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:	Seanchara Community Unit
Centre ID:	0515
Centre Address:	St Canice's Rd Glasnevin Dublin 11
Telephone number:	01 -7044400
Fax number:	01 – 7044490
Email address:	siobhanbyrne@hse.ie
Type of centre:	☐ **Private** ☐ **Voluntary** ☒ **Public**
Registered provider:	Health Service Executive
Person in charge:	Mary Flanagan
Date of inspection:	10 and 11 May 2011
Time inspection took place:	**Day 1: Start:** 10:30 hrs **Completion:** 17:30 hrs **Day 2: Start:** 10:20 hrs **Completion:** 16:10 hrs
Lead inspector:	Sheila Mckevitt
Support inspector(s):	Leone Ewings
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.higa.ie.

About the centre

Description of services and premises

Claremont Residential and Community Services are based in Dublin North Central. The services are divided into three units and Seanchara Community Unit is one of these.

Clarehaven Home, Anam Chara housing care unit and a day care facility are all situated on the same site. The latter two are directly accessible via a lift from Seanchara Community Unit.

Seanchara Community Unit is a 40 bedded purpose-built, single-storey residential unit for people over the age of 65 years. Bed numbers have reduced by eight since the previous inspection. There are two wings east and West with 20 beds on each.

There are six single bedrooms, four twin rooms, two three-bedded and five four-bedded rooms spread over two wings. Four single rooms share two en suites showers and toilets all other bedrooms have one wash hand basin in the room. There are two sitting rooms and two dining rooms one of which has a comfortable seating area and kitchenette accessible to residents. There is one main kitchen and a kitchenette on each wing. Staff have their own restaurant, rest room and changing facilities.

Other facilities include an oratory, a visitors' room, an activities room, a snozelen room, a physiotherapy room, a hairdressing room, a complimentary therapy room, a reception area, a porters desk and administration offices.

There are two enclosed wheelchair accessible courtyards and two enclosed wheelchair accessible gardens which residents can access freely.

There is ample car parking around the building.

Location

Seanchara Community Unit is situated in parish of Ballygall, Glasnevin, Dublin. It is located in a residential area.

Date centre was first established:	01 October 1999
Number of residents on the date of inspection	38
Number of vacancies on the date of inspection	2

Dependency level of current residents	Max	High	Medium	Low
Number of residents	19	9	7	3

Management structure

The nominee on behalf of the Health Service Executive (HSE) is John Kelly. Pat Lane, Administration Manager and Mary Flanagan, the Person in Charge all report to John Kelly. The Assistant Director of Nursing, the Practice Development Officer and the Catering Manager, report to the Person in Charge. Administration staff report to Pat Lane.

The Assistant Director of Nursing and the Practice Development Coordinator are supported by two Clinical Nurse Managers grade II and two Clinical Nurse Managers grade I to whom all staff nurses and care assistants report. The catering staff report to the catering manager.

A contract cleaning company supply the cleaning staff and they report to a company supervisor.

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	6	5	10	6	2	*10

*Porter
Administration staff x 2
Complimentary therapists x 2
Activities coordinator
Practice development coordinator
Physiotherapists x 2
Occupational therapists

Summary of findings from this inspection

This report set out the findings of a registration inspection, which took place following an application to the Health Information and Quality Authority for registration under Section 48 of the Health Act 2007.

Inspectors met with residents, relatives, and staff members, over the two day inspection. Inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files. Separate fit person interviews were carried out with the provider and the person in charge, both of whom had completed the fit person self-assessment document in advance of the inspection. This was reviewed by inspectors, along with all the information provided in the registration application form and supporting documentation.

Positive changes had taken place since inspectors first visited the centre in January 2010. 14 of the 16 action plans had been fully addressed. One regarding the statement of purpose had been partially addressed and one relating to the number of bathroom/showers to meet the needs of residents was not addressed. However, plans were in place according to the person in charge.

The person in charge played an active role in the management of the centre supported by the assistant director of nursing. However, a second key senior manager is required to take over the day to day running of Seanchara in the absence of the assistant director of nursing. The fire compliance document needs to be submitted together with an up to date statement of purpose.

Inspectors were satisfied that the quality of service provided to residents was good. Residents' independence was promoted, their rights respected and they had choice of their preferred daily routine. Clinical nurse managers and staff nurses were not familiar with required notifications.

Medical, nursing and other health care needs of residents were provided to a high standard.

Staffing numbers were good. However, the allocation of staff particularly high numbers of agency staff required reviewing.

The premises were clean, tidy and bright. Bedrooms and communal areas were of a good size. The bathroom doors did not facilitate residents' privacy and catering staff did not have a separate cleaning room. Although residents had access to all assistive devices required the servicing of some equipment was not kept up to date. Records of all fire servicing and actions taken to remedy defects identified were not available on inspection.

The action plan at the end of this report identifies the areas mentioned above where improvements are required.

Comments by residents and relatives

Resident and relative questionnaires were sent to the centre prior to the inspection. Two relatives and seven residents provided responses. Inspectors talked to some residents and relatives during the inspection.

All residents spoken with said they felt safe living in the centre. One resident stated she was “delighted with here” and another that she felt “very safe”, “all the time”.

Residents’ spoken with felt well cared for and a number said all their needs were cared for by staff. Residents said they would speak to a member of staff or the “person in charge” if they had a complaint. However, residents had no complaints they were all satisfied with the quality of care they received particularly with the wide variety of activities they had to choose from including access to activities outside of the centre.

Residents told inspectors about their regular meetings, where their opinions were sought, listened too and acted upon by staff.

Overall, residents were happy the way things were. However, two residents wrote that they were not satisfied with having to smoke outside.

Most relatives said their family member was attending the centre for respite care prior to being admitted for long term care. All had been invited to visit the centre prior to the admission, one relative said she visited a few times and spoke to staff.

Relatives were satisfied with the variety of activities available to residents. However, one commented that there were no activities at the weekends.

Relatives stated they were kept up to date on their relatives’ general progress by nursing staff and the doctor.

Relatives said the manager and all nursing staff were very approachable and they would go to either if they had a complaint. Relatives stated they did not have cause to complain.

One relative felt that the personal wardrobes were too small.

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 detailed account of all accidents and incidents was recorded. Documents examined demonstrated that all accidents/incidents were audited on a monthly basis and learning used to inform practice to prevent accidents/incidents re-occurring.

The centre-specific risk management policy had been updated since the last inspection and complied with the requirements in the regulations, each area of the centre had been risk assessed. All residents who were identified as being at risk of falling had risk assessments completed. Records of staff training in manual handling seen by inspectors were up to date and practice observed was to a good standard.

The recently updated safety statement showed that the centre was risk assessed by a member of the health, safety and quality committee at the beginning of this year. Minutes of the monthly committee meetings were reviewed, these showed that identified risks were rated and addressed promptly. Prevention of risk was evident, for example, mock fire evacuations, mock absconsion and falls prevention refresher course were all planned for staff.

There was a clear and concise emergency plan in place. The responsibilities of staff in the event of an emergency were outlined. Staff spoken with displayed a good understanding of their role in the plan.

The quality of care provided was audited monthly by management and staff nurses on the following areas of practice: falls sustained by residents, forms of restraint used, pressure ulcers, residents with infections and any other new infections. Inspectors saw information from the audits displayed on staff notice boards and records of staff meetings indicated results were discussed and used to inform future practice.

Inspectors viewed the issues log on each wing and found that it contained a small number of minor verbal complaints, all of which were addressed in a timely and satisfactory manner by the clinical nurse managers.

The complaints policy had been updated since the last inspection and complied with the requirements in the regulations and it was displayed in a prominent place, and detailed in the resident's guide. Staff spoken with were aware of the complaints procedure. Residents and relatives confirmed that they were aware how to use the informal and formal complaints policy.

The insurance policy in place for the centre met the regulatory requirements.

A certificate confirming that the centre complies with the building codes, Planning and Development Act 2000-2006, was in place further to the recent building works.

The record of residents' money held had improved since the previous inspection. The inspector reviewed an accurate record of cash held for each resident. Records were individualised and held in a confidential and secure manner in the safe.

Some improvements required

The person in charge was employed fulltime with responsibility for three centres, two of which are on the same site; the third is located within a mile radius. Staff confirmed to inspectors that the person in charge visited Seanchara on a daily basis. The assistant director of nursing assumed responsibility for the day to day management of the centre and deputised for the person in charge when she was absent. However, on inspection the assistant director of nursing was off duty for a period, the person in charge had taken on the day-to-day management of the centre in her absence. Inspectors found this arrangement was not sustainable for a long period taking into consideration her responsibility for two other centres.

Three of the four clinical nurse managers were met on inspection. They were familiar with the Standards and were enthusiastic about making continuous quality improvements in the service. Clinical nurse managers spoken with were not clear of the regulations particularly about notifications to be made to the Authority. For example, inspectors found that a resident had a grade two sacral ulcer in February, it has now healed. However, it had not been reported to the Authority.

Inspectors found that the procedures in place for preventing, detecting and responding to fire were satisfactory. Inspectors reviewed records of fire maintenance and found the names of staff who attended the regular fire drills. There were records to indicate that all of the staff had attended training on fire prevention and procedures. The means of escape and fire doors were seen to be kept clear at all times during the inspection. However, records of emergency light checks completed were not available at the centre. On request they were obtained and reviewed. The maintenance manager could not confirm to the inspector and there was no written evidence that any actions had been taken to remedy defects identified in the last four quarterly reports.

Inspectors reviewed written confirmation submitted to the Authority, from a competent person that all requirements of the statutory fire authority were complied with.

However, the document did not fully meet the requirements of the legislation, and an additional template was issued to the person in charge for completion by the relevant personnel identifies on the form.

The statement of purpose updated since the last inspection, accurately reflected the services and facilities provided. However, the management structure needs to be updated to reflect the newly appointed nominee on behalf of the Health Service Executive.

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

A high level of engagement and interaction between staff and residents was observed. Respect was shown for individual preferences as demonstrated by staff.

The inspectors observed that staff encouraged residents to maintain their independence and autonomy as much as possible. Inspectors joined residents for lunch and observed that independent dining was encouraged with any staff assistance given in a sensitive and personalised manner. At mealtimes, and throughout the day, residents were provided with a choice of food and drinks.

Inspectors observed that staff were considerate of the privacy and dignity of residents. Lunchtime was not rushed and staff addressed each resident respectfully. They knocked and waited for a response before entering rooms. Doors were closed during personal care and when residents sought time alone. All the residents were wearing clean clothes and appeared comfortable.

Residents were supported to continue the daily routines they had prior to admission. Residents were facilitated to pay for their own hair appointments when the hairdresser visited.

Training in elder abuse prevention and response had now been provided to all staff and those who were interviewed understood their role in adult protection. Information about an advocacy service for those who needed assistance with expressing their views was observed on information boards.

Staff, residents and relatives described the availability of a number of different activities and commented on the value of activities that had a purpose. Residents interviewed spoke of joining in these activities according to their choice and inspectors observed this in practice and viewed written and pictorial activity programme.

Attention was paid to individual interests to the extent that one gentleman, who

could not leave his room, was provided with one to one complimentary therapy in his room. The on site complimentary therapists and staff spoke about positive changes to his mood post delivery of such therapy. Examples of activity opportunities provided for more dependent residents were massage, aromatherapy and reflexology which could be carried out in the well equipped complimentary room or in the residents' bedroom.

The snozelen room was used as a form of therapy for residents suffering from a cognitive impairment. The complimentary therapists explained residents benefited from spending quite one to one time in this well equipped room.

Residents maintained social relationships and enjoyed the visits. Social interaction with families was encouraged and relatives and residents expressed satisfaction that they were always welcomed by staff and the atmosphere was hospitable.

The local parish priest and on site chaplain looked after the residents' spiritual needs. There was an oratory on site for residents' use. Daily morning mass was transmitted from the local church which residents could attend if the wished. Those who wished often attended mass said by the local priest in Clarehaven House situated beside Seanchara.

There was also a relatives' support group established and chaired by the chaplain. They met on a regular basis, provided support to relatives of residents living in the centre and to those who have suffered a recent bereavement.

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 told inspectors that a number of opportunities for physical activity were available. Residents spoke of their enjoyment of the exercise programme and cooking classes which also formed part of their activities.

Home baking was a part of the kitchen routine and snacks and drinks were readily available. Lunch served on the day of inspection was sufficient and nutritious. The inspectors saw that records of residents' weight for purposes of monitoring weight gain or loss were maintained.

Inspectors found that residents had access to peripatetic services on site including physiotherapy, occupational therapy, dietician, chiropody and social work and they were supported to attend scheduled hospital appointments. There was a direct nurse referral system in place. Records of such referrals were viewed by inspectors in resident files.

Residents had access to a general practitioner who was on site every weekday morning. However, residents can retain their own general practitioner if they wish Doctor on call services are accessed out of hours and on weekends.
Inspectors reviewed residents files which showed residents had a medical review completed every three months, including a review of their medications.

When intervention was required from inter disciplinary team members this was sought without delay. Evidence of referrals together with an inter-disciplinary narrative note was reviewed in residents' files' which allowed for clear communication between disciplines. For example, inspectors noted a inter disciplinary team conference took place to discuss one resident who had sustained a high number of falls over a short period of time, changes were made to her medication, an alarm mat put in place which led to a reduction in the number of falls.

Residents were admitted following an assessment of their needs. This practice was confirmed by residents and relatives in their questionnaires. Resident records reviewed by inspectors contained assessments and care plans reviewed quarterly and resuscitation orders which were now reviewed on an annual basis.

An inspector accompanied the nurse on a medication round and observed that staff adhered to procedures for prescribing, recording, storage, handling and disposal of medicines in accordance with professional regulatory requirements. Records were kept to account for all medicines. Scheduled controlled drugs were found to be secured in the correct manner. A register of controlled drugs was maintained by the nurses who counted these medications at the time of administration and at the change of each shift. Two nurses signed and dated the register and the stock sheets at the change over of each shift.

There was a nutrition policy in place that guided practice. Catering staff had teamed up with other interdisciplinary team members to form a group called “The Good Life”, whose aim was to discuss issues relating to eating, drinking, swallowing and nutrition. They planned some positive changes to enhance the service they provided for residents, such as displaying a picture of each meal on the summer menu so residents could visualise the meal.

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

Single bedrooms were spacious with facilities such as a call bell system, lockable cupboard space, and televisions. Twin, three and four bedded rooms met the minimum spatial requirements of the Standards. Inspectors visited bedrooms with residents' permission and found that residents were encouraged to bring in their personal possessions and there was adequate storage for their belongings with a locked cupboard for valuables. Most rooms were seen to be decorated with personal mementoes or photographs and other items.

The centre was clean and well maintained throughout. The organisation of the cleaning schedule and supervision of cleaning staff was to a high standard. This was evident from the three awards they had recently received for the standard of cleanliness in the centre.

Inspectors found that there was a sense of homeliness and warmth. Positive improvements were noted. Relatives and residents confirmed they felt that the centre was "homely" in its' decoration. There were two sitting rooms and two dining rooms, all of which were used by residents. One of the dining rooms had a kitchenette area for residents use. Residents had independent access to four secure enclosed courtyards.

There was maintenance book held at the, porters desk to record any items which required repair. Inspectors were informed the maintenance person had access to plumbers and electricians when necessary, links were well established.

The kitchen was kept in pristine condition. The inspector observed a large and diverse amount of dry, fresh and frozen food stored for residents' use.

Some improvements required

There was no cleaning room available for catering staff. Catering staff tried to promote safe practice with the facilities available to them by obtaining hot water from the taps in the kitchen, discarding waste water in the outside drain and storing equipment in the general cleaning room.

Inspectors noted that some of the communal bathrooms did not have functioning privacy locks in place.

There were two assisted shower/bathrooms for use by 36 residents which was not adequate to meet the needs of all residents; the ventilation in one of these was not in working order.

The hairdressing room was large, bright and spacious. However, it did not include a separate wash-hand basin.

Inspectors observed that the centre was generally kept in a good state of repair. However, noted some bedroom doors had peeling paint.

Storage space was available for equipment. Inspectors found there was an adequate amount of assistive equipment such as hoists, pressure relieving mattresses and mobility aids available to meet residents' needs. There was ceiling hoists in three of the four bedded rooms and in the two communal bathrooms. Records of servicing to electric beds, hoists and pressure relieving mattresses were reviewed. Although most equipment had been serviced on a routine basis, inspectors found that the hoists which were due to be serviced the week prior to inspection had not been serviced.

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

Interaction between staff and residents was good. Staff used a variety of means to communicate with residents. For example, at meal times catering staff displayed the choice of meals on offer on a notice board in addition they showed residents a plated sample of the food available. Staff knew residents well and informed inspectors about their capabilities.

Staff wore uniforms and large name badges. Residents appeared to be familiar with staff calling them by name.

All policies outlined in schedule five were available including provision of information to residents. Staff signed off on policies and procedures to verify they had read them and staff members interviewed were knowledgeable of the content of key policies. Additional policies based on best practice had also been developed on topics such as falls prevention and continence promotion.

Records required to be kept by legislation were in place. For example, the directory of residents was available and found to meet the regulatory requirements.

There was a newly developed written guide available, referred to as the Residents' Guide, as a means of providing information to residents about the centre and its services. On review inspectors found it met the regulatory requirements. Copies were seen in some residents' bedrooms.

Comment cards were available throughout the centre. These included 20 questions regarding the quality of service provided by the centre. Inspectors read a number of those returned, which showed a high level of satisfaction with the level of service received.

Information for residents was displayed on a number of notice boards throughout the centre including orientation clues for residents' with a cognitive impairment.

In addition, the activity timetable included pictures to facilitate communication with residents' with a cognitive impairment.

Staff meetings were held on a regular basis and good record keeping practices were noted. Minutes of these meeting were available to staff and inspectors for review.

Relatives and families reported feeling welcome at any time. They stated that access to the person in charge and to all staff was straightforward. They knew whom to contact if they wanted to make a complaint. Signed contracts of care were in place, they contain terms and conditions of residents stay.

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

Staff recruitment was in line with best practice. The health care executives' recruitment policy was adhered to when recruiting staff. The person in charge provided inspectors with a signed declaration that at sample of staff files were checked and contained the documents outlined on schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

There were records to indicate that staff received mandatory training in manual handling, prevention and detection of elder abuse and fire prevention and detection. Inspectors found that some staff had also received training on issues such as cardio-pulmonary resuscitation (CPR), best practice in dementia care, behaviours that challenge, phlebotomy training and medication management.

Staff appraisals were completed by managers on an annual basis.

There were a number of working groups established between the three centres in the Claremont Services. These included:

- continence promotion
- restraint
- activities
- falls
- dementia.
- health, safety and quality
- policy committee.

These groups included a link nurse from each centre, catering staff and members of the multidisciplinary team. It was evident; on review of minutes of meetings, these groups were completing good work. For example, the dementia working group had developed and published a dementia booklet and organised a relatives evening to launch it.

New staff were supernumerary for their first week of employment. They were provided with an introduction folder and checklist. This had to be completed by the end of their probationary period, which was usually three months.

Changing facilities were available for staff. Staff had there own separate restaurant and rest room.

Inspectors spoke with a volunteer working in the centre who confirmed she had completed garda vetting and had her roles and responsibilities outlined to her prior to commencing work in the centre.

Some improvements required

Inspectors reviewed the actual staff roster and confirmed that there was adequate staff numbers on duty to meet the needs of residents. However, there was a high use of agency staff. For example, on 06 May, on day duty, there were two health care assistants, two staff nurses and two kitchen assistants employed from different agencies. On night duty, there were two agency health care assistants employed. Inspectors had the following concerns:

- on a number of occasions, an agency staff nurse was left in charge on night duty although the second nurse on duty was a fulltime employee of the Health Service Executive
- on a number of nights two out of four staff on night duty were agency
- the two agency staff i.e. an agency staff nurse and an agency care assistant were often allocated to work on the same wing when the two fulltime employees worked together on the other wing
- all agency staff could not be identified on the staff rota.

Staff rosters did not reflect the names or the actual hours worked for the two administration staff based in offices in Seanchara.

Closing the visit

At the close of the inspection visit, a feedback meeting was held with the provider, person in charge, practice development officer, administration manager, catering manager and two clinical nurse managers 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:

Sheila Mckevitt
Inspector of Social Services
Social Services Inspectorate
Health Information and Quality Authority

25 May 2011

Chronology of previous HIQA inspections	
Date of previous inspection:	**Type of inspection:**
21 January 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:	Seanchara Community Unit
Centre ID:	0515
Date of inspection:	10 and 11 May 2011
Date of response:	14 July 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 provider has failed to comply with a regulatory requirement in the following respect:

Adequate arrangements were not in place for the management of the designated centre in the absence of the person in charge and the assistant director of nursing.

Action required:

Give notice in writing to the Chief Inspector of the procedures and arrangements that will be in place for the management of the designated centre during the absence of the person in charge, setting out the matters contained in Regulation 38(2).

Reference:

Health Act, 2007
Regulation 38: Notification of the procedures and arrangements for periods when the person in charge is absent from a Designated Centre
Standard 27: Operational Management

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

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: The director of nursing is the person in charge. However, her deputy the assistant director of nursing was on leave and a CNM 2 had been covering her role (by coincidence she was also on annual leave the week of the inspection. Additional arrangements have been put in place for the management of the designated centre in the absence of the PIC or her deputy.	Completed

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

The statement of purpose does not reflect the recently revised management structure.

Action required:

Compile an updated Statement of purpose that consists of all matters listed in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

Reference:

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

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: The amendment has been made.	Completed

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

The written confirmation received did not state that all the requirements of the statutory fire authority have been complied with and therefore does not meet the regulatory requirements.

Records of emergency lighting checks carried out on a quarterly basis with the result of any such test were not available in the centre.

There was no evidence that actions had been taken to remedy defects identified.

Action required:

Provide to the Chief Inspector of Social Services, together with the application for registration or renewal of registration, written confirmation from a competent person that all the requirements of the statutory fire authority have been complied with.

Action required:

Maintain, in a safe and accessible place, a record of all fire equipment checks carried out at the designated centre together with the result of any such test and the action taken to remedy defects.

Reference:

Health Act, 2007
Regulation 32: Fire precautions and records
Standard 26: Health and Safety

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The fire register at the designated centre maintains a record of all fire equipment checks carried out at the designated centre. The result of any such test and the action taken to remedy defects is forwarded to the fire officer to action. Copies of such actions will now be sent to the PIC to hold in the designated centre and remedy in collaboration with the fire officer. The fire officer will supply written confirmation from a competent person that all the requirements of the statutory fire authority have been complied.	July 2011

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

Records of emergency lighting checks carried out on a quarterly basis with the result of any such test were not available in the centre.

There was no written evidence that actions had been taken to remedy defects identified.

Action required:

Maintain, in a safe and accessible place, a record of every fire practice, drill test of fire equipment (including fire alarm equipment) conducted in a designated centre and any action taken to remedy defects in the fire equipment.

Reference: Health Act, 2007 Regulation 22: Maintenance of records Standard 32: Register and Residents' Records	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The fire officer has confirmed that the system is in compliance with IS 3217. The variations identified by the inspector are minor variations to the standard. These are being addressed within the fire safety officers department and his programme of works. Some matters have already been corrected.	Sept 2011

5. The person in charge has failed to comply with a regulatory requirement in the following respect: Staff members were not aware, commensurate with their role, of the provisions of the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 as amended.	
Action required: Make staff members aware, commensurate with their role, of the provisions of the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 as amended.	
Reference: Health Act, 2007 Regulation 17: Training and Staff Development Standard 24: Training and Supervision	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: An education programme has been put in place to ensure that notifications are appropriately reported to the Chief Inspector of Social Services without delay.	Completed

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

The allocation of agency staff is not always in line with best practice.

Action required:

Ensure that the numbers and skill mix of staff are appropriate to the assessed needs of residents, and the size and layout of the designated centre.

Reference:

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

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The PIC and registered provider acknowledge the difficulties given the current moratorium on recruitment. The unit endeavours to ensure that all agency staff has adequate induction and orientation and that there is continuity of care when agency staff is used. This is on an ongoing difficulty for the unit .All rosters are reviewed by the PIC to ensure appropriate assignment of agency staff.	Completed

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

The premises do not contain all the necessary facilities to safely meet the needs of 40 residents:

- service of hoists were not up to date
- bedroom doors had paint peeling
- only two bathroom/shower rooms available for 36 residents'
- no cleaning room available for catering staff
- ventilation was not in working order in one of the two bathroom/shower rooms
- no wash-hand basin in hairdressers room

Action required:

Maintain the equipment for use by residents or people who work at the designated centre in good working order.

Action required: Keep all parts of the designated centre clean and suitably decorated by repainting areas as and when required.	
Action required: Provide a sufficient number of assisted baths and showers, having regard to the dependency of residents in the designated centre.	
Action required: Provide a cleaning room containing all required equipment for use by catering staff only.	
Action required: Provide ventilation, heating and lighting suitable for residents in all parts of the designated centre, which are used, by residents.	
Action required: Provide sufficient numbers of washbasins fitted with a hot and cold water supply, which incorporates thermostatic control valves or other suitable anti-scalding protection, at appropriate places in the premises.	
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: Service of hoists were not up to date o The unit has a service contract for patient hoists which was viewed by the inspectors on their visit. Due to the Easter holidays the 6 monthly reviews had not been completed. The regulation allows for a review at 6 monthly intervals and does not give a plus or minus tolerance. Bedroom doors had paint peeling. Only two bathroom/shower rooms available for 36 residents'. No cleaning room available for catering staff. Provider's response: HSE estates is putting in place a	May 2011 December 2011

programme of work to address these areas Ventilation was not in working order in one of the two bathroom/shower rooms Provider's response: completed No wash-hand basin in hairdressers room Provider's response: request for same made	 May 2011 August 2011

8. The provider has failed to comply with a regulatory requirement in the following respect: The two communal bathroom/shower rooms did not have privacy locks in place.	
Action required: Provide residents with privacy to the extent that each resident is able to undertake personal activities in private by fitting both communal bathrooms/shower rooms with privacy locks.	
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: Locks have now been provided.	 Completed

Any comments the provider may wish to make:

Provider's response:

The provider acknowledges the findings of the inspectors. The person in charge and the provider is anxious that the good work in the unit and the high standards of care be reflected in the report and not over shadowed by events that could not have been foreseen such as the servicing of the hoist and the absence of the deputy PIC.

Provider's name: John Kelly

Date: 14 July 2011