

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Riada House Community Nursing Unit
Centre ID:	OSV-0000529
Centre address:	Arden Road, Tullamore, Offaly.
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Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Jude O'Neill
Lead inspector:	Catherine Rose Connolly Gargan
Support inspector(s):	Leanne Crowe
Type of inspection	Unannounced
Number of residents on the date of inspection:	29
Number of vacancies on the date of inspection:	6

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.

Please note the definition of the following term used in reports: responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

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 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 monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
10 August 2017 09:20	10 August 2017 19:15
11 August 2017 09:10	11 August 2017 14:10

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

Outcome	Our Judgment
Outcome 02: Governance and Management	Non Compliant - Moderate
Outcome 05: Documentation to be kept at a designated centre	Compliant
Outcome 07: Safeguarding and Safety	Compliant
Outcome 08: Health and Safety and Risk Management	Substantially Compliant
Outcome 10: Notification of Incidents	Compliant
Outcome 11: Health and Social Care Needs	Non Compliant - Major
Outcome 12: Safe and Suitable Premises	Non Compliant - Major
Outcome 13: Complaints procedures	Non Compliant - Moderate
Outcome 14: End of Life Care	Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Non Compliant - Major
Outcome 18: Suitable Staffing	Compliant

Summary of findings from this inspection

This monitoring inspection was unannounced and took place to monitor ongoing compliance with the regulations. The inspectors followed up on progress with completion of the action plan from the last inspection of the centre in March 2016 and found that nine of the 16 actions required were completed. The remaining seven actions were not completed within the timescale proposed by the provider and remain outstanding. These actions have been restated in the action plan from this inspection. Inspectors also reviewed unsolicited information received since the last inspection in relation to access to respite care for residents in the community. Inspectors found that access to respite care in the centre was suspended for the period of the building refurbishment works and alternative respite accommodation had been arranged for residents to ensure they could continue to avail of this service in an alternative centre.

Residents were protected and safeguarded from abuse. Residents spoken with by

inspectors spoke positively about the care they received and the staff caring for them. All interactions by staff with residents were observed by inspectors to be supportive, respectful and kind.

As found on the last inspection in March 2016, governance arrangements in the centre required improvement. Inspectors found that the systems in place to monitor the quality and safety of clinical care and the quality of life for residents were not robust.

Inspectors found that the standard of décor was poor and the challenges of confined space in a single bedroom, and the layout and limited space in twin and multi-occupancy rooms did not support the privacy and dignity of residents. Premises refurbishment work was underway on the days of this inspection. While a bedroom with four beds was reduced to three beds since the last inspection, the layout of a number of residents' bedrooms did not ensure their privacy and dignity needs were met. Some parts of the premises occupied by residents were in disrepair. There was insufficient storage available for residents' equipment.

Overall staff in the centre worked to provide appropriate medical and nursing services to residents. However the lack of timely access to allied healthcare services impacted significantly on the residents health, social care and quality of life. Improvements were also required with documenting residents' assessed care needs and the interventions necessary to address some identified healthcare needs.

There was sufficient staff numbers and skill mix to meet the needs of residents on the day of inspection, however the staff roles and responsibilities required review in order to ensure that all residents social needs were consistently met.

Inspectors found that six outcomes were compliant or substantially compliant. Improvements were required in relation to the management of complaints and three outcomes merited a judgment of major non compliance. These related to the premises and its impact on the privacy and dignity of residents and the failure to provide residents with timely access to allied health services.

The Action Plan at the end of this report identifies improvements that must be made to meet the requirements 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 People in Ireland 2016.

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 Standards for Residential Care Settings for Older People in Ireland.

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):

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

Findings:

The management structure in place outlined the lines of authority and accountability. However improvement was required in respect to governance of the centre to ensure positive outcomes for residents in some aspects of the service provided. For example: access to community allied health professional expertise to support residents with optimizing their health and quality of life was not sufficient as discussed in Outcome 11. A regional quarterly forum attended by the person in charge was convened by the provider representative. Minutes of these meetings were made available to inspectors. The person in charge also attended regular meetings convened with the building refurbishment project team. However, opportunity for improvement in staff team meetings and meeting frequencies at all staff levels was identified to ensure effective communication procedures.

A system was in place to monitor and review aspects of the service in terms of quality and safety. Inspectors saw that key areas of performance and risk were monitored through regular auditing by the person in charge and clinical nurse managers. However, the monitoring system in place required improvement to ensure that the auditing process was comprehensive. For example, infection prevention and control audits completed did not identify missing/peeling paint and surface damage to walls as requiring improvement to ensure effective cleaning procedures could be achieved. Action plans were not consistently developed from an analysis of the findings of some audits to address areas identified for improvement. Inspectors also found that some of the action plans developed required review to ensure that remedial actions taken to address deficits were appropriate and when completed were closed off. A process was in place for communicating the findings from audits to the staff team but the procedures for ensuring actions were taken as specified were not clear. An annual review of the quality and safety of care delivered in 2016 was available on this inspection.

Parts of the premises as discussed and actioned in outcome 12 negatively impacted on the quality of life of residents in the centre. A building refurbishment project was underway on the day of this inspection. Arrangements were in place to ensure progress with completion was monitored and that any negative impacts from the works on residents were minimized. However resources provided to meet residents' needs in terms of sufficient access to physiotherapy, occupational therapy and speech and language therapy services required improvement. This finding is actioned in outcome 11.

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):

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

Findings:

A sample of staff files reviewed contained confirmation from the provider that An Garda Síochána vetting was completed for these staff members. As the original vetting disclosures were not available for review by inspectors on the day of inspection, they were forwarded to HIQA following the inspection as requested by inspectors. All other information as required by Schedule 2 of the Regulations was made available for inspection.

Since the last inspection in March 2016, a directory of residents with all details as required by Schedule 3 of the Regulations was maintained and the information found to be absent on the last inspection was available on this inspection. However, this information was not easily accessed and was held in different locations. Actions were immediately taken to ensure ease of accessibility.

Other records to be maintained in respect of each resident and otherwise as described by Schedules 3 and 4 of the Regulations were in place and were stored securely.

All operational policies as required by Schedule 5 of the Regulations were available and up to date. These policies were accessible to staff to inform and guide their practice.

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 that there were measures in place to protect residents from being harmed or suffering abuse. While systems were in place to support residents with responsive behaviours, improvement was required with regard to behavioural support plans to ensure staff were guided by appropriate de-escalation techniques.

There were systems in place to safeguard residents. There was a policy and procedure in place to inform prevention, detection and response to abuse and the policy had been demonstrated in practice. Records indicated that all staff had received up-to-date training in the prevention, detection and response to abuse. Staff who spoke with inspectors were knowledgeable regarding their training and could describe what they would do in the event of an incident, allegation, suspicion or disclosure of abuse. Residents told inspectors that they felt safe in the centre and spoke highly of the staff caring for them. All interactions between staff and residents observed by inspectors on the days of this inspection were supportive, respectful and kind.

There was a policy and procedure in place to guide staff with managing responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). Due to their complex medical conditions, some residents experienced responsive behaviours. Inspectors saw that assessments of the behaviours had been completed for these residents. Staff were knowledgeable regarding the triggers to each resident's behaviours and the effective de-escalation techniques they would use and there were no responsive behaviours observed by inspectors on the days of inspection. However, residents' behaviour support care needs were not clearly documented in a care plan that referenced the triggers to the behaviour and the effective de-escalation strategies to ensure a consistent approach was taken by the staff team. This finding is actioned in Outcome 11.

The person in charge promoted a restraint-free environment in the centre. While bedrails were in use for a number of residents, their need was assessed and alternatives were available and tried. Risk assessments were completed for each resident using

bedrails and care plans were developed to inform their care with bedrails in place. There was evidence that safety checks were consistently completed when bed rails were in use. The inspector noted that additional equipment such as half-length bed rails, low-low beds and crash mats were used where possible.

The centre had a system in place for the management of residents' finances. Residents' money was held securely. Records were maintained for all transactions, and were signed by two staff members and the resident where possible. Inspectors checked a sample of balances and these were found to correspond with the recorded transactions.

Judgment:
Compliant

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

Findings:
The findings of this inspection evidenced that improvements has been made since the last inspection in March 2016 to ensure the health and safety of residents, staff and others was promoted and protected. A risk management policy and procedures was available and included the measures and actions in place to control the specified risks outlined by Regulation 26 to protect vulnerable residents. A register of hazards identified inside and outside the centre was maintained. It referenced identification and assessment of risks with controls stated and implemented to manage and prevent adverse incidents to residents, visitors and staff. Inspectors found that a proactive approach was evident regarding management of risk associated with work underway to refurbish the centre premises. Risk assessments were completed with controls in place to mitigate risk of injury and any potential negative impact on residents from noise or dust. With the exception of a risk not identified for trip or injury due to equipment stored in alcoves off circulating corridors used by residents, all other risks were identified. While controls were in place for all other risks identified, this reference documentation required review to ensure the controls stated effectively mitigated the risks identified. Hazardous areas such as the sluice were secured to prevent access by unauthorized persons.

Residents were protected against the risk of fire in the centre. All residents had evacuation risk assessments completed and documented that referenced their evacuation needs in terms of staffing and equipment. Fire safety management checking procedures were in place and the confirmation of checking records was consistently

completed. All fire exits were clearly indicated and were free of any obstruction. Equipment including fire extinguishers was available at various points throughout the centre. Fire evacuation drills were completed and reflected testing of day and night-time staffing resources and conditions to ensure residents could be safely evacuated in an emergency. Staff training records referenced that all staff had completed fire safety training and that they had participated in a fire evacuation drill in 2016. Inspectors were advised that fire safety training and evacuation drills were scheduled for all staff for 2017. Staff spoken with by inspectors were aware of the emergency procedures in the event of a fire in the centre.

There was a proactive approach to falls prevention in the centre. There was a low incidence of falls by residents in the centre. Each resident's risk of falls was assessed and reassessed following an incident or change in their mobility with implementation of falls prevention measures as appropriate. Inspectors observed that residents assessed as being at risk of falling were well supervised by staff. Each resident had their moving and handling needs assessed and all procedures observed by inspectors reflected evidence based practice and were safely completed by staff. All staff had completed mandatory training in safe moving and handling procedures.

There was an infection prevention and control policy to inform practice. Staff were observed to carry out hand hygiene procedures as appropriate and had access to personal protective equipment as necessary. A senior member of staff was the designated link nurse in infection prevention and control for the centre and ensured practices were monitored and staff were kept informed of updates in evidence based procedures. Hygiene audits were completed as part of the system in place for monitoring the service's quality and safety. The centre was visibly clean. A number of areas of disrepair in the fabric of the internal centre premises had been addressed since the last inspection. However inspectors found on this inspection that an area of the plaster surface on a wall in a single bedroom was missing, paintwork was peeling or missing on some wall surfaces and the surfaces on some door-frames were scored and damaged by equipment used to meet residents' needs. These findings did not ensure that effective cleaning procedures could be completed in the affected areas.

Judgment:
Substantially 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:
A record of all accidents and incidents that occurred in the centre was maintained. All notifications were forwarded to the Health Information and Quality Authority (HIQA) as

required by the legislation with the exception of an incident of staff misconduct in February 2017. This incident was appropriately addressed and retrospective notification was forwarded to HIQA in the days immediately following the inspection.

All quarterly notification requirements to HIQA were met.

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):

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

Findings:

There were 29 residents residing in the centre on the day of this inspection. Many residents had complex care needs. The majority of residents had assessed maximum and high dependency needs including one resident who required one-to-one supervision from 10:00hrs to 22:00hrs each day.

Residents had access to general practitioners and special medical expertise such as psychiatry of older age and palliative care services. Residents with unintentional weight loss or gain had good access to a dietician. Provision of a permanent chiropody service for residents in the centre was nearing completion. However inspectors found that residents with complex healthcare needs did not have timely access to speech and language therapy (SALT), occupation therapy and physiotherapy services and this impacted on their health and quality of life. Staff told the inspectors that residents did not have timely access to these services. The inspectors reviewed residents case files and found that some residents with swallowing problems and with communication difficulties referred for initial and follow-up assessments by speech and language therapy services were waiting for prolonged periods. From the sample of files reviewed inspectors found that residents had been referred and the waiting time was unacceptable. One resident with swallowing and significant speech difficulties was still waiting for a SALT assessment for over four months even though staff had followed up with the speech language department on a number of occasions. Inspectors also found that some residents referred for seating assessments by the occupational therapy services were waiting for prolonged periods. One resident told inspectors that they could

not pursue activities in the community and was unable to attend physiotherapy appointments because they did not have a suitable chair. Their records showed that the referral for a seating assessment was made two months previously. The physiotherapy service provided was inadequate and impacted on the mobility and rehabilitation of residents. Inspectors observed that staff were working to support a resident with regaining their mobility. While this resident was reviewed on two occasions by the physiotherapy service since March 2017, their last review was in July 2017. Staff were unaware when a follow-up review by the physiotherapy service would occur and did not have a programme available to them to advise them on supporting this resident with improving their mobilization.

Gentle chair-based exercises were facilitated in the sitting room by the centre's activity coordinator as part of residents' social programme. In the absence of a coordinated physiotherapy programme, inspectors observed that staff in the centre made efforts to encourage and support residents recovering post fall or following medical events to regain their mobility. Inspectors also found that the recommendations from consultations carried out for residents by speech and language, physiotherapy and occupational therapy professionals were not documented by them in residents' records in the centre or included as part of their information on admission from the hospital. These findings did not ensure residents' on-going health and quality of life was optimized or that their needs were sufficiently communicated to all members of the care team.

Each resident's needs were determined by a comprehensive assessment of their health and wellbeing. A number of accredited assessment tools were used by staff to assess each resident's risk of falling, developing pressure ulcers, mobility and nutrition needs, among others. The arrangements to meet each resident's assessed needs were set out in a care plan which informed the interventions staff should carry out to meet their assessed care needs. As found on previous inspections since December 2014, improvements were required on this inspection in assessment of residents' needs and care planning. Although residents' needs were met in practice, some residents' needs were not informed by a corresponding care plan and some care plans in place did not comprehensively inform the actions that care staff should carry out to address identified needs. For example, one resident with significant speech problems and one resident with visual impairment in both eyes did not have a care plan in place to inform the interventions staff should carry out to meet their communication needs. The needs of residents with responsive behaviours were met by staff in practice. However their behaviour support care needs were not clearly documented in a care plan that referenced the triggers to the behaviour and the effective de-escalation strategies to ensure a consistent approach was taken by the staff team. Since the last inspection in March 2016, improvements were completed to ensure residents or their relatives as appropriate were involved in care plan development and consulted with regarding reviews or changes to their care plans on a four monthly basis or more often if a resident's needs changed.

Residents were appropriately supervised by staff and there was a low incidence of falls by residents resulting in injury. Risk of falls and mobility assessments were completed for each resident on admission and regularly thereafter. Measures such as sensor alert equipment, low level beds, foam floor mats and hip protection equipment were

implemented to mitigate residents' risk of fall or serious injury in each case.

Procedures were in place to prevent pressure related skin injury to residents. Their level of risk was assessed on admission and regularly thereafter. Equipment such as pressure relieving mattresses and cushions, in addition to care procedures, including repositioning schedules were used as prevention strategies. Arrangements were in place to ensure residents with wounds were assessed by staff using an appropriate measurement system which assessed size, type, and exudate and specified a treatment plan to inform care procedures. Tissue viability and dietician specialists were available as necessary to support staff with management of residents' wounds that were slow to heal or deteriorating. This care was demonstrated in practice for one resident with a pressure ulcer that developed in the centre.

Overall staff in the centre worked to provide appropriate medical and nursing services to residents. However the lack of timely access to allied healthcare services impacted significantly on the residents health, social care and quality of life and this merited a judgment of major non compliance.

Judgment:
Non Compliant - Major

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:

Following the last inspection, the provider advised HIQA that refurbishment work to the premises would be completed by 30 April 2017. However, inspectors found on this inspection that while refurbishment work had commenced to improve the physical environment for residents, further work was required. The premises refurbishment work was being carried out in three phases to minimize any negative impact on residents. On the days of the inspection, construction work on phases one and two was in progress to refurbish residents' existing bedroom accommodation, build a new palliative care suite and new utility facilities. Inspectors observed that some work had been completed to improve communal toilet/shower facilities for residents in San Pio unit. The occupancy levels in four bed multiple occupancy bedrooms had been reduced to three beds.

A number of communal areas were available for residents, including a large sitting/dining room, a smaller sitting room, an oratory and a sensory room. An accessible, landscaped internal courtyard provided outdoor seating, some shaded areas and a number of raised flower beds for residents. Inspectors observed that residents could freely access the courtyard throughout the day if they wished. Good efforts had been made by staff to support residents with personalizing their bedrooms by displaying their photographs, possessions and ornaments.

However, as found on the last inspection in March 2016, the physical environment in some parts of the centre did not meet its stated purpose. The layout and floor space available in some residents' bedrooms did not meet their needs. Missing/peeling paint on a number of walls and an area of missing surface plaster on a wall adjacent to a resident's bed in one bedroom had not been repaired. As discussed in Outcome 16, residents' privacy and dignity needs were not met due to the layout and insufficient floor space available in some twin bedrooms and one single bedroom.

Inspectors found that there was insufficient storage for residents' equipment in the centre. Inspectors observed inappropriate storage in a bedroom accommodating two residents. Inspectors found that a trolley with clean linen for the centre and a laundry skip for segregation of used linen were stored at the end of one resident's bed. Two items of assistive seating equipment was stored at the end of the other bed. Inspectors were told that while one of these assistive chairs belonged to a resident that was accommodated in this bedroom, the other chair belonged to a resident who resided in a room that couldn't accommodate large equipment. A laundry skip for segregation of used linen was also stored in the ensuite toilet/shower off this bedroom. Staff informed inspectors that these items were not stored in this bedroom at all times. Cleaning equipment, hoists and chairs were stored in alcove areas off some corridors. Inspectors were told that cleaning equipment was also not usually stored in these areas but was done so before and during cleaning as the designated cleaning equipment storage area was in another part of the building due to the refurbishment works.

While screening was in place in multi-occupancy rooms to ensure privacy for residents, optimal function of ceiling hoists was hindered in some residents' bedrooms due to bed screen rails. This limited their effectiveness in supporting residents' moving and handling needs. Handrails were in place in circulation areas to support the movement of residents. A functioning call bell system was in place for residents throughout the centre.

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):

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

Findings:

There was a policy and procedure in place for the management of complaints, however this was not being implemented in practice. Inspectors found that an action from the last inspection in March 2016 requiring improvement in recording of complaints had not been satisfactorily completed on this inspection. A complaints log recording all complaints received was maintained in the centre and was reviewed by inspectors. This record of the complaints received did not consistently contain sufficient details of the complaint investigation or whether the complainant was satisfied with the outcome of the investigation. There was an appeals process in place for complainants, should they choose to use it.

A summary of the complaints process was displayed in the centre, but inspectors found that this did not align with the complaints policy that had been developed for use in the centre. For example, the documents identified two different people as the person nominated to deal with complaints. The person deputising for the person in charge told inspectors that the complaints summary correctly outlined the process, however, complaint records did not indicate that this was the case. Inspectors were told that all Schedule 5 policies, including the complaints policy, were currently under review.

Judgment:

Non Compliant - Moderate

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:

There was a policy available to staff to inform residents' end-of-life care. The inspector was informed by the deputy person in charge that there were no residents in receipt of end-of-life care. Palliative care services were available and attended residents in the centre as necessary. They were supporting care of one resident who experienced pain during wound dressing procedures. Staff training records confirmed that some staff had attended training on end-of-life care.

An end-of-life checklist and care pathway was available to ensure the needs of residents were met. The wishes of residents or relatives on their behalf as appropriate were documented regarding advance directives. This documentation was co-signed by their general practitioner and a member of the nursing team. Decisions regarding advance directives were regularly reviewed to reflect changes in residents' wishes or needs. Arrangements were in place to meet the end-of-life spiritual, physical and psychological wishes and needs of residents as necessary.

The centre provided accommodation and refreshments for relatives of residents at the end stage of their lives to facilitate residents to have their families with them at this time. Single room accommodation was available for residents receiving end-of-life care. While the number of single bedrooms currently available will be reduced with completion of the premises refurbishment work, the project plans provide for a palliative care suite to address the end-of-life privacy and comfort needs of residents accommodated in twin bedrooms. Members of the local clergy from various faiths attended residents as requested to provide pastoral and spiritual support at the end stage of their lives. A small oratory was available to residents in the centre. Arrangements were in place for transmission of the funeral services of deceased residents via webcam into the centre.

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 that the social needs of some residents were not met in the centre. The arrangements in place to cover planned leave by the activity co-ordinator were not adequate. Staff assigned to covering the activity co-ordinator's planned leave were also on planned leave at the time of the inspection. Staff told inspectors that care staff had been asked to carry out activities during this period but designated time had not been allocated to do so and therefore the facilitation of activities were dependent on staff first completing other care tasks. On the day of the inspection, notice boards throughout the centre displayed the activity schedule for Friday 04 August 2017(six days ago). An activity programme for the day of the inspection was not available, and while inspectors did observe staff carrying out some activities throughout the day, these were not

sufficient to adequately engage residents in a meaningful way.

Activity needs assessments were completed for each resident and were documented in residents' care plans. Records were maintained to record each resident's participation in activities but did not evaluate each resident's level of engagement in the activities they participated in. Therefore it could not be determined whether each resident was supported to participate in activities that met their capabilities and interests. For example a record was used to document that residents participated in particular activities from a list provided but this record did not detail the level of each residents' engagement.

The inspectors saw where a number of events had been held in the centre this year, including two summer fetes which relatives and visitors had been invited to attend. While an outing had taken place in 2016 with a number of residents, no outings had been facilitated in 2017 to date. Staff told inspectors that the centre no longer had access to appropriate transport to facilitate any further outings for residents.

While residents were consulted with and participated in the organisation of the centre, improvement was required to ensure that this was done on a frequent basis. Inspectors were informed that residents' meetings were held on a monthly or six-weekly basis, but minutes from meetings made available to inspectors indicated that meetings were held on 6 June 2017, 9 March 2017, 11 October 2016 and September 2014. Residents meeting minutes reviewed by inspectors did not record reference to any discussion or information given to residents at this forum about the premises refurbishment project underway. Residents spoken with by inspectors were aware that building works were in progress but did not know what work was being done.

Residents were facilitated to exercise their civil, political and religious rights. The person deputising for the person in charge stated that residents were supported to vote, either in the centre or in their local polling centre. Residents were supported to observe or abstain from religious practice in accordance with their wishes. A small oratory was available in the centre and residents were visited by clergy from their respective faith on a weekly basis.

There were arrangements in place for residents to meet their visitors in private if they wished. The person deputising for the person in charge told inspectors that in order to support residents, a protected mealtime policy was in place and visitors could assist residents with eating outside the dining room if they wished. Visiting was not restricted at any other time and a record of visitors to the designated centre was available and maintained at the entrance to the centre.

Communication devices and aids were used by some residents to support their communication needs such as hearing aids and spectacles. A communication policy and communication care plans were in place for most residents and were reviewed by inspectors. However, two residents with significant speech and visual difficulties did not have a care plan to meet their communication needs. This finding is actioned in Outcome 11. Broadband internet was available in the building and residents were supported to access a telephone in private if they wished. Advocacy services were available to residents and the service was visiting a resident on the day of the

inspection.

Inspectors found that the standard of décor was poor and the challenges of confined space in a single bedroom, and the layout and limited space in twin and multi-occupancy rooms did not support the privacy and dignity of residents. While bed screens were available in multiple occupancy bedrooms to provide privacy for residents, the layout of one twin bedroom did not respect residents' personal space as one resident could only access the toilet/shower by passing through the personal bed space of the other resident. The layout and limited floor space available in a second twin bedroom did not accommodate a chair for each resident. There was insufficient floor space available in one single bedroom to meet the needs of a resident who used an assistive chair when out of bed. Therefore this resident had to stay in bed while in their bedroom and in the sitting room while resting in a chair. One resident in a twin bedroom could not sit beside their bed as the space between their bed and the wall was too limited to accommodate a chair. Since the last inspection in March 2016, a four bed multiple occupancy bedroom had been reduced to three beds. Inspectors were told that completion of the building refurbishment work will ensure that no bedroom in the centre would be accommodated by more than two residents. However, the interim reduction in the bedroom occupancy did not significantly improve individual space and layout for residents or control noise or odours. Inspectors also found that the location of a television in one twin bedroom did not ensure that each resident could view the television provided at the same time.

Judgment:

Non Compliant - Major

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:

While there were appropriate staff numbers and skill-mix on duty to meet the assessed clinical needs of residents, the social needs of residents were not met. There were not sufficient arrangements in place to cover planned leave by the activity co-ordinator resulting in some residents' activation needs not being met. This finding is discussed in further detail and actioned under Outcome 16.

On the day of the inspection, the person deputising for the person in charge, a clinical nurse manager, two staff nurses and eight care staff were working in the centre from 08.00hrs. Staffing reduced in the evening to two nurses and three care staff from 17.00 to 08:00hrs. A resident was receiving one-to-one care from 10:00hrs to 22:00hrs each day. An actual and planned staffing roster was in place and reflected the actual number of staff on duty on the days of the inspection. While inspectors were assured that the staffing levels and skill-mix provided met residents' clinical needs, a review of staff roles was required to ensure that the social needs of all residents were consistently met.

While staff from an external provider were still being utilised to address staff shortages, inspectors found that this arrangement had been reviewed to ensure that continuity of care and staffing levels and skill-mix was not compromised. The provider had also recently recruited three staff. Inspectors reviewed records confirming that all nursing staff were registered with An Bord Altranais agus Cnáimhseachais na hÉireann.

A sample of staff files were reviewed by inspectors and these were found to contain the majority of information required by the regulations. While An Garda Síochána vetting disclosures were not being held in the centre, these were forwarded to HIQA following the inspection. The deputising person in charge told inspectors that all staff in the centre had An Garda Síochána vetting disclosures in place.

Training records were provided to inspectors and indicated that all staff had completed training in fire safety, safe moving and handling procedures and the prevention, detection and response to abuse. Some staff had also completed training in basic life support, hand hygiene, consent and capacity and dementia care among other training to maintain their professional development and skills. Professional development for staff facilitated since the previous inspection included training in continence care, end of life care, medication management and urinary catheterisation. Staff spoken with by inspectors were knowledgeable regarding the training that they had completed.

Staff appraisals were completed by the person in charge on an annual basis, and evidence of the appraisals completed to date this year were provided to and reviewed by inspectors. Actions following these appraisals had been recorded where required.

One volunteer was operating in the centre at the time of the inspection. Evidence of An Garda Síochána vetting was seen by inspectors, and their roles and responsibilities were set out in writing.

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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Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	Riada House Community Nursing Unit
Centre ID:	OSV-0000529
Date of inspection:	10/08/2017
Date of response:	20/09/2017

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 quality and safety monitoring system in place required improvement to ensure that the auditing process was comprehensive.

1. Action Required:

Under Regulation 23(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

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