Health Information and Quality Authority
Regulation Directorate

Compliance Monitoring Inspection Report
Designated Centres under Health Act 2007, as amended

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

Centre name:	Farranlea Road Community Nursing Unit
Centre ID:	0713
Centre address:	Farranlea Road Wilton Cork
Telephone number:	021 4927650
Email address:	teresa.odonovan2@hse.ie
Type of centre:	☒ **Private** ☐ **Voluntary** ☒ **Public**
Registered provider:	Health Service Executive
Person authorised to act on behalf of the provider:	Teresa O'Donovan
Person in charge:	Barbara Ryan
Date of inspection:	30 July 2013 and 31 July 2013
Time inspection took place:	**Day 1-Start:** 09:25hrs **Completion:** 18:45hrs **Day 2-Start:** 08:45hrs **Completion:** 16:45hrs
Lead inspector:	John Greaney
Support inspectors:	Caroline Connelly
Type of inspection	☐ **announced** ☒ **unannounced**
Number of residents on the date of inspection:	44
Number of vacancies on the date of inspection:	56

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.

Summary of compliance with 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*.

This inspection report sets out the findings of a monitoring inspection, in which 11 of the 18 outcomes were inspected against. The purpose of the inspection was:

- ☐ to inform a registration decision
- ☐ to inform a registration renewal decision
- ☒ to monitor ongoing compliance with Regulations and Standards
- ☐ following an application to vary registration conditions
- ☐ following a notification of a significant incident or event
- ☐ following a notification of a change in person in charge
- ☒ following information received in relation to a concern/complaint

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

Outcome 1: Statement of Purpose	☐
Outcome 2: Contract for the Provision of Services	☒
Outcome 3: Suitable Person in Charge	☒
Outcome 4: Records and documentation to be kept at a designated centres	☐
Outcome 5: Absence of the person in charge	☐
Outcome 6: Safeguarding and Safety	☒
Outcome 7: Health and Safety and Risk Management	☒
Outcome 8: Medication Management	☒
Outcome 9: Notification of Incidents	☐
Outcome 10: Reviewing and improving the quality and safety of care	☒
Outcome 11: Health and Social Care Needs	☒
Outcome 12: Safe and Suitable Premises	☒
Outcome 13: Complaints procedures	☒
Outcome 14: End of Life Care	☐
Outcome 15: Food and Nutrition	☒
Outcome 16: Residents' Rights, Dignity and Consultation	☐
Outcome 17: Residents' clothing and personal property and possessions	☐
Outcome 18: Suitable Staffing	☒

Farranlea Road Community Nursing Unit is a 100 bedded facility divided into four units, each with 25 beds. Two of the units, Willow and Oak currently provide long-term residential accommodation for primarily older dependant persons and the third unit, Sycamore, will also accommodate older dependant adults when it is opened. The fourth unit, Cedar View, currently provides residential accommodation for five young adults with complex high-support needs.

This was the third inspection of Farranlea Road CNU. The first inspection was a registration inspection and was carried out prior to the centre being occupied by residents.

The second inspection was an 18 outcome inspection and took place in June 2012. During that inspection inspectors found that the centre was undergoing a period of transition as the centre had only recently become operational, the person in charge was due to cease employment and a new person in charge had not been appointed, and staff were in the process of being redeployed from other HSE facilities. Following that inspection the provider was issued with an immediate action plan to address fire safety, risk management and staffing. Additional improvements required included staff training, records management, management of residents' finances, care planning, restraint management, communication with kitchen staff, consulting with residents, absence of the person in charge and notifications to the Chief Inspector.

This inspection was unannounced and took place over two days. As part of the monitoring inspection, inspectors met with residents, relatives and staff members. Inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files. Since the last inspection the Authority had received information in relation to staffing levels, the care and welfare of residents, the suitability of admissions and lack of ventilation during a period of hot weather in July 2013. These issues were reviewed during this inspection and the findings are contained in the report.

Overall inspectors found that residents were well care for and staff demonstrated a commitment to person-centred care. There was ready access to allied/specialist health service and there was evidence that these services were utilised appropriately and also supported staff development through the provision of training. Residents and relatives spoken with were complimentary of staff and the care they provided.

Inspectors found evidence of improvements since the last inspection and many of the issues identified for improvement were satisfactorily addressed, however, some improvements were still required to comply with 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*. The provider was required to complete an action plan to address these areas.

These improvements included:

- contracts of care
- training on the prevention, detection and response to abuse
- health and safety statement
- risk management
- medication management
- consultation with residents
- an emergency exit that was not alarmed
- complaints policy
- end-of-life preferences
- nutritional assessment
- personnel files.

Section 41(1)(c) of the Health Act 2007

Compliance with 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*.

Theme: Leadership, Governance and Management

Effective governance, leadership and management, in keeping with the size and complexity of the service, are fundamental prerequisites for the sustainable delivery of safe, effective person-centred care and support.

Outcome 2

Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

References:

Regulation 28: Contract for the Provision of Services
Standard 1: Information
Standard 7: Contract/Statement of Terms and Conditions

Actions required from previous inspection:

Agree a centre-specific contract with each resident within one month of admission to the designated centre.

Inspection findings

Inspectors viewed the contracts of care and found that a significant number of residents did not have agreed contracts of care. Inspectors were informed that this was due to lack of clerical support. Management were informed that it was a regulatory requirement for residents to have an agreed contract of care in place within one month of admission.

Outcome 3

The designated centre is managed by a suitably qualified and experienced nurse with authority, accountability and responsibility for the provision of the service.

References:

Regulation 15: Person in Charge
Standard 27: Operational Management

Actions required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

The person in charge is the director of nursing and is also the person in charge for Heather House Community Nursing Unit, which is located approximately four kilometres from Farranlea Road. The person in charge is an experienced nurse and manager and is actively involved in the operational management of the centre.

The person in charge is supported in her role at Farranlea Road CNU by an Assistant Director of Nursing (ADON) and five Clinical Nurse Manager 2 (CNM 2). There was a good reporting system in place as evidenced by her knowledge of residents.

The person in charge demonstrated a commitment to quality improvement and had implemented a number of improvements since the last inspection. She demonstrated good knowledge of 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*.

Based on her qualifications, experience and the findings from this inspection, inspectors formed the view that the person in charge was a suitably experienced nurse with authority, accountability and responsibility for the provision of the service.

Theme: Safe care and support

Safe care and support recognises that the safety of service users is paramount. A service focused on safe care and support is continually looking for ways to be more reliable and to improve the quality and safety of the service it delivers.

In a safe service, a focus on quality and safety improvement becomes part of a service-wide culture and is embedded in the service's daily practices and processes rather than being viewed or undertaken as a separate activity.

To achieve a culture of quality and safety everyone in the service has a responsibility to identify and manage risk and use evidence-based decision-making to maximise the safety outcomes for service users.

Outcome 6

Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse.

References:

Regulation 6: General Welfare and Protection
Standard 8: Protection
Standard 9: The Resident's Finances

Action required from previous inspection:

Make all necessary arrangements, by training staff or by other measures, aimed at preventing residents being harmed or suffering abuse or being placed at risk of harm or abuse.

Inspection findings

There was policy on the prevention and detection of elder abuse, most recently reviewed in March 2013. The policy comprehensively addressed the prevention and detection of abuse of the older person but required revision in order to reflect the diverse age range and needs of residents in the centre.

There was evidence of ongoing training on the prevention and detection of abuse, however, a number of staff had not received the requisite training since commencing employment in the centre. Inspectors were informed that discussions had taken place around the need and suitability of elder abuse training for staff in Cedar Unit, as all of the residents were young adults. Management were informed by inspectors that all staff members employed in the centre required training on the prevention and detection of abuse and the training should be adapted to reflect the needs of all residents in the centre.

Staff members spoken with by inspectors were knowledgeable of what to do in the event of suspicions of allegations of abuse.

Inspectors viewed records of financial transactions involving residents and were satisfied there were adequate systems in place to safeguard residents' finances.

Outcome 7
The health and safety of residents, visitors and staff is promoted and protected.

References:
Regulation 30: Health and Safety
Regulation 31: Risk Management Procedures
Regulation 32: Fire Precautions and Records
Standard 26: Health and Safety
Standard 29: Management Systems

Actions required from previous inspection:

The actions required from the previous inspection were satisfactorily implemented.

Inspection findings

There was a health and safety statement dated October 2011 and scheduled for review in October 2012, however, there was no evidence that this review had taken place.

Inspectors reviewed risk management practices and found there was evidence of good practice, however, improvements were required. There was a risk management policy, however, it was generic and required review to ensure it adequately addressed risks specific to Farranlea Road CNU; elements of the risk management policy were stored in separate folders making it fragmented and difficult to retrieve.

Incident report and near miss forms were comprehensive and a detailed report was completed following each incident or near miss. There were also individual risk assessments for issues such as tracheostomies, smoking and the risk of wandering.

There was an emergency plan that comprehensively addressed major emergencies, such as natural disasters and fire, however, it did not adequately address emergencies such as loss of water, relocation of residents during a prolonged evacuation or loss of kitchen facilities.

There were adequate procedures in place for the prevention and control of infection including the strategic location of hand sanitisers throughout the premises and appropriate usage of personal protective equipment such as gloves and aprons by staff.

Manual handling practices observed by inspectors were in compliance with good practice, however, records of training indicated that a number of staff did not have up-to-date training in moving and handling.

Inspectors viewed the fire safety register. Training records indicated that most but not all staff had received up-to-date training in fire safety. Records indicated that the most recent fire drill in Cedar Unit took place in February 2013, however, the most recent fire drill in Willow Unit was in November 2012 and in Oak Unit was in October 2012. Staff members spoken with by inspectors were knowledgeable of what to do in the event of a fire, however, one staff member was not knowledgeable of the location of the stairs. There were records of the annual maintenance of emergency lighting, most recently in March 2013; annual maintenance of fire safety equipment, most recently in July 2013; and the quarterly maintenance of the fire alarm system, most recently in June 2013. Records indicated that there was a visual inspection of emergency exits daily, however, they were not completed for a number of days prior to the inspection. Emergency exits were seen to be unobstructed on the days of inspection.

Outcome 8
Each resident is protected by the designated centres' policies and procedures for medication management.

References:
Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines
Standard 14: Medication Management

Action required from previous inspection:

Ensure that medications administered in a modified form are prescribed by a medical practitioner.

Inspection findings

There was a centre specific policy on medication management dated March 2013. Medication administration practice was observed to be in line with professional guidance, however, a number of prescription sheets did not contain a photograph of the resident and there was not always appropriate evidence of authorisation on the current prescription sheet for medications to be crushed.

There was evidence that residents' prescriptions were reviewed regularly and at least at three-monthly intervals. Medications requiring special control measures were managed according to professional guidance. Medications requiring refrigeration were managed appropriately and there was evidence that the temperature of the fridges were monitored and recorded daily. Inspectors were informed that the centre did not keep a supply of stock medications and medications were ordered and supplied on an as needed basis.

There was evidence of regular medication audits, most recently in February 2013. The results of the audits were relayed to the CNM 2 of each unit, who in turn fed back the results to the staff in each unit. Medication errors were recorded on incident forms and there was evidence of learning and feedback to staff in relation to medication errors and near misses.

The centre is in the process of moving to a new pharmacy supplier which was planned to come into effect a number of days following the date of this inspection. Training had been provided by the new pharmacist.

Theme: Effective care and support
The fundamental principle of effective care and support is that it consistently delivers the best achievable outcomes for people using a service within the context of that service and resources available to it. This is achieved by using best available national and international evidence and ongoing evaluation of service-user outcomes to determine the effectiveness of the design and delivery of care and support. How this care and support is designed and delivered should meet service users' assessed needs in a timely manner, while balancing the needs of other service users.

Outcome 10
The quality of care and experience of the residents are monitored and developed on an ongoing basis.

References:
Regulation 35: Review of Quality and Safety of Care and Quality of Life
Standard 30: Quality Assurance and Continuous Improvement

Actions required from previous inspection:

The actions required from the previous inspection were satisfactorily implemented.

Inspection findings

There was evidence of a system in place to review and monitor the quality of care and quality of life of residents. The system of review included consultation with residents, feedback to staff and actions as a result of findings.

There was a multidisciplinary working group established to develop a falls management strategy. A falls management pathway was developed for residents that were identified as at risk of falling or had fallen that included a review and assessment by physiotherapy. There were regular falls audits that included a review of the time of day that falls took place and the location of each fall. There was evidence of action as result of the audits that included a review and amendment of the staff roster.

There were hygiene audits carried out in each of the units in July 2013 and the results of the audits were generally positive. This was supported by observations of inspectors who found that the centre was clean and there was evidence of good practice by staff on the management of hygiene.

There was an audit of care plan documentation, most recently completed in April 2013. The audit identified that some care plans needed to be updated to include a reassessment of the residents. A review of care plans by inspectors found that most, but not all, had been reviewed regularly.

There were resident satisfaction surveys completed in February 2013 and the overall findings were good to excellent in all areas except for evening tea. This was supported by minutes of residents' meetings that also identified the lack of choice at tea time. There were no records available to identify if this issue was addressed to the satisfaction of residents as the most recent residents' meeting was held in January 2013. More frequent consultation, such as through residents' meetings, is required to ensure that routines and practices take into consideration the views of residents/relatives.

Outcome 11
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

References:
Regulation 6: General Welfare and Protection
Regulation 8: Assessment and Care Plan
Regulation 9: Health Care
Regulation 29: Temporary Absence and Discharge of Residents
Standard 3: Consent
Standard 10: Assessment

Standard 11: The Resident's Care Plan Standard 12: Health Promotion Standard 13: Healthcare Standard 15: Medication Monitoring and Review Standard 17: Autonomy and Independence Standard 21: Responding to Behaviour that is Challenging
Actions required from previous inspection: The actions required from the previous inspection were satisfactorily implemented.

Inspection findings

There was evidence that residents were regularly reviewed by their general practitioners (GPs) and access to out-of-hours GP service was also available. Where there was evidence of changes in residents' condition there was evidence of communication with GPs and appropriate interventions.

There was evidence of referral and regular review by allied health and specialist services, including speech and language therapy (SALT), physiotherapy, dietician and occupational therapy. There was also evidence that allied health/specialist services facilitated training for staff members on an ongoing basis. A medical consultant specialising in care of the older person visited the centre on a regular basis and participated in multidisciplinary case reviews.

Prior to admission, all residents underwent a pre-admission assessment to determine the suitability of admission to the centre and to ensure the centre could adequately meet their needs. Inspectors viewed a sample of care plans in each unit and found that residents were comprehensively assessed following admission using evidence-based tools for issues such as falls prevention, moving and handling, falls risk and pressure sore risk assessment. A number of residents did not have a nutritional assessment completed on admission, however, they were weighed monthly and where risk of malnutrition was identified, they were referred to a dietician for assessment and review.

Residents had detailed person-centred care plans developed for issues identified during assessment. However, not all residents' care plans were reviewed at three-monthly intervals. Wound care plans contained a detailed assessment and plan of care for wounds.

A number of residents' records contained instructions in relation to the management of end-of-life in the event of sudden cardio-pulmonary arrest. However, there were inadequate records maintained that, for all residents, these instructions were underpinned by current clinical review, a clear clinical rationale, discussed with the resident and reviewed regularly.

There were opportunities for residents to participate in activities appropriate to their needs, however, some improvements were required.

There was an activities programme that was facilitated for three days each week and included arts and crafts, card games, baking, music and bingo. The centre had access to a small bus for one day each week and residents were taken on outings to various locations in Cork city and surrounds. Residents also had access to complementary therapy for one day each week that included aromatherapy, Indian head massage, and foot and hand massages. However, even though residents had access to a broad range of activities, there were no activities facilitated for three days each week and there were no activities available to residents in the centre while other residents were on outings.

There were risk assessments carried out for the use of restraints in the form of bedrails and there were records maintained of type and time restraint was in place and of safety checks when restraint was in place. However, the safety checks were carried out two-hourly for all residents and the individual risk assessments were not used to determine the frequency of checks suitable for each resident. Where restraint was in the form of lap belts, there were no records maintained of safety checks while the lap belt was in place or of a schedule of release from the restraint.

Outcome 12
The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

References:
Regulation 19: Premises
Standard 25: Physical Environment

Actions required from previous inspection:

The actions required from the previous inspection were satisfactorily implemented.

Inspection findings

The centre was bright, spacious, suitably decorated and appeared to be clean throughout. The corridors were wide and had handrails throughout, facilitating easy access for residents with mobility aids. Bedrooms were bright, personalised with residents' personal possessions and all had en suite shower, wash-hand basin and toilet facilities. There were adequate storage facilities for personal belongings including a secure lockable cupboard.

There was adequate communal space in each unit comprising a sitting room, a quite room, dining room and seating in a number of alcoves along corridors. Seating was also provided in link areas between the units. Residents were provided with adequate space to meet with visitors in private, separate from their own bedrooms. Residents had access to two enclosed gardens, however, one of the gardens was in the early stages of becoming overgrown.

There were adequate laundry facilities that were primarily used for household items Residents' personal property is laundered by relatives or by an external contractor and the laundry is only.

Each unit had an assisted bathroom that contained an assisted bath, a shower trolley, a toilet, standing and chair weighing scales and a ceiling-mounted electronic hoist system. Each unit also had a sluice room that contained a bedpan washer, a bedpan macerator, a sluice sink and a wash-hand basin.

Windows throughout both the ground and first floor units were restricted from opening completely and were within the maximum width of 100 millimetres specified in the safety statement. There was evidence of the regular preventive maintenance of equipment such as beds and hoists. There was an emergency exit that opened out onto the car park that was not alarmed and posed a risk to residents at risk of wandering.

There was a patio on the first floor enclosed by a railing which was usually accessible through a locked door. A temporary wooden structure had been put in place to raise the height of the railing so that the door to the patio could be left open to aid ventilation during the warm weather. Plans were in place to put an unobtrusive fitting to raise the height of the railings on the patio.

Prior to this inspection, the Authority had received information that the centre, and in particular the first floor, was excessively warm during a period of hot weather in July 2013. The Authority had received assurances from management that temporary measures were in place to alleviate the heat, including portable air conditioning units, fans and the application of temporary structures to raise railings in order to open the patio doors. Inspectors observed that these measures were still in place on the days of the inspection. Residents and visitors spoken with by inspectors stated that they would like more access to the patio and would like the doors to be left open during warm weather to aid ventilation. Inspectors were satisfied that the provider and person in charge had implemented appropriate temporary measures to aid ventilation, but a more permanent solution is required. Management were requested to carry out a risk assessment to ascertain the suitability of the patio for use by residents.

Theme: Person-centred care and support

Person-centred care and support has service users at the centre of all that the service does. It does this by advocating for the needs of service users, protecting their rights, respecting their values, preferences and diversity and actively involving them in the provision of care. Person-centred care and support promotes kindness, consideration and respect for service users' dignity, privacy and autonomy.

Outcome 13
The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

References:
Regulation 39: Complaints Procedures
Standard 6: Complaints

Actions required from previous inspection:

To make the operational policies and procedures relating to the making, handling and investigation of complaints available in all units of the designated centre.

Inspection findings

The centre uses the health service executive (HSE) "your service, your say" complaints policy. The procedure for making complaints was on display in the reception area and in each unit and clearly identified the person responsible for dealing with complaints in the centre.

Complaint logs were held locally in each unit. Inspectors viewed a sample of complaints and were satisfied that adequate records were maintained outlining the details of each complaint, the actions taken as a result of the complaint and the outcome of the complaint.

Outcome 15
Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discreet and sensitive manner.

References:
Regulation 20: Food and Nutrition
Standard 19: Meals and Mealtimes

Actions required from previous inspection:

The actions required from the previous inspection were satisfactorily implemented.

Inspection findings

There was a policy on the management of nutrition dated May 2013. Records viewed by inspectors indicated that most, but not all residents, receive a nutritional assessment on admission and at regular intervals thereafter. All residents, however, were weighed monthly and more frequently if required. Where concerns were identified, there was evidence of referral for review and assessment by a dietician and/or speech and language therapist.

Records indicated that all catering staff had received up-to-date training in food safety management. There was evidence of a programme of ongoing training of staff on nutrition that was facilitated by a dietician and speech and language therapist.

There was evidence of a good system of communication with kitchen staff of the dietary requirements and preferences of individual residents. Each unit contained a pantry to which meals were delivered from the main kitchen prior to being served to residents. The main kitchen and each pantry contained a white board with a list of residents that outlined their individual dietary needs and preferences, including details of modified diets and fluids.

Residents were offered a choice at mealtimes and food was nutritious and available in sufficient quantities. Residents spoken with by inspectors were complimentary of the food at mealtimes, however, as discussed in Outcome 10 not all residents were satisfied with the choice of menu at tea time. Residents were seen to be offered snacks and refreshments throughout the day and there was access to fresh drinking water at all times.

There was adequate dining space and residents requiring assistance at mealtimes were assisted in a dignified and respectful manner.

Theme: Workforce
The workforce providing a health and social care and support service consists of all the people who work in, for, or with the service provider and they are all integral to the delivery of a high quality, person-centred and safe service. Service providers must be able to assure the public, service users and their workforce that everyone working in the service is contributing to a high quality safe service.

Outcome 18
There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

References:
Regulation 16: Staffing
Regulation 17: Training and Staff Development
Regulation 18: Recruitment
Regulation 34: Volunteers
Standard 22: Recruitment
Standard 23: Staffing Levels and Qualifications
Standard 24: Training and Supervision

Actions required from previous inspection:

The actions required from the previous inspection were satisfactorily implemented.

Inspection findings

Inspectors observed practices and reviewed the staff roster and were satisfied that there were adequate staff and skill mix to meet the needs of residents during the days of the inspection. Due to the moratorium on recruitment in the HSE, the centre uses agency staff, however, efforts are made to ensure that the same agency staff are used on a regular basis.

Nursing staff in both Willow and Oak units consisted of a Clinical Nurse Manager and three staff nurses on duty during the morning and afternoon in each unit. There was one staff nurse on duty between 17:30hrs and 20:00hrs and from 20:00hrs to 07:45hrs in each unit. There were four healthcare assistants (HCAs) on duty in both Willow and Oak during the morning and afternoon. There were two healthcare assistants on duty in each of the units between 18:30hrs and 20:00hrs and between 20:00hrs and 08:00hrs.

Staffing in Cedar View consisted of a Clinical Nurse Manager and three staff nurses from 07:45hrs to 18:30hrs and one staff nurse between 18:30hrs and 20:00hrs and between 20:00hrs and 08:00hrs. There were two HCAs on duty between 08:00hrs and 24:00hrs each day and one HCA between 24:00hrs and 08:00hrs. The current roster included an additional HCA between the hours of 18:00hrs and 24:00hrs, following a review of staffing prompted by concerns raised by relatives. Inspectors were informed that the CNM 2 on night duty was also available to assist staff when required.

A number of induction days had been held for new staff that had transferred from other HSE facilities. The programme of induction included Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009, National Quality Standards for Residential Care Settings for Older People in Ireland, Health and Safety, Risk Management, food/catering and care planning. There was also evidence of ongoing training that included falls prevention, advanced care planning and nutritional assessment. Training particularly relevant to Cedar View unit included tracheostomy care, tracheostomy reinsertion, ventilator training, pharmacy, working with families and person centred care.

A sample of staff files viewed by the inspector did not contain all the information specified in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

Closing the visit

At the close of the inspection visit a feedback meeting was held with the person in charge and the assistant director of nursing 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:

John Greaney
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

7 August 2013

Health Information and Quality Authority
Regulation Directorate

Action Plan

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

Provider's response to inspection report *

Centre Name:	Farranlea Road Community Nursing Unit
Centre ID:	0713
Date of inspection:	30 July 2013 and 31 July 2013
Date of response:	19 August 2013

Requirements

These requirements set out the actions that must be taken to meet the requirements of the Health Act 2007 as amended, 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*.

Theme: Governance, Leadership and Management

Outcome 2: Contract for the provision of services

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

A significant number of residents did not have agreed contracts of care.

Action required:

Agree a contract with each resident within one month of admission to the designated centre.

Reference:

Health Act, 2007
Regulation 28: Contract for the Provision of Services
Standard 1: Information
Standard 7: Contract/Statement of Terms and Conditions

* 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: Due to a deficit in clerical administration support there was a delay in the completion of current contracts of care. All residents will be furnished with a contract of care by 31 October 2013.	31 October 2013

Theme: Safe care and support

Outcome 6: Safeguarding and safety

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

The policy on abuse addressed the prevention and detection of abuse of the older person but required revision in order to reflect the diverse age range and needs of residents in the centre.

A number of staff had not received training on the prevention and detection of abuse since commencing employment in the centre.

Action required:

Update the policy on and procedures for the prevention, detection and response to abuse.

Action required:

Make all necessary arrangements, by training staff or by other measures, aimed at preventing residents being harmed or suffering abuse or being placed at risk of harm or abuse.

Reference:

Health Act, 2007
Regulation 6: General Welfare and Protection
Standard 8: Protection
Standard 9: The Resident's Finances

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: A review of the policy document on abuse is in progress to reflect the diverse age range of residents in the centre. The appropriate training on recognising abuse and dealing with allegations of abuse to elderly/vulnerable adults will be facilitated in September	Ongoing

2013 and will be repeated as required to include all staff.	

Outcome 7: Health and safety and risk management

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

The health and safety statement was scheduled for review in October 2012, however, there was no evidence that this review had taken place.

The risk management policy was generic and elements of risk management were stored in separate folders making it fragmented and difficult to retrieve.

The emergency plan did not adequately address emergencies such as loss of water, relocation of residents during a prolonged evacuation or loss of kitchen.

Records of training indicated that a number of staff did not have up-to-date training in moving and handling.

Training records indicated that most but not all staff had received up-to-date training in fire safety.

Daily inspection of emergency exits was not completed for a number of days prior to the inspection.

Residents and visitors spoken with by inspectors stated that they would like more access to the patio.

Action required:

Ensure that operational policies and procedures relating to the health and safety, including food safety, of residents, staff and visitors are up-to-date.

Action required:

Put in place a comprehensive written centre-specific risk management policy and implement this throughout the designated centre. Ensure that the policy is easily retrievable and readily available to all staff.

Action required:

Put in place a comprehensive emergency plan for responding to emergencies.

Action required:

Provide training for staff in the moving and handling of residents.

Action required: Provide suitable training for staff in fire prevention.	
Action required: Ensure, by means of fire drills and fire practices at suitable intervals, that the staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire, including the procedure for saving life.	
Action required: Make adequate arrangements for reviewing fire precautions, and testing fire equipment, at suitable intervals.	
Action required: Carry out a risk assessment to ascertain the suitability of the patio for use by residents.	
Reference: Health Act, 2007 Regulation 30: Health and Safety Regulation 31: Risk Management Procedures Regulation 32: Fire Precautions and Records Standard 26: Health and Safety Standard 29: Management Systems	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: A review of the safety statements by a working group has commenced. Up to date risk assessments were available and reviewed on the date of the inspection. There is a centre specific risk management/incident reporting flow chart in place on all units. The HSE risk management policy is in place. A centre specific risk management policy will be drafted to reflect the practice in dealing with risks as outlined in the flow chart. All relevant risk management documentation will be collated for easy access by all staff in the centre. In the event of loss of water, loss of catering facilities or the need to relocate residents, the HSE area emergency team and the fire brigade will make the necessary arrangements to deal	31 November 2013

with these issues and if required alternate accommodation may be made available in other community hospitals, CNU's or acute hospitals or in local community facilities. The centre's internal emergency plan will be amended to reflect this. Dates have been identified for staff with outstanding training needs in moving and handling and fire training. This training will include education for staff and residents (in so far as is possible) and will include staff who work out of hours. There is fire drill scheduled for 18 September 2012 for all available staff and it will be hosted in Willow Unit. A date in October 2013 is to be confirmed with the fire officer to facilitate staff and will be facilitated in Oak Unit. A schedule of fire drills is to be agreed with the fire safety officer for the HSE on her next visit pending her availability. A daily fire check list is completed on each unit daily. The daily visual inspection of fire exits is carried out routinely by our general operative. Arrangements have been put in place to complete this in his absence. Individual risk assessments will be carried out on residents who wish to use the patios. Work is underway to fit the patio areas with "storm glass" to facilitate safe use.	

Outcome 8: Medication management

The provider is failing to comply with a regulatory requirement in the following respect: A number of prescription sheets did not contain a photograph of the resident and there was not always appropriate evidence of authorisation on the current prescription sheet for medications to be crushed.
Action required: Put in place appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents and ensure that staff are familiar with such policies and procedures.
Reference: Health Act, 2007 Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines Standard 14: Medication Management

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: As indicated in the report there is a change in provider for pharmacy services since 5 August 2013. The photographs of the residents will be completed in full by the new provider following this transition. There is a centre specific medication management policy in place and the practice of "crushing of medications" is included in this policy and this has been brought to the attention of the medical officers who visit the unit.	31 August 2013

Theme: Effective care and support

Outcome 10: Reviewing and improving the quality and safety of care

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

There were no records available to identify if residents' dissatisfaction with the menu choice available at tea time was addressed to the satisfaction of residents and the most recent residents' meeting was held in January 2013.

Action required:

Consult with residents and their representatives on a regular basis in relation to the system for reviewing and improving the quality and safety of care, and the quality of life of residents.

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: Feedback from the food satisfaction survey completed in July 2013 was not made available to the inspectors on the day but has since been forwarded to the Authority's Inspector for Farranlea Road CNU. Residents meetings will be held quarterly and the next one is scheduled for September 2013. A relatives meeting was held in May 2013 and a satisfaction survey was completed in March 2013, where quality improvement initiatives were identified and are being addressed on an ongoing basis.	Completed

Outcome 11: Health and social care needs

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

There were inadequate records maintained that, for all residents, instructions in relation to the management of end-of-life in the event of sudden cardio-pulmonary arrest were underpinned by current clinical review and were reviewed regularly.

There were no activities facilitated for three days each week and there were no activities available to residents in the centre while other residents were on outings.

The frequency of safety checks for residents with restraints was not based on individual risk assessments and there were no records maintained of safety checks while the lap belt was in place or of a schedule of release from the restraint.

Not all residents' care plans were reviewed at least three-monthly.

Action required:

Ensure that end-of-life preferences have clear clinical rationale and there is a process for the review of such decisions.

Action required:

Provide opportunities for each resident to participate in activities appropriate to his/her interests and capacities.

Action required:

Put in place appropriate and suitable practices relating to the restraints in accordance with evidence-based practice.

Action required:

Keep each resident's care plan under formal review as required by the resident's changing needs or circumstances and no less frequent than at three-monthly intervals.

Reference:

Health Act, 2007
Regulation 6: General Welfare and Protection
Regulation 8: Assessment and Care Plan
Regulation 9: Health Care
Standard 3: Consent
Standard 10: Assessment
Standard 11: The Resident's Care Plan
Standard 13: Health Care
Standard 17: Autonomy and Independence
Standard 18: Routines and Expectations

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response:	
Following discussion with a consultant geriatrician to Farranlea Road CNU on this issue, it was recommended that best practice for end of life decisions should be consultative with the resident/ family but that the clinical decision that is to be made in the best interest of the resident lies with the medical and nursing team. This process is documented and signed in the residents' medical file by the medical officer who leads the consultation. On the advice received from the consultant geriatrician, a review will occur if the "residents condition changes". The policy underpinning the end of life care in Farranlea Road CNU is currently being reviewed in liaison with the consultant geriatrician and the medical officers.	30 September 2013
The comprehensive structured activity programme now takes place four days per week. This is supplemented by a range of staff led activities in each unit which are available when the activity programme is not occurring and when outings are taking place. The ongoing review of the appropriateness of the activity programme to the needs, interests and abilities of the residents by the MDT will occur.	Ongoing
A record of the use and release of restraint in the form of a lap belt is now in place.	Completed
The review of care plans are carried out at three monthly intervals and this will be monitored and audited on a regular basis.	Ongoing

Outcome 12: Safe and suitable premises

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

One of the enclosed gardens was in the early stages of becoming overgrown.

There was an emergency exit that opened out onto the car park that was not alarmed and posed a risk to residents at risk of wandering.

Carry out a risk assessment to ascertain the suitability of the patio for use by residents.

Action required: Provide and maintain external grounds which are suitable for, and safe for use by residents.	
Action required: Ensure the physical design of the premises meets the needs of each resident, having regard to the number and needs of the residents.	
Action required: Carry out a risk assessment to ascertain the suitability of the patio on the first floor for use by residents.	
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: The requirement for regular maintenance of the internal gardens has been identified to the maintenance department and has been addressed. A review of the emergency exits has been completed. Alarms to the 2 doors identified on the date of inspection will be reviewed by the HSE fire and safety officer at a meeting to be held on 21 August 2013. As previously stated there is ongoing works to the patio areas with glass being fitted to increase the safety of the area. This will also benefit the comfort of the building on the first floor as it will permit the opening of the doors to allow air flow during periods of very warm weather. Risk assessments will be carried out on residents who wish to avail of the patios when the works are completed.	30 September 2013

Theme: Person-centred care and support

Outcome 15: Food and nutrition

The provider is failing to comply with a regulatory requirement in the following respect: Not all residents had a nutritional assessment completed on admission.
Action required: Implement a comprehensive policy and guidelines for the monitoring and documentation of residents' nutritional intake.
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: The in-house dietitian works with the staff at unit level to complete evaluations of residents' nutritional intake. Each resident now has a completed assessment included in their care plan.	Completed

Outcome 16: Residents' rights, dignity and consultation

The provider is failing to comply with a regulatory requirement in the following respect: The most recent residents' meeting was held in January 2013.
Action required: Put in place arrangements to facilitate residents' consultation and participation in the organisation of the designated centre.
Reference: Health Act, 2007 Regulation 10: Residents' Rights, Dignity and Consultation Regulation 11: Communication Regulation 12: Visits Standard 1: Information Standard 2: Consultation and Participation Standard 5: Civil, Political and Religious Rights Standard 17: Autonomy and Independence

Standard 18: Routines and Expectations Standard 20: Social Contacts	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Quarterly residents meetings will be held to facilitate consultation by the residents in the organisation of the centre. A date in September 2013 has been identified for the next meeting.	Completed

Theme: Workforce

Outcome 18: Suitable staffing

The provider is failing to comply with a regulatory requirement in the following respect: A sample of staff files viewed by the inspector did not contain all the information specified in Schedule 2 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 recruitment procedures to ensure no staff member is employed unless the person is fit to work at the designated centre and full and satisfactory information and documents specified in Schedule 2 have been obtained in respect of each person.	
Reference: Health Act 2007 Regulation 16: Staffing Regulation 17: Training and Staff Development Regulation 18: Recruitment Regulation 34: Volunteers Standards 22: Recruitment Standard 24: Training and Supervision Standard 23: Staffing Levels and Qualifications	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Due to the moratorium within the public sector, all staff have been redeployed due to reconfiguration of the Health Services with the exception of one CNM2. Work is ongoing in collate all the relevant documentation required under Schedule 2.	31 November 2013

A gap analysis has been completed to identify the deficits and work is ongoing to source this documentation.	