction between residents and chairs were placed around the perimeter of the room.

The inspector noted that the sluice room was adequately equipped and the linen trolleys were no longer stored in the sluice room.

The inspector observed that there was a suitable, well maintained courtyard which provided a secure outdoor space for residents. Access to the courtyard was via two fire doors which were noisy when opened and was difficult for residents to open.

There were grab rails in all communal areas and the wide corridors facilitated residents to walk unimpeded. There were seating bays to provide rest areas for residents.
The relaxation area was suitably furnished and had two specific lights to provide 'day light' to residents. Staff found that residents who were agitated found this space very restful.

Despite its limitations, the provider and staff had worked to maximise the potential of the existing building and to create an environment which suited residents with dementia. A mural was painted near the entrance and furniture had been sourced to create a homely environment for residents. A vintage radio and telephone were displayed on the table in the foyer. Furnishings in the activity room were homely and interesting. There were wall clocks in all the bedrooms and some rooms had photographs on the door to help residents to identify their bedroom. Further consideration should be given to the use of colour and signage to support way-finding for residents.

Service contracts were in place for the maintenance of all assistive equipment provided in the centre.

Judgment:
Non Compliant - Moderate

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:
The actions required from the previous inspection were all completed.

The inspector did a tour of the centre and made the following observations:

The entrance at the front of the centre and the two exits at the rear were now suitable for use by people using wheelchairs.

Access to the sluice room was via a key code pad. Cleaning chemicals were locked away safely. The linen trolley which had previously been stored in the sluice room was now stored close to the laundry area.

The drain in the shower room in the back corridor had been reconfigured to aid drainage. The shower room was clean and old shower screens had been replaced. Two other shower rooms and the bathroom had also been refurbished to a high standard. The cleaning schedules in all the bathroom and shower-rooms showed that these rooms were regularly cleaned.

Fire doors in all the single rooms and the store room had been fitted with self-closing devices.
The fire doors at the rear of the centre had been fitted with key code pads which would be easily opened in an emergency.

A new template for evacuations had been developed and posted throughout the centre. The signage depicted the sub compartments and zones. The information and level of detail was sufficient to guide staff in the event of an emergency which required phased evacuation. Staff who spoke with the inspector were familiar with fire evacuation procedures.

Fire safety records were checked and found to comply with regulatory requirements as set out in schedule four.

Service records for fire safety equipment showed that equipment was serviced on a three monthly basis. The most recent servicing was done on 19 Sept 2016. Fire extinguishers were stored in a manner that made them accessible to staff in an emergency but not accessible to residents. Emergency lighting was checked every two weeks. The emergency exits were all clear and the fire panel and all emergency lighting appeared to be in working order.

Records of fire safety training showed that six fire drills were carried out in 2016. All staff had attended fire safety training and fire drills which included simulated evacuation based on night time conditions. Fire drill records included the names of staff in attendance, the zone where the drill took place, the time taken to execute the evacuation and leanings from the exercise.

The inspector noted that all the residents had a personal emergency evacuation plan (PEEPs). The PEEPs included details of assistance required to overcome disabilities such as poor mobility, impaired hearing and vision but did not reference the supports required by residents with dementia.

Judgment:
Substantially Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Mary O'Donnell
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	Boyne View House
Centre ID:	OSV-0000532
Date of inspection:	15/11/2016
Date of response:	07/12/2016

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 Registered Provider is failing to comply with a regulatory requirement in the following respect:
Records of nutritional intake was not maintained in line with the policy.
Two of the charts viewed for the previous day had no entries after 5pm. Staff confirmed that these residents had taken food and drink after 5pm which was not recorded.

1. Action Required:
Under Regulation 04(1) you are required to: Prepare in writing, adopt and implement

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

policies and procedures on the matters set out in Schedule 5.

Please state the actions you have taken or are planning to take:
The Person in Charge will ensure that the new 24 hour intake and output chart is updated and fully totalled by all staff concerned with responsibility for recording Nutritional intake to include food and fluid. These will be continuously audited and monitored to ensure that these are being recorded at the time of intake.
A new touch screen electronic device is purchased and awaiting installation. This will allow the immediate electronic recording of all nutritional intake immediately by using a touch screen.
A meeting is arranged with staff on 07/12/2016 to discuss these findings and this action will be raised at this meeting.

Proposed Timescale: Immediately and ongoing.

Proposed Timescale: 07/12/2016

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all care plans were comprehensively reviewed. In the case of a resident who had fallen a number of times, their falls history was not analysed to inform their care plan.

2. Action Required:
Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.

Please state the actions you have taken or are planning to take:
A falls Protocol is in place for all residents. If a resident experiences a fall, the protocol is enacted and is followed through on the Risk Management Reporting system and follow up forms. Unfortunately theses follow up were not being transferred to the daily care plans. We will now ensure that the full multidisciplinary falls protocol is adhered to and that the findings from these are incorporated into the Resident's Care Plan. A meeting is arranged with staff on 07/12/2016 to discuss these findings and this action will be raised at this meeting. We will monitor and audit all falls to ensure that the care plan is revised appropriately

Proposed Timescale: Immediately and ongoing.

Proposed Timescale: 07/12/2016

Theme:

Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Although residents had access to dental services, the waiting times varied. One resident waited for over three weeks before accessing dental services privately. Residents with natural teeth did not have routine dental checkups.

3. Action Required:
Under Regulation 06(2)(b) you are required to: Make available to a resident medical treatment recommended by a medical practitioner, where the resident agrees to the recommended treatment.

Please state the actions you have taken or are planning to take:
Dental services are provided by the Health Service Executive on referral. The Director of Nursing and the Person in Charge will now develop a protocol in order to ensure that no resident is awaiting for dental services for such long periods. We will link in with local dental practices to ascertain the feasibility of private dental visits and will also facilitate the visits of dentists of the person's choice. We will now examine opportunities to work with a private dental service, where a HSE dentist is not available, in the event of emergency treatment being required.
The Person in Charge recognises that this is an area that has been neglected and overlooked and will now explore and put in place systems for residents to ensure good ongoing dental care.

Proposed Timescale: 01/03/2017

Outcome 02: Safeguarding and Safety

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no evidence that less restrictive devices which could achieve the goals of care, were available and tried before bed rails were used.

There was no documentary evidence that residents were checked on a two hours basis when bed rails were in use.

4. 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 Provider and the Person in Charge recognises that the use of bedrails is very high. A decision tree is used as per National Restraint Policy. However alternatives that were

tried or tested were not recorded. Going forward we will begin a process of replacing a number of beds with low low beds and fall mats. However we will also ensure that the decision to use bed rails is properly assessed and documented and that all alternatives will be tried and tested and recorded as per National Policy.
Staff training on the use of restrictive devices is planned for January 2017 for all staff.

We will now ensure that two hourly checks of any bed rail usage is recorded over a 24 hour basis. This will be audited and monitored to ensure full compliance. A meeting is arranged with staff on 07/12/2016 to discuss these findings and this action will be raised at this meeting.

Proposed Timescale: Immediately and ongoing

Proposed Timescale: 07/12/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The centre could not meet the needs of a resident with BPSD (Responsive Behaviours) who presented with violent behaviours. The inspector found that arrangements in place for one to one supervision did not sufficiently protect vulnerable residents from the risk of violence.

5. 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:
The Director of Nursing and the Person in Charge has been actively seeking alternative accommodation for a particular resident. Appropriate accommodation is proving very difficult to find as all options have been explored for alternative accommodation but we will continue to explore all avenues available.
We are seeking a review once more from the psychologist on the Mental Health Team.
We will explore any incidents using the ABC assessment tool and really ensure that all staff consistently follow and learn from any incident.
CNM2 is establishing a system to review all behaviours to ensure that all positive interventions are utilised and to recognise a possible pattern of triggers
We will continue to use 1:1 Supervision and therapy.
The Registered Provider is now seeking accommodation elsewhere and we will keep the Authority updated with progress.

Proposed Timescale: 07/12/2016

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Consultation with residents who had dementia was proving to be a challenge.
Relatives views informed end of life care plans and it could not be determined if residents were invited to participate in the process.
Records of residents meetings showed that they were poorly attended and the most recent meeting did not have any residents in attendance.

6. Action Required:
Under Regulation 09(3)(d) you are required to: Ensure that each resident is consulted about and participates in the organisation of the designated centre concerned.

Please state the actions you have taken or are planning to take:
From January 2017 a new post is being created as Dementia Care Key Worker. This person will work closely with people newly diagnosed with dementia and for those who have some capacity to make decisions. The Dementia Care Key Worker will also follow through on residents admitted from the community to Residential Services in order to effectively manage this transition. We will, going forward, completely respect any Powers of Attorney as well as enduring Powers of Attorney.
Group meetings for people with dementia are not working effectively. We will therefore rearrange to consult with residents on an individual basis. Decisions of residents on an individual issue at a particular time will be respected and worked upon. We will then be able to theme commonalities that emerge and plan services around same. We will continue to use the services of SAGE Advocacy. We will ensure that all staff attend the awareness raising sessions on the New Capacity Act and its implications. In February 2017 we will establish a Rights Forum in conjunction with people with dementia and their representatives and with Advocates to highlight areas where a person's rights are supported to maximum extent possible

Proposed Timescale: 01/12/2017

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:
The provider has not submitted a costed, time-bound plan to bring the premises into compliance with the Regulations.

7. 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:
A meeting with the planners and HSE Estates is taking place on the 07/12/2016 and the Registered Provider commits to furnishing the Authority with a costed, time bound plan as soon as finalised. Residents and Relative representatives are involved with the planning process

Proposed Timescale: 30/03/2017

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The programme of refurbishment was on-going but not scheduled for completion by January 2017 the timeline identified in the action plan:
Some bedrooms were in a poor state of repair and required redecoration and the installation of shelving for personal possessions. The flooring in the bedrooms was not suitable for mobile residents who were at risk of slips and falls.
The furniture and bed tables in some bedrooms was chipped and could not be adequately cleaned.

The small quiet dining room was quite bleak and would benefit from some refurbishment.

Access to the courtyard was via two fire doors which were noisy when opened and was difficult for residents to open.

8. 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:
Quotations have now been sought for the repainting of all bedrooms in single rooms.
We will ensure that new shelving is installed in all bedrooms for personal effects.
Quotations have now been received for the removal of old floor covering and replacement with new non slip floor covering. The old bed tables are now in the process of being removed and replaced. The small dining room will be refurbished as part of these ongoing works
Doors going into the Courtyard will be replaced with doors that allow much easier access to the Courtyard.

Proposed Timescale: 01/03/2017

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Call bells were wall mounted and not accessible to residents who were in bed. The call bell system installed in the refurbished bathrooms did not have a hand held piece required for residents use.

9. 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:
We have commenced a programme for call bell replacement. The main alert call bell system has been installed for all toilets. New hand sets are now being purchased on a phased basis and can be directly linked to this system

Proposed Timescale: 01/03/2017

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:
The inspector noted that all the residents had a personal emergency evacuation plan (PEEPs). The PEEPs included details of assistance required to overcome disabilities such as poor mobility, impaired hearing and vision but did not reference the supports required by residents with dementia.

10. 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:
The PEEPS will now be individually revised to ensure that all assistance required by individual residents are recorded properly and that will be used in the event of an evacuation.

Proposed Timescale: 15/01/2017