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:	Raheny Community Nursing Unit
Centre ID:	OSV-0000704
Centre address:	Harmonstown Road, Raheny, Dublin 5.
Telephone number:	01 850 5600
Email address:	rcnu@beaumont.ie
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Beaumont Hospital
Provider Nominee:	Mary Keogh
Lead inspector:	Nuala Rafferty
Support inspector(s):	PJ Wynne
Type of inspection	Unannounced
Number of residents on the date of inspection:	96
Number of vacancies on the date of inspection:	4

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was following receipt of unsolicited information. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
09 October 2017 15:00	09 October 2017 21:00
10 October 2017 07:00	10 October 2017 18:00

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

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

Summary of findings from this inspection

This was an unannounced inspection by the Health Information and Quality Authority (HIQA). The inspection focused on the safeguarding measures in place to protect residents following unsolicited information received, notifications forwarded by the provider and the standard and safety of care delivered to residents.

An immediate action plan was issued to the provider representative on the day after the inspection, in relation to the lack of adequate safeguarding measures in place to ensure residents safety.

Over the two days, inspectors met and spoke with residents, relatives and care staff, clinical nurse managers and the person in charge. The views of residents and their relatives were listened to, practices were observed and documentation was reviewed.

The centre was clean and well maintained in the areas inspected. Residents' rooms were personalised and those viewed were suitably equipped to meet their individual needs.
Residents and relatives spoken with said they did not have any concerns for their safety.

However, significant improvements were required in relation to safeguarding practices and the supervision of staff, where performance issues were identified. Inspectors were not satisfied that adequate safeguarding arrangements were put in place, to safeguard residents, when there were suspicions or allegations of abuse.

Improvements to governance and management arrangements were also required in relation to:
• the inappropriate use of restraint
• inadequate supervision, direction and guidance of staff
• inadequate corporate governance to ensure the health, safety and protection of residents
• lack of contingency measures to ensure sufficient staff were available to provide consistent and safe standards of care.

The action plan at the end of this report sets out the actions necessary to ensure compliance with the Health Act 2007(Care and Welfare of Residents in Designated Centre's for Older People) Regulations 2013 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.

The action plan response, submitted by the provider to some of the required actions, did not satisfactorily address all of the failings identified in the report. As some of the responses were not acceptable, HIQA have taken the decision not to include these responses in the published report.

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

Outcome 02: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.

Theme:
Governance, Leadership and Management

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

Findings:
The governance systems in the centre were fully reviewed on the last inspection and found to be compliant. The governance structure and the management systems remained unchanged. These included regular management team meetings to review all aspects of service delivery.
This inspection was carried out as a result of unsolicited information received and a notification forwarded by the provider further to an allegation of abuse made against staff employed by the provider in the centre. The inspection focused on the safeguarding measures in place to protect residents.
Inspectors were not assured that there was sufficient corporate governance and oversight to ensure that risks related to the safety and protection of residents were mitigated.
The inspector found that the governance and management arrangements did not include appropriate, consistent and effective monitoring of staff to ensure the health, safety and welfare of residents on a continuous basis.

There was a lack of management oversight that included, robust reporting structures, communication and accountability arrangements between the provider representative, the serious incident review team, the person in charge and the director of nursing to whom the person in charge reports.

There was evidence of poor leadership, direction and risk management. A lack of forward planning, reporting and management of available resources did not assure inspectors, that the management structure in place was effectively implemented and that persons holding roles with responsibilities, for all areas of care provision and safeguarding, held the appropriate level of authority to enable them to be accountable for their specified roles.

On receipt of the concern and notification, HIQA required the provider to conduct a provider led investigation and forward a report This report was to include any measures the provider intended to implement, as a result of the investigation, to improve practice and standards of care in the service.
The provider's report identified the following specific measures which, HIQA were told were implemented on receipt of the allegation of abuse on 25 August 2017:
- An additional clinical nurse manager placed on night duty to ensure supervision of staff over a 24 hour period within the centre.
-All staff against whom the allegations were made were limited to day duties and not permitted to work unsupervised at any time until further notice.
- Additional supervisory and practice support rostered onto the unit to assist with supervision, education, training and practice requirements.

However, evidence was found that these measures were not being implemented in full and that the governance systems in place were inadequate. Inspectors found:
-Three recorded incidents involving residents with responsive behaviours were viewed where staff members, who were supposed to be continuously supervised, were delivering care unsupervised.
- No additional supports were provided for supervision with the exception of the rotation of a clinical nurse manager to cover night shifts. A training or re-education plan was not discussed or prepared for delivery to the staff involved in the allegation.
-There was a lack of leadership, direction and guidance to staff, in particular the clinical nurse management team, to enable them to provide consistent, continuous supervision and support to staff. Structured supervision and reporting processes to improve staff knowledge, skills, and general performance to an acceptable level, were not in place.
-There was a lack of contingency measures, to ensure sufficient staff were available to provide consistent and safe standards of care.
- The person in charge made a written request for additional nurse management resources on day shifts. This request was made to ensure the implementation of continuous supervision of the identified staff. However, although this request was subsequently approved, the additional resource was not put in place for a further ten days, which resulted in the additional supervisory measures not being fully implemented.
- Approved operational policies were not implemented in practice to ensure resident and staff health and safety, identify and manage risks, safeguard residents, recruit, train and develop staff appropriately. These included the safeguarding, restraint and supervision policies.
The cumulative findings of this inspection identify that governance and management arrangements in place require significant and sustained improvement.

Judgment:
Non Compliant - Major

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

is promoted.

Theme:
Safe care and support

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

Findings:
Significant improvements were required in relation to safeguarding practices. There was a policy in place in relation to safeguarding residents from abuse. Training records indicated that all staff had up-to-date training on recognising and responding to abuse. Staff members spoken with by inspectors were knowledgeable of what constituted abuse and what to do in the event of suspicions or allegations of abuse. However, inspectors were not satisfied that the training provided was effective, or that the content was sufficiently detailed or relevant, to the policy in place in the centre, to enable staff fulfil their statutory responsibilities and duty of care to residents.
Inspectors found that the policy in place was the Health Service Executive's 'Safeguarding Vulnerable Persons at Risk of Abuse 2014'. However, the training provided to staff was a video on the prevention of elder abuse and did not fully reflect this policy. The training provided did not include the detailed processes or procedures involved, to consider, detect, report and respond to abuse under the 2014 policy.
In addition, all staff were not provided with the required training, this is fully referenced under Outcome 18 Staffing.

Where allegations of abuse were made against staff members, records indicated that these were investigated. However, inspectors were not assured that adequate measures were put in place to safeguard residents in the immediate aftermath of the allegation, while the preliminary screening process was being initiated and during the preliminary screen. There was a considerable delay in the completion of the preliminary screening process to determine whether there were grounds for concern. The screening process is recommended to be completed within three days but took six weeks. This also delayed the full investigation of the incidents and implementation of further safeguarding measures. However, inspectors acknowledge that this delay was primarily due to the inability of management to arrange meetings with external staff within a reasonable timeframe.
The full findings of inspectors, following review of the safeguarding measures in place to protect residents, subsequent to the allegations, is also referenced under Outcomes 2 Governance & management and 18 Staffing.

Inspectors reviewed the use and management of restrictive practices in the centre. It was found that the use of restraint was not excessive and where it was used, it was, for the most part, regularly reviewed. The primary types of restraints used were bed rails, lap belts and medications. These were included on the restraint risk register and each occurrence of use was recorded. In a sample of documentation viewed, inspectors noted that alternatives were trialled prior to the use of the restraints and assessments and reviews were also in place.

However, inspectors also found instances where limitations of residents' freedom through physical holding during personal care interventions were used. Inspectors were told that this was restraint was used to manage responsive behaviours associated with personal care and had been discussed and agreed with the multi-disciplinary team and the residents family. However, evidence of the discussion and agreements were not available. The decision making rationale for the use of this restrictive practice, documentation of alternatives trialled, assessment or review were not evidenced, in this case. This restraint was not included on the restraint register and each occurrence was not clearly recorded, although it was used on an ongoing basis each day. There was a policy in place on the management of restraint. However, inspectors found that the use of this restraint did not accord with the policy in place, where the policy directs staff that:
- Indefinite restraint orders must not be used.
-Physical restraint is used only as an emergency measure when unanticipated behaviour can place the resident in immediate danger.
- A four point restraint is never to be used.
It was further noted that this restraint was not reported to HIQA on the quarterly notifications as required by the regulations.

Judgment:
Non Compliant - Major

Outcome 16: Residents' Rights, Dignity and Consultation
Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

Theme:
Person-centred care and support

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

Findings:
All aspects of this outcome were not reviewed on this inspection. There were no restrictions on visitors and visitors were seen to come and go throughout the day. Visitors appeared to be familiar with, and were welcomed by staff. Residents had access to radio, television and newspapers. A programme of activities was facilitated by two activity coordinators working on opposite shifts five days per week. The programme included chair based exercises, bingo, music sessions, and arts and crafts.
In the evening, inspectors observed the care staff remained in the sitting room with a group of residents who were watching the TV and waiting to see the news. Some of the men asked what time the football match was on. The carer didn't know, but said they would watch the news first and then check the time of the match. The care staff tried to ensure all the residents had a good view of the TV and for those who were hard of hearing, the carer repeated what was being said. Others were reading newspapers and

magazines.

Feedback from residents and their relatives on the level of consultation with them and access to meaningful activities was very positive. All those spoken too praised the staff for the cheerful and respectful manner in which they delivered care. Most residents spoken with said staff were very helpful and quick to respond to their needs, but some residents said they sometimes had to wait for staff to assist them to get washed and dressed. Relatives were also happy with how staff kept them informed of any changes in their loved ones health condition and on the warm and friendly atmosphere in the centre.
Inspectors observed that residents were neatly groomed and well dressed. Most staff interactions with residents were positive, with care delivered in a person centred manner, involving good eye contact, low-key tone of voice, smiles and patience.

However, inspectors also observed examples of task orientated care. These were noted during the provision of care in the morning.
Inspectors observed that the assistance provided to residents during the breakfast service to be particularly rushed. Regular staff were seen rushing to ensure all residents were seated upright to enable them have their breakfasts in a timely manner. Staff spoken with at this time said they were trying to make sure everyone got their breakfast when it was hot. The staff said they were working with a lot of agency staff who did not know the residents well, and this created more pressure on the regular staff, who had to check all the residents in their allocated area.
However, there were negative impacts to this rushed care provision, including where residents were assisted to eat their breakfast, prior to their soiled incontinence wear being changed.

Access to independent advocacy services was available and displayed in the centre. However, inspectors found that these services were not contacted for one resident and the family who may have benefitted from the service.

Judgment:
Non Compliant - Major

Outcome 18: Suitable Staffing
There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

Theme:
Workforce

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

Findings:
Staffing levels and skill-mix on planned rosters appeared adequate on planned rosters but all shifts were not always filled.
Adequate, direct care staffing resources were not available to manage unexpected absences and planned shifts. Despite a relatively low staff turnover, there was a heavy reliance on agency staff to fill shifts. This was because the overall whole time equivalent (w.t.e.) staffing complement, did not take account of the additional staff required to provide one-to-one care and supervision to identified residents. Inspectors noted that this has been a long term problem dating back over 12 months.
As a consequence, the unit required upwards of 15 w.t.e. staff each week to fill planned shifts.
This impacted negatively on the delivery of safe, consistent care to residents. Examples included; inappropriate use of restraints, and inconsistent management of responsive behaviours.

A review of staffing levels during the morning was required. Inspectors observed that staff were rushed and there were delays in meeting residents needs or preferences. Examples include where inspectors observed a number of residents being left to wait for up to 30 minutes on the corridor at the nurses' station, until staff were available to bring them to the sitting room. Inspectors were told this was for supervision purposes. Some residents spoken with said they sometimes had to wait for staff to assist them to get washed and dressed. There was also an instance where residents' dignity was compromised this is referenced under outcome 16 rights dignity and consultation.

Additional resources to ensure the continuous supervision for identified staff were not provided. The staff, against whom the allegations were made, was a mix of nurses and carers. A senior nurse was to supervise the carers' involved. On review of the rosters, inspectors noted that there were occasions when the care staff, who were to be supervised, were transferred to other units for this purpose. The clinical nurse managers were to supervise the nurses. The clinical nurse mangers facilitated the process by voluntarily agreeing to rotate onto night shift to provide management oversight. However, this resulted in depletion of this managerial resource on the day shift, when all the staff who were not to work without close supervision were on duty. The additional nurse manager was not provided until two weeks later.

During this two week period, inspectors found there were six occasions when there were between one and three nurses, who were not to work without close supervision, rostered on duty, on the same unit, when a clinical nurse manager was not on duty in the unit. Inspectors were told a clinical nurse manager was brought from other areas, to provide this supervision, but when the nurse manager was off duty, the roster, for this unit, did not identify whether another clinical nurse manager provided relief cover. In addition, there was no evidence that each nurse was individually supervised. During this period three incidents involving residents with responsive behaviours occurred, when members of staff who were to be supervised were unsupervised.

Inspectors found evidence of poor leadership, direction and supervision provided to staff. Particularly where this related to the additional safeguarding measures in place to protect residents on foot of allegations of abuse.

Inspectors found that adequate governance and management systems were not in place to prevent recurrence.
Examples include:
-No staff member had received training on the Safeguarding policy in place in the centre.
-The person in charge, who is the designated officer, under the policy, with specific responsibilities to receive, respond and address concerns or complaints of abuse, had not received the specific training required for the role.
- A training plan or schedule to assess the clinical practice skills and knowledge of identified staff and up-skill where required was not in place. Inspectors were told that a clinical practice facilitator was providing support in this area, but this was not confirmed by any staff member. It was subsequently found, that the clinical practice facilitator was informally asked to monitor staff, but was not formally requested to deliver a training plan, or be involved in supporting staff in any way.
-Structured supervision and reporting processes to improve staff knowledge, skills, and general performance to an acceptable level, were not in place for those staff identified as requiring same.

Judgment:
Non Compliant - Major

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Nuala Rafferty
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	Raheny Community Nursing Unit
Centre ID:	OSV-0000704
Date of inspection:	09/10/2017
Date of response:	24/11/2017

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 02: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was insufficient corporate governance and oversight to ensure that risks related to the safety and protection of residents were mitigated. This was reflected in the cumulative findings of this inspection with major non-compliances found in relation to governance and management, safeguarding and staffing.

One notification had not been submitted to the Authority as required under the

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

regulations.

1. Action Required:
Under Regulation 23(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

Please state the actions you have taken or are planning to take:
1. Periodic formal review and gap analysis of risk management processes against the HSE Standard for Quality & Risk management (2007) framework undertaken 01/11/17 by Head of Risk & legal Services with improvement plan initiated.
Specific actions of the improvement plan are as follows:
a) Continue to demonstrate that all RCNU policies are reviewed and updated within agreed timeframes and having oversight of status via the Quality & Resident Safety oversight committee (QRSC)
b) Continue to demonstrate that all staff receive education on RCNU specific policies through a formal written training and education plan for employees with monthly training compliance reports to the PIC.
c) Expansion of the clinical audit annual schedule to include restraint usage and behaviours that challenge, has been implemented in the unit since 22/10/17 and will be reported monthly through (QRSC) by PIC.
d) Future training needs analysis being undertaken and due for completion on 24/11/17for all clinical and non clinical employees with a comprehensive training plan in place for all staff based on this analysis. (see b)
e) Updated Risk register specific to the unit developed on 15/11/17 with monthly reviews scheduled at the QRSC and agreed actions undertaken in line with Beaumont Hospital policy, procedure & guideline for maintaining its risk register.
f) All risks, complaints and incidents will continue to be reported to the risk & legal department via the PIC with a review of trends monthly at QRSC to identify and implement learning's / recommendations in line with Beaumont Hospital risk management/ incident management policy.

2. An enhanced Quality Assurance programme has been established which involves establishing the QRSC, further expansion of a suite of quality metrics, development of a unit specific risk register, incident and complaint review and trending which will be monitored by PIC and reported to QRSC monthly and to the corporate clinical governance committee at scheduled intervals.

3. A Quality and Resident Safety Committee has been established co-chaired by Deputy Director of Nursing and Quality manager with agreed terms of reference that include the monthly review of a suite of quality indicators - serious reportable events, falls incidence and management, pressure injury occurrence, restraints, food and nutrition, medication management, complaints, risk occurrence and dependency levels, absenteeism and flu vaccine update. The committee is scheduled to convene monthly from December 2017

4. A Quality & Resident Assurance Forum have increased the frequency of meetings from 6 weekly to monthly to ensure residents have an opportunity to voice their needs with quality improvement plans being implemented where improvements are identified

with oversight through the QRSC.

5. An enhanced tool to risk assess residents identified with behaviours that challenge (Appendix 1) has been developed and is currently being tested in one unit.

6. To formalise an agreed admission criteria based on complexity and current resident dependency levels and resources. Until these criteria are established resident admissions with maximum to high dependency care needs have not been admitted since 25/08/17.

Proposed Timescale:
1. Complete on 01/11/17 a) 08/12/17 b) Complete and monitored monthly c) 22/10/17 d) 24/11/17 e) 15/11/17 f) 08/12/17
2. 08/12/17
3. 08/12/17
4. Complete – meeting took place 06/10/17 and 14/11/17
5. Complete – 21/11/17
6. Complete – 31/12/17

Proposed Timescale: 31/12/2017

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Adequate staffing resources and contingency measures were not available to manage unexpected absences and planned shifts. As a consequence there was a heavy reliance on agency staff on a weekly basis on a continuous basis.

2. Action Required:
Under Regulation 23(a) you are required to: Ensure the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.

Please state the actions you have taken or are planning to take:
1. Agency staff continue to be booked in advance to continue to secure consistent and regular supply of staff that are familiar with the residents and unit
2. Further agency conversion underway to stabilise the nursing workforce

Proposed Timescale:
1. Complete
2. Ongoing with individual post timelines being dependent on successful recruitment process.

Proposed Timescale: 22/11/2017

Outcome 07: Safeguarding and Safety

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Restrictive practices in place in the centre did not fully accord with the policy in place where the policy directs staff that:
- Indefinite restraint orders must not be used.
-Physical restraint is used only as an emergency measure when unanticipated behaviour can place the resident in immediate danger.
- A four point restraint is never to be used

3. 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 action plan submitted by the provider for this action was not acceptable to HIQA, as it did not satisfactorily address all of the failings identified in this outcome of the report.

Proposed Timescale:

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Evidence was not found that the least restrictive option was used to manage responsive behaviours in all instances.

4. Action Required:
Under Regulation 07(2) you are required to: Manage and respond to behaviour that is challenging or poses a risk to the resident concerned or to other persons, in so far as possible, in a manner that is not restrictive.

Please state the actions you have taken or are planning to take:
1. PIC or designate continues to attend weekly interdisciplinary meeting and has full oversight with regard to any restrictive practice. The decision to use a restraint is made in accordance with the restraints policy and current practice against same forms part of the clinical audit schedule for the unit.
2. Establish an interdisciplinary restraint use and prevention group co-chaired by PIC and Occupational Therapy lead to oversee and support effective implementation and ongoing monitoring of restraint use in line with the policy and develop an implementation plan to support a culture of least restrictive restraint usage.

3. 100% of staff re-trained in the Appropriate Use of Restraints policy by 09/11/17 and have obtained 100% competency

Proposed Timescale:
1. Complete
2. 05/12/17
3. Complete – 09/11/17

Proposed Timescale: 05/12/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors were not assured that:
•Risks identified on foot of concerns and notifications received by HIQA, were mitigated.
•Where allegations of abuse were made against staff members that adequate and appropriate safeguarding measures were put in place that ensured the protection of residents.
This was issued as an immediate action to the provider on the day following the inspection.

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:
1. Designated officer and provider informed of alleged incident on day of occurrence.
2. Gardai informed on day of occurrence.
3. Open disclosure meeting with family of resident during which they were offered the opportunity to move the resident to another unit.
4. Written notice to HIQA.
5. Safeguarding protection team CHO 9 informed.
6. Serious Incident Review Team meeting convened in Beaumont Hospital.
7. A CNM was rostered on night duty from 30/08/17 to oversee care delivery.
8. The employees involved in the allegation were prohibited from working night duty.
9. 6 WTE staff members placed on Administrative leave on 11/10/17 post conclusion of the preliminary screening process on 10/10/17
10. Elder Abuse re-training was delivered to all staff in RCNU on 10/10/17.
11. Beaumont hospital safeguarding vulnerable adults programme was developed and delivered to 100% staff in RCNU by 09/11/17.
12. The Person in Charge is to complete the national train the trainer on the first available training date (5th of December).
13. Re-trained 100% of staff in the Appropriate Use of Restraints by 09/11/17.
14. All residents invited to attend a resident forum meeting on 06/10/17 and 14/11/17 where information was provided on procedure for reporting allegations of abuse. As a

follow on and to ensure all residents and their families were aware written information was provided on 01/11/17
15. Safeguarding requirements will not be affected by unintended delays in preliminary screening processes where possible in compliance with Trust in Care policy.

Proposed Timescale:
1. 25/08/17
2. 25/08/17
3. 26/08/17
4. 28/08/17
5. 01/09/17
6. 30/08/17
7. 30/08/17
8. 02/09/17
9. Complete – 11/10/17
10. Complete – 10/10/17
11. Complete – 09/11/17
12. 05/12/17
13. Complete – 09/11/17
14. Complete – 01/11/17
15. Ongoing

Proposed Timescale: 05/12/2017

Outcome 16: 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:
Advocacy services were not contacted for one resident and the family who may have benefitted from the service.

6. Action Required:
Under Regulation 09(3)(f) you are required to: Ensure that each resident has access to independent advocacy services.

Please state the actions you have taken or are planning to take:
1. Advocacy service offered to resident and family
2. Advocacy support to be discussed at resident/family forum meeting

Proposed Timescale:
1. Complete
2. 16/11/17

Proposed Timescale: 16/11/2017

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The rights of some residents to be provided with care and meals, in a manner that is not rushed, and that respects their dignity was not always upheld.

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

Please state the actions you have taken or are planning to take:
The action plan. submitted by the provider for this action, was not acceptable to HIQA, as it did not satisfactorily address all of the failings identified in this outcome of the report.

Proposed Timescale:

Outcome 18: Suitable Staffing

Theme:
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Adequate staffing resources were not available to manage unexpected absences and planned shifts. There was a heavy reliance on agency staff to fill shifts.
A review of staffing levels during the morning was required. Inspectors observed that staff were rushed and there were delays in meeting residents needs or preferences.

8. Action Required:
Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

Please state the actions you have taken or are planning to take:
1. Agency conversion underway to stabilise the nursing workforce and ensure continuity of care to residents.
2. 2 WTE CNM 2's in addition have been allocated to the unit with a further 1 WTE CNM 2 being recruited currently to support roster sustainability.
3. CNM 2 roster initially initiated from 30/08/17 and regularised from 10/09/17 to ensure appropriate and effective out of hours management provision for night duty and weekends.

Proposed Timescale:
1. 31/01/18 (timeline dependent on successful recruitment process)

2. 31/01/18
3. Complete – 30/08/17

Proposed Timescale: 31/01/2018

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
No staff member had received training on the Safeguarding policy in place in the centre.
The person in charge, who is the designated officer, under the policy, with specific responsibilities to receive, respond and address concerns or complaints of abuse, had not received the specific training required for the role.
A training plan or schedule to assess the clinical practice skills and knowledge of identified staff and up-skill where required was not in place.

9. Action Required:
Under Regulation 16(1)(a) you are required to: Ensure that staff have access to appropriate training.

Please state the actions you have taken or are planning to take:
1. 5 staff members had received part 1 of national training in February 2017.
2. Beaumont hospital safeguarding vulnerable adults programme was developed and delivered to 100% staff in RCNU.
3. Designated officer to complete remaining components of national safeguarding training on 5th December with full implementation of national training to all staff by 31/03/18 inclusive of an audit programme for monitoring compliance and application to practice.
4. 0.5 WTE practice support resource was deployed to the unit on 28/08/17 with an additional 0.5 WTE education resource deployed from 16/10/17 to oversee training and development plans for all staff. A gap analysis of education requirements has been undertaken within the Unit and an education programme based on the learning needs of the staff is being developed to support the current education and training plans in place. This includes a staff questionnaire on learning needs, portfolio development and personal development plans to achieve requirements.
5. An initial meeting has been scheduled on 15/12/17 with HSE older person's quality improvement team to determine how the programme can further support and enhance collaboration for continuing development of a person centred environment for all residents in RCNU.

Proposed Timescale:
1. Complete
2. Complete - 09/11/17
3. 31/03/18
4. 16/10/17
5. 15/12/17

Proposed Timescale: 31/03/2018

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Structured supervision and reporting processes to improve staff knowledge, skills, and general performance to an acceptable level, were not in place for those staff identified as requiring same.

10. Action Required:
Under Regulation 16(1)(b) you are required to: Ensure that staff are appropriately supervised.

Please state the actions you have taken or are planning to take:
1. Staff placed on administrative leave on 11/10/17
2. CNM 2 assigned to unit at night and weekends from 30/08/17
3. A Professional Development Plan for all staff commenced on 13/11/17
4. 1 WTE designated education/practice support resource assigned to undertake training needs analysis and oversee development needs of staff and provide in-house support based on formal needs assessment.

Proposed Timescale:
1. Complete – 11/10/17
2. Complete – 30/08/17
3. 31/01/18
4. 16/10/17

Proposed Timescale: 31/01/2018