

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Clonskeagh Community Nursing Unit
<b>Centre ID:</b>	ORG-0000491
<b>Centre address:</b>	Clonskeagh Road, Dublin 6.
<b>Telephone number:</b>	01 268 0300
<b>Email address:</b>	mary.nally@hse.ie
<b>Type of centre:</b>	The Health Service Executive
<b>Registered provider:</b>	Health Service Executive
<b>Provider Nominee:</b>	John O'Donovan
<b>Person in charge:</b>	Mary Nally
<b>Lead inspector:</b>	Deirdre Byrne
<b>Support inspector(s):</b>	Maeve O'Sullivan
<b>Type of inspection</b>	Announced
<b>Number of residents on the date of inspection:</b>	81
<b>Number of vacancies on the date of inspection:</b>	10

## About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

**Compliance with 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, the purpose of which was to inform a registration decision. This monitoring inspection was announced and took place over 2 day(s).

**The inspection took place over the following dates and times**

From:	To:
14 January 2014 09:00	14 January 2014 18:00
15 January 2014 09:00	15 January 2014 16:00

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

Outcome 01: Statement of Purpose
Outcome 02: Contract for the Provision of Services
Outcome 03: Suitable Person in Charge
Outcome 04: Records and documentation to be kept at a designated centre
Outcome 05: Absence of the person in charge
Outcome 06: Safeguarding and Safety
Outcome 07: Health and Safety and Risk Management
Outcome 08: Medication Management
Outcome 09: 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

**Summary of findings from this inspection**

This monitoring inspection was carried out in response to an application from the provider to renew registration. As part of the monitoring inspection, inspectors met with residents, relatives and staff members and interviews were held with the person in charge and the provider. Inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files. Inspectors also reviewed questionnaires submitted by residents and relatives prior to the inspection.

Overall inspectors found that improvements were required in a number of areas in order to bring about substantial compliance with the requirements 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.

Inspectors found progress had been made to address some issues raised at the previous inspection. However, inspectors had concerns regarding the participation of the person in charge in relation to clinical governance and leadership of the centre. Issues identified at the previous inspection such as care planning had not been addressed. Other clinical areas including restraint and falls management also required improvement. Inspectors informed the provider of their concerns at a meeting on the second day of the inspection.

The response to an allegation of abuse, and the management of fire safety required improvement. Neither, were inspectors satisfied with the management of complaints. The physical environment did not meet the needs of all residents with regard to the multi-occupancy bedrooms, communal areas, storage space and the decor of the centre. The notification of incidents to the Authority was found to be unsatisfactory at this inspection with a number of key incidents not reported.

Information received by the Authority prior to the inspection was also reviewed, and concerns relating to the overall management of a complaint were found to be substantiated. The matter was discussed with the provider, who said they were in the process of reviewing the complaint further.

Inspectors found evidence of improved practice in relation to medication management, risk management, and the vetting of volunteers in the centre.

Questionnaires returned by residents and relatives expressed a high level of satisfaction overall with the service provided.

These issues are further discussed in the body of the report and in the Action Plan at the end of the report.

**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.**

**Outcome 01: Statement of Purpose**

*There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.*

**Theme:**

Leadership, Governance and Management

**Judgement:**

Non Compliant - Minor

**Outstanding requirement(s) from previous inspection:**

No actions were required from the previous inspection.

**Findings:**

Inspectors found the statement of purpose for the centre did not meet the requirements of Regulation 5 and Schedule 1 of the Regulations.

The statement of purpose did not describe the new day-care facility which had commenced operation before the inspection day. In addition, it did not include the name and address of the registered provider, all conditions of the centre's registration, an accurate complaints procedure, and details of the fire and associated emergency procedures.

Inspectors found that care was not consistently delivered in line with the aims and objectives set out in the statement of purpose. For example, the provision of opportunities for meaningful social engagement was not provided based on all residents' assessed needs and interests as described in the statement of purpose. This is further discussed under Outcome 11.

**Outcome 02: Contract for the Provision of Services**

*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.*

**Theme:**

Leadership, Governance and Management

**Judgement:**

Non Compliant - Minor

**Outstanding requirement(s) from previous inspection:**

No actions were required from the previous inspection.

**Findings:**

There were improvements required in the contract of care provided to residents.

Inspectors reviewed a sample of residents care files, and found that a written contract of care was in place and developed within the mandatory timeframe. It set out the services to be provided. However, some improvements were identified. For example, contracts did not include full information on the fees to be charged, along with any additional services provided or their respective charges.

**Outcome 03: Suitable Person in Charge**

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

**Theme:**

Leadership, Governance and Management

**Judgement:**

Non Compliant - Moderate

**Outstanding requirement(s) from previous inspection:**

No actions were required from the previous inspection.

**Findings:**

Inspectors had concerns regarding the clinical governance and leadership in the centre. The appointed person in charge was a registered nurse. She worked full-time at the centre. She had the relevant length of experience required by the Regulations and had attended all mandatory training. Additionally, the person in charge was currently completing a certificate in leadership management. The person in charge demonstrated her commitment to meeting the requirements of the Regulations and the Authority's Standards.

However, on this inspection, there were some weaknesses in the knowledge of the person in charge of her responsibilities as required under the Regulations. For example, the reporting of certain notifiable incidents, the management of aspects of residents health care, fire safety and management of complaints. In a discussion with the provider during the inspection, the provider gave a commitment to address the issues raised, and ensured appropriate supports would be provided. The person in charge did not consistently demonstrate authority and accountability for the provision of the service.

The person in charge had appropriate deputising and on call arrangements in place to cover during her absence.

**Outcome 04: Records and documentation to be kept at a designated centre**

*The records listed in Part 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).*

**Theme:**

Leadership, Governance and Management

**Judgement:**

Non Compliant - Moderate

**Outstanding requirement(s) from previous inspection:**

No actions were required from the previous inspection.

**Findings:**

Inspectors noted that some incomplete and inaccurate records were maintained and improvements were required in a number of areas.

A register of residents was maintained however, it did not include all of the information in respect of each resident as required by Regulations. There were centre-specific operational procedures to inform practice and provide some guidance to staff.

Inspectors found that staff members were sufficiently knowledgeable regarding these operational policies. However, the policy on falls prevention, the policy on risk management, and the policy on complaints were not sufficiently detailed to provide appropriate guidance.

Inspectors found that medical records and other records relating to residents and staff were maintained. However, inspectors noted an unlocked office where records relating to residents were not stored in a secure manner. The Residents' Guide reviewed was not in line with the requirements of the Regulations, for example it did not include a reference to the recent inspection report and a copy of the contract of care. There was up-to-date insurance cover was in place with regard to accidents and incidents and residents' personal property.

**Outcome 05: Absence of the person in charge**

*The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.*

**Theme:**

Leadership, Governance and Management

**Judgement:**

Compliant

**Outstanding requirement(s) from previous inspection:**

No actions were required from the previous inspection.

**Findings:**

The provider was aware of the requirement to notify the Chief Inspector of any proposed absence of the person in charge for a period of more than 28 days. The provider had appropriate contingency plans in place to manage any such absence. Two assistant directors of nursing (ADON) deputised for the person in charge in her absence.

**Outcome 06: Safeguarding and Safety**

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

**Theme:**

Safe Care and Support

**Judgement:**

Non Compliant - Major

**Outstanding requirement(s) from previous inspection:**

No actions were required from the previous inspection.

**Findings:**

Inspectors found systems were in place to protect residents from being harmed or suffering abuse. However, improvements were required in the implementation of the policy on protection of vulnerable residents, and the arrangement in place to safeguard residents' finances.

Although some details such as notification to the Authority of all allegations of abuse were absent, the policy on the protection of vulnerable adults provided good detail to guide staff on the steps to follow in the event of an allegation of abuse. Inspectors read a report into an investigation of a recent allegation of abuse. However, inspectors found the person in charge was not fully knowledgeable of the policy and the procedures to investigate an allegation of abuse. For example, the elder abuse officer of the Health Service Executive (HSE), the person nominated to carry out an investigation, had not been notified.

Inspectors reviewed the arrangements in place to safeguard residents' finances, and improvements were identified. There was a procedure in place to guide staff. However, it was not fully implemented in practice. For example, residents records cash transactions records reviewed by inspectors were signed off by one signature. In addition, the system in place to withdraw residents' money was not robust. These matters were discussed with the provider and person in charge, who agreed to review

the procedures, and practices in the centre.

All residents spoken to said that they felt safe and secure in the centre. Residents stated that they attributed this to the staff who said they were caring and trustworthy. The training records showed that staff had received training on how to respond to an allegation of abuse. Inspectors found that staff on duty on the days of inspection were knowledgeable with regard to their responsibilities in adult protection.

### **Outcome 07: Health and Safety and Risk Management**

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

**Theme:**

Safe Care and Support

**Judgement:**

Non Compliant - Major

**Outstanding requirement(s) from previous inspection:**

Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**

Inspectors were concerned with the management of fire safety in the centre. During the inspection, the fire alarm activated a number of times. Inspectors observed staff not responding to the alarm in line with the centres' emergency procedures. Inspectors found no one person took overall responsibility for managing fire safety in the centre during the incident. The lack of staff compliance with fire evacuation procedures was brought to the attention of the provider, who acknowledged improvements were required and the matter would be addressed.

Inspectors found that fire drills were not taking place at regular intervals in the centre. The person in charge informed inspectors that these took place at unit level. However, there was no evidence drills had been carried out in the centre. This was an action at the previous inspection, and continued to be an issue.

Although there was suitable fire fighting equipment in place, and evidence that it was regularly serviced, improvements were identified. Apart from a date label on fire extinguishers there was no record of a certificate of service in the centre. This had been an issue at the previous inspection and was not addressed.

Staff had completed mandatory training in fire safety, and records confirmed all staff's fire training was up to date.

The risk management policy which was updated in 2013. However, it did not fully meet the requirements of the Regulations. For example, it did not cover the arrangements in place to manage adverse events or serious incidents involving residents. This had been an action at the previous inspection and was not completed.

A safety statement was seen by inspectors and had been updated in 2013. Along with ongoing clinical risk assessments, the provider carried out risk assessments in a range of non clinical hazards identified in the centre, and identified controls to manage them. For example, residents who smoked were risk assessed and controls measures were in place to minimise the risks associated with smoking. A risk register was kept at each of the four units. A health and safety committee had been established, and inspectors read minutes of the previous two meetings. Matters such as the risk register and clinical risks related to falls and wounds were discussed at the meetings.

There were infection control policies and procedures which provided direction to staff. Inspectors spoke to staff who were knowledgeable of the infection control procedures, and records confirmed staff had received training in 2013.

An emergency plan was in place which contained details of alternative accommodation should residents need to be relocated. However, some improvements were required. For example, it was limited to procedures to follow in the event of a fire emergency, with no other type of major incident documented.

The staff were knowledgeable of the movement and handling procedures. Records confirmed all staff had up-to-date training. Safe floor hand and grab rails were provided throughout the centre.

### **Outcome 08: Medication Management**

*Each resident is protected by the designated centres policies and procedures for medication management.*

**Theme:**

Safe Care and Support

**Judgement:**

Non Compliant - Minor

**Outstanding requirement(s) from previous inspection:**

Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**

Overall good practices were found in the medication management policies and procedures for the centre however, some improvements were required.

The medication policy reviewed by inspectors was comprehensive and guided practices. However, it did not contain procedures for the prescribing, administration and review of PRN (as required) medications. This was an action at the last inspection, and was not completed.

Inspectors reviewed a sample of residents' prescription and administration sheets in one unit. Generally good practices were found, however, there was no named GP on each

prescription sheet and, the route of administration for medications was not prescribed.

Inspectors found that reviews of medications were undertaken, and evidence of three-monthly medication reviews by a GP which were recorded in residents' medical notes.

There were procedures in place for the storage and management of medications that required strict control measures (MDAs). Medications that needed temperature controls were safely stored in a locked refrigerator, with adequate controls measures in place.

All nursing staff had undertaken medication management training in February and March 2013. Inspectors spoke to staff and found them to be knowledgeable of the procedures to follow in the administration of medication.

### **Outcome 09: Notification of Incidents**

*A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.*

**Theme:**

Safe Care and Support

**Judgement:**

Non Compliant - Major

**Outstanding requirement(s) from previous inspection:**

Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**

The person in charge had failed to ensure notice was provided to the Chief Inspector of certain incidents that occurred in the centre.

Inspectors found an action from the last inspection had not been fully addressed. Although the person in charge had been reporting certain notifiable incidents to the Chief Inspector, there was evidence of incidents of staff misconduct which had not been notified. An allegation of abuse had not been notified within the required timeframe. These failures are a breach of the obligations of the person in charge to meet her legal obligations. These matters were identified as needing be addressed as a matter of urgency. The person in charge acknowledged they should have been notified and that improvements were required.

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

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

**Theme:**

Effective Care and Support

**Judgement:**

Non Compliant - Moderate

**Outstanding requirement(s) from previous inspection:**

No actions were required from the previous inspection.

**Findings:**

Inspectors found some procedures were in place to monitor and review the safety and quality of care of residents in the centre. However, improvements were identified as the procedures in place were not comprehensive enough to effect change and drive improvement.

The ADONs showed inspectors records of data collected which they reviewed, it included data on some key performance indicators (KPI) such as wounds and falls. While there was analysis of the information collected, there was no evidence of continued improvements or changes brought about to enhance quality and safety of care.

Inspectors found residents were not consulted with in reviews and audits, and staff were not informed of the findings for learning purposes. Furthermore there was no formal plan in place to review other key performance indicators.

**Outcome 11: Health and Social Care Needs**

*Each residents 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 residents 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.*

**Theme:**

Effective Care and Support

**Judgement:**

Non Compliant - Moderate

**Outstanding requirement(s) from previous inspection:**

Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**

Inspectors found residents' received a good standard of nursing care, from staff who were familiar with the residents, and their health and social care needs. While progress had been made to address some of the issues raised at the previous inspection, improvements were required in relation to the areas of restraint and falls. Issues identified at the previous inspection including care planning and opportunities for social engagement also remained outstanding.

Arrangements to meet residents' assessed needs were set out in individual care plans based on a range of assessments which had been carried out at regular intervals. However, in some cases the care plans did not address all the identified needs of residents. For example, in relation to restraint, activities and communication. There was inconsistent evidence that the residents and where appropriate the next of kin had been consulted in relation to the development of care plans, this was an action at the last inspection and had not been addressed. Residents healthcare needs were supported by good access to the GP and an out-of-hours service was available.

Inspectors found aspects of the management of restraint required improvement. There was a policy on the use restraint. However, it was not fully implemented in practice. For example, residents who used lap belts had not been assessed for their use. In addition, the assessment did not outline the alternatives considered, or if there was a risk of entrapment. There were a high number of residents using bedrails and lap belts, out of 81 residents, 35 residents used bedrails and 36 residents used lap belts. There was evidence of consultation with residents or their next of kin. Inspectors read records which confirmed restraint was monitored.

Inspectors found the management of falls required improvement. A falls policy was in place. However, it did not provide direction to staff. For example, it did not provide clear guidance on the post fall procedures to be followed. Neurological observations were not completed for all un-witnessed falls. Where they had been carried out, there were incomplete records. When a fall occurred an accident/incident form was complete, a review by the GP and physiotherapist was undertaken.

There were a small number of residents with behaviours that challenged. However, inspectors found inconsistent practices meant not all residents' needs were met. While a policy was in place to guide practice, it was not fully implemented to ensure consistency of care for all residents. For example, while residents needs were set out in care plans which outlined their behaviours, the strategies to be carried out to minimise the challenging behaviours were not outlined.

Inspectors found good practices in the management of wound care. There were records of wound assessments and wound dressing, and care plan in place to guide care for each wound. Staff were familiar with residents' needs, and training had been provided to enhance their skills in this area.

The residents had access to a range of allied health professionals, for example, dietician, speech and language therapist, dentistry, and occupational therapy. There were letters of referrals and appointments were seen on their files. The staff had a good understanding of the care needs of the residents.

Inspectors found the social care needs of residents were not fully met. There was a programme of activities displayed in the hallway of each unit which outlined the daily activities provided for residents. Since the last inspection staff had completed training in Sonas (a therapeutic programme for people with communication challenges), and this was observed taking place during the inspection. Inspectors noted activities took place once a day for one to two hours, and consisted of mostly group activities such as an

exercise class, or bingo, and on other days, music sessions or mass was facilitated. However, inspectors found the sitting rooms on each unit level were not large enough to facilitate all residents to participate in activities at the same time. Two communal areas were provided on the ground floor. One was used for day care each day, and the other as an open plan activity area. However, residents with high dependency levels did not consistently have their social care needs met. Inspectors read comments in the questionnaires submitted as part of the registration inspection that activities were limited, and residents spent large parts of their day in their bedrooms with little to do. This was also reported by some relatives on the day of inspection.

### **Outcome 12: Safe and Suitable Premises**

*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.*

**Theme:**

Effective Care and Support

**Judgement:**

Non Compliant - Moderate

**Outstanding requirement(s) from previous inspection:**

Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**

The inspector found the design and layout of building did not fully meet the requirements of the Regulations and the Authority's Standards, and the individual and collective needs of the residents. The person in charge told inspectors she is very aware of these deficits. However, there were no definite plans in place to address them.

The issues are outlined as follows:

- There were three three-bedded rooms which did not meet the requirements of the Authority's Standards.
- Mobile screening provided in the three-bedded rooms was insufficient to ensure residents privacy.
- Each unit had a living and dining room which were small in size, and only accommodated a maximum of eight to ten residents at any one time.
- A clinical atmosphere pervaded throughout the centre, with little decoration provided to make the four units more homely. The person in charge had plans to paint resident's bedrooms, and each had been consulted over their choice of colour.

- There was inadequate storage space, with the assistive shower room and sluice room being used to store equipment.
- There was no provision of a communal toilet for residents close to each of the dining and living areas on each unit.

The centre was kept clean, and was well maintained to a good standard of repair. A number of residents' bedrooms were seen by inspectors, and most had an en suite shower, wash-hand basin and toilet. All beds had a call bell fitted, and inspectors found these were regularly serviced. All bedrooms had a wardrobe and locker for personal items. The residents had added their own personal touches, with photos and paintings.

There was a secure, enclosed garden, directly accessible from the centre. It was pleasantly laid out, with paved tiling, and seating areas, along with many potted plants and flowers. An internal, smoking area was located on the ground floor, and since the last inspection mechanical ventilation had been installed.

There was provision of assistive equipment such as hoists and lifts. Servicing reports were read by inspectors and confirmed they had been recently serviced and were in good working order.

### **Outcome 13: Complaints procedures**

*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.*

**Theme:**

Person-centred care and support

**Judgement:**

Non Compliant - Moderate

**Outstanding requirement(s) from previous inspection:**

No actions were required from the previous inspection.

**Findings:**

Inspectors found the overall management of complaints in the centre required improvements.

There was a centre specific procedure on complaints. However, this document had not been drawn up in line with the requirements of the Regulations as the complaints officer was not clearly identified and it did not identify an independent person to oversee the complaints process. The complaints procedure was not displayed in the centre so as to inform residents and visitor of the complaints process. Inspectors reviewed a complaints log on each floor. A number of complaints had been made, and there was evidence both written and verbal complaints were recorded in the log. However, there were no details of the investigation carried out, actions taken and whether the complainant was satisfied with the outcome of the investigation.

**Outcome 14: End of Life Care**

*Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.*

**Theme:**

Person-centred care and support

**Judgement:**

Non Compliant - Moderate

**Outstanding requirement(s) from previous inspection:**

No actions were required from the previous inspection.

**Findings:**

Inspectors found improvements were required in the management of residents' needs who were approaching end of life.

While inspectors found there was a comprehensive policy on end-of-life care, it was not fully implemented in practice by staff. There was access to the services of a palliative care team if required, and staff had received training in this area. Inspectors reviewed the end-of-life care plan for a resident. However, improvements were required as it did not guide practice. For example, the residents' religious and cultural needs were not outlined in the care plan. Residents' end-of-life care needs were not consistently assessed and recorded in accordance with the centres' policy.

A visitor's room was available for relatives and friends for privacy if and when required.

**Outcome 15: Food and Nutrition**

*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 discrete and sensitive manner.*

**Theme:**

Person-centred care and support

**Judgement:**

Compliant

**Outstanding requirement(s) from previous inspection:**

No actions were required from the previous inspection.

**Findings:**

Inspectors were satisfied that residents were provided with meals that were wholesome and in accordance with their assessed needs. Residents' dietary requirements were met to a good standard.

Inspectors spent time with residents in the dining room at lunch time and found residents were discreetly and respectfully assisted with their meals where required. A menu was displayed on each table with the choice of meal for the day and there was evidence of choice for residents on a modified consistency diet. The staff were familiar with the special dietary requirements and preferences of residents' and, were knowledgeable of the residents' assessed needs. There was a three-week rolling menu which was reviewed by the person in charge along with the dietician to ensure quality meals and choice at meal times. Inspectors reviewed records of a residents food consultation group who met on a regular basis and observed that suggestions made around food options were taken on board.

Inspectors saw residents being offered a variety of snacks and fresh water, fruit juices and hot drinks during the day.

### **Outcome 16: Residents Rights, Dignity and Consultation**

*Residents are consulted with and participate in the organisation of the centre. Each residents privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence.*

**Theme:**

Person-centred care and support

**Judgement:**

Non Compliant - Minor

**Outstanding requirement(s) from previous inspection:**

No actions were required from the previous inspection.

**Findings:**

Inspectors found residents were consulted with and participated in the organisation of the centre. Their privacy and dignity was respected however, improvements were required in this area.

Inspectors observed that tables which had been set for mealtimes had personalised table mats for each resident that contained confidential information about the residents dietary needs. Additionally, detailed information of a resident's dietary requirements were displayed on the door of the dining room.

There were arrangements in place to facilitate consultation and participation with residents in the organisation of the centre. A residents' committee met every two months. An advocacy group facilitated the meetings since June 2012, and a meeting took place on the second day of the inspection. On the second day of inspection, a residents committee meeting had taken place. Inspectors met members of the advocacy group who discussed the matters raised at these meetings. Part of the work included meeting with residents, who either could not or chose not to attend the meetings.

Religious and spiritual needs of residents were respected. The person in charge outlined the services available to the residents. Mass was celebrated in the centre every week.

Throughout the inspection staff were friendly and personable to residents. The residents seemed comfortable and happy in their surroundings. Inspectors spoke to a number of residents, families and staff and all expressed their satisfaction with the centre.

Communication needs were facilitated. The residents had access to a telephone on each floor. There were televisions provided and available in each bedroom. The newspapers were available each day including weekends.

The provider and person in charge ensured residents voting rights were maintained. The residents were supported to attend a local polling station at each election.

**Outcome 17: Residents clothing and personal property and possessions**

*Adequate space is provided for residents personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.*

**Theme:**

Person-centred care and support

**Judgement:**

Non Compliant - Minor

**Outstanding requirement(s) from previous inspection:**

No actions were required from the previous inspection.

**Findings:**

Inspectors found residents had sufficient space for their personal belongings and their clothes were suitably laundered and returned to them. Inspectors observed and residents confirmed, that they were encouraged to personalise their rooms. However, there was no up-to-date record of residents' personal belongings maintained on their file. Many of the bedrooms were decorated with pictures and photographs from residents' own homes. Residents had private lockable space to store personal valuables.

Clothing items were clearly marked with the name of the resident. There was a laundry service on the grounds of the centre. Inspectors talked to residents who confirmed they were satisfied with the way in which their clothes were cared for and were happy with the service.

**Outcome 18: Suitable Staffing**

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

**Theme:**

Workforce

**Judgement:**

Non Compliant - Moderate

**Outstanding requirement(s) from previous inspection:**

Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**

Inspectors found staff in place were familiar with the residents, and their health care needs. They received a wide range of training and education to meet the specific needs of residents. However, improvements were required as inspectors were not satisfied that the staffing levels at certain times of day met the needs of residents. Additionally staff documentation did not fully meet the requirements of the Regulations.

There was a planned roster seen by inspectors, and a nurse was on duty on every floor at all times in the centre. However, inspectors found that the numbers of staff on duty at night time did not meet the assessed needs of residents. From 7.30pm till 7.30am, four staff nurses and four health care assistants (HCA) covered the four floors in the centre. Inspectors read questionnaires which stated that night staffing levels "were tight, particularly around "hygiene care" and residents may have to "wait at times for call bells" to be answered. Some relatives and staff told inspectors that staffing levels were not suitable in the evening to meet resident's needs and that residents often waited for assistance. The person in charge said staffing levels had not been formally reviewed since the centre had opened in 2009. She said there was no formal assessment system in place ensure that staffing levels and skills mix met the needs of residents.

There were improvements in the information and documentation required to be kept by the Regulations for staff. However, some gaps were also found. For example, there no evidence of the fitness of one staff member, and only two references had been provided for another staff. This was an action at the previous inspection, and continued to be an issue.

Inspectors found there was no system to appraise the work of staff in place. There was also no supervisory arrangements in place for staff. These matters were discussed with the person in charge during the inspection, who confirmed neither was in place.

Staff had received a variety of education and training to meet residents' clinical needs since the last inspection in November 2012. Inspectors viewed training records which included training in areas such as dementia care, infection control, nutrition, pressure care, wound care, care after a stroke and, cardio pulmonary resuscitation (CPR). The person in charge had plans to provide additional training in 2014. Inspectors read records that confirmed all staff had received mandatory training in elder abuse, manual handling and fire safety.

Inspectors reviewed a sample of files for volunteers. A written agreement was in place, and there was evidence of An Garda Síochána vetting. This had been an action at the last inspection, and was completed.

Inspectors saw that all nursing staff personal identification numbers (PIN) with their professional registration body, were in place and up-to-date.

## **Closing the Visit**

At the close of the inspection a feedback meeting was held to report on the inspection findings, which highlighted both good practice and where improvements were required.

### **Acknowledgements**

The inspector wishes to acknowledge the cooperation and assistance of the residents, relatives, and staff during the inspection.

### ***Report Compiled by:***

Deirdre Byrne  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority

**Action Plan**

**Provider's response to inspection report<sup>1</sup>**

<b>Centre name:</b>	Clonskeagh Community Nursing Unit
<b>Centre ID:</b>	ORG-0000491
<b>Date of inspection:</b>	14/01/2014
<b>Date of response:</b>	27/02/2014

**Requirements**

This section sets out the actions that must be taken by the provider or person in charge to ensure Compliance with 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.

**Outcome 01: Statement of Purpose**

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The statement of purpose did not include all matters outlined in Regulation 5 and Schedule 1 of the Regulations.

**Action Required:**

Under Regulation 5 (1) (c) you are required to: Compile a 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).

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

The Statement of Purpose has been amended to include those items referred to as omissions in the Inspection Report. The complaint policy is awaiting approval and will be submitted in accordance with the timeframe outlined in the Improvement Plan. A revised Statement of Purpose has been submitted with the Improvement Plan to include a revised full scope of services, identity of Registered Provider and a current Fire

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

Compliance Certificate.

**Proposed Timescale:** 28/02/2014

### **Outcome 02: Contract for the Provision of Services**

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The contract of care did not include details of the fees charged and, any additional services which incurred an additional cost.

**Action Required:**

Under Regulation 28 (2) you are required to: Ensure each residents contract deals with the care and welfare of the resident in the designated centre and includes details of the services to be provided for that resident and the fees to be charged.

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

The Contract of Care for each resident will be amended to include the overall cost of care and the client/HSE contribution separately. A summary of services available within that cost are defined within schedule 4 of the current contract and we will also ensure that direction is given as to where residents/relatives can access information relative to costs and availability of non-standard/personalised services/support/items should the resident require same.

**Proposed Timescale:** 30/06/2014

### **Outcome 03: Suitable Person in Charge**

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The person in charge did not consistently demonstrate authority and accountability for the provision of the service.

**Action Required:**

Under Regulation 15 (2) you are required to: Ensure that the post of person in charge of the designated centre is full time and that the person in charge is a nurse with a minimum of three years experience in the area of geriatric nursing within the previous six years.

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

The Person in Charge is a full-time registered nurse and has more than adequate experience as defined within the Regulations as acknowledged within the Inspection report. The Registered Provider has engaged in detailed discussion with the Person in Charge (post Inspection) to re-enforce the importance of full implementation of the Regulations and in order to put in place an improvement plan with regular systematic

reviews to ensure full implementation and required improvement. The Registered Provider has put a formal process of evaluation in place relative to the implementation of this improvement plan

The Person in Charge is fully cognisant of the Regulations pertaining to Notifiable Events and has given absolute assurance to comply in this regard. The Person in Charge is conscious of the availability of advice (from Inspectorate) if/where necessary.

**Proposed Timescale:** 28/02/2014

**Outcome 04: Records and documentation to be kept at a designated centre**

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The Residents' Guide did not include all information required by Regulations.

**Action Required:**

Under Regulation 21 (1) you are required to: Produce a residents guide which includes a summary of the statement of purpose; the terms and conditions in respect of accommodation to be provided for residents; a standard form of contract for the provision of services and facilities to residents; the most recent inspection report; a summary of the complaints procedure provided for in Regulation 39; and the address and telephone number of the Chief Inspector.

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

The Resident's Guide/Care Centre Booklet does include the Contract of Care (to be updated in respect of outcome 2 above) and also includes contact details for the Chief Inspector. The complaints procedures will also be incorporated within the guide/handbook when amended (31.03.2014). The revised Statement of Purpose will also be incorporated within this document (when amended) and the final most recent Inspection report to include improvement plan will be appended.

**Proposed Timescale:** 30/04/2014

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Not all resident records were stored in a safe and secure manner.

**Action Required:**

Under Regulation 22 (1) (ii) -(iii) you are required to: Keep the records listed under Schedule 3 (records in relation to residents) and Schedule 4 (general records) up-to-date and in good order and in a safe and secure place.

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

The storage of both resident and staff records has been reviewed and the Centre manager has advised that all appropriate measures are in place to ensure security and confidentiality of all records held within the centre. The Registered Provider will review this matter in line with structure reviews of the overall improvement plan.

**Proposed Timescale:** 31/03/2014

**Theme:** Leadership, Governance and Management

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

The directory of residents did not include all the information as per Schedule 3 of the Regulations.

**Action Required:**

Under Regulation 23 (2) you are required to: Ensure that the directory of residents includes the information specified in Schedule 3 paragraph (3) of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 as amended.

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

The Register of Residents has been amended to include all information required under Regulation 23.

**Proposed Timescale:** 28/02/2014

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The policy relating to falls prevention, the risk management policy and, the policy on complaints required additional detail in order to fully guide staff.

**Action Required:**

Under Regulation 27 (2) you are required to: Review all the written operational policies and procedures of the designated centre on the recommendation of the Chief Inspector and at least every three years.

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

The Register of residents will be consolidated into one document to incorporate all information required under Standard 32 with particular reference to paragraphs 32.2 and 32.3 of said standards.

The Falls Prevention Policy is being updated presently with the resident physiotherapist and occupational therapist. A periodic (monthly) after falls audit review will be completed at Ward level and will inform multidisciplinary Improvement plan to support pro-active measures targeted at reducing falls amongst our residents.

The Risk Management policy is being revised with the Registered Provider to support further integration and pro-active risk avoidance measures. A quality and risk forum is in place with appropriate risk registers, fire compliance assurance and safety statements in place. All risks and incidents are reviewed by the Quality and Risk Group with appropriate "learning" feedback to the Unit managers/staff to ensure general and patient specific risk avoidance measures are in place. The Registered Provider has put in place HSE supports (Quality & Risk Advisor) to support external audit and assist with overall implementation of the quality and risk agenda.

The complaints policy has been amended and is awaiting review by the Registered Provider.

**Proposed Timescale:** 31/03/2014

### **Outcome 06: Safeguarding and Safety**

**Theme:** Safe Care and Support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

The person in charge was not clear of the centres policy and procedures to follow in the investigation of an allegation of abuse.

Practices in relation to the management of residents' monies was not in line with the centres procedures.

**Action Required:**

Under Regulation 6 (1) (b) you are required to: Put in place a policy on and procedures for the prevention, detection and response to abuse.

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

The centre's policy on the investigation, management and reporting of alleged incidents of Elder Abuse is currently under detailed review with additional support and training from the dedicated officer for Dublin South-East. The Register Provider will ensure that the revised policy reflects best practice and current national policy and will ensure that adequate resources are in place to achieve implementation and appropriate review to ensure compliance with the regulations and re-enforce protection for our residents in the event of an alleged or suspected incidence of Elder Abuse.

There is a robust procedure in place regarding security of cash, both residents and non-residents which is in compliance with the HSE's national Financial Regulations (amended December 2013) the appropriate sections are,  
NFR 08 - Retention of financial records  
NFR 14 - Financial management in Community residences  
NFR 22 – Management of Patients(Residents) Private Property

The Manager of the Care Centre will carry out regular reviews (including at ward level) to ensure full compliance with the appropriate Financial Regulations and will re-enforce

such requirements with all staff who are engaged in processes of handling/managing cash and property belonging to residents.

**Proposed Timescale:** 31/03/2014

### **Outcome 07: Health and Safety and Risk Management**

**Theme:** Safe Care and Support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The risk management policy did not include the arrangements in place to manage adverse events involving residents.

**Action Required:**

Under Regulation 31 (2) (d) you are required to: Ensure that the risk management policy covers the arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents.

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

The Risk Management Policy will be amended to include procedures to be followed in the event of all potential adverse events involving the Centre and/or resident(s). Specific training has been identified for all Persons in Charge with HSE/DML to commence in late March 2014. The HSE (South-East Dublin/Wicklow) has a unified management process of which Clonskeagh Community Nursing Unit is an integral part where adverse event contingencies and adverse events requiring escalation are evaluated and discussed. The HSE has a robust serious incident management process which encompasses all services at the Centre. This process involves, communication protocols (internal and external), alerting and engaging with all emergency support services, HSE emergency management structures and defining alternative accommodation arrangements if necessary, logistical supports, professional advice and assistance both internal (HSE) and external, such as local authorities, emergency response services and law enforcement. The Person in Charge is fully briefed and aware of how to enable such supports in the event of a serious/adverse event within or in close proximity to the centre.

The Registered Provider will ensure that the Centre Policy reflects the above protocols and procedures.

**Proposed Timescale:** 30/04/2014

**Theme:** Safe Care and Support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The emergency plan only included the procedures to follow in the event of a fire.

**Action Required:**

Under Regulation 31 (3) you are required to: Put in place an emergency plan for responding to emergencies.

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

Please see response and action proposed under 31 (2) above

**Proposed Timescale:** 30/04/2014

**Theme:** Safe Care and Support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Not all staff were familiar with the fire safety procedures to be followed in the centre.

There was no evidence that fire drills were carried out at regular intervals.

**Action Required:**

Under Regulation 32 (1) (e) you are required to: 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.

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

There are comprehensive and robust fire procedures in place within the Centre. The fire alarm system is a modern, addressable system which is maintained and fully serviced in accordance with the manufacturer's specifications. Fire logs are completed on each ward daily which includes alarm tests, checking of fire exists to ensure ease of egress in the event of an emergency. This information is maintained and validated by a designated individual on each unit. Maintenance/service records are available on site within the engineering base records. The Registered Provider will ensure that such records can be accessed within the Centre. Fire Drills are carried out regularly by staff and the Registered Provider will ensure that these procedures are fully documented to ensure appropriate evidence of same. The Registered Provider has also engaged with the HSE Fire Officer to ensure that such exercises are audited in order to validate appropriate protocols and expected responses and take corrective action where necessary.

On the date of Inspection following an activation of the fire alarm staff quickly ascertained that there was no risk to residents or staff. However, the Registered Provider accepts that there were deficiencies in how this situation was managed and communicated within the centre. This was further complicated as a result of a technical fault which developed in the break-glass mechanism which prevented the system reset. This could not have been anticipated or prevented in any way. The system was reset later that afternoon but caused confusion as the system alarm repeated for some time during the Inspection.

The Registered Provider and Person In Charge view the welfare and protection of residents as paramount and are committed to re-enforcing and strengthening protective

measures already in place to include the appropriate documentation of all such measures.

**Proposed Timescale:** 30/04/2014

**Theme:** Safe Care and Support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

There were no service records for fire extinguishers maintained in the centre.

**Action Required:**

Under Regulation 32 (2) (c) you are required to: Maintain, in a safe and accessible place, a record of the number, type and maintenance record of fire-fighting equipment.

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

All fire protection equipment is service regularly and maintained in accordance with current legislation and manufactures instructions. The Registered Provider is aware of the necessity to maintain such records on site and is conscious that this was an action from previous Inspection. The Registered Provider will ensure that this action is corrected and that all relevant service records (or copies thereof) are maintained within the centre.

**Proposed Timescale:** 31/03/2014

### **Outcome 08: Medication Management**

**Theme:** Safe Care and Support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The medication policy did not outline the procedures to follow for the prescribing and administration of as required (PRN) medications.

The route of medications to be administered was not prescribed for.

The residents GPs name was not provided on the prescription sheet.

**Action Required:**

Under Regulation 33 (1) you are required to: 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.

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

The current Medication Management Policy is being reviewed presently to incorporate protocols relative to the dispensing of PRN medication. This is being reviewed locally with the centre pharmacist and the appropriate centre medical officers. This revised protocol will include the name of prescribing GP and date of prescription in all cases.

The final draft Medication Management Policy will be discussed on the 10th of March to achieve final approval.

It is proposed to implement the next policy immediately post the 10th of March 2014.

**Proposed Timescale:** 11/03/2014

### **Outcome 09: Notification of Incidents**

**Theme:** Safe Care and Support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

An allegation of abuse was not reported to the Chief Inspector within the legislative timeframe.

**Action Required:**

Under Regulation 36 (2) (e) you are required to: Give notice to the Chief Inspector without delay of the occurrence in the designated centre of any allegation, suspected or confirmed abuse of any resident.

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

The Register Provider has discussed this non-compliance with the Person in Charge post Inspection. The Person in Charge has confirmed and validated her understanding of her obligations under the Regulations and is committed to ensuring that all "notifiable events" will be forwarded to HIQA in the prescribed format and within the timeframe defined within the Regulations.

**Proposed Timescale:** 28/02/2014

**Theme:** Safe Care and Support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Allegations of staff misconduct were not notified to the Chief Inspector.

**Action Required:**

Under Regulation 36 (2) (f) you are required to: Give notice to the Chief Inspector without delay of the occurrence in the designated centre of any allegation of misconduct by the registered provider or any person who works in the designated centre.

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

The Register Provider has discussed this non-compliance with the Person in Charge post Inspection. The Person in Charge has confirmed and validated her understanding of her obligations under the Regulations and is committed to ensuring that all "notifiable events" will be forwarded to HIQA in the prescribed format and within the timeframe defined within the Regulations.

**Proposed Timescale: 28/02/2014**

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

**Theme:** Effective Care and Support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

There was no effective system auditing and monitoring in place to improve and enhance the quality and safety of care and quality of life for the residents.

**Action Required:**

Under Regulation 35 (1) (b) you are required to: Establish and maintain a system for improving the quality of care provided at, and the quality of life of residents in, the designated centre.

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

The Registered Provider and Person in Charge are acutely conscious of the necessity for audit (both internal and external) to inform and guide continuous pro-active quality improvement to enhance the welfare and protection of our residents while at the same time ensuring that their time of residency at the Centre is pleasant and peaceful.

We encourage and support the continued development of Advocacy services within the centre, to capture and assist in the identification of residents' desires and wishes and to help inform and influence service delivery on an individual and collective basis. We have established a Quality and Risk forum in order to identify, record and evaluate service risks to develop pro-active measures in development of risk avoidance strategies. We are endeavouring to secure support locally (through Primary Care) from a recently appointed Infection Control Nurse in order to put in place a process of external audit to evaluate and improve such practices at our Centre.

The Registered Provider has reaffirmed with the Person in Charge the absolute necessity to ensure that Nurse Management are conscious of their key role in supporting audit and ensuring that learning from same is translated into practice within the centre. This key function will be continuously reviewed and performance managed on an individual basis if necessary.

**Proposed Timescale: 30/04/2014**

**Outcome 11: Health and Social Care Needs**

**Theme:** Effective Care and Support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

There were improvements identified in the management of restraint, falls and behaviours that challenge.

**Action Required:**

Under Regulation 6 (3) (a) you are required to: Put in place suitable and sufficient care to maintain each residents welfare and wellbeing, having regard to the nature and extent of each residents dependency and needs.

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

In consultation with the resident Physiotherapist the PIC will develop post fall procedures to incorporate within existing Falls Policy. This will be reviewed with all CNM's and implemented Centre wide.

Care Plans for residents with behaviours that challenge will be systematically reviewed to ensure individualised measures/triggers are identified in order to avoid giving rise to challenging behaviour. The PIC will ensure that nursing/non nursing interventions will take account of information/guidance recommended within the residents care plan which are assessed as having potential "calming" influences on the residents behaviour in such circumstances. The PIC will ensure that the current policy is revised to guide regular reviews and ensure the implementation of measures which have been documented in the residents care plan as appropriate.

The Registered Provider is conscious of the recommendations from the most recent Inspection relative to consultation with residents and/or their next of kin in the development and update of their care plan. The Registered Provider and PIC will ensure that this important standard is re-enforced with all staff and that there is appropriate documentation of such occurrences and that subsequent care is delivered in accordance with such interactions where possible/appropriate.

**Proposed Timescale:** 30/04/2014

**Theme:** Effective Care and Support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Residents were provided with limited opportunities to engage in activities relevant to their interests and likes.

**Action Required:**

Under Regulation 6 (3) (d) you are required to: Provide opportunities for each resident to participate in activities appropriate to his/her interests and capacities.

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

The PIC is committed to offering the residents the greatest range of activities possible. The activities coordinator has been instructed to engage with all residents in order to review and update their individualised activities plan. The PIC will continue to support appropriate training to staff in order to support the delivery of identified activities/therapies to residents. The Registered Provider is committed to resourcing an appropriate level of activities for all residents.

**Proposed Timescale:** 30/06/2014

**Theme:** Effective Care and Support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Resident needs were not consistently set out in a care plan in relation to restraint, communication and activities.

**Action Required:**

Under Regulation 8 (1) you are required to: Set out each resident's needs in an individual care plan developed and agreed with the resident.

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

As indicated above the PIC will ensure appropriate management audits and reviews to assist in achieving a level of consistency in the delivery of care and recording of same. Presently, audits of Care Plans and care delivery are Carried out by Clinical Nurse Managers on night duty. These audits will be further focused on the prescribed use and documentation of the use of restraint, management of challenging behaviour and review of falls within the centre in line with the proposed review of these policies as outlined above.

**Proposed Timescale:** 30/06/2014

**Theme:** Effective Care and Support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

There was inconsistent evidence of resident involvement in the care plans.

**Action Required:**

Under Regulation 8 (2) (c) you are required to: Revise each residents care plan, after consultation with him/her.

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

The PIC, together with nurse management within the Centre will ensure that there is appropriate engagement with residents and/or their families/next of kin in the development and continuous review of the residents care plan. Nurse management will re-enforce this with all staff and ensure that such interventions/discussion is recorded and that clear evidence is documented where these interventions influence the manner or method by which care is delivered. In cases where residents needs/desires cannot be met or indeed are deemed inappropriate/impractical this should be documented and show clear evidence that this information was relayed back to the resident and/or their family/next of kin where appropriate.

**Proposed Timescale:** 30/04/2014

## Outcome 12: Safe and Suitable Premises

**Theme:** Effective Care and Support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

There were three three-bedded rooms which did not fully meet the needs of residents.

The layout and design of the premises did not meet the needs of all residents.

The decor in parts of the centre was not homely in appearance.

The Chief Inspector requests a costed plan, with definite timeframes to address the premises deficits as outlined in the report and the action plan above to be submitted to the Authority.

**Action Required:**

Under Regulation 19 (3) (a) you are required to: Ensure the physical design and layout of the premises meets the needs of each resident, having regard to the number and needs of the residents.

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

The three-bedded rooms referred to in the Inspection report are utilised and defined as short-stay respite beds. The Registered Provider has been advised by the Person in Charge that a waiting list is in existence in respect of the nine designated respite care beds within the centre. The PIC has undertaken to review all such current respite clients (including the frequency of their respite) to establish a programme whereby the nine beds can be reduced to six without negatively impacting upon our respite care clients in the short term. The Registered Provider is confident that such a plan would reach a level of compliance under 25.54 of the National Quality Standards for Residential Care Settings for Older People in Ireland. However, the Registered Provider and PIC are acutely aware that the loss of such capacity (3 beds) may have a significantly negative impact on current or future anticipated clients. The Registered Provider and Person in Charge undertake to provide the Inspector with an evaluation of this plan by the 31st of July 2014 to indicate when it is planned to reduce the respite beds to two per room.

In the interim, the internal decoration including client privacy screens have been reviewed and any necessary upgrade will be funded through minor capital funding allocated to the Centre for 2014.

The Inspection Report indicates that each unit had a living and dining room which was small in size. The centre was designed with a dedicated dining/activities area on the ground floor which has adequate space for such activities. The Registered Provider and Person in Charge encourage all residents to take meals and activities outside of their "normal" communal space and will again ensure that this choice is afforded to all residents and that staff are aware of their obligation to accommodate residents in their choices in this regard.

The Registered Provider has secured appropriate resources to implement a programme of redecoration at the centre. A process of tender is already underway which will involve

the commencement of an incremental programme of internal painting at the centre. The patient advocacy group are central to such decisions. The PIC affords every reasonable opportunity to residents in order to personalise their own rooms.

**Proposed Timescale:** 31/07/2014

**Theme:** Effective Care and Support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

There was no provision of independently located toilets close to the communal areas on all floors.

**Action Required:**

Under Regulation 19 (3) (j) part 2 you are required to: Provide sufficient numbers of toilets and wash-basins which incorporate thermostatic control valves or other suitable anti-scalding protection, at appropriate places in the premises.

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

The Registered Provider will review this matter in the context of the Regulations and with the advices of the PIC and a design architect if necessary. The Registered Provider will revert to the Inspectorate in this regard.

**Proposed Timescale:** 31/03/2014

**Theme:** Effective Care and Support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

There was inadequate provision of storage space for assistive equipment.

**Action Required:**

Under Regulation 19 (3) (l) you are required to: Ensure suitable provision for storage of equipment in the designated centre

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

The Registered Provider will review this matter with the PIC and the Centre manager. Storage space is available on the ground floor and the Centre manager has reviewed all equipping needs to ensure only those essential for daily use are maintained on the units. This matter will be reviewed on an ongoing basis to ensure appropriate housekeeping and safe storage of equipment during periods of non-usage.

**Proposed Timescale:** 31/03/2014

**Theme:** Effective Care and Support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

There was insufficient screening provided in the three-bedded rooms.

**Action Required:**

Under Regulation 19 (3) (e) part 2 you are required to: Provide adequate private accommodation for residents.

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

The Register Provider has requested the PIC to review this matter and identify what enhancements are available to improve privacy for persons availing of services associated with the multi-occupancy rooms. The Registered Provider has committed resources to this end.

**Proposed Timescale:** 30/04/2014

**Outcome 13: Complaints procedures**

**Theme:** Person-centred care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The policy and procedures on complaints was not comprehensive enough to guide practice.

**Action Required:**

Under Regulation 39 (1) you are required to: Provide written operational policies and procedures relating to the making, handling and investigation of complaints from any person about any aspects of service, care and treatment provided in, or on behalf of a designated centre.

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

The Centres complaints policy is being reviewed by the Registered Provider to ensure that it conforms to the Regulations and is specific to the Centre. The Registered Provider is also conscious of the necessity to make such documents simple to understand and user friendly in order to afford residents and/or their families an opportunity to make a complaint and have it dealt with at the appropriate level within a defined timeframe.

**Proposed Timescale:** 31/03/2014

**Theme:** Person-centred care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

An independent appeals process was not outlined in the complaints procedure.

**Action Required:**

Under Regulation 39 (2) you are required to: Ensure the complaints procedure contains an independent appeals process, the operation of which is included in the designated centres policies and procedures.

**Please state the actions you have taken or are planning to take:**  
This will be incorporated within the revised Complaints Policy as outlined above.

**Proposed Timescale:** 31/03/2014

**Theme:** Person-centred care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

There was inconsistent evidence that complaints had been fully investigated.

**Action Required:**

Under Regulation 39 (6) you are required to: Investigate all complaints promptly.

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

This will be re-enforced with the introduction of the revised complaint policy. The Registered Provider will also require the PIC to submit details of all complaints received at the Centre (by month) to include those outstanding (from previous periods) and the reasons for same to include a "status" report on the management of each.

**Proposed Timescale:** 30/04/2014

**Theme:** Person-centred care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

There was no record of the investigation and outcome of each complaint reviewed, along with the satisfaction of the complainant.

**Action Required:**

Under Regulation 39 (7) you are required to: Maintain a record of all complaints detailing the investigation and outcome of the complaint and whether or not the resident was satisfied.

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

The Registered Provider has engaged in a number of such complaints recently and is conscious that there were weaknesses in the process of investigation of complaints. These deficiencies have been pointed out to the PIC and the Centre manager. The Registered Provider will ensure that such deficiencies are addressed for each outstanding complaint and that appropriate action is taken in the event that the practice of investigation falls short of the desired standards.

**Proposed Timescale:** 30/04/2013

## Outcome 14: End of Life Care

**Theme:** Person-centred care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Residents' approaching end of life did not have their religious needs set out in their care plan.

Residents' end-of-life care needs were not consistently assessed or recorded.

**Action Required:**

Under Regulation 14 (2) (a) you are required to: Provide appropriate care and comfort to each resident approaching end of life to address his/her physical, emotional, psychological and spiritual needs.

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

The "Spiritual Needs" and "End of Life" care assessment components of the existing HSE Care Plan document will be reviewed with all residents and/or their family in order to fully inform their anticipated needs and desires when/if they enter this phase of their residency within the Centre. The PIC is acutely aware of the programme of self assessment recently announced by HIQA and is engaged with colleagues to ensure a robust review of these elements of care within the centre. The PIC is also a member of the Hospice Friendly Hospitals Group where up to date information and advice is available to aid practice locally. The PIC and Registered Provider are committed to enhance training in end of life care and are supporting two clinical nurse managers to undertake formal training programmes in this regard.

The PIC will re-enforce with staff (through nurse management) the absolute necessity to ensure that practice within the Centre is guided by policy and that needs defined by patients/relatives and resulting care/spiritual interventions are recorded and reviewed if necessary, to meet the needs/ wishes of the residents/family.

**Proposed Timescale:** 30/04/2014

## Outcome 16: Residents Rights, Dignity and Consultation

**Theme:** Person-centred care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Residents' were not consulted with in having personal dietary information displayed.

**Action Required:**

Under Regulation 10 (b) you are required to: Provide each resident with the freedom to exercise choice to the extent that such freedom does not infringe on the rights of other residents.

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

The Person in Charge has reviewed the practice of displaying confidential dietary information relative to residents in a "public" area of the Centre. This process was discussed with the dietician and discontinued. Such information will remain confidential to the resident and staff engaged in the delivery of care.

**Proposed Timescale:** 28/02/2014

**Outcome 17: Residents clothing and personal property and possessions**

**Theme:** Person-centred care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

There was no up-to-date record of each resident's personal possessions.

**Action Required:**

Under Regulation 7 (2) you are required to: Maintain an up to date record of each residents personal property that is signed by the resident.

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

A list to record resident's personal possessions is being developed and a protocol put in place to ensure that this list is updated as required by the resident/family should additional possessions be procured, brought into the Centre or indeed removed from the Centre by a resident, their family or on their instruction. The PIC and Centre manager will ensure that all staff and residents/family members are circulated with this protocol and that the implementation is subject to regular review and audit.

**Proposed Timescale:** 30/04/2014

**Outcome 18: Suitable Staffing**

**Theme:** Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Staffing levels at night were not appropriate to meet the assessed needs of residents.

**Action Required:**

Under Regulation 16 (1) you are required to: 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.

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

The Registered Provider has requested the Person In Charge to review staffing levels within the Centre particularly during the evening and night-time hours. The Person in Charge is in the process of this evaluation but indications are that staffing levels are appropriate in terms of meeting the needs of the numbers of residents, taking into account their current dependence levels. The Person in Charge has the authority to

adjust staffing levels when and where required and initial investigation has indicated that there may be deficiencies during twilight hours – 6.00 – 10.00 in particular. The Person in Charge is reviewing this situation at the moment and will enhance staffing at such times as residents needs dictate.

**Proposed Timescale:** 30/04/2014

**Theme:** Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Some staff files did not contain all of the information required by Regulations.

**Action Required:**

Under Regulation 18 (2) (a) and (b) you are required to: 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.

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

No individual is permitted to work within the Centre unless they have satisfied a robust selection process which includes validation of qualifications, suitability for role (in accordance with job specification and interview(s)), receipt and validation of suitable references and attainment of appropriate Garda clearance. Significant efforts have been undertaken, following on from last Inspection, to put in place locally accessible records which satisfy documentary evidence in accordance with Schedule 2. These records will be re-examined in the context of this Inspection report and re-enforced locally by the Registered Provider.

**Proposed Timescale:** 30/04/2014