

Health Information and Quality Authority  
Social Services Inspectorate

Inspection report  
Designated centres for older people



<b>Centre name:</b>	Bishopscourt Residential Care Ltd
<b>Centre ID:</b>	0200
<b>Centre address:</b>	Liskillea
	Waterfall
	Co Cork
<b>Telephone number:</b>	021-4885833
<b>Fax number:</b>	021-4885864
<b>Email address:</b>	bishopscourt@eircom.net
<b>Type of centre:</b>	<input checked="" type="checkbox"/> <b>Private</b> <input type="checkbox"/> <b>Voluntary</b> <input type="checkbox"/> <b>Public</b>
<b>Registered provider:</b>	Bishopscourt Residential Care Ltd
<b>Person in charge:</b>	Ligimol George
<b>Date of inspection:</b>	15 June 2010 and 16 June 2010
<b>Time inspection took place:</b>	<b>Day-1 Start:</b> 09:00hrs <b>Completion</b> 17:15hrs <b>Day-2 Start:</b> 10:30hrs <b>Completion</b> 17:40hrs
<b>Lead inspector:</b>	Allison Cummings
<b>Support inspector(s):</b>	Patricia Sheehan
<b>Type of inspection:</b>	<input checked="" type="checkbox"/> <b>Registration</b> <input type="checkbox"/> <b>Scheduled</b>  <input checked="" type="checkbox"/> <b>Announced</b> <input type="checkbox"/> <b>Unannounced</b>

## About inspection

The purpose of inspection is to gather evidence on which to make judgments about the fitness of the registered provider and to report on the quality of the service. This is to ensure that providers are complying with the requirements and conditions of their registration and meet the standards; that they have systems in place to both safeguard the welfare of service users and to provide information and evidence of good and poor practice.

In assessing the overall quality of the service provided, inspectors examine how well the provider has met the requirements of the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland* under the following topics:

1. Governance and leadership: how well the centre is organised.
2. The quality of the service.
3. How well the healthcare needs of residents are met.
4. Premises and equipment: appropriateness and adequacy.
5. Communication: information provided to residents, relatives and staff.
6. Staffing: the recruitment, supervision and competence of staff.

This report summarises the findings of the inspection under some or all of these topics, highlighting areas of good practice as well as areas where improvements were required as follows:

**Evidence of good practice** – this means that an acceptable standard was reached and the provider demonstrated a culture of review and improvement and aimed to drive forward best practice.

**Some improvements required** – this means that practice was generally satisfactory but there were areas that need attention.

**Significant improvements required** – this means that unacceptable practice was found.

The report also identifies minor issues, where applicable, to which the provider should give consideration to enhance the quality of the service.

**Registration inspections** are part of a process to assess whether providers are fit and legally permitted to provide a service. The registration of a designated centre is for three years. After that the provider must make an application for registration renewal at least six months before the expiration date of the current registration.

New providers must make an application for first time registration six months prior to the time the provider wishes to commence.

In controlling entry to service provision, the Chief Inspector of Social Services is fulfilling an important regulatory duty under section 40 of the Health Act 2007. Part of this duty is a statutory discretion to refuse registration if the Chief Inspector is not satisfied about a provider's fitness to provide services, or the fitness of any other person involved in the management of a centre.

The registration inspection is one element for the Chief Inspector to consider in making a proposal to the provider in respect of registration. Other elements of the process designed to assess the provider's fitness include the information provided in the application to register, the Fit Person self-assessment and the Fit Person interviews. Together these elements are used to assess the provider's understanding of, and capacity to, comply with the requirements of the regulations and the Standards. Following assessment of these elements, a recommendation will be made to the Chief Inspector and the formal legal process for registration will proceed. As a result, this report does not outline a final decision in respect of registration.

The report is available to residents, relatives, providers of services and members of the public, and is published on our website [www.hiqa.ie](http://www.hiqa.ie).

## About the centre

### Description of services and premises

Bishopscourt Residential Care Ltd. has a capacity for 60 residents and caters for older people, including dementia, but excluding those with challenging behaviour. They also provide respite and convalescent care to older people. At the time of inspection there were 60 older people in residence. There were 24 residents with dementia.

It is a single-storey, purpose built centre situated on three acres of land. At the front of the building, there are landscaped gardens and footpaths for residents and visitors to go for walks. There is also plenty of car parking space.

There are two wings: Heather and Fuschia. In the Fuschia wing there are 30 single bedrooms. In the Heather wing there are 12 twin and six single bedrooms. All rooms have an en suite shower, toilet and wash-hand basin. There is one assisted toilet near communal areas. A nurses' station is located in each wing.

There are four internal sitting rooms as well as secure outdoor gardens with seating which can be accessed from the Heather wing. There is also a covered walkway approximately 50 metres long that links each end of the Heather wing. The ledges contain potted plants brought in from home by residents. The dining room is located centrally and is divided into two areas for those who need assistance and those who eat independently it is secured by key-pad entry. The kitchen is directly off the dining room. There is a dedicated room for the hairdresser to attend to residents' appointments. It is fitted with two sinks and a bath (the bath is not used).

### Location

Bishopscourt Residential Care Ltd. is located within a cluster of houses in a rural setting off the N71 heading west from Cork city to Bandon. It is four miles from Bishopstown. Access is via a narrow road and the centre is well signposted.

<b>Date centre was first established:</b>	1998
<b>Number of residents on the date of inspection</b>	60
<b>Number of vacancies on the date of inspection</b>	0

<b>Dependency level of current residents</b>	<b>Max</b>	<b>High</b>	<b>Medium</b>	<b>Low</b>
<b>Number of residents</b>	2	14	41	3

## Management structure

Bishopscourt Residential Care is a limited company with four directors. Catherine O'Connor was recently nominated by the directors as Register Provider. Another director, Patricia O'Sullivan, works as a staff nurse at the centre. The other two directors have no operational role in the running of the business other than major decision making such as the approval of significant amounts of expenditure.

The Person in Charge is Ligimol George. She has been acting in this capacity since February 2010 when the previous Person in Charge resigned. The provider informed inspectors that the recruitment process is complete and that a new person in charge will commence employment in September 2010.

The company has been in operation since 1998 when it purchased what was then a 20 bed facility. It has expanded in two stages up to 32 beds, and now 60 beds.

There are 45 members of staff in total. All carers and nurses report to the person in charge. In her absence, these staff report to a senior nurse, Lincy Thomas. All other staff report to the provider.

Staff designation	Person in Charge	Nurses	Care staff	Catering staff	Cleaning and laundry staff	Admin staff	Other staff
Number of staff on duty on day of inspection	1	3	6	1	2	1	2

## Summary of findings from this inspection

This was an announced registration inspection and it was carried out over two days. It was the centre's first inspection undertaken by the Health Information and Quality Authority. As part of the registration process, the registered provider had to satisfy the Chief Inspector of the Social Services Inspectorate that she was fit to provide the service and that the service will comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

Inspectors met with residents, staff and relatives. They reviewed documents such as staff rosters, policies, minutes of meetings and resident care plans. They spent time sitting with residents and observing practice to gain a greater insight into residents' experience of the service.

An interview was carried out with the person in charge. She was very clear that she was providing temporary cover and that a new person in charge was due to commence employment in September 2010. She explained that she had previously deputised for her predecessor until she left in early 2010. She did not complete the "fit person" self-assessment. She was committed to the welfare and well being of the residents.

An interview was also carried out with the provider, Catherine O'Connor. The provider completed the "fit person" self-assessment. This document was reviewed by the inspectors, along with all the information in the registration application form and associated documents.

Overall, the management and staff were committed to the residents and there were good working relationships between staff and management. However, inspectors concluded that the service lacked strong leadership due to the recent changes at senior management level.

Furthermore, there were significant issues to be resolved in relation to the establishment of a quality system for reviewing and improving the quality and safety of care provided to residents, staffing levels and management of complaints. Other significant improvements are required in relation to restraint practices, the management of allegations of elder abuse, medication management, staff qualifications and training.

A number of other improvements are required. These relate to:

- processes for the safekeeping of residents' finances
- residents' dining experience
- care planning for residents' social needs
- access to a dietician
- referrals made to peripatetic services
- visual elements of the premises for residents with cognitive impairment
- information to be obtained with respect to staff working in the centre.

These issues are addressed in the Action Plan and recommendations at the end of this report.

### **Comments by residents and relatives**

Inspectors received written feedback from eight residents and six relatives prior to the inspection. Inspectors also met with five residents and one relative during the inspection and their responses provided valuable information on their experiences in the centre.

All residents said that they felt well cared for and safe in their environment. Residents said that they enjoyed playing cards, listening to music, conversing with other residents, reading the paper and exercise. However, one resident said that she was bored and another resident seemed dissatisfied with her life in the centre by commenting "you can't expect too much from anything, so I accept it". When speaking with a group of residents, all four agreed that there were not sufficient staff, particularly in the mornings and evenings. One resident said that she liked to go to bed at 21:00hrs but because there were not enough staff, she was assisted to bed at 22:00hrs instead. During lunchtime, some residents complained that it took a long time to receive their meal.

Relatives said that they were satisfied with the service, providing a high level of positive feedback to inspectors.

## Overall findings

### 1. Governance: how well the centre is organised

**Outcome:** The centre is well organised and managed and complies with the requirements of the Health Act 2007, the regulations and standards.

**Good governance involves the effective and efficient deployment of resources in accordance with the stated purpose and function of the centre. Governance includes setting clear direction for the service, a commitment to continual improvement and having a system in place to effectively assess and manage risk.**

#### Evidence of good practice

Although in draft form, the statement of purpose accurately reflected the services provided to residents and the range of needs that the service intends to meet. The other information contained within it was also compliant with the regulations.

There was sufficient insurance cover in place which included cover for residents' personal belongings.

Inspectors observed that the person in charge was actively involved in the care of residents and staff understood their roles. During the fit person interviews, inspectors found that the person in charge and the provider were still in the process of familiarising themselves with the legal responsibilities of their respective posts. The person in charge was acting temporarily in her role. The provider said that she had recruited another person in charge. Although a contract had not been agreed, the provider had clear expectations of the contributions to be made by the new person in charge.

An inspector met with the nominated complaints officer and was shown a system for processing and resolving complaints as per the centre procedure.

#### Some improvements required

Inspectors observed that there were two different systems for recording residents' money and personal belongings which was not in accordance with the written policy. This compromised their security.

#### Significant improvements required

There were insufficient staff employed to meet the needs of residents. Inspectors met with staff who commented that they felt under pressure and constrained by time. Consequently, inspectors were informed by staff and residents that medicines were administered early morning by the night staff, disrupting residents' sleep

patterns and overall quality of life. Records showed that one resident complained about this practice. The times were changed for this resident but, there was no evidence that this practice was reviewed or changed for the benefit of other residents. Additionally, inspectors saw that staff had little interaction with residents other than at times when direct care was provided. The roster also showed that there was one catering staff member rostered each day to prepare meals for 60 residents. Inspectors heard some residents commenting about their frustration with the length of time it took for their meal to be served, and also observed the delay.

The provider had not established a system for reviewing and improving the quality and safety of care provided to residents, including residents' quality of life.

The procedures in place for managing complaints were not effective. Inspectors met with the complaints officer and found that she was also the appeals officer. In the event that a resident appealed the outcome of a complaint, this arrangement meant that the outcome would be reviewed by the same person who did the initial investigation. Therefore, there was effectively no independent review.

On review of the complaints book and other documents, inspectors found that the complaints book was not an accurate record of all complaints made. The complaints officer explained that this was because there were three systems in operation:

- minor complaints were recorded in the resident's care plan
- major complaints were recorded in the complaints book
- other complaints were raised at residents' committee meetings and recorded in the minutes.

These different systems impacted on overall learning from complaints and limited the potential to identify trends in order to make service improvements.

Although the policy stated that where complaints are resolved locally, they should be documented in the resident's records, there was no definitive record of all complaints.

## 2. Quality of the service

**Outcome: Residents receive a good standard of service, appropriate treatment and are treated with courtesy and respect.**

**A quality service is one where residents are protected from harm or abuse, where practice is person-centred, where rights are protected, where residents are enabled to play an active part in the centre and where management, staff and residents work together towards continuous improvement.**

### Evidence of good practice

On review of documentation, observations made and discussions with staff and residents, inspectors found evidence of good practice in the following areas:

- maintaining residents' privacy and dignity
- arrangements for respecting residents' religious beliefs
- a primary nurse and carer system to promote continuity of care
- progress towards volunteer involvement from the local parish to facilitate more meaningful activities such as an arts exhibition
- resident enablement and participation in the running of the centre through the establishment of a regular resident's committee facilitated by an advocate
- there were systems in place for the provider to respond to issues raised by residents at committee meetings
- suggestion box in place for seeking residents' views on service improvements
- fortnightly mobile library service for residents
- residents' self-esteem was enhanced through a regular hair dressing service
- staff had been trained in preventing, detecting and responding to elder abuse and conveyed a good understanding of what constituted abuse.

### Some improvements required

Mealtimes were not person centred or a rewarding experience for residents. The dining room could only be accessed by staff who knew the code to enter into a key-pad which ensured the room remained locked at all times. The person in charge said they did this because residents and visitors were coming into the room outside of meal time. Inspectors were advised that the dining room was set for lunch by staff the night before and this suggested that the smooth running of the centre to meet the needs of staff was prioritized over the preferences of residents.

Inspectors joined residents for lunch and found that it took a long time to serve meals 50 minutes had passed before some resident's meals were served and they were not served at a similar time. The room was hot and ventilation was poor. Space was limited and inspectors observed that it was difficult for some residents to get in

and out of their chairs. Inspectors heard some residents complaining about these issues over lunch.

There was an established programme of activities that addressed lots of residents' interests and staff demonstrated a good knowledge of residents' life histories. However, care plans did not reflect the interventions that were used to meet their social needs. Furthermore, the activities co-ordinator had an understanding of meaningful activities for residents with dementia but inspectors could not determine how frequently these happened.

### **Significant improvements required**

Restraint practices were reviewed in depth. Discussions were had with staff, observations were made and a sample of residents' records were examined. It was clear that a large number of residents were inappropriately restrained with bed rails at night in response to behavioural symptoms with nursing records stating "trying to get out of bed at night". No medical reasons had been identified or recorded which would warrant the need to initiate any form of physical restraint, and no risk assessments had been carried out to determine alternatives. Furthermore, there was no evidence that residents had consented. Rather, a relative and the resident's GP had inappropriately consented on the residents' behalf even when they were capable of consenting themselves. There was also no evidence of the duration of the restraint, regular checks on the resident or opportunities for range of movement exercises.

On 6 May 2010 a notification from the provider was received by the Authority, of an incident where two residents were extremely distressed by the challenging behaviour of another. A provider led investigation was issued by the Authority to the provider. She completed the investigation form and submitted this with further information. This included an outdated written policy for responding to allegations of abuse which was not in accordance with best practice initiatives and guidelines including the need for the resident affected to make a complaint before any investigation took place. Inspectors also confirmed that the person in charge was not aware of her legal responsibilities to complete and report the incident. Instead, it was completed by the corporate secretary who is not the person who is legally required to notify the Authority. While the issue was resolved, the manner in which it was done was not in accordance with best practice.

### **Minor issues to be addressed**

In the care plans reviewed by inspectors, it was noted that the interventions implemented by nursing staff were not always linked to a relevant aim which impacted on the how well nursing staff could evaluate the outcome.

### 3. Healthcare needs

**Outcome: Residents' healthcare needs are met.**

**Healthcare is integral to meeting individual's needs. It requires that residents' health, personal and social care needs are assessed and reviewed on an ongoing basis, within a care planning process, that is person centred. Emphasis is firmly placed on health promotion, independence and meaningful activity.**

#### Evidence of good practice

On review of documentation, observations made and discussions with staff and residents, inspectors found evidence of good practice in the following areas:

- health promotion interventions including an exercise programme, access to safe outdoor areas, access to water in communal areas, residents being encouraged to walk with the assistance of staff
- safe medication administration included photographic identification of residents
- regular GP and pharmacist review and six monthly pharmacy audits
- effective assessment and monitoring of wounds
- a four weekly rotation of the menu, healthy snacks offered and effective communication between nursing and catering staff which resulted in a good knowledge of residents' likes and dislikes and special requirements
- adequate access to specialist services including gerontology, speech and language therapy, occupational health, physiotherapy and audiology.

#### Some improvements required

Residents did not have access to a dietician. However, inspectors were informed by the provider there were formal plans for this, particularly for one resident who needed a weight reduction plan.

There was no record of referrals made to peripatetic services.

#### Significant improvements required

There were no arrangements in place to audit medication management practices. Additionally, there was no procedure for pro re nata (as required) medication prescribing and administration.

## **4. Premises and equipment: appropriateness and adequacy**

**Outcome: The residential care setting provides premises and equipment that are safe, secure and suitable.**

**A good physical environment is one that enhances the quality of life for residents and is a pleasant place to live. It meets residents' individual and collective needs in a comfortable and homely way, and is accessible, safe, clean and well-maintained. Equipment is provided in response to the assessed needs of each of the residents and maintained appropriately.**

### **Evidence of good practice**

On review of documentation, observations made and discussions with staff and residents, inspectors found evidence of good practice in the following areas:

- bedrooms are spacious and meet the requirements set out in the Standards
- all 24 residents with dementia have their own bedroom
- staff promoted regular toileting, availing of the residents' own en suite toilets. Hence, sluicing facilities were not needed and therefore were not provided
- four sitting rooms afford pleasant views of the grounds and promote privacy for residents to meet with visitors
- the most recent environmental health report illustrated compliance with relevant regulations
- cleaning procedures were in line with best practice
- access to three acres of maintained grounds, ample car parking space and safe gardens within the building complex for residents with cognitive impairment
- a system is in place for upkeep of physical premises
- provision of storage space for assistive equipment.

### **Some improvements required**

There were a lack of landmarks, cueing and distinctive visual elements to orient residents and to promote their independence.

### **Minor issues to be addressed**

There was a lack of wash-hand basins and antimicrobial gel near communal areas for infection control purposes. This meant that staff had to access a wash-hand basin in the staff room or in the en suite of residents' bedrooms.

## **5. Communication: information provided to residents, relatives and staff**

**Outcome: Information is relevant, clear and up to date for residents.**

**Information is accessible, accurate, and appropriate to residents' and staff needs. Feedback is actively sought from residents and relatives and this informs future planning and service provision. Information is recorded and maintained in accordance with legal requirements and best practice and is communicated to staff on a need to know basis to ensure residents' privacy is respected.**

### **Evidence of good practice**

On review of documentation, observations made and discussions with staff and residents, inspectors found evidence of good practice in the following areas:

- the activities coordinator had completed a course on providing advocacy to residents with dementia
- activities available to residents were displayed prominently, in large print and creatively to increase levels of participation
- there were systems in place for regular communication between carers and staff to ensure continuity of care for residents.

## **6. Staff: the recruitment, supervision and competence of staff**

**Outcome: Staff are competent and recruited in sufficient numbers to meet residents' needs**

**Staff numbers and skill-mix are determined by the size and complexity of the service and there should be sufficient competent staff on duty, both day and night, to meet the needs of residents. Robust recruitment and selection procedures ensure the appointment of suitably qualified and experienced staff. Staff are supported in their work by ongoing training and supervision.**

### **Evidence of good practice**

On review of documentation, observations made and discussions with staff and residents, inspectors found evidence of good practice in the following areas:

- Garda Síochána vetting was in place for all staff
- rotas were up to date and comprehensively completed and reflected the staff complement on the day of inspection.

### **Some improvements required**

The policy for the recruitment, selection and appointment of staff was not adhered to in that there was no evidence of three written references, qualifications, full employment history and medical/physical fitness of two personnel files reviewed by inspectors. These omissions compromised the provider's ability to determine fitness and suitability of staff employed to work with vulnerable older people.

### **Significant improvements required**

There was little capital investment in staff training. Inspectors found that there were low levels of care staff with a relevant care qualification. Only three of the 26 care staff were qualified to Further Education and Training Awards Council (FETAC) level 5. The remaining care staff had no relevant qualification.

Only two staff nurses had received training in dementia-specific care in the last 12 months. There was no evidence of staff training in managing challenging behaviour. This was further illustrated when a resident was discharged within eight months of admission due to the inability to manage his challenging behaviour.

The provider gave inspectors a list of training provided to staff. It showed that only 10 out of the 45 staff employed at the centre had been provided with manual handling training since 2006. The provider stated that the trainer (a staff nurse and one of the directors of the company) provided the training to staff but it appeared that she last underwent a refresher course in manual handling in January 2006.

Inspectors also observed on one occasion that a staff member inappropriately held a resident by the top of his trousers when he was assisted to transfer from a wheelchair to an armchair.

## Closing the visit

At the close of the inspection visit a feedback meeting was held with the provider and the acting person in charge to report on the inspectors' findings, which highlighted both good practice and where improvements were needed.

### **Acknowledgements**

The inspectors wish to acknowledge the cooperation and assistance of the residents, relatives, provider and staff during the inspection.

#### ***REPORT COMPILED BY***

Allison Cummings  
Inspector of Social Services  
Social Services Inspectorate  
Health Information and Quality Authority

15 June 2010

## Provider's response to inspection report

<b>Centre:</b>	Bishopscourt Residential Care Ltd
<b>Centre ID:</b>	0200
<b>Date of inspection:</b>	15 June 2010 and 16 June 2010
<b>Date of response:</b>	12 November 2010

### Requirements

These requirements set out what the registered provider must do to meet the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

#### 1. The provider is failing to comply with a regulatory requirement in the following respect:

Restraint practices did not adhere to current best practice. Documentation was inadequate.

#### Action required:

Make arrangements to aim for a restraint-free environment. In doing so, document the assessment of each resident prior to any consideration of physical restraint. The assessment must identify and consider:

- the specific medical symptom to be treated by the use of physical restraint
- the steps taken to identify the underlying physical and/or psychological causes of the medical symptom
- the alternative measures that have been taken, for how long, how recently and with what results
- the evidence that a physical restraint will benefit the symptom
- the risks involved in using the physical restraint

<ul style="list-style-type: none"> <li>▪ the specific circumstances under which physical restraint is being considered</li> <li>▪ the type of physical restraint, period of physical restraint, and location of physical restraint.</li> </ul>	
<p><b>Action required:</b></p> <p>Ensure that the resident is not restrained without his/her informed consent.</p>	
<p><b>Action required:</b></p> <p>Keep a record of any occasion on which restraint is used, the nature of the restraint and its duration.</p>	
<p><b>Reference:</b></p> <p style="padding-left: 40px;">Health Act, 2007 Regulation 25: Medical Records Standard 21: Responding to Behaviour that is Challenging</p>	
<b>Please state the actions you have taken or are planning to take with timescales:</b>	<b>Timescale:</b>
<p>Provider's response:</p> <p>Restraint assessments were completed on all relevant residents and included details of the medical symptoms to be treated, the steps taken to identify the underlying physical and /or psychological causes of that symptom. The assessments examined the alternate measures taken, the evidence that physical restraint would be effective, any risks and the specific circumstances under which physical restraint was being considered. The documentation now contains all of the relevant information and all relevant residents' signatures have been obtained.</p>	<p>Completed</p>

<p><b>2. The provider and the person in charge failed to comply with a regulatory requirement in the following respect:</b></p> <p>An alleged incident of abuse was poorly handled.</p>
<p><b>Action required:</b></p> <p>Amend the policy so that it takes into account current legal requirements and best practice initiatives.</p>
<p><b>Action required:</b></p> <p>Ensure that future incidences are fully and promptly investigated in accordance with the policies and procedures.</p>

<b>Action required:</b>	
Within three working days, the person in charge must notify the Chief Inspector of the occurrence of any allegation, suspected or confirmed abuse of any resident.	
<b>Reference:</b> Health Act, 2007 Regulation 6: General Welfare and Protection Standard 8: Protection	
<b>Please state the actions you have taken or are planning to take with timescales:</b>	<b>Timescale:</b>
Provider's response:  Our policy has been updated to meet current legal requirements and to ensure the investigation procedure is clear and unambiguous and that the relevant authorities are notified promptly as appropriate.	Completed

<b>3. The provider and the person in charge have failed to comply with a regulatory requirement in the following respect:</b>	
The procedures in place for managing complaints were not effective.	
<b>Action required:</b>	
The provider must make certain that the appeals process is independent.	
<b>Action required:</b>	
The provider must ensure that the nominated person for dealing with complaints maintains a record of all complaints detailing the investigation and outcome of the complaint and whether or not the resident was satisfied.	
<b>Action required:</b>	
Establish and maintain a system for improving the quality and safety of care provided at, and the quality of life of residents in, the designated centre, which includes the review of complaints made.	
<b>Reference:</b> Health Act, 2007 Regulation 35: Review of Quality and Safety of Care and Quality of Life Regulation 39: Complaints Procedures Standard 6: Complaints	
<b>Please state the actions you have taken or are planning to take with timescales:</b>	<b>Timescale:</b>

<p>Provider's response:</p> <p>Immediately following the inspection the complaint policy was updated. A copy of the updated policy was sent to HIQA offices on 6 July 2010. The director of nursing is now the appeals officer, meaning appeals are no longer heard by the complaints officer. All complaints are now locked into medical tracking software used in the sector and operating at the home for the past three years to be tracked and outcomes outlined. Further, a monthly review by management is undertaken to ensure improvements of care.</p>	<p>Completed</p>
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<p><b>4. The person in charge failed to comply with a regulatory requirement in the following respect:</b></p>	
<p>There were inadequate techniques to facilitate and encourage residents with dementia to communicate.</p>	
<p><b>Action required:</b></p> <p>Make arrangements to facilitate and encourage residents with dementia to communicate, including the provision of techniques such as life stories, reminiscence, reality orientation, validation, sensory equipment and music.</p>	
<p><b>Reference:</b></p> <p>Health Act 2007  Regulation 11: Communication  Standard: Supplementary Criteria for Dementia-Specific Residential Care Units for Older People</p>	
<p><b>Please state the actions you have taken or are planning to take with timescales:</b></p>	<p><b>Timescale:</b></p>
<p>Provider's response:</p> <p>All staff received An Bord Altranais (Irish Nursing Board) approved training in dementia and challenging behaviour on 4 August 2010 and 11 August 2010. Our activities coordinator has commenced reminiscence therapy sessions in both group and one to one settings. All staff promotes reality orientation through daily conversation with residents. Visual cards are available for communications with residents if necessary.</p> <p>We have begun the process of collecting and collaborating with residents and families for life books and memory boxes for appropriate residents. Our sensory programme will be developed in the immediate future</p>	<p>Training complete. New policies in place</p> <p>Programme to be completed by 1 January 2010</p>

**5. The person in charge has failed to comply with a regulatory requirement in the following respect:**

There were low levels of care staff with a relevant care qualification.

There were low levels of training provided in dementia-specific care and manual handling. There was no evidence of training provided in managing challenging behaviours.

**Action required:**

Make certain that staff members have access to education and training to enable them to provide care in accordance with contemporary evidence based practice.

**Action required:**

Train all staff in the moving and handling of residents.

**Reference:**

- Health Act, 2007
- Regulation 17: Training and Staff Development
- Regulation 31: Risk Management Procedures
- Standard 24: Training and Supervision
- Standard 26: Health and Safety

**Please state the actions you have taken or are planning to take following the inspection with timescales:**

**Timescale:**

Provider's response:

All staff have had training in dementia and challenging behaviour as of 11 August 2010.

Training complete

We have informed staff of the HIQA requirements in manual handling – the remaining staff will be trained by 31 October 2010.

20 November 2010

All but 10 of the staff have had updated training in manual handling – the remaining staff will be trained by 31 October 2010.

1 December 2010

Our new director of nursing is qualified with an MA in gerontology and has recently received approval to run An Bord Altranais Category 1 courses for all staff in the nursing home. A complete training schedule for the coming year has been devised for staff. We are also in the process of providing in services training with the involvement of GPs and the pharmacist.

26 October 2010

**6. The person in charge has failed to comply with a regulatory requirement in the following respect:**

There were insufficient staff deployed to meet the needs of residents.

**Action required:**

Make certain that at all times the numbers of staff and skill mix of staff are appropriate to the assessed needs of residents, and the size and layout of the centre.

**Reference:**

Health Act, 2007  
Regulation 16: Staffing  
Standard 23: Staffing levels and Qualifications

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

**Timescale:**

Provider's response:

Our director of nursing has re-examined our staff rotas and matching patients' needs to staffing levels in the layout and size of the centre.

15 October 2010

**7. The provider and the person in charge have failed to comply with a regulatory requirement in the following respect:**

There were two different systems for recording money and personal belongings in place. Additionally, the policy relating to residents' personal property and possessions had not been adhered to. These issues combined, compromised the security of residents' property and possessions.

**Action required:**

The registered provider must ensure written policies and procedures relating to residents' personal property and possessions are operational.

**Action required:**

The person in charge must ensure that a record is kept of each resident's personal property signed by the resident and this record must be kept up to date.

**Reference:**

Health Act, 2007  
Regulation 7: Residents' Personal Property and Possessions  
Standard 9: The Resident's Finances

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

**Timescale:**

Provider's response:	
Our policy has been reviewed and all relevant staff have been informed of procedure. A review of this policy implementation will be conducted.	15 November 2010

**8. The provider and the person in charge have failed to comply with a regulatory requirement in the following respect:**

The dining experience was not enjoyed by residents in that:

- residents were seated for long periods prior to meals being served
- meals were served to some residents at different times from others dining with them
- the room was hot with poor ventilation
- there was inadequate space which made it difficult for some residents to get in and out of their chairs.

Outside of meal times, the dining room was locked, preventing residents from accessing this communal space.

**Action required:**

The person in charge must make certain that at all times the numbers of staff are appropriate to the assessed needs of residents, and the size and layout of the centre. This includes the staff employed to prepare meals for residents and care staff who assist with setting the dining area.

**Action required:**

The provider must review the size and layout of the dining room so that is accessible to residents at all times, and suitable for residents' needs.

**Action required:**

The provider must make sure that the ventilation and heating in communal areas is suitable for residents.

**Action required:**

The provider must make certain that communal areas, including the dining room, can be used by residents.

**Reference:**

- Health Act, 2007
- Regulation 16: Staffing
- Regulation 19: Premises
- Standard 25: Physical Environment
- Standard 23: Staffing levels and Qualifications

<b>Please state the actions you have taken or are planning to take with timescales:</b>	<b>Timescale:</b>
<p>Provider's response:</p> <p>They layout of the dining room has been reviewed to ensure easy access for residents.</p> <p>We have reviewed and changed our practice in relation to the serving of meals and have eliminated the delays.</p>	<p>Completed by 30 September 2010</p> <p>Completed by 30 September 2010</p>

**9. The provider is failing to comply with a regulatory requirement in the following respect:**

Care plans did not address residents' social needs.

**Action required:**

Ensure each resident's social needs are set out in an individual care plan.

**Reference:**

Health Act 2007  
 Regulation 8: Assessment and Care Plan  
 Standard 11: The Resident's Care Plan

<b>Please state the actions you have taken or are planning to take with timescales:</b>	<b>Timescale:</b>
<p>Provider's response:</p> <p>Residents' social preferences are now always included in residents' care plans</p>	<p>Update of existing care plans completed 30 September 2010</p>

**10. The provider has failed to comply with a regulatory requirement in the following respect:**

Medication management practices were inadequate in that there was no:

- arrangements in place to audit medication management practices
- procedure for PRN (as necessary) medication prescribing and administration.

**Action required:**

Amend written operational policies to include the prescription and administration of PRN (as required) medicines to residents.

<b>Action required:</b>	
Audit medication management practices on a regular basis to ensure effective and safe resident care.	
<b>Reference:</b>	
Health Act, 2007 Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines Standard 14: Medication Management	
<b>Please state the actions you have taken or are planning to take with timescales:</b>	<b>Timescale:</b>
Provider's response:	
Our medication policy was updated to include PRN medicines and auditing and a copy sent to HIQA office on 6 July 2010.	Completed 23 June 2010

<b>11. The provider has failed to comply with a regulatory requirement in the following respect:</b>	
There was no evidence of referrals made to peripatetic services.	
Residents did not have access to a dietician.	
<b>Action required:</b>	
Facilitate residents to have access to a dietician if required.	
<b>Action required:</b>	
Keep records of all referrals made to specialist services.	
<b>Reference:</b>	
Health Act 2007 Regulation 9: Health Care Standard 13: Healthcare	
<b>Please state the actions you have taken or are planning to take with timescales:</b>	<b>Timescale:</b>
Provider's response:	
A dietician has been made available to residents as and from 5 July 2010. Staff also received a talk on nutrition from the dietician on 6 June 2010.	6 July 2010

**12. The provider is failing to comply with a regulatory requirement in the following respect:**

The physical environment for residents with dementia lacked landmarks, cueing and distinctive visual elements to orient residents and to promote their independence.

**Action required:**

The physical design and layout of the premises to be used as the designated centre meets the needs of each resident with dementia.

**Reference:**

Health Act 2007  
Regulation 19: Premises  
Standard 25: Physical Environment  
Supplementary Criteria for Dementia-specific Residential Care Units for Older People

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

**Timescale:**

Provider's response:

The facility now features landmarks and cues to help orient residents.

Completed 30  
September 2010

**13. The provider is failing to comply with a regulatory requirement in the following respect:**

The policy for the recruitment, selection and appointment of staff was not adhered to in that there was no evidence of three written references, qualifications, full employment history and medical/physical fitness when two personnel files were reviewed.

**Action required:**

With respect to staff working in the centre, obtain the information and documents as specified in Schedule 2.

**Reference:**

Health Act 2007  
Regulation 18: Recruitment  
Standard 22: Recruitment

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

**Timescale:**

Provider's response:

We are in the process of accumulating all of the above information.

15 November  
2010

## Recommendations

These recommendations are taken from the best practice described in the *National Quality Standards for Residential Care Settings for Older People in Ireland* and the registered provider should consider them as a way of improving the service.

Standard	Best practice recommendations
Standard 6: Complaints	The person in charge ensures that complaints and comments are raised at team meetings for feedback and future learning. Measures required for improvement are put in place.
Standard 24: Training and Supervision	All newly recruited care staff and those in post less than one year commence training to FETAC Level 5 or equivalent within two years of taking up employment. Long standing care staff have their competency and skills assessed to determine their need for further training and suitable arrangements are put in place to meet their identified training needs.
Standard 11: The Resident's Care Plan	The care plan meets clinical guidelines produced by professional bodies concerned with the care of older people, particularly with respect to the linkage between the aims and interventions identified for each resident.
Standard 26: Health and Safety	Alcohol rub and hand-washing facilities are prominently sited throughout the residential care setting in accordance with current infection control guidelines. They are available with separate hand-washing sinks in areas where infected material and/or clinical waste is handled.

**Any comments the provider may wish to make:**

**Provider's response:**

The staff and management at Bishopscourt are pleased at a number of the most significant findings in the report. Specifically, it is reassuring to see it stated that " All residents felt cared for and safe". The acknowledgement from the inspectors that the facility is well managed and organised is gratifying as is the finding that a good standard of treatment and services applies and that our residents are treated with courtesy and respect.

At the same time, there were a number of areas that required improvements to be made. As the previous pages demonstrate, we have quickly acted on every one of these and they have all wither been fully dealt with, or the deadline for their completion is noted.

**Provider's name:** Bishopscourt Residential Care Ltd.

**Date:** 12 November 2010