Health Information and Quality Authority
Social Services Inspectorate

Inspection report
Designated centres for older people

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	Lusk Community Unit
Centre ID:	505
Centre Address:	Station Road Lusk Co Dublin
Telephone number:	01-8071240 01-8071241
Fax number:	01-8071259
Email address:	mary.carney2@hse.ie
Type of centre:	☐ **Private** ☐ **Voluntary** ☒ **Public**
Registered provider:	Sheila Marshall
Person in charge:	Mary Carney
Date of inspection:	8 and 9 February 2011
Time inspection took place:	**Day 1: Start:** 10:20 hrs **Completion:** 17:45 hrs **Day 2: Start:** 05:55 hrs **Completion:** 16:30 hrs
Lead inspector:	Nuala Rafferty
Support inspector(s):	Sheila McKevitt
Type of inspection:	☒ **Registration** ☐ **Scheduled** ☒ **Announced** ☐ **Unannounced**

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 one element 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 6 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.

About the centre

Description of services and premises

Lusk Community Unit is a single-storey, purpose-built facility with accommodation for up to 50 residents and provides continuing and respite care for older persons with dementia, intellectual and physical disabilities. The centre opened in 2001.

All accommodation is at ground floor level, the unit is separated into two smaller wards named “Lusk” and “Rush”.

The centre contains eight single en suite shower bedrooms, seven twin bedrooms and seven four-bedded rooms without en suite. There are four assisted bathrooms/shower areas, eight assisted toilets, nurses’ office, two nurses’ stations, one clinical room, cleaning room, two sluice rooms, five store rooms, laundry, staff lockers, change areas and toilets, administration and nurse managers offices, main kitchen and kitchenette and visitors’ toilets.

It also has a reception area, two dining rooms, two large sitting rooms, and two smaller sitting rooms, beauty therapy room, oratory, snoezelen room and physiotherapy treatment room.

A day hospital facility operates for the local community two days a week, for up to 36 persons. A nurse led day care service for up to 20 persons operates three days a week and a dementia specific service for up to ten persons takes place one day per week, at the centre.

The building is surrounded by mature grounds and has an enclosed courtyard with games area for residents at the rear of the building. To the side there are four separate seated areas and a remembrance garden which are wheelchair accessible with well maintained shrubberies for residents and visitors to enjoy.

Car parking is provided to the front and side of the building

Location

Lusk Community Unit is located in Lusk village, North County Dublin.
The local shops, church and other community services are within walking distance. The centre is located close to the local bus routes to Swords, Dublin and Rush.

Date centre was first established:	10 December 2001
Number of residents on the date of inspection	48
Number of vacancies on the date of inspection	2 residents in acute services

Dependency level of current residents	Max	High	Medium	Low
Number of residents	19	10	3	5

* Dependencies available for continuing care residents only.

Management structure

The Health Services Executive is the provider. The nominated person on behalf of the HSE is the general manager Sheila Marshall who attends the centre for management meetings. The person in charge (referred to as the acting director of nursing) Mary Carney is in post since 24 May 2009 and reports to the general manager.

The nursing team is lead by the acting director of nursing and an acting assistant director of nursing. Each of the two ward teams has a lead clinical nurse manager (CNM). Staff nurses and two part-time activities coordinators report to the clinical nurse manager, and care assistants report directly to either the staff nurse or clinical nurse manager on duty.

Administrative and catering staff report to the administrative officer and catering officer respectively who report directly to the person in charge. Laundry and portering staff report to the person in charge.

A full time physiotherapist and physiotherapy assistant are based at the centre who form part of the interdisciplinary team and also provide physiotherapy to the local community. They report to the community physiotherapy manager.

Support staff that are available from the HSE include a dietetic service, speech and language therapy, chiropody, dental service, pharmacy support and infection control nurse specialist.

Both household cleaning and security services are provided by private companies.

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	5	7	6	3*	3	*

* 1 part time laundry person and 2 household staff (private company)
* 1 clinical nurse manager
* 1 porter
* 2 part time activities coordinators

Summary of findings from this inspection

This was an announced inspection in response to an application by the provider for the centre to be registered under the Health Act 2007 and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2009(as amended). As part of the registration process the provider had to satisfy the Chief Inspector of their fitness 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). This registration inspection took place over two days.

As part of the registration process separate fit persons interviews were held with the person in charge and registered provider. The fit person self assessment document was completed in advance of the visit however, due to a change in the nominated provider in the weeks preceding the inspection only the person in charge had input into the documentation in advance of the visit. The provider submitted a second document following the inspection and prior to fit person interview.

Inspectors met with residents, the person in charge, staff nurses, administrative staff, catering officer and other members of staff. Records were examined including care plans, medical records, risk management and health and safety, accident and incident log, staff records including training records, policies and procedures.

The inspection found the overall care delivered in the centre was of a good standard. Staffing levels and skill mix were appropriate to meet the needs of the current residents' profile. Ongoing efforts to improve person centred care practices were evident.

Inspectors were satisfied that the medical and other healthcare needs of residents were catered for. Staff demonstrated knowledge of the residents' needs, likes, dislikes and preferences.

The inspectors found that the premises, fittings and equipment were clean and well maintained. There was a good standard of décor throughout the centre.

While considerable preparations had been made by the provider for this registration application, this report identifies where some improvements are necessary to comply with the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 and amendments and the *National Quality Standards for Residential Care Settings for Older People in Ireland.*

These include:

- privacy and confidentiality of residents information
- care plans
- premises
- contract of care
- statement of purpose

Comments by residents and relatives

Eleven residents questionnaires were returned to the Authority following the inspection.
Comments included:
‘‘carers and nurses are very good’’
‘‘if you want something you get a quick response’’
‘‘everything’s perfect’’
‘‘security is 100%’’
Other comments were:
‘‘(staff) fairly efficient and obliging some give cold shoulder, majority all right’’
‘‘the girls in the stripes know what they are doing, the night girls just gawk at you’’

Eighteen relatives questionnaires were returned to the Authority following the inspection.
Comments included:
‘‘if there are any problems they contact us by phone’’
‘‘I find staff very respectful and thoughtful’’
‘‘all staff most pleasant and welcoming’’
‘‘I feel (name of resident) is well cared for both day and night’’
‘‘I have a very high opinion of nursing staff and staff at all levels’’
‘‘nurse director always makes herself available, very approachable’’
‘‘every detail in the care plan (was discussed) which was very reassuring for me’’
Other comments were:
‘‘living room needs to be updated where patients stay all day’’
‘‘I don’t know how many staff are on at night but I am a bit worried’’
‘‘I think there should be more (staff) on night duty’’

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

A clear organisational structure was available and this was included in the statement of purpose. It consisted of the nominated person on behalf of the provider at general manager level and the person in charge. They are supported by an assistant director of nursing, two clinical nurse managers, an administrative officer and catering officer. Staff interviewed demonstrated a clear understanding of their role and responsibilities. They described the staff structure and reporting mechanisms in place to ensure appropriate delegation, supervision and competence in the delivery of service to the residents.

The acting person in charge demonstrated sound knowledge and awareness of the (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 and *National Quality Standards for Residential Care Settings for Older People in Ireland.* She has been the assistant director of nursing in the centre since 2003 and acting person in charge since 2009. Inspectors found she was aware of her responsibilities in relation to the legislation and had a person-centred approach to care.

The newly nominated person on behalf of the provider demonstrated sound knowledge and awareness of the (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 and *National Quality Standards for Residential Care Settings for Older People in Ireland.* From an administrative background she has a master's degree in health services management and showed a keen understanding of clinical issues. Overall, inspectors found both the person in charge and the nominated person displayed a willingness to implement and drive a quality assured person centred service.

Following completion of the fit person entry programme self-assessment, improvements were made. These included commencement of professional development interviews for all staff to address identified individual and collective training needs. Ongoing staff training in prevention of elder abuse and management of confrontational behaviour was noted.

Improvements to residents quality of life were also being implemented through a more person centred activities programme with a, 'key to me', being used to establish residents social and recreational preferences.

Good risk management procedures were noted. Ongoing monitoring of risk was carried out by the person in charge through use of a 'risk register' which identifies key risk areas such as falls, aggressive behaviour, choking, infection and absconding. The person in charge informed the inspectors, that she attended at the nurse handover on a daily basis and updated the register, where an increase in any one risk area was identified a full audit was initiated. Inspectors observed her attendance at handover during inspection. Inspectors viewed a falls audit carried out over a six month period in 2010. The audit identified the process used, the outcome and actions taken to control the risk. Actions and required learning were communicated to staff through the management team.

An effective complaints management procedure was in place which meets legislative requirements. All verbal and written complaints were recorded, and included detail of the complaint, action taken and follow up required.

Inspectors found that all complaints were investigated and responded to in an appropriate and timely manner.

A certificate confirming that the centre complies with the Building Codes, Planning and Development Act 2000-2006 was available.

The insurance for the centre is provided for under the National Treasury Management Agency (State Authority) Order 2009.

Fire policies and procedures were reviewed by inspectors and were found to meet legislative requirements. Fire records indicated that fire safety training took place regularly and fire escape routes and fire fighting equipment were checked in line with best practice.

Residents' safety and security was ensured through the use of a key pad operated security system linked to the main door. On arrival at the centre the inspectors were asked to sign the visitor's book.

Some improvements required

An emergency plan was in place which identified the specific resources available in the event of evacuation and the contact details of staff. However, when asked not all staff demonstrated knowledge of the emergency plan, could identify the relevant people to contact or the designated building to where residents would be evacuated.

A contract of care was available and agreed with residents, their families or advocate. However it did not meet all legislative requirements in that it did not reference the limit of residents' liability.

A directory of residents was available and found to be maintained. However, it did not meet all the requirements of Schedule 3 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) in that the referral source, the name and address of any authority, organisation or other body who arranged the residents' admission was not included, details on cause of death or transfer to hospital. In addition the directory was not fully maintained in that it did not contain a record of any of the information required in respect of respite residents admitted to the centre.

The insurance for the centre is provided for under the National Treasury Management Agency (State Authority) Order 2009 a copy of the insurance was requested but not available and therefore not viewed to determine whether it meets the legislation. However, on review of the insurance cover detailed in the contract of care, the limitation of residents' liability was not included.

Significant improvements required

Although the statement of purpose meets all legislative requirements, the admission criteria required further clarification and review in relation to the type of services it intends to provide to residents.

A residents' guide was available which did not meet all legislative requirements. It did not contain the most recent inspection report or the address of the Chief Inspector of the Authority. Furthermore it inaccurately directed complaints to be made to the Authority which is not part of the Authority's remit

Minor issues to be addressed

Appropriate financial processes were overseen by the administrative officer and found to be transparent and well managed. A statement of each residents account is retained in the centre and updated on a quarterly basis. This is discussed with each resident and the balance agreed and dated. Where the residents or family request a copy of the statement this is provided. A process is in place for the administration of monies retained in safekeeping for respite residents. Where monies are entrusted to the centre for safekeeping by family on behalf of respite residents this is documented on a patients property form and all withdrawals are witnessed and signed for by two staff members. On discharge a copy of the form is placed on the resident's file. However, a review of the financial management system is required to provide residents or their families with a copy of the property form detailing withdrawals and balance of monies returned on discharge.

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

Residents were enabled to contribute to life in the centre, views were sought and evidence that residents were influencing change was found.

A residents' forum was established, meetings were held on a regular basis and minutes of the meeting held in January were viewed. The meeting was facilitated by an activity coordinator, although usually an external volunteer performs this role. Suggestions from the residents included use of thermostats to monitor room temperature as the extension to the dining room could sometimes feel cold. It was agreed that extra heaters would be provided during cold weather. Minutes reflected updates and actions taken on previously raised issues and identified that the problem of porridge being cold when served at breakfast was now resolved. Copies of the minutes of these meetings were provided to all residents.

Through conversations with relatives, in documentation and through observing interactions, inspectors found ongoing and effective communications between staff, management, relatives and residents.

Arrangements were in place to respect residents' right to privacy and choice.

Inspectors heard residents being addressed in an appropriate and respectful manner. All residents were well groomed and smartly dressed in clothing of their own choice.

Call bells were promptly responded to and were readily accessible throughout the centre.

Residents spoken with confirmed they choose when they wish to rise and return to bed, they also decide which activities they wish to participate in. All residents spoken to knew they could make a complaint to staff if they wished and would feel comfortable going to the person in charge.

Systems were in place to enable residents to fulfil their own potential and participate in events and activities based on individual interests and preferences. Inspectors viewed the activities programme, an individual assessment of each residents' interests and capabilities was undertaken to improve the programme of activities available on a daily basis. One recent undertaking involved the provision of a polytunnel to grow plants from seeds.

Opportunities were available for residents to access the community with trips arranged every three months. The most recent trip in January involved ten residents going to a pantomime.

Residents' religious and spiritual needs were met. Mass was held each Friday. A pastoral care person was available to provide spiritual support each Sunday and as required on a sessional basis.

Policies and procedures were in place to protect residents from harm. Staff were aware of the policies and could discuss the principles of the training received. Staff could recognise the signs, explain the different types and knew what their responsibilities were in relation to reporting suspected abuse.

Delivery of care is through a team-based system on each unit. Staff were divided into teams of two consisting of one nurse and one carer per team. The clinical nurse manager or senior nurse in charge allocate the teams to groups of residents on a daily basis.

Staff nurses were allocated a number of residents for whose three monthly re-assessment and review of care plan they were directly responsible.

Some improvements required

Residents' privacy was respected and promoted by staff and inspectors observed staff members knocking before entering residents' bedrooms and ensuring screening was in place in communal bedrooms. However, all bedrooms were not capable of being locked and residents were not offered a key to their bedroom door.

Overall, respect for the privacy and confidentiality of residents' information both written and verbal was observed. However, not all residents information was maintained in a confidential manner. For example, personal information on named residents' dietary needs were displayed on information boards at the nurses' station which could lead to unauthorised persons having access to residents' private information.

A review of the level of supervision provided to high dependency residents in communal areas at busy periods or during staff meal breaks is required. During an hour long period from 13:40 hrs to 14:40 hrs inspectors observed residents were either unsupervised or being supervised by a transition year student from a local school.

Minor issues to be addressed

Suggestion boxes and service user questionnaires were available for residents and their relatives to make suggestions and comments on the service provided. Inspectors viewed some questionnaires completed by residents in 2010. However, on enquiry staff said that an evaluation of the questionnaires was not undertaken. This was raised with the person in charge who advised that this was underway.

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

Residents received good quality health care. They were encouraged to retain their own general practitioner (GP) following admission and some residents had done so. Where this was not possible medical services were provided by a team of two GPs who visited the centre on a daily and on an as required basis.

Residents were referred for respite care by the public health nurses from a local acute hospital and from psychiatry of old age at the local mental health facility. Continuing care residents were admitted from a waiting list maintained by the Health Service Executive (HSE) north Dublin local placement forum.

Each resident was assessed by the person in charge prior to admission. A record of the potential residents' nursing needs and personal circumstances together with medical diagnosis, medication and risk assessments which included dependency pressure ulcers cognition and falls risk were completed prior to admission. Additional assessments such as wound care, nutritional assessment, manual handling, risk of absconding and incontinence assessments were completed following admission. Identified risks were reflected in residents care plans which were reviewed on a three-monthly basis by nursing staff; this was confirmed by looking at residents charts and speaking with staff members. Efforts to personalise assessments and care plans were noted which included an individual assessment of residents' hobbies, interests and social history. Involvement of residents and their relatives, next of kin or advocates in care planning through annual review meetings was documented in residents' files.

Good practice in relation to transfer of information within and between the centre and other health services was found. Documentation included transfer and discharge letters and updated referrals and reviews by external allied health professionals such as speech and language and psychiatric reviews. Documentation regarding one gentleman who was transferred to an acute hospital facility five days earlier evidenced regular phone calls made by nursing staff in the centre requesting updates on his condition.

Health was promoted through regular monitoring of each resident's general health status, their blood pressure and blood sugars were recorded as required and their weight was monitored every month. Flu vaccinations were provided and consent for treatment was indicated on the form.

Inspectors observed safe practice in medication administration and recording of the drugs administered. Medication management was supported by specific policies and procedures reflected in practice. Controlled drugs were checked at the end of each shift and this was observed during the inspection.

Residents looked well nourished and hydrated, staff were aware of residents dietary needs, their likes and dislikes and residents had access to dietician.
Residents' special dietary needs were notified to the catering officer by nursing staff on admission and as changes occurred. The catering assistants serve breakfast each morning to residents from a heated trolley, which ensures all hot food, was maintained at optimal temperatures. They also collect menu choices each afternoon. Staff spoken with were aware of individual residents' likes and dislikes and communicated this information to the chef's and catering officer.

Inspectors visited the main kitchen, which was appropriately zoned for food preparation. Access to the kitchen was restricted to catering staff. It contained large stocks of varied and nutritious food with fresh fruit and vegetables. A four-week rolling menu was viewed, which was adapted to accommodate special events.

Snacks were available to residents outside of mealtimes in the kitchenette and drinks were available throughout the day. This was confirmed by residents who said they could get tea and biscuits whenever they wanted and relatives said they were always offered a cup of tea/coffee whenever they came to visit. Inspectors also saw jugs of water in residents' rooms.

Some improvements required

Inspectors observed that meal times were an inviting and enjoyable experience. Menus were displayed on the table. Tables were set in an attractive manner with tablecloths, place settings, condiments and napkins.The choice, quality and presentation of meals was of a high standard. Residents confirmed that the food was "a la carte". However, the inspectors noted the while there were two dining rooms, only the main dining room was used on a daily basis by the majority of residents. The second smaller dining room was used only occasionally at residents or families request for a special 'fine dining' experience.

The large dining room was not sufficiently large to cater for all residents at the same time and only one lunch sitting was provided due to staffing limitations. Inspectors observed that the majority of residents who require assistance with their meals remain in the sitting rooms on both units and do not attend the main dining room. Consequently, these residents remained in the sitting areas throughout the day and did not have an opportunity to experience a change of environment or a different dining atmosphere.

Residents were encouraged to maintain their independence where possible. Assistance was offered to those who needed it. However, this was not always provided in a respectful manner and inspectors observed some staff stood over residents whilst providing assistance.

Significant improvements required

Medical and nursing documentation in respect of six residents were reviewed by inspectors. Overall, good documentation practice in the care planning and evaluation of residents care was found and evidence of referral and review by allied health professionals where required was noted. However, inspectors found that care plans were not referenced in nursing evaluation progress notes as being implemented or effective and reviews by allied health professionals were not included in all care plans.

Evidence that care plans were in place for every identified need or were updated to reflect residents changing needs was not consistently found. In the case of one resident who had a chest infection and was commenced on antibiotics a care plan was not in place.

Although evidence of regular review by their GP and referral to allied health professionals on an as-required basis was found, on review of a sample number of residents' medical and nursing documentation, not all residents general health status were reviewed by the GP on a regular three month basis as required by legislation.

Minor issues to be addressed

End of life care was supported by a policy and process which included interdisciplinary meetings with residents, their family, next of kin or advocate. Documentation of discussion and decision reached in respect of residents' wishes for end of life care was viewed. However, the minutes were signed only by the senior nurse and general practitioner in attendance and not co signed by either the resident or their representative to indicate agreement or understanding of the decision made.

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

The design and layout of the centre was appropriate to meet the assessed needs of residents. All areas were warm, clean and well-maintained.

The centre was purpose-built, with a good standard of private and communal space and facilities. The environment was observed to be bright and clean throughout, with tactile pictures, soft furnishings and colour schemes.

Adequate numbers of assisted showers, baths and toilet facilities were available

Secure and well-maintained grounds with seating areas were available for residents and visitors to enjoy.

Management provided equipment in response to the assessed needs of the residents. Such equipment included lifting hoists and walking aids, weighing scales, residents' call system, pressure relieving mattresses and profile beds. Servicing contracts for all equipment were in place and evidence that remedial action carried out as required were reviewed by inspectors.

A monthly check on hot water temperature and weekly flushing of showers and taps to manage risk of legionella virus was in place. All radiators were fitted with guards to prevent burns

Clinical and domestic waste was appropriately separated and disposal contracts were viewed and found to be current.

Adequate storage areas were available throughout the centre.

Staff changing areas and toilets were available with separate facilities for catering staff.

Good fire safety systems and procedures were found to be in place and staff demonstrated good knowledge of the procedures to be followed in the event of a fire. All corridors were zoned for fire safety purposes and were wide enough to provide safe walking areas for residents. Good directional signage, appropriate fire procedures and exit directions were available on all corridors.

Good emphasis was placed on residents' safety with a key pad operated lock on the front gates and door, a visitors book was situated in the reception area and visitors were asked to sign on entering and leaving the building. A private security firm was contracted to provide night security guard who carried out an hourly check of the premises internally and externally. This was monitored through use of a hand-held recorder which could be checked by a patrol driver who reviewed the recorder at least weekly.

Hand rails were located in all the corridors. A call bell system was available in all private and communal areas for residents to summon assistance as required.

Telephones were available for residents' private use.

An emphasis on the promotion of cleanliness and prevention of infection was evidenced by up to date and signed cleaning schedules and practices. There was sufficient availability of alcohol rub and / or hand-washing facilities and inspectors observed staff using these appropriately. Cleaning staff spoken to were knowledgeable of infection control procedures around methicillin resistant *Staphylococcus aureus* (MRSA).

A health and safety committee was in place with four elected representatives identified. The health and safety statement was made available and included hazard audits and identified responsible persons for each department. Minutes of recent health and safety committee meetings in May and December 2010 were viewed.

Some improvements required

Final architectural plans submitted to the Authority prior to inspection did not reflect the designated function of rooms as found on inspection. Signs identifying the designated function of all rooms were not in place.

A routine programme of maintenance and fabric renewal was not in place. Overall, the building was in a state of good repair however, maintenance was provided through the maintenance department staff that were based at a separate HSE service and not under the control or management of the person in charge. Therefore, although the person in charge stated that response to both emergency and routine needs were addressed in a timely manner, a timeframe for some aspects of routine maintenance such as room painting, repair of plasterwork and other maintenance items which inspectors noted were required was not available.

Significant improvements required

Other improvements were required to meet the *National Quality Standards for Residential Care Settings for Older People in Ireland.* (standards) and include:

- communal bedrooms which accommodate between four and six residents do not meet the requirements of the standards unless they are designated as high dependency units for residents requiring 24 hour high support nursing care or in transition from hospital to nursing home care and this is reflected in the centre's statement of purpose, registration application and in the profile of residents

- only one wash hand basin was available in communal rooms
- private lockable space was not provided for each resident
- bedroom doors were not fitted with locks to facilitate residents lock their rooms if they choose to do so
- separate dining space sufficient to cater for 50 residents was not available
- there was a lack of spaced seating or areas of interest or diversion for residents
- the laundry did not contain a stainless steel sink with double drainer, wash hand basin or mechanical extraction ventilation and there was inadequate space to separate clean and soiled laundry
- a beauty therapy room which was in part used for visiting hairdressers did not contain a separate wash hand basin or mechanical extraction ventilation
- hand rails not provided in the reception/lobby area
- cleaners room did not contain a wash hand basin or mechanical extraction ventilation

Minor issues to be addressed

Limited personalisation of residents' bedrooms was noted. All except one of the single bedrooms in the centre were occupied by respite residents. All other residents were in shared bedroom accommodation. Some residents, particularly those in twin rooms, showed a high degree of personalisation with framed photos, pictures, books and other personal mementos. However, residents in the four-bedded rooms had few personal possessions and these were limited to a couple of pictures posted onto the side of their wardrobes. Inspectors noted that the residents guide discouraged residents and their families from bringing in 'large items' as 'space is limited'.

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

Inspectors found that there were many good practices in respect of communication and information. Notices advertising the inspection visit were prominently displayed, residents and staff told inspectors they were informed of the inspection. As a result, both residents and staff were available to inspectors for interviews and discussions.

The person in charge told inspectors that she visited all areas of the centre daily. This was confirmed in conversations with residents who told inspectors they saw the person in charge regularly and knew her by name.

Notice boards were strategically placed throughout the centre and provided information on activities on a daily basis.

There was a handover at the start of each shift on each unit. Both carers and nurses attended. The person in charge or the assistant director of nursing attended when on duty. An in-depth exchange of information was found to take place. The night nurse placed great emphasis on updating staff that had been off duty on previous days regarding resident's condition and advising how recently-admitted residents were settling down. Specific issues found through the night were discussed and instructions given by the person in charge or senior nurse to teams delivering care. For example, one resident admitted on the previous day had not slept well. The night staff found that as a result of wearing too many layers of clothing around a wound site, the area was inflamed and tender. The person in charge instructed the team to attend to this person first and the senior nurse advised the team to monitor mobility as the resident had fallen at home the previous week.

Evidence of ongoing regular communication between residents, their relatives and staff were found and both residents and relatives spoken with confirmed that they were always informed of changes in their loved ones condition and family meetings were held to discuss care plans and consent for treatment options was always sought. Inspectors observed staff engaged with residents in a respectful manner and were aware of their preferred forms of address. Good eye contact and measured tones of voice ensured good engagement with all residents including those with cognitive impairment.

Inspectors were told by staff that regular team meetings were held on each unit. The agenda for the meetings were set by the clinical nurse manager but staff could give input to the agenda. Inspectors viewed minutes which showed that team meetings at unit level for nurses and carers were held on a two-monthly basis. In addition, the person in charge, registered provider and clinical nurse manager team met on a two-monthly basis. Also, inspectors viewed minutes of senior management meetings which included the multi disciplinary team.

Some improvements required

A comprehensive list of centre-specific policies and procedures were available and found to be in compliance with relevant legislation. These had been reviewed and were being updated on a regular basis. However, a policy on the provision of information to residents was not available as required by the regulations.

An effective management structure was in place. However, although staff were very familiar with the internal organisation and reporting relationships within the centre, they did not know the broader governance structure. Staff were unaware of the position of the nominated person on behalf of the provider or to whom the person in charge reports.

Significant improvements required

Residents' records were not securely stored. These records were stored at the nurses' station which was situated beside the sitting room on a busy corridor where staff, residents and visitors pass frequently. Current records were stored on open shelving behind the desk. Although there were generally many people around the desk, the security of residents' information could not be fully assured at times when staff were busy and records were easily accessible.

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

The dependency level and the number of residents determined staffing. The roster was viewed and staffing appeared adequate. Staff were supported and supervised in the delivery of care by two clinical nurse managers.

The numbers and skill mix of staff were adequate to meet the needs of the residents on the days of inspection. Staff absences were managed appropriately.

If necessary, staff were replaced from an agency with whom a contract had been signed. Agency staff spoken with were familiar with the centre and worked there regularly.

Comments from relatives' questionnaires received prior to inspection raised concerns regarding the level of staff on night duty. However, inspectors visited the centre at 05:00 hrs on the second day of inspection and found all residents were in bed and staff, although busy, were attentive and meeting residents' needs.

All staff demonstrated knowledge and awareness of the needs and personal preferences of residents and carried out their duties in a calm, respectful and competent manner.

An induction programme was in place. It took place over the first two weeks of employment and included all mandatory training. A personal development record for staff recently commenced, which included the detail of induction, qualifications, training and supervision

A robust process of recruitment and vetting was in place, all personnel files included qualifications, experience, Garda vetting and photographic identification. The person in charge provided evidence that all nursing staff were registered with their professional body, An Bord Altranais, prior to the end of inspection. Records contained all of the requirements of Schedule 2 of the (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

Staff training records viewed found that mandatory training on manual handling, fire safety and prevention of elder abuse was provided. Additional training included intravenous cannulation, phlebotomy, medication management and prescribing.

Training on management of confrontational behaviour in dementia care had not yet been delivered but was included in the training plan for 2011. Staff spoken with could discuss the principles of the training provided.

Some improvements required

Inspectors observed several instances of moving and handling practice by staff throughout the course of the inspection. Overall staff were found to be safe and competent and practiced the principles of training received appropriately. However, one instance of an inappropriate and unsafe underarm lift was observed.

An actual and planned rota for staff was available and included the full names of all staff with the exception of agency staff whose surnames were not included. In addition a legend explaining shifts such as, 'L/D' which staff informed inspectors referred to a 'long day' or 12 hours shift from 08:00 hrs to 20:00 hrs and 'N/D' which meant 'night duty' or 20:00 to 08:00 hours was not available and therefore it was not clear from the rota what hours staff were actually working on each shift.

Closing the visit

At the close of the inspection visit, a feedback meeting was held with the provider person in charge administrative officer, clinical nurse manager and senior staff nurses 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:

Nuala Rafferty
Inspector of Social Services
Social Services Inspectorate
Health Information and Quality Authority

17 February 2011

Chronology of previous HIQA inspections	
Date of previous inspection	**Type of inspection:**
15 October 2009	☐ Registration ☒ Scheduled ☐ Follow up inspection ☒ Announced ☐ Unannounced
10 February 2010	☐ Registration ☐ Scheduled ☒ Follow up inspection ☐ Announced ☒ Unannounced

Health Information and Quality Authority
Social Services Inspectorate

Action Plan

Provider's response to inspection report*

Centre:	Lusk Community Unit
Centre ID:	0505
Date of inspection:	8 and 9 February 2011
Date of response:	17 May 2011

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 person in charge has failed to comply with a regulatory requirement in the following respect:

Initial and continuous assessment, monitoring and evaluation of residents' changing needs were not reflected in the care plans. Care plans, risk assessments and nursing evaluations were not linked and were not consistent.

A care plan was not in place for every identified need.

Action required:

The person in charge shall ensure each resident's needs are set out in an individual care plan developed and agreed with each resident. The interventions required to meet the changing needs of residents to be continuously assessed, monitored and evaluated on an as required basis and no less frequently than every three months.

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

Action required:

Put systems in place to ensure that all residents' identified needs are set out in an individual care plan developed and agreed with each resident.

Action required:

Ensure that care plans in place consistently reflect residents' current health status.

Reference:

Health Act, 2007
Regulation 8:Assessment and Care Plan
Standard 10: Assessment

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response:	
1. New assessment documentation which prompts staff as to the need for a care plan in use since 20 March 2011.	20 March 2011
2. Daily nursing evaluation documentation redesigned to include a column for care plan number. This will ensure staff refer back to the care plan for daily updating.	20 March 2011
3. Since inspection staff were notified of this requirement at daily ward reports. It is an agenda item for staff meeting on 4 April 2011.	Ongoing 4 April 2011
4. The Acting Assistant Director of Nursing with responsibilities for clinical care standards has been delegated to audit care plan documentation to ensure resident care needs are assessed when their condition improves or deteriorates.	Ongoing 24 April 2011

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

It was not evident that residents healthcare needs were reviewed on a three monthly basis as required by the regulations.

Action required:

All residents' healthcare needs to be reviewed by the GP on a regular basis and not less than every three months.

Reference: Health Act, 2007 Regulation 8:Assessment and Care Plan Standard 10: Assessment	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response 1. Following inspection feedback on 9 February 2011 the person in charge had a meeting with the medical officer attending Lusk community unit to outline this issue. 2. The medical officer examined all residents who had not been examined by her in the previous three months. Examination of all such residents took place on 19 and 20 February 2011 and the outcome of that examination documented in each residents chart	9 February 2011 19 and 20 February 2011

3. The provider failed to comply with a regulatory requirement in the following respect: An admission criteria was not included in the statement of purpose to assure the appropriate placement and management of the level of need of residents.
Action required: Devise an admission criteria and appropriate operational policies and procedures in relation to admissions to ensure appropriate placements of residents and that the type of services provided meets the needs of those residents admitted as outlined in the statement of purpose.
Action required: Ensure the statement of purpose accurately describes the service provided.
Reference: Health Act, 2007 Regulation 27: Operating Policies and Procedures Standard 28: Purpose and Function

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

Provider's response: Statement of purpose and admission criteria were updated to include a statement "Lusk Community Unit cannot provide for the care need of residents with a history of physical aggression". The amended statement of purpose was sent to the Health Information and Quality Authority at their Co Cork office on Monday 28 February 2011.	28 February 2011

4. The provider has failed to comply with a regulatory requirement in the following respect: Current residents' records were not stored in a suitably secure and confidential facility.
Action required: Ensure all records are stored safely and securely and in a manner which facilitates ease of retrieval maintenance and confidentiality
Reference: Health Act, 2007 Regulation 22: Maintenance of Records Standard 32: Register and Resident Records

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: 1. Since 1 March 2011 residents' records are now stored in the Clinical Nurse Manager's office. 2. Access is through a coded entrance door which is closed when not in use. 3. A code is known only to staff who must use the code to enter the office. 4. Audit of effectiveness. Door closed on inspection	1 March 2011 Ongoing from 15 April 2011

5. The provider has failed to comply with a regulatory requirement in the following respect: The physical design and layout of the centre and the level of equipment provided does not meet the needs of all residents.

Action required:

Provide adequate communal and private space to meet the needs of each resident specifically in relation to, private and communal space.

Action required:

A complete review of the design and layout of the premises and the provision of suitable and sufficient equipment required to meet the needs of all residents is required.

Action required:

Provide suitable and sufficient communal space which includes; sufficient dining room space and space for interest and diversion for residents.

Action required:

Ensure all bedrooms meet the requirements of the *National Quality Standards for Residential Care Settings for Older People in Ireland* in regards to usable floor space and provision of wash-hand basins.

Action required:

Signs identifying the designated function of all rooms were not in place.

Action required:

Ensure all areas in the centre safely accommodates' residents mobility and hand rails are provided where required.

Action required:

Provide suitable and appropriate hand washing and ventilation facilities in designated beauty therapy room.

Action required:

Review the provision of lockable space in residents bedrooms and ensure that this is provided and accessible to all residents particularly those with mobility difficulties.

Action required:

Provide adequate ventilation in all areas of the centre and specifically in the laundry and cleaners rooms.

Action required:

Provide a wash hand basin in the cleaners' room.

Action required: Review the layout of the laundry to ensure that a wash hand basin and the necessary sluicing facilities are provided and that adequate space is available to separate clean and soiled laundry.	
Action required: Make provision to facilitate residents autonomy and choice to lock their bedrooms doors where deemed appropriate and safe to do so.	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response 1. A management meeting was held on 18 February 2011. Representatives of Estates attended. Major structural issues such as single rooms for 80% of residents, provision of two wash-hand basins in four-bedded rooms, access for all residents to dining room, ventilation to the beauty room and cleaners room was discussed. The meeting was informed by Estates personnel that funding was allocated with a view to making this facility HIQA compliant. The person in charge informed the meeting that a definite plan for structural changes with costs and funding was a HIQA requirement pending registration. 2. The meeting was informed that the time frame for addressing the major structural changes will be realistic but must be addressed less than four years otherwise each structural change would have to proceed individually. 3. Two architects surveyed the building on 23 February 2011.They were contracted to produce a plan to provide single en suite accommodation for 80% residents with 20% accommodated for high dependency residents in 2 four-bedded rooms. Storage space and larger dining room facilities was also in the specification. 4. A follow-up meeting to review the redesigned accommodation arranged with HSE management, estates and maintenance departments for 1 April 2011. The architects plan was outlined. It outlined a division of all four-bedded rooms into two-bedded with no en suite facility and with beds positioned by the wall. The person in charge stated that this plan did not address the issues of the privacy and dignity of a resident who would be admitted to this room. It was agreed that a meeting to review the plans and a site visit would be requested of HIQA inspectors.	18 February 2011 23 February 2011 1 April 2011

5. Map indicating the present designated function of the rooms was completed on 20 March 2011 copy not large enough. Estates requested to provide a copy in A3 size.	
6. Occupational therapist surveyed the requirement for a handrail in reception area. Handrail to match the present handrail was costed at €1,300. Application for funding was sent on 20 March 2011.	
7. Maintenance manager visited the unit on 11 March 2011 and 13 April 2011 following a request for the following: ▪ painting bedroom and sitting room. Planned for April 2011 ▪ locks on wardrobes are being sourced with a master key for staff. Will be fitted by St Ita's maintenance dept. when the order is received. ▪ hand-washing sinks and air ventilation in laundry and cleaners to be sourced following agreement to fund. If there is a short timeframe for major structural changes these changes may be accommodated at that time. ▪ locks on the bedroom doors at present are not safe if resident was given a key. Maintenance staff confirm the most suitable system flip lock on the inside with a master key to allow staff access. This is being sourced at present and will be fitted by St Ita's maintenance department when delivered. Residents views are being sought at present as to who would wish for locked doors to their bedrooms.	19-27 April 2011 20 February 2011
8. No sluicing in the laundry as per policy. Alginate bags are used on the ward for soiled clothing. Soiled clothing in alginate bags are put directly into the washing machine. Machines are externally vented. A window provides external ventilation. Laundry person confirms she takes in the laundry over a period and using this system she has adequate space to separate clean and dirty laundry.	
9. Meeting with estates, area manager, registered provider (general manager), architect and the person in charge outlined the refurbishment of the bedroom accommodation . The plan outlined a division of the four bedded rooms making two bedded rooms. In total 17 two-bedded rooms.	
10. Meeting on 11 May 2011 with the person in charge of the unit and estates personnel. The person in charge took the architect on a tour of the building to clarify for all the effect of the proposed change. It was outlined that all maintenance	

issues would be address in September if HIQA chief inspector approved of the plan. A ceiling hoist is proposed for inclusion in all two bedded rooms. To allow access for all residents to dining facilities a conservatory extension to the dining room is also included in the plan.	

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

The residents' guide did not contain all of all of the information as required by legislation.

Action required:

Compile a residents' guide which contains all of the information required by legislation.

Reference:

Health Act, 2007
Regulation 21: Provision of Information
Standard 1: Information

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response:	
1. Reference to the Health Information and Quality Authority investigation complaints has been withdrawn and replaced with details of how to access the Chief inspector and inspection reports as in Standard 1.	18 March 2011
2. Policy on Information for Residents was implemented on 20 March 2011. Resident's guide is Appendix 3 on that policy.	20 March 2011

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

The insurance cover for the designated centre did not identify the limitation of liability in respect of residents' personal property.

Action required:

Review the insurance cover provided to ensure residents' liability meets the (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 as amended and that this is stated on the centres' insurance policy.

Reference: Health Act, 2007 Regulation 26: Insurance Cover Standard 31: Financial Procedures	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Application has been made to HSE insurers for written confirmation as to the limitation of liability in respect of resident's private property. Now available.	2 April 2011

8. The provider has failed to comply with a regulatory requirement in the following respect: All staff did not demonstrate knowledge of the emergency plan.
Action required: Ensure all staff are knowledgeable in respect of the emergency plan and competent in terms of the implementation of the plan.
Action required: Establish a system of regular review and audit of all resources and procedures to include determination of staff knowledge.
Reference: Health Act, 2007 Regulation 31: Risk Management Procedures Standard 26: Health and Safety

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: 1. Major emergency plan and place of evacuation covered with staff from Sunday 27 March onwards. 2. Copy of policy given to each staff member. 3. Staff signature as evidence available.	Ongoing from 27 March 2011

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

Ensure appropriate assistance is provided to residents who require assistance with eating and drinking.

Action required:

Provide appropriate assistance to residents who require assistance with eating and drinking.

Action required:

Ensure residents' dignity is maintained at all times and that assistance is offered discreetly, sensitively and individually.

Action required:

Establish a system for ongoing review and audit of the quality of the service provided, staff practice and consult with residents in this regard.

Reference:

Health Act, 2007
Regulation 20: Food and Nutrition
Standard 19: Meals and Mealtimes

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response:	
1. Two sittings at mealtime in operation ensuring access to dining room for all residents.	31 March 2011
2. Space and seating for a staff member left beside each resident who requires assistance.	
3. Staff ask if resident requires assistance.	
4. Quality of service questionnaires completed in 2010 are now audited.	20 March 2011
5. The present questionnaire in use will be update in week 1 April to address quality of life and safety and risk issues as identified in this inspection.	24 April 2011

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

Communal space and staffing limitations were negatively impacting on residents quality of life.

Action required:

Establish and maintain a system for reviewing and auditing the quality and safety of care and the quality of life of residents in the centre at regular intervals.

Action required:

Establish and maintain a system for improving quality and safety of care and the quality of life of residents in the centre at regular intervals.

Action required:

Make a report in respect of these reviews and audits and improvements and provide a copy of these reports within three months of receipt of this inspection report.

Action required:

Consult with residents and their representatives in relation to the system for reviewing and improving the quality and safety of care, and the quality of life of residents and include evidence of these consultations in the report.

Reference:

Health Act, 2007
Regulation 35: Review of Quality and Safety of Care and Quality of Life
Standard 30: Quality Assurance and Continuous Improvement

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: 1. There is documentary evidence in ward diary that a staff member from Lusk Community Unit's staff complement has been allocated to supervise communal areas when residents are present. 2. Ward managers and staff are informed that they must allocate this person and relief for breaks at morning report time. 3. Senior manager on duty will monitor that this supervision is implemented.	20 February 2011 12 February 2011 Ongoing

4. An audit tool will be designed to audit safety issues, quality of life issues is been sourced as documented in Care and Welfare Regulations 2009. Report completed on all elements audited. 5. Report will be forwarded to HIQA within the three month timeframe.	24 April 2011 25 April 2011

11. The provider has failed to comply with a regulatory requirement in the following respect: Residents' privacy was not maintained at all times.
Action required: Ensure that residents' privacy in relation to confidential information is respected at all times.
Action required: Establish a process to review access to residents information which maintains confidentiality and respect for residents.
Action required: Ensure audits of such access are regularly and routinely carried out and that the results of these audits are made known to staff to ensure best practice.
Reference: Health Act, 2007 Regulation 10: Residents' Rights, Dignity and Consultation Standard 4: Privacy and Dignity

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response 1. All documentation relating to residents has been moved into the Clinical Nurse Manager's office. 2. The entrance door is fitted with a coded lock. The code is known only to staff. 3. Morning report is held in CNM2 office. 4. Audit will identify if this door is locked when staff are otherwise engaged.	 20 March 2011 16 April 2011

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

Staff members did not demonstrate knowledge of appropriate techniques in the moving and handling of residents.

Action required:

Establish best practice procedures in the moving and handling of residents, to include assessment of residents, individual moving and handling plans, staff training and monitoring of practice.

Reference:

Health Act, 2007
Regulation 31: Risk Management Procedures
Standard 24: Training and Supervision

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response:	
1. The annual 2011 manual handling training for all staff is planned for 19, 20, 26 April and 3 and 4 May. The instructor has been informed to cover the risks to patients and staff if an arm lift is used.	March / April 2011
2. Manual handling policy will be explained again to staff fro Sunday 27 March 2011.Staff will be required to sign off that they were informed.	27 March 2011 ongoing
3. A copy of the manual handling policy will be given to all staff at manual handling training.	27 March 2011 ongoing

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

An ongoing maintenance programme which ensures the premises are kept in a good state of repair was not in place.

Action required:

Put in place a system for an ongoing maintenance programme which ensures the premises are kept in a good state of repair.

Action required:

Establish a maintenance programme to ensure the premises and all equipment is maintained in a good state of repair at all times and that equipment provided is maintained in good working order.

Action required:

Review the maintenance programme on a regular basis and no less frequently than every six months and update as required.

Reference:

Health Act, 2007
Regulation 19: Premises
Standard 25: Physical Environment

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response	
1. Maintenance manager was informed of ongoing planned refurbishment of the building on 11 March 2011 during a visit to survey the refurbishment requirements.	11 March 2011
2. This requirement was confirmed in emails on 28 March 2011.	
3. A management meeting with maintenance department and estates is planned for 1 April 2011. This issue is on the agenda for agreement. Further meeting with maintenance manager on 13 April 2011. It was agreed that the person in charge or administration person will submit a weekly maintenance request to be responded by St Ita's maintenance department.	13 April 2011
4. An annual service contract is in place for equipment. Records of previous services are available.	
5. The management team will have a review of the refurbishment and structural change on its agenda at its three monthly meetings.	18 April 2011

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

The range of policies, procedures and guidelines available in the centre were not in compliance with schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

Action required: Put in place policies and procedures on all items listed in schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).	
Action required: Ensure that all policies and procedures meet the requirements of the legislation.	
Action required: Ensure staff are aware of the policies and procedures and knowledgeable in relation to their responsibilities towards their implementation.	
Action required: Establish a system which audits and reviews implementation of policies and procedures and disseminates learning to all staff.	
Reference: Health Act, 2007 Regulation 11: Communication Standard 27: Operating Policies and Procedures	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: 1. A policy on the provision of information to residents was drawn up and approved on 20 March 2011. Included as appendices in this policy are other relevant policies on communication, family meeting and resident pre-admission meeting documentation. 2. A plan is in place to communicate all policies to staff as they are reviewed and updated. There is evidence that staff at present are been updated on the major emergency policy, manual handling policy and HSE management structure where it directly relates to Lusk community unit. 3. The plan is to update staff on all communication policies and patient information policy from 21 May 2011. 4. A signed copy of all attendees at policy information days will be available for inspection	20 March 2011 20 March - 30 April 2011 21 May 2011

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

The staff rota does not include the full names and working hours of all of the staff employed in the centre.

Action required:

The person in charge shall ensure that there is a planned and actual staff rota, showing the full names of all staff on duty at any time during the day and night and that it is maintained.

Action required:

The full names of all relief staff and/or agency staff to be included in the rota.

Action required:

A legend to be provided which clarifies the working hours, start and finish times of each shift to be included on the rota.

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: 1. From 10 March 2011 the full names of all staff including agency staff was manually inserted on planned off duty. 2. From 13 March 2011 the full names off all staff including agency staff was inputted on computer for ongoing use in planned and actual duty rosters. 3. A legend of all staff and roster hours is documented on all rosters sheets as a clarification of roster times and abbreviations. 4. A separate page providing a legend of rosters and roster abbreviations is provided in all roster folders	10 March 2011 13 March 2011

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

Staff was not aware of the roles and responsibilities of all members of the management team or the overall management structure of the service.

Action required:

Ensure that each member of staff are aware of the roles of each other member of the team and that lines of accountability and responsibilities are clearly defined.

Action required:

Establish a system of regular review of communication which ensures staff are aware of the reporting relationships governing the centre.

Reference:

Health Act, 2007
Regulation 5: Statement of Purpose and Function
Standard 28: Purpose and Function

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response:	
1. At staff morning report staff were informed of local management structure each day following HIQA feedback on 9 March 2011.	9 March 2011
2. Local management structure is documented and displayed on staff notice board. Employees given a copy.	9 March 2011
3. Induction and local recruitment policy will be reviewed on 31 March 2011. Management structure is included in induction and staff recruitment policy.	27 March 2011

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

Contracts of care did not meet the requirements of the legislation.

Action required:

Amend the contract of care and ensure it meets all the requirements of the legislation.

Reference:

Health Act 2007
Regulation 28: Contract for the Provision of Services
Standard 7: Contract/Statement of Terms and Conditions

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: 1. The registered provider requested a review of the HSE national contract of care on 15 March 2011. 2. Reply received on 22 March 2011 indicating the document was referred to the legal department for review. 3. Confirmation was received on 23 March 2011 that this process in nearing completion	15 March 2011 22 March 2011

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

Precautions in place to control identified risks were not implemented at all times.

Action required:

Review systems and practices in place to provide appropriate levels of supervision where required for residents in private and communal areas to ensure safe standards of care.

Reference:

Health Act 2007
Regulation 31: Risk Management Procedures
Standard 26: Health and Safety

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: 1. Senior managers have commenced review of major emergency plan and manual handling policy on 27 March 2011. This will be ongoing until all staff get instruction. 2. There is documentary evidence that all staff have received this instruction and were given a copy of the relevant policies. 3. Annual manual handling training is planned for 19, 20 and 26 April 2011 and 3, 4 and 10 May 2011. Instructor will cover the risk associated with a manual lift.	27 March 2011 ongoing

19. The provider is failing to comply with a regulatory requirement in the following respect: The directory of residents did not include all of the information specified in schedule 3 of the (Care and Welfare of Residents in Designated Centres for Older People)Regulations 2009	
Action required: Review or replace the directory of residents to ensure it includes all of the information specified in schedule 3 of the (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009	
Reference: Health Act 2007 Regulation 23: Directory of Residents Standard 32:Register and Residents' Records	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: 1. Information technology department was contacted to ensure all information required can be inputted on the computer admission system. 2. Cause of death will be inserted manually by the person in charge. 3. A spreadsheet was designed to supplement the information required by legislation.	 31 March 2011 20 February 2011 30 March 2011

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 9: Resident's Finances	Review the administration of finances retained for safekeeping to include the provision of a statement of account to respite residents on discharge. **Provider's response:** Reviewed by administration staff on 10 March 2011. Respite residents account now given to the client after final transaction or on discharge.
Standard: 16 End of Life Care	Review the documentation of residents' wishes regarding end of life care to include residents and or their representative's agreement. **Provider's response:** Resident / family member signature inserted on family meeting record. March 2011
Standard :17 Autonomy and Independence	Review the extent to which residents are facilitated to retain a reasonable number of their personal possessions and provide adequate space. **Provider's response:** Residents are encouraged to bring small items of personal or sentimental value. If a resident/family member requests accommodation a larger item it will be considered. This is documented in resident information booklet. Other references to accommodation of personal items are withdrawn from resident information booklet.

Any comments the provider may wish to make:

Provider's response:

Updated on 25 April 2011.

Provider's name: Sheila Marshall
Date: 17 May 2011