Health Information and Quality Authority
Regulation Directorate

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

Centre name:	Dalkey Community Unit for Older Persons
Centre ID:	OSV-0000510
Centre address:	Kilbegnet Close, Co. Dublin.
Telephone number:	01 235 3200
Email address:	alice.harding@hse.ie
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	John O'Donovan
Lead inspector:	Deirdre Byrne
Support inspector(s):	Liam Strahan
Type of inspection	Announced
Number of residents on the date of inspection:	46
Number of vacancies on the date of inspection:	4

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National 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 renewal 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:
25 February 2015 09:30	25 February 2015 19:30
26 February 2015 07:30	26 February 2015 13:30

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

Outcome
Outcome 01: Statement of Purpose
Outcome 02: Governance and Management
Outcome 03: Information for residents
Outcome 04: Suitable Person in Charge
Outcome 05: Documentation to be kept at a designated centre
Outcome 06: Absence of the Person in charge
Outcome 07: Safeguarding and Safety
Outcome 08: Health and Safety and Risk Management
Outcome 09: Medication Management
Outcome 10: Notification of Incidents
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 report sets out the findings of a registration inspection, which took place following an application to the Health Information and Quality Authority's (the Authority) to renew registration. As part of the inspection, the 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.

The registered providers are the Health Service Executive (HSE). John O' Donovan, the area operations manager, is the nominated person on behalf of the provider (the provider). Inspectors met the provider and the person in charge during the

inspection. Overall, inspectors were satisfied with their ongoing fitness at this registration renewal, through discussions with the nominee of the provider and the person in charge during the inspection process, ongoing monitoring and compliance, response to action plans, and review of notifications in the intervening registration period. They both demonstrated an understanding of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, and the National Quality Standards for Residential Care Settings for Older Persons in Ireland and their statutory obligations.

However, the person in charge was also responsible for another designated centre within the organisation, and while there were clear lines of authority and reporting arrangements to govern the centre in her absence, inspectors were not satisfied that these arrangements were robust. There was evidence of poor clinical governance and leadership evidenced in relation to outcomes on health care in terms of care planning, the use of restrictive practices, social care needs and interactions with residents. This was discussed with the provider and person in charge during the inspection, who assured inspectors appropriate action would be taken to address this issues.

Inspectors found a good standard of nursing care was provided to the residents, with care provided by staff who were familiar with their health care needs. However, as outlined above and in the report, issues regarding care planning and the management of restrictive practices were identified.

The provider and person in charge promoted the safety of residents and a comprehensive risk management process was in place for the centre. There were suitable fire safety procedures in place. Staff had received frequent training in all mandatory areas, and they were knowledgeable about the prevention of elder abuse.

Inspectors found nearly all of the five actions identified at the previous inspection in April 2014 had been addressed with the exception of one. The action related to deficits in the premises.

As identified at previous inspections carried out since 2009, inspectors found that aspects of the design and layout of the premises did not fully meet residents' needs. A number of improvements are required to the premises in order to comply with the Regulations and the National Standards by 01 July 2015. The nominated provider was aware of the deficits and constraints of the premises.

A number of actions were required from this inspection which are detailed in the report and included in the Action Plan at the end of the report.

Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National 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:
Governance, Leadership and Management

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

Findings:
Inspectors were satisfied there was a statement of purpose that met the requirements of schedule 1 and regulation 3 of the Regulations. It accurately described the services and facilities, the management structure, staffing levels and the way in which care was to be provided to residents.

Judgment:
Compliant

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

Theme:
Governance, Leadership and Management

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

Findings:
Inspectors found there were appropriate systems in place to manage the centre however, the governance arrangements in the absence of the person in charge and monitoring systems in place required improvement.

The provider had put systems in place to manage the centre, with clear lines of authority and accountability that demarcated the roles and responsibilities of individuals. However, as outlined in detail in outcome 4 (person in charge), the arrangements to manage the centre in the absence of the person in charge were not adequately robust.

There were systems in place to monitor and review the quality and safety of care provided to residents. Inspectors read a range of audits carried out internally and externally in areas such as health and safety, call bells, restraint, medication management and falls. While audits were regularly carried out, they did not consistently identify areas of improvement and change to be brought about. For example, the audit on restraint had not identified the use of wander tags as a type of restraint or the gaps in the documentation used for assessing the use of restraint (see outcome 7). In addition, while detailed external care plan audits had been carried out, the actions recommended had not been fully implemented by staff in practice to bring about improvement. For example, gaps were identified in care plan documentation, that had also been identified at the last audit but not fully addressed (see outcome 11).

While there was no annual report on the review of the quality and safety of care delivered to residents, the provider and person in charge were aware of the requirement to prepare one and make it available to residents.

Judgment:
Non Compliant - Moderate

Outcome 03: Information for residents
A guide in respect of the centre is available to residents. 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:
Governance, Leadership and Management

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

Findings:
Inspectors were satisfied that a guide to the centre was available to residents and a contract of care was agreed with each resident on their admission to the centre.

There was evidence a written contract of care was agreed with residents on their admission to the centre. A sample of contracts were reviewed and they set out the services to be provided and the fees to be charged. Where services incurred an additional fee, these charges were included in the contract.

The residents guide to the centre was reviewed and met the requirements of the Regulations.

Judgment:
Compliant

Outcome 04: Suitable Person in Charge
The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:
Governance, Leadership and Management

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

Findings:
Inspectors were satisfied that the centre was managed full time by a registered nurse with experience in care of the elderly. However, the arrangements in place to govern the centre in the absence of the person in charge required improvement.

The person in charge was also the person in charge of another designated centre since June 2014. The person in charge spent one day a week in the centre, which had recently increased to two days a week. However, the governance arrangements in place to manage the centre in her absence were not adequately robust, and improvements were required to ensure effective clinical governance in the centre. For example, inspectors found evidence of poor outcomes for residents in relation to restrictive practices (as discussed in outcome 7), care planning (outcome 11), and the response and social interaction between staff and residents at certain times of the day (see outcome 16). These matters were discussed with the person in charge and the provider during and following the inspection, who acknowledged this and assured inspectors improvements would be carried out to address the issues identified.

The person in charge demonstrated her knowledge of the the Regulations and the Standards, and had a very clear understanding of her legal obligations. For example, she was familiar with the records, documentation and information required to be kept in the centre for residents and staff. She was knowledgeable of the notification process and the provision of training for staff. Inspectors found the person in charge managed the centre with authority and accountability, with improvements identified above. There were frequent staff meetings, and inspectors read minutes of these which outlined a range of health care issues discussed.

The person in charge was knowledgeable of the residents and their health and social care needs. It was evident she very familiar with the residents, and was observed stopping to spend time and talk with residents. Inspectors were informed by residents they saw the person in charge as "friend" and someone they could "easily talk to" and go with their concerns.

The person in charge had continued her own professional development, through attendance at seminars and talks.

She was supported in her role by an assistant director of nursing (ADON), who deputised in her absence and by three clinical nurse managers (CNM). A unit manager also provided support in the administration and management of non clinical tasks in the centre.

Judgment:
Non Compliant - Moderate

Outcome 05: Documentation to be kept at a designated centre
The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 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 2013.

Theme:
Governance, Leadership and Management

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

Findings:
Inspectors found that all documents as outlined in Schedules 2,3 and 4 of the Regulations were maintained in a manner to ensure completeness, accuracy and ease of retrieval. However, improvements were required in relation to policies and the directory of residents.

There were policies and procedures in place as required by Schedule 5 of the Regulations. Inspectors found most policies were up-to-date, centre specific, and guided practice. However, the policy on the management of restraint was not comprehensive enough to guide practice. This is detailed under outcome 7. Furthermore, the systems in place to ensure staff understood key operational policies required improvement. For example, some staff were not familiar with the policy on behaviours that challenge and the emergency plan.

There was an electronic directory of residents seen by inspectors. However, not all information required by the Regulations was contained. For example, cause of death, the authority responsible for referral of residents and temporary transfer. Inspectors discussed this with management, who were aware of the issues and who outlined the action being taken to ensure all resident information was captured. In addition, work was underway to address the deficits in the electronic directory.

There was evidence to confirm the centre was adequately insured against loss or damage to residents property, along with insurance against injury to residents.

Judgment:
Substantially Compliant

Outcome 06: 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:
Governance, Leadership and Management

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

While there were appropriate contingency plans in place to manage any such absence, improvements were identified as outlined in outcome 4.

Judgment:
Compliant

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

Theme:
Safe care and support

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

Findings:
Inspectors found systems were in place to protect residents from being harmed or suffering abuse. However, improvements were required in the management of restrictive practices.

There were systems in place to ensure good management of restrictive practices. However, improvements were identified. Inspectors read a policy on restrictive practices and, as outlined in outcome 5, it did not fully guide staff practice. For example, there were no procedures on the use of wandering tags. In addition, the assessment process was not in line with the national policy on restraint "Towards a Restraint Free Environment". Inspectors found a high number of residents with physical restraint in place, with approximately fifty percent of residents using bedrails. Five residents had wander tags and one used a lap belt. While bedrails and lap belts were routinely risk assessed, wandering tags were not comprehensively assessed. For example, there was no evidence of the least restrictive form of restraint being considered or alternatives tried, the risk of entrapment, and the rationale for its use.

Inspectors read a policy on the management of behaviours that challenged that guided practice. However, it was not fully implemented in practice. For example, evidence based assessment tools were not consistently completed for all residents who exhibited behaviours that challenge. This is actioned under outcome 5. Inspectors spoke to staff who could describe residents behaviours that challenged and the interventions they would follow. The person in charge confirmed training in this area would be provided for some staff in 2015.

There was a detailed policy on the protection of vulnerable adults that provided sufficient detail to staff on the steps to follow in the event of an allegation of abuse. Inspectors spoke to the person in charge, ADON and senior nursing staff who were familiar with the policy regarding how they would investigate an allegation of abuse. Records read confirmed all staff had received training in the protection of vulnerable adults, with regular training taking place. Staff spoken to were knowledgeable of the types of abuse and the reporting arrangements in place.

An allegation of abuse had been notified to the Authority prior to the inspection. Inspectors read reports on the investigation and action taken upon the allegation being made had been, and were satisfied that that the procedures on the investigation into allegations of abuse had been implemented.

Inspectors found suitable arrangements were in place to safeguard residents' finances. There was a procedure in place to guide staff that was implemented in practice. Inspectors saw records of residents cash transactions were signed off by two staff.

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.

Judgment:
Non Compliant - Moderate

Outcome 08: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Safe care and support

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

Findings:
Inspectors were satisfied that the provider and person in charge had ensured robust systems in place to protect and promote the health and safety of residents, visitors and staff.

Inspectors reviewed a suite of polices that governed risk management and found they met the requirements of the Regulations. A risk register was read and it contained risk assessments for a range of hazards identified along with control measures to manage them. There were documented reviews of the risks and controls measures outlined in risk risk register by the ADON and the unit manager. Individual risk assessments were also completed for residents. For example, risk assessments were completed for residents who smoked, that considered the dangers involved. Care plans were completed that outlined the control measures in place. Inspectors saw these controls were implemented in practice.

There was a quality, risk and safety committee, and minutes were read of meetings that took place approximately every two months. A range of issues regarding risk management in the centre were discussed. There were arrangements in place to manage adverse events involving residents. Inspectors reviewed incidents records and there was evidence that appropriate action was taken to address each incident and they were investigated in a timely manner.

Inspectors saw residents were encouraged to be actively mobile and were seen being escorted around the centre. Staff were observed following best practice in the movement of residents. There was regular training in the movement and handling of residents. Records were read and confirmed staff had completed up-to-date training.

There was safe floor covering and handrails throughout the centre and a passenger lift accessed the centres two floors.

A comprehensive emergency plan that guided practice was in place, which identified what to do in the event of fire, flood, loss of power or heat and any other possible emergency. This was seen to be displayed in the centres two units and reception area.

Inspectors found measures and policies were in place to control and prevent infection. Staff appeared to follow best practice. There was an infection control committee that

met to review infection control procedures. A hygiene audit had been carried out in January 2015 to assess compliance and practice by staff. There was access to supplies of gloves and disposable aprons and staff were observed using the alcohol hand gels which were available throughout the centre.

Inspectors were satisfied suitable fire precautions were in place. Fire procedures were prominently displayed throughout the centre. Service records showed that the emergency lighting and fire alarm system was serviced regularly and fire equipment was serviced annually. It was noted that the fire panels were in order and fire exits, which had weekly checks, were unobstructed.

Inspectors read training records which confirmed that all staff had attended training within the last year. Regular fire drills were conducted and reports of these read outlined the findings, outcomes and any learning. Staff spoken with were knowledgeable of the procedure to follow in the event of a fire.

Judgment:
Compliant

Outcome 09: Medication Management
Each resident is protected by the designated centre's policies and procedures for medication management.

Theme:
Safe care and support

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

Findings:
Inspectors were satisfied that each resident was protected by policies and procedures for medication management.

There were comprehensive policies relating to the prescribing, storing and administration of medicines for residents. There were policies in place on out of date and the disposal of medication. Inspectors reviewed one residents medication prescription and administration sheets and good practice was observed. The nursing staff spoken with were knowledge of the best practices to follow.

Inspectors saw procedures were in place and observed good practice on the management and storage of medications that required strict controls (MDAs). A register of controlled medications was held, and two nurses checked the balance of the medications at the end of every shift. At the time of inspection no resident was self medicating however, procedures were in place to guide practice if required.

There was regular review of residents medication by a general practitioner (GP). There was a system in place for monitoring safe medication practices. Inspectors read audits

carried out by the pharmacy, and also by an external auditor. There was evidence that where recommendations had been made, they were acted on by the person in charge, and improvements brought about.

Inspectors saw records of medication errors that had occurred in the centre. The person in charge had investigated each, and there was evidence appropriate action was taken. Records read by inspectors confirmed nursing staff completed medication management training.

Judgment:
Compliant

Outcome 10: 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

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

Findings:
Inspectors were satisfied that a record of all incidents was maintained and where required were notified within the specified time frame to the Chief Inspector.

The person in charge was aware of the requirement to notify the Chief Inspector of certain incidents. In addition, a quarterly report outlining other incidents in the centre was made to the Chief Inspector.

Judgment:
Compliant

Outcome 11: Health and Social Care Needs
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. 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.

Theme:
Effective care and support

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

The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
Inspectors found residents received a good standard of nursing care from staff who were familiar with their health care needs. There was good access to GP services and a range of allied health professionals. However, there were improvements required in the documentation of care plans. Additionally, improvements were required to ensure care plans contained the most up-to-date allied health recommendations.

Inspectors reviewed a sample of residents care plans in both of the centres two units during the inspection. There was evidence that residents were regularly assessed for a range of clinical needs and there was evidence of consultation with them. However, improvements were identified in the documentation of care plans. For example, care plans were not completed for all residents identified needs such as the use of wandering tags. In addition, where care plans were developed, they did not consistently guide practice, for example, nutrition and the prevention of falls. In addition, some care plans had not been reviewed at a minimum every four months as required by Regulations. These matters were brought to the attention of the attention of a CNM and the person in charge who assured inspectors that they would be reviewed. There was evidence of consultation with residents on their care plan which had been an issue at the previous inspection and addressed.

In addition, the recommendations of allied health professionals in some residents care plans were not up-to-date. For example, the modified texture guidelines for one resident was not clearly outlined in their care plan, with conflicting guidelines read by inspectors both on their file and in guidance for catering staff at mealtimes. This was brought to the attention of the CNM during the inspection, who was requested to take appropriate action. The person in charge later provided the most up-to-date information and the residents care plan was revised.

Inspectors found good practices in the management of falls and wounds. There was evidence of regular assessments and care plans were put in place to ensure a consistent and standard approach of care, with an area of improvement in relation to falls care plans as outlined above. Staff were familiar with the residents health care needs and interventions to be carried out.

Judgment:
Non Compliant - Moderate

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. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:
Effective care and support

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

Findings:
Inspectors found aspects of the centre did not meet the requirements of the Regulations and National Standards, and the design and layout did not fully promote resident's dignity and independence. A proposed plan to address the structural deficits in the centres had been submitted to the Authority prior to the inspection. During the inspection, the provider met inspectors to discuss the proposed plans, which he said would address the majority of deficits in the premises. However, the plans had yet to be drawn up, and planning permission had not been applied for. The provider advised inspectors that the Authority would be updated on any progress in relation to the plans.

The issues are outlined as follows:

- there were eight four-bedded rooms which will not meet the requirements of the Standards. There were no en-suite bathroom facilities provided in these bedrooms. There were communal bathrooms located in the hall outside the bedrooms. There was sufficient number of bathrooms and showers to meet the needs of the residents. The residents had their own wardrobe and locker by their bed for personal items. However, there was insufficient space around each bed to access residents with a hoist if required. Staff informed inspectors that beds would need to be moved to one side to do so. The bedrooms were pleasantly decorated. These bedrooms were discussed with the provider at the meeting outlined above.

- general storage space was not sufficient as equipment was stored in communal areas and bathrooms.

- the dining room did not accommodate all residents at any one time. However, inspectors found the person in charge had made improvements to ensure all residents could be accommodated. For example, the lunchtime meal was staggered over two sittings. The evening meal took place in the dining room and another sitting was set up in the day room on the ground floor. This is discussed further in outcome 15.

Inspectors found the centre was comfortable, and pleasantly decorated. It felt warm to be in. There were paintings, plants and paintings, some by the residents themselves, and seating throughout. As outlined above, the residents' bedrooms were nicely decorated, and some with their own furniture and personal touches added. A call bell was provided by each bed.

There were a number of two bedded rooms along with the eight four- bedded rooms mentioned above and each were provided with suitable screening between beds. The centre was kept in a clean condition, and was well maintained to a good standard of repair. There were a number of secure, enclosed gardens, directly accessible from the centre.

There was provision of assistive equipment such as hoists. A lift provided access between the two floors. Servicing reports read confirmed they had been recently serviced and were in good working order.

Judgment:
Non Compliant - Major

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

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

Findings:
Inspectors were satisfied that the provider and person in charge ensured a proactive approach to the management of complaints.

There was a detailed complaint's management policy in place that met the requirements of the Regulations. The complaints procedure was displayed at the entrance of the centre, and it outlined the complaints process. An appeals process was in place, that was fair and objective.

Residents who spoke to inspectors said they would have no problem making a complaint if they needed to, and some examples of these were discussed with inspectors. They were able to name the person in charge who was the complaints officer.

A complaints log was maintained and a sample of records were reviewed. There was evidence that each complaint was appropriately responded to, with details of the investigation carried out, the action taken, and whether the satisfaction of the complainant.

Judgment:
Compliant

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

Outstanding requirement(s) from previous inspection(s):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
Inspectors were satisfied that end-of-life policies and procedures were in place. There were system in place to record residents wishes and preferences.

An end-of-life policy reviewed provided guidance to staff. Inspectors were informed that one resident was approaching end-of-life care on the day of inspection. There was a detailed care plan developed, although it was noted that the residents spiritual and emotional wishes were not outlined in their care plan. This was discussed with the CNM on the unit who was overseeing the end-of-life care plan for the resident. The CNM outlined that all the residents or their relatives or representatives were consulted with to discuss the residents preferences, and where possible all wishes were discussed in care plans.

There was evidence of regular review of residents end-of-life wishes, and care plans were developed where required.

There was access to the local palliative care team who provided support and advice when required. There was evidence that staff had completed training in end-of-life care, with additional training from the local hospice for staff in the centre.

There were a number of private areas and meeting rooms available for relatives and friends for privacy if required. As reported in the previous inspection report, a single room was not available, however, the person in charge explained residents approaching end-of-life would always be offered a single room if one was available. An oratory was available if families wished to use it. Staff and residents were informed of any residents passing.

Judgment:
Compliant

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

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

Findings:
Inspectors were satisfied that resident's were provided with meals that were wholesome and in accordance with their assessed needs.

There was a policy which provided guidance on the practice regarding residents nutritional and dietary needs. There were systems in place to ensure residents did not experience poor nutrition with regular assessments of residents using a mini nutritional assessment (MNA) tool. There were care plans were developed (with an area of improvement discussed in outcome 11), along with monthly weights of each resident. Where residents were at risk the person in charge carried out increased monitoring, with more frequent weights, food balance sheets and referral to the GP and dietician. Inspectors read that recommendations were followed up by staff for example, supplements were prescribed by the GP were required.

Inspectors spent time with residents in the dining room at the lunchtime meal. To address the lack of space in the dining room, there were two sittings at the lunchtime meal, and the day room was set up as a dining room for the evening time meal. Staff distributed a menu to each resident each morning that outlined the choice of meal for the day. In addition, the menu was displayed on a each table in the dining room. The tables were pleasantly set and residents were served as they sat. Inspectors observed meals were presented by staff who asked residents what they wanted to eat. 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.

The residents were discreetly and respectfully assisted with their meals where required. Both residents and staff chatted amongst each other in a familiar, meaningful manner. A number of residents expressed their satisfaction with the quality of meals served and choice they had.

Inspectors met the catering manager and chef and found they were knowledgeable of special dietary requirements of residents. Inspectors were shown a list outlining each residents most up-to-date dietary requirements. Inspectors visited the chef in the kitchen which was well stocked. The chef showed inspectors the four week rolling menu,

which he reviewed along with a nutritionist. The chef was also familiar with the types of consistency diets residents were on. To enhance the mealtime experience for these residents the chef used moulds to present these meals in a pleasant and appetising way.

A nutrition committee referred to as the nutrition circle, met once or twice a year, to discuss catering related matters. Inspectors read minutes of the most recent meeting held in February 2015. There were issues discussed such as the dining experience and complaints regarding meals, along with the action to be address them.

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

Judgment:
Compliant

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

Theme:
Person-centred care and support

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

Findings:
Inspectors found residents were consulted with and participated in the organisation of the centre. However, improvements were identified to ensure there was adequate response and social interaction to residents in the evening time.

Inspectors found routine and practices at certain times of the day did not fully maximise residents independence or choice. Generally, staff were observed to interact in a responsive and friendly manner with residents, and ensured they had interesting things to do. However, this was not the case on the first day of inspection when inspectors spent time in one unit after the evening meal. Residents were observed sitting in their bedrooms, or in chairs beside the nurse station. While there was sufficient staff rostered on duty, no staff were observed to spend time and interact with these residents. In addition, inspectors observed a number of residents calling out for assistance. Staff were observed not to respond to these calls or enter these rooms to check on the residents. Inspectors spent time with these residents and spoke to other residents in the rooms. The other residents told inspectors these residents did not bother them but that they did call out a lot. Inspectors also observed that the residents spoken to had very little to do in the evening. Some residents confirmed this or said they would watch television. There

were no residents sitting or being supported to use the sitting room at this time. During this time, there was no evidence of staff taking charge to address the situation. All staff continued carrying out routine tasks such as hygiene care or completing documentation.

There was an activities programme completed each month. This was displayed in each unit, and included activities such as art classes, exercise, and Sonas (a therapeutic sensory programme done to music for residents with a communication impairment). The residents each had a "key to me" developed which was a document that outlined their background, family, interests, hobbies and likes. An activities assessment was also completed to ensure that activities were appropriate to their needs, likes and preferences. There was evidence of outings from the centre, and one resident told inspectors about day trips they took. These included events in the local area and the city centre.

There were systems in place to ensure residents were consulted with about how the centre was planned and run and to facilitate participation in the organisation of the centre. A residents' committee met four times a year. The minutes of the last meeting held in February 2015 were read. The issues discussed included: the management of the centre, the use of call bells, food, outings, religious needs, HIQA, voting rights, and a new advocate replacing the person in charge. There was evidence that the person in charge took appropriate taken to address each comment raised. In addition, a new advocate had been recently appointed to facilitate these meetings. Residents told inspectors they attended these meetings and found them to be beneficial. The minutes of the residents committee meetings, along with advocacy services information were displayed on the residents notice board

Religious and spiritual needs of residents were respected. The centre had a Roman Catholic ethos and person in charge outlined the services available to the residents. Residents of all religious denominations were facilitated. Voting rights were not reviewed at this time.

There were no restrictions on visits except where requested by residents. There were arrangements in place for residents to receive visitors in private and a number of meeting rooms were available.

The residents had access to telephones located on each floor at the nurse station. There were televisions provided, with one supplied to each resident in their bedroom. The newspapers were available each day including weekends.

There were adequate facilities for recreation with a number of sitting areas for residents to choose to sit in, including the sitting room mentioned above.

Judgment:
Non Compliant - Moderate

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

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

Findings:
Inspectors were satisfied that residents had adequate space for their personal belongings and their clothes were suitably laundered and returned to them.

Residents were encouraged to personalise their bedrooms. Many of the bedrooms were decorated with pictures and photographs from residents' own homes. There was adequate storage space for residents clothing and belongings.

Residents personal clothing was laundered in house. Inspectors spoke to residents who confirmed they were satisfied with how their clothes were cared for and returned to them.

Judgment:
Compliant

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

Theme:
Workforce

Outstanding requirement(s) from previous inspection(s):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:

Inspectors were satisfied that the current staffing levels, qualifications and skill mix were appropriate for the assessed needs of residents on the day of inspection.

Inspectors found there were adequate staffing levels and skill mix provided on the days of inspection. At a minimum at any one time there were two nurses on duty, over a 24 hour period. A two week roster was read that accurately outlined the staff on duty.

There was a recruitment policy that met the requirement of the Regulations. Inspectors reviewed four staff files and found recruitment practices were in line with the Regulations.

There was a large number of agency staff employed by the provider, with up to fifty percent of agency staff covering shifts. The person in charge ensured the agency staff rostered were regular staff to ensure continuity of care. There were systems in place to ensure agency staff had up-to-date mandatory training and these staff were required to attend regular fire drills and other training. Inspectors reviewed service level agreement from the agency confirming the staff information held and the mandatory training staff had attended such as elder abuse and fire safety.

Inspectors reviewed a sample of files and found that nursing staff had up-to-date registration with An Bord Altranais agus Cnáimhseachais na hÉireann (Nursing and Midwifery Board of Ireland).

The person in charge informed inspectors that there were a number of volunteers and external service providers working in the centre. Two volunteer files read confirmed there was appropriate An Garda Siochana vetting, and a written agreement of their roles and responsibilities.

There was education and training available to staff in a broad range of areas. All staff had completed up to date training in mandatory areas. Inspectors saw a training records and a programme in place, which included hand hygiene infection control, cardio-pulmonary resuscitation, falls training, and end-of-life, which had been an action at the previous inspection and was completed.

Judgment:
Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	Dalkey Community Unit for Older Persons
Centre ID:	OSV-0000510
Date of inspection:	25/02/2015 and 26/02/2015
Date of response:	31/03/2015

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 02: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The system of monitoring and reviewing the safety and quality of care required review.

Action Required:
Under Regulation 23(d) you are required to: Ensure there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8

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

of the Act and approved by the Minister under section 10 of the Act.

Please state the actions you have taken or are planning to take:
An annual review will be presented at the end of 2015. This review will provide evidence of the audits carried out throughout the year, of the quality and safety of care delivered to residents.

The Registered Provider and PIC will ensure that the robust quality & risk systems which are already in place within the Centre are enhanced to generate more specific lines of communication relative to areas of improvement (as dictated by audits/incidents/risk analysis) to ensure that implementation timeframes and lines of accountability for actions are clearly defined. This matter was discussed at the Integrated Quality & Risk meeting on the 10/03/2015 at which measures to enhance changes in practice were agreed. These include circulation of minutes to all staff and clearly defining actions, responsible persons and implementation timeframes. The necessity to implement and record interim measures to mitigate risk was also re-enforced. These measures will be reviewed further on the 16/06/2016.

The Register Provider has allocated a specific resource to focus on Care Planning. Particular focus will be to draw from the extensive level of audits undertaken and to ensure that recommended measures are recorded and implemented in each residents care plan. The review of Care Plans with the assistance of this resource has commenced with an anticipated completion date of the 31/05/2014 at which time a full Centre-wide audit will be undertaken.

It is proposed to maintain this specific focus for a two-month period initially, following which there will be a detailed analysis and review of care planning to include performance review where standards are not of an appropriate level. The Registered Provider and PIC are committed to ensuring that there is significant improvement in this regard. The Provider Nominee will review the Care Planning Audit output with the PIC on completion by the 30/06/2015

Proposed Timescale: 31/03/2015

Outcome 04: Suitable Person in Charge

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The governance arrangements of the centre in the absence of the person in charge required improvement.

Action Required:
Under Regulation 14(4) you are required to: If the person in charge is in charge of more than one designated centre provide evidence to the chief inspector that the person in charge is engaged in the effective governance, operational management and administration of the designated centres concerned.

Please state the actions you have taken or are planning to take:
The Registered Provider acknowledges that weaknesses in governance arrangements have been identified through this Inspection due to the absence of a full-time PIC at the Centre. The Register Provider is committed to ensuring that this situation is rectified and that a full-time PIC will be in place within this Centre at the earliest possible juncture.

In the interim the Registered Provider will ensure that the existing PIC maintains a substantial presence at Dalkey Community Nursing Unit in order that the deficiencies identified through this Inspection are addressed with immediate effect. This presence will consist of a minimum of a two day presence on site weekly. The Registered Provider will also seek to enhance support to management at Dalkey Community Nursing Unit in the absence of the PIC.

The Provider Nominee has reinforced this position with the management team at Dalkey Community Nursing Unit and will be maintaining a close personal review of the situation to ensure improvements identified within this plan are achieved.

Proposed Timescale: 31/07/2015

Outcome 05: Documentation to be kept at a designated centre

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The system in place to ensure staff had read and understood policies required improvement.

Action Required:
Under Regulation 04(2) you are required to: Make the written policies and procedures referred to in regulation 4(1) available to staff.

Please state the actions you have taken or are planning to take:
All policies within the Unit have been updated towards meeting the Standards. To ensure that all staff have read and understood the policies, the CNM2 will provide "protected" time for staff to discuss the contents of each policy. Each sub-unit will host two policy specific meetings per month where staff can seek clarification and guidance towards the practical interpretation and implementation of procedures outlined in each policy. Staff will then sign that they have read and understood the Policies. Algorithms have been developed for most Policies and can be located at each Nurses station in a flip chart on the wall. (This is also used for agency staff induction). The PIC will ensure that a close overview is maintained on policy application and that practical care provision will inform policy reviews where appropriate and/or practical.

Proposed Timescale: 30/09/2015

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were gaps in the information required to be maintained in the directory of residents.

Action Required:
Under Regulation 19(3) you are required to: Ensure the directory includes the information specified in paragraph (3) of Schedule 3.

Please state the actions you have taken or are planning to take:
The Directory of Residents maintained in the Unit will be expanded through a software upgrade in the coming month(s) to include all information Under Regulation 19(3) paragraph number (3) of Schedule 3. In the interim the information identified in this Inspection as an omission will be maintained manually.

Proposed Timescale: 30/09/2015

Outcome 07: Safeguarding and Safety

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The management of restrictive practices required improvement.

Action Required:
Under Regulation 07(3) you are required to: Ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.

Please state the actions you have taken or are planning to take:
Restraint auditing has been ongoing using comparative data collected to monitor the reduction of the use of bed rails and lap belts; this will now also include the use of wandering tags.

A comprehensive review of the local Restraint Policy will be undertaken which will include the recommendations from the Department of Health – "Towards a Restraint Free Environment in Nursing Homes" This Policy will include the use of a multi-disciplinary risk audit tool and risk assessment tool. This risk evaluation tool is incorporated within the HSE's Risk Assessment process as defined within the HSE's Quality and Risk Policy which was reviewed in July 2014.

The risk assessment tool utilises the prescribed risk evaluation matrix while taking into account the residents MMSE score, the residents Barthel assessment performance and

the FRAT (Falls assessment) data. Cognisance is also taken of the residents expressed wishes and of observations recorded from sources of referral and/or information gleaned from family members and others. This assessment process which has been utilised for the management of restrictive practices will now be extended to incorporate the use of wandering tags within the Centre.

The MDT assessment above will inform where care delivery changes are required in order to seek to reduce the use of restraint, to consider and propose and records alternatives to restraint and to ensure that if restraint is to be utilised, that the restraint policy is fully adhered to.

The PIC will ensure that the policy and associated operation protocols governing the use of restrictive practices is reviewed by the 30/04/2014 and that this review incorporates the recording of "consent" or "non-consent" in its application to all residents where restrictive practices are deemed clinically appropriate.

Proposed Timescale: 30/04/2015 with review 30/06/2015

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:
Care plans were not developed for all residents identified needs for example, the use of wander tags.

Action Required:
Under Regulation 05(1) you are required to: Arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2).

Please state the actions you have taken or are planning to take:
As advised under Outcome 2 above, the Registered Provider will provide a specific resource to audit and review care planning practices with the Centre. This review will focus on all aspects of the care planning process including the requirement for systematic reviews in line with the Regulations.

The PIC will ensure that the use of wandering targets will be specifically noted within the local restraint policy. Nursing care plans which reflect the need for the use of restraints will reflect the Multi-Disciplinary Team assessment and recommendations arising.

Proposed Timescale: 30/04/2015

Theme:
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement

in the following respect:
Care plans did not consistently guide practice for example, nutrition and falls.

Some care plans contained conflicting information which may pose a risk to residents.

Action Required:
Under Regulation 05(3) you are required to: Prepare a care plan, based on the assessment referred to in Regulation 5(2), for a resident no later than 48 hours after that resident's admission to the designated centre.

Please state the actions you have taken or are planning to take:
The Care Planning process will be reviewed and an external HSE support will assist the Person in Charge to ensure that all Care Plans consistently guide practice. This will build on the work already completed by external consultants in 2014.

The PIC and Registered Provider are particularly disappointed that deficiencies have arisen again in this respect and will be requesting the HSE support person to focus on individual performance where audit and analysis demonstrate that this is below standard. The Registered Provider and PIC have re-enforced this position within the Care Centre.

Proposed Timescale: 31/05/2015

Theme:
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Care plans were not consistently reviewed every four months as required by Regulations.

Action Required:
Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.

Please state the actions you have taken or are planning to take:
The Person in Charge will ensure that the Care Plans are reviewed at intervals not exceeding 4 months. The Person in Charge will support the Clinical Nurse Managers to ensure that this requirement is achieved.

Proposed Timescale: 31/05/2015

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:
The eight four bedded bedrooms do not allow for sufficient space for maneuvering assistive equipment such as hoists.

There was insufficient storage space with assistive equipment stored in communal bathrooms and common areas.

Action Required:
Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

Please state the actions you have taken or are planning to take:
The Registered Provider presented the Authority with a detailed programme of works (including design detail) towards improving the internal infrastructure of the Centre which if implemented, would significantly enhance the resident's dignity and privacy.

This plan proposes to reduce to 2, the number of 4 bedded rooms within the Centre and in the case of these, only short-term (respite) patients will be accommodated. These rooms will have dedicated bathroom and toilet facilities in close proximity. The remainder of the rooms would be as follows, 10 x single rooms (en-suite), and 14 x 2 person rooms with dedicated washing and toilet facilities.

The project plan as submitted to the Authority also incorporates the installation of ceiling hoists and the provision of extra storage space as well as a general upgrade of the Centre. The project plan proposed to commence the above works in March 2016 (subject to the appropriate planning permission) and following engagement with the appropriate stakeholders within and outside of the Centre.

The proposed timeframe for completion of said works would be 6 – 8 months thereby anticipating a completion date by the end of 2016.

Proposed Timescale: 31/12/2016

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:
There were limited opportunities for social interaction and occupation for residents in

the evening time.

Action Required:
Under Regulation 09(2)(a) you are required to: Provide for residents facilities for occupation and recreation.

Please state the actions you have taken or are planning to take:
The PIC will ensure that a dedicated resource is deployed within the centre to focus on the provision of social activities in the evening time (after evening meal) where residents express a wish to engage in social activities. The PIC has already commenced a process of capturing the requirements in this regard.

A practice has been in place whereby those residents who are prone to persistently "calling out for assistance" were moved to be accommodated in line of sight with the relevant nursing station to ensure that staff and management could observe such residents on a continuous basis. In light of the observations by the Inspector, the PIC has advised the Clinical Nurse Managers to note this observance formally and also to direct the above resource to the assistance of such residents for both their comfort and reassurance and indeed for the comfort of all other residents in the vicinity. The PIC is committed to ensuring the facilitation of evening activities.

Proposed Timescale: 30/03/2015