**Health Information and Quality Authority Regulation Directorate**

**Compliance Monitoring Inspection report**

**Designated Centres under Health Act 2007, as amended**

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Seanchara Community Unit</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000515</td>
</tr>
<tr>
<td>Centre address:</td>
<td>St. Canice's Road, Glasnevin, Dublin 11.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>01 704 4401</td>
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<tr>
<td>Email address:</td>
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<tr>
<td>Type of centre:</td>
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<tr>
<td>Registered provider:</td>
<td>Health Service Executive</td>
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<tr>
<td>Lead inspector:</td>
<td>Sheila McKevitt</td>
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<tr>
<td>Support inspector(s):</td>
<td>Leone Ewings</td>
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<tr>
<td>Type of inspection</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>39</td>
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<tr>
<td>Number of vacancies on the date of inspection:</td>
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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 inform a registration renewal decision. This monitoring inspection was announced and took place over 1 day(s).

The inspection took place over the following dates and times
From: 29 January 2018 09:30  
To: 29 January 2018 17:00

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

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<thead>
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<th>Outcome</th>
<th>Our Judgment</th>
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<tbody>
<tr>
<td>Outcome 01: Statement of Purpose</td>
<td>Substantially Compliant</td>
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<td>Outcome 02: Governance and Management</td>
<td>Non Compliant - Moderate</td>
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<tr>
<td>Outcome 05: Documentation to be kept at a designated centre</td>
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<tr>
<td>Outcome 07: Safeguarding and Safety</td>
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<tr>
<td>Outcome 08: Health and Safety and Risk Management</td>
<td>Non Compliant - Moderate</td>
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<tr>
<td>Outcome 09: Medication Management</td>
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<tr>
<td>Outcome 11: Health and Social Care Needs</td>
<td>Compliant</td>
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<tr>
<td>Outcome 12: Safe and Suitable Premises</td>
<td>Non Compliant - Major</td>
</tr>
<tr>
<td>Outcome 13: Complaints procedures</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 16: Residents' Rights, Dignity and Consultation</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 17: Residents' clothing and personal property and possessions</td>
<td>Substantially Compliant</td>
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<tr>
<td>Outcome 18: Suitable Staffing</td>
<td>Substantially Compliant</td>
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Summary of findings from this inspection
This was an announced inspection which took place over one day and was for the purpose of monitoring and informing an application to renew the registration of Seanchara Community Unit. The centre was purpose built in the 1990's and is one of four services which make up Claremont Residential and Community Services. The designated centre provides long and short term care for older persons and the provider had applied for registration renewal for 40 beds. This report sets out the findings of the inspection and areas identified for improvements.

Inspectors found that the health needs of residents were met to a high standard. Residents had access to medical care, to a full range of other allied health services and the nursing care provided was of a high standard. The quality of residents’ lives was enhanced by the provision of a choice of interesting things for them to do during the day with activity and diversional therapies available.
There was a management team in place. Changes to the provider representative and person in charge had taken place since the last registration renewal. Inspectors found that the governance arrangements did not provide enough support to the person in charge. Inspectors noted management issues which had not been identified by the management team.

Residents were consulted about the operation of the centre and there was an active residents’ and relatives meeting. Residents and relatives knew the management team and who to contact should there be any dissatisfaction with service provision. The collective feedback from residents was one of satisfaction with the service and care provided.

The provider representative and person in charge promoted the safety and quality of life of residents. A risk management process was in place for all areas of the centre. Staff had received training and were knowledgeable about the prevention and detection of elder abuse, safeguarding and other relevant areas. Staffing levels were found to be adequate on the day of the inspection.

Areas for improvement include those mentioned above together with the contents of staff files, filing of fire records, referencing of policies, and implementation of plans to address shared bedrooms and provision of an additional shower/bathrooms. Condition 8 on the centres current certificate of registration stated the reconfiguration of the centre must be complete by December 2018. Inspectors were informed that this project had not commenced to date. The areas for improvement are discussed further in the report and are included in the action plan at the end of this 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 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:
A statement of purpose dated November 2017 was submitted to HIQA with the application to renew registration. It reflected the services available to residents. It did not accurately reflect the make-up of the bedrooms currently in use in the centre. Inspectors were informed during this inspection that room two registered as a single room was now being used as a twin room (this will be discussed further in outcome 2). In the past this single bedroom was registered as a twin room, it did contain adequate space to accommodate two residents.

A copy of the statement of purpose was available to residents. Inspector saw a copy on display at the reception.

Judgment:
Substantially 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 the governance of the centre was not strong enough to ensure
There was a clearly defined management structure. It included the provider representative, person in charge and director of nursing. The person in charge (PIC) worked full-time in Seanchara Community Unit. The provider representative, and director of nursing worked full-time between four registered centres.

Inspectors were informed that the provider representative, the person in charge of each of the four registered centres, the director of nursing and finance manager met every six weeks. In between these meetings the person in charge and provider communicated with each other via email and over the telephone. The nursing management team from all four registered centres met with the director of nursing once every quarter. A schedule for meetings for 2018 was seen and minutes of all meetings were available for review. Inspectors found the governance arrangements did not provide enough support to the person in charge. This was reflected by a number of governance issues that had not been addressed in line with the Health Act 2007. These included:

- two incidents of inappropriate behaviours by a resident had not been recorded as an incident and therefore the risk associated with such behaviours escalating had not been identified in the risk register
- one fire drill been carried out in centre in 2017 which was not in line with the centres policy
- there was no evidence that complaints were being overviewed
- not updating and submitting a revised statement of purpose to reflect the change of use of a single bedroom being used as a twin bedroom
- one staff member had changed role. There was no evidence that a competency assessment, an appraisal or the provision of suitable training was provided to the member of staff to support them in their new role. This left both the staff member and residents in a vulnerable place.

Inspectors saw that lots of positive work was being completed to improve areas of clinical practice. Audits were being completed on the use of bedrails, accident and incident and falls, nursing documentation and the management of medications. The results of these audits were clearly analysed, and communicated to staff at staff meetings. Where action plans were included there was evidence that these actions had been addressed or were in the process of being addressed. Non clinical areas of practice such as procedures and practices of fire drills and staff files were not being audited and were found to be in non compliance.

An annual review of the quality and safety of care delivered to residents had been completed for 2017 and was submitted to HIQA prior to this inspection. The review was comprehensive and included feedback from residents on the quality of service being delivered. This feedback was positive and reflected that received in returned HIQA questionnaires.

**Judgment:**
Non Compliant - Moderate

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**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 the majority of records listed in schedules 2, 3 and 4 of the regulations were maintained in a manner to ensure completeness, accuracy and ease of retrieval. Inspectors found the filing and safe keeping of fire records required review.

The centre had all operational polices as per schedule 5 of the regulations. Inspectors noted that some did not reference the "National standards for Residential Care Settings for Older People in Ireland (2016)".

Inspectors reviewed a sample of residents' records. They contained all of the health and medical information as listed in schedule 3.

All other records as per schedule 4 were maintained and readily available. The centre had insurance in place. The residents guide on display contained out of date information, for example the person in charge named on it had left the post.

A sample of four staff files reviewed. Three were found to contain all the requirements as per schedule 2 of the regulations. One file reviewed did not contain two of the required documents. As mentioned in outcome 2, there was no system in place to audit these files.

**Judgment:**
Substantially 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:**

Measures to protect residents being harmed or suffering abuse were in place.

Residents spoken with stated they felt safe in the centre. There was a policy and procedures in place for the prevention, detection and response to abuse. It provided guidance for staff if a member of the management team were involved in an alleged incident. Staff spoken with demonstrated a good clear knowledge of what constituted abuse and those spoken with confirmed they had up-to-date refresher training in place. Inspectors were told all staff had a vetting disclosure in place in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012. Inspectors saw evidence of this in the staff files reviewed.

Residents with displaying behaviours that may challenge had a corresponding behavioural support plan in place. Incidents of behaviours that challenge were being recorded on the resident's antecedents, behaviour and consequences chart, in their progress notes and reported to the resident's. Inspectors were satisfied that the residents' received appropriate care and review post these incidents.

There was a significant reduction in the use of restraint in the centre and this was reflected in the last quarterly return submitted to the Authority. Where bedrails were in use there was a record of alternatives trialled, tested and failed prior to bedrails being used. Residents with bedrails in use also had a care plan in place to reflect their use. The restraint free environment working group set up in 2016 were driving this reduction in the use of restraint.

**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):**

No actions were required from the previous inspection.

**Findings:**

Inspectors found that the health and safety of residents, staff and visitors to the centre was promoted. the fact that only one fire drill had been practiced in the centre in 2017 raised concern with inspectors.

Fire procedures were clearly displayed in the centre and the evacuation routes were clearly marked in all areas. Inspectors observed that there was a sufficient number of fire fighting equipment throughout the centre and it was serviced annually. Inspectors reviewed the records of the fire alarm, emergency lighting which was serviced on a
quarterly basis in 2016 and 2017. Daily visual checks of equipment and fire doors were carried out by staff and recorded. Each resident had a personal evacuation plan in their file.

All staff had been trained in fire safety within the last year. A number of staff spoken with were clear on the procedure to follow when the fire alarm sounded. On review of fire records inspectors noted that only one fire drill had been completed with staff in 2017. No fire drill had been practiced at night time when there would be a maximum of four staff on duty with responsibility for evacuating residents from the centre.

The centre had a risk management policy in place. The policy outlined the procedure for identifying and assessing risks in the centre. It also outlined the measures that can be put in place to mitigate risk. The risk register identified some risks in the centre. The risks contained information on actions and additional actions taken following the initial assessment in order to control or mitigate the risks.

Inspectors reviewed the incidents and accidents in the centre 2017. Accidents were documented and a risk assessment was carried out following accident, such as a resident falling. The physiotherapist reviewed each resident post a fall and all accidents were discussed at the residents' multidisciplinary review. Inspectors noted that two incidents of inappropriate behaviours by a resident towards staff had not been recorded in the accident/incident book and were not managed in-line with the risk management policy which stated that they should be recorded in the accident/incident book. The risk associated with this behaviour escalating had not been highlighted to management team as it had not been entered in the risk register.

There was an infection control policy in place for the centre. Inspectors saw that there were sufficient numbers of hand-wash basins and hand sanitiser gels available throughout the centre. Inspectors were informed that rooms were cleaned daily. The practice of storing dirty laundry in open top laundry bins by the side of each bed in the four bedded shared bedrooms required review.

The centre had an emergency plan in place in case of the occurrence of a fire, a flood, a gas leak, power outage, water loss and other possible scenarios. These plans were detailed and had sourced alternative areas to move residents to if a full evacuation of the centre was required. There was a health and safety statement in place which had been updated in 2018.

Judgment:
Non Compliant - Moderate

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:**
Medication management was found to be safe.

Inspectors saw that there was a medication management policy in place which gave appropriate guidance to staff. Practices observed reflected the policies. Inspectors reviewed the prescription records and medication administration records for a sample of residents and found that this documentation was completed and maintained in accordance with the centre’s policies and professional guidelines for the most part.

Medications that required strict control measures (MDAs) were carefully managed and kept in a secure cabinet in keeping with professional guidelines and the centre’s policy. Nurses kept a register of MDAs. The stock balance was checked and signed by two nurses at the time of administration and at the change of each shift. Inspectors checked the balances and found them to be correct.

Medication errors were recorded and followed up on by the person-in-charge. They were also reviewed by the drugs and therapeutic committee who met every four months. Minutes of these meetings confirmed that all aspects of medication management were discussed in detail.

Medication audits were completed on a six monthly basis by the supplier of medications to the centre. Issues identified were addressed by the management team and discussed at the drugs and therapeutic committee meeting.

**Judgment:**
Compliant

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**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):**
No actions were required from the previous inspection.

**Findings:**
Each resident's wellbeing and welfare was maintained by a high standard of evidence-based nursing care.

Inspectors saw evidence that residents received appropriate medical and allied health care without delay. Residents were seen by their GP on a frequent basis and had their
medications reviewed. They also had access to an optician, dentist, tissue viability nurse and chiropodist. An ear care service and diabetic retinal screening was provided on site. The multidisciplinary team met on a frequent basis to discuss the care provided to each resident.

A sample of residents’ documents were reviewed. Residents had a comprehensive assessment completed on admission and these were reviewed on a four monthly basis. Each need identified on assessment had a care plan in place to reflect this need. These records were been audited on a frequent basis and it was evident that recording practices were continuing to improve.

There was a variety of activities for residents to choose from. These included the provision of weekly art therapy, craft therapy and holistic therapies. There were two alternative therapists on site who provided therapies to residents’ in a calm, relaxing environment. A reflexologist came into the centre to provide residents’ with treatments. Activities specifically meeting the needs of residents’ with dementia were reflected on the schedule on display. Residents’ had access to an enclosed secure garden which contained points of interest for residents and seating. Wifi was now available throughout the centre and residents had access to a computer in the communal area.

**Judgment:**
Compliant

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

**Findings:**
The centre is a purpose-built centre with all accommodation on the ground floor level. The centre was constructed to provide long-term care to 40 older people requiring long-term care. The centre did not meet the requirements of the regulations and the Standards for Residential Care Settings for Older People in Ireland (2016) were not met in full.

As part of the last registration renewal a non-standard condition of registration was applied by the Chief Inspector to ensure the premises were improved within an agreed time frame which was 31 December 2018. Inspectors were informed that this remained the plan. A refurbishment and refit of the existing premises was going to be completed by 31 December 2018. Currently additional funding was being sought as the costs
involved had elevated. Inspectors were informed that if funding was not approved they planned to convert a store room into a bathroom. There were plans available to complete this conversion.

20 of the 40 residents are accommodated in four bedded shared rooms, the remainder in a mix of triple, twin and single bedrooms. One bedroom has an en-suite shower room, and the remaining 39 residents share three bathrooms, two equipped with a bath and shower and one with a shower only. However, the bath in one of these bathrooms was out of order the second bathroom had a functioning assisted bath. The ventilation in both bathrooms was functioning. Sufficient assisted toilets and hand washing facilities were available to meet the needs of the residents on the day of the inspection.

Communal space included two sitting rooms, a sun room with seating and a dining area. Inspectors were informed that some chairs had been sent for re-upholstering. Some bedroom and bathroom facilities were clinical in appearance in décor and fittings. There were privacy locks on all of the toilets, showers and bathrooms visited. Equipment provided allowed for independent living, and was consistent with the assessed needs of each resident. Grab-rails and hand-rails were in place and were appropriate to the dependency of the residents. Safe secure landscaped internal gardens are located on the premises and both areas are fully accessible to residents.

The environment required maintenance throughout, inspectors saw some areas; such as the corridors, bedroom doors and skirting boards which were shabby in appearance requiring repainting.

In the three and four bedded rooms, space around beds was limited. Each resident had an electric bed, chair, wardrobe, locker and bedside table in the space provided for them behind their bed screen. Semi-rigid screening in place restricted movement around the bedside for staff providing care to residents. It also limited the amount of private space available to each resident.

There was a single bedroom protected for resident’ in shared rooms to receive end-of-life care in private. This bedroom was in addition to the 40 registered beds.

**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:**
Complaints made were managed in line with the centres complaints policy. The policy did not state who was responsible for overseeing the complaint process and inspectors saw that nobody was carrying out this role. The complaints process was not being reviewed by anyone.

The complaints policy was outlined in the statement of purpose and the residents guide. The process was accessible to residents.

Inspectors reviewed records of those complaints made, all had been fully investigated and the residents’ level of satisfaction with the outcome of the complaint was recorded. Inspectors noted that the complaints process had not been reviewed/audited by a nominated person to ensure all complaints were appropriately responded to and to ensure records of complaints were maintained as required by the regulations.

The annual review stated that there were three formal complaints. Inspectors were informed that formal meant written. Inspectors noted that a number of verbal complaints on file had not been included in the annual review.

Judgment:
Non Compliant - Moderate

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:
Residents were consulted with and actively participated in the organisation of the centre.

Residents were treated with dignity and respect. Staff appeared to know the residents well, inspectors observed staff interact with residents in a kind, calm, professional yet friendly manner. Residents received personal care in private in multi-occupancy bedrooms and those bathrooms in use could be locked.

There were no restrictions on visitors, relatives informed inspectors that they visited during the day and late evening. There was a private visitor’s room available to mobile residents’. The main dining room and lounge was seen to be used by some visitors. Maximum dependent and immobile residents living in shared rooms could not receive their visitors in private. They were seen receiving visitors by their bed in their shared
Residents had been registered to vote and they were given the choice at election time. A polling officer visited the centre to enable people to vote. Residents confirmed that their religious and civil rights were supported. Residents were able to watch Mass streamed to the television from a local church and it was said in the centre once every week by the local parish priest. The oratory was left open so residents could access independently. A chaplain was also available to residents'.

Residents' meeting were held and minutes were available on the residents notice board. They covered topics such as proposed new changes to the premises, and the plans for trips out. There were contact details available on the notice board about advocacy services, and residents could be supported to access them if they required.

The provider had carried out surveys with residents and family members about the quality of the service provided in 2017. The issues identified were being addressed by the management team; this was reflected in the annual review.

**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:**
There was a policy on residents’ personal property and possessions and this was reflected in practice.

Inspectors observed that residents in shared bedrooms had a limited amount of storage space to store and maintain his/her clothes and other possessions within their private space. Feedback from HIQA questionnaires issued to residents prior to this inspection were overall positive, two residents' commented on the lack of space for personal belongings in shared bedrooms.

**Judgment:**
Substantially Compliant

### Outcome 18: Suitable Staffing

**There are appropriate staff numbers and skill mix to meet the assessed needs**
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.

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<td>Workforce</td>
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<table>
<thead>
<tr>
<th>Outstanding requirement(s) from previous inspection(s):</th>
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<tbody>
<tr>
<td>No actions were required from the previous inspection.</td>
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<tr>
<th>Findings:</th>
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<tr>
<td>There were sufficient numbers of staff with the right skills, qualifications and experience to meet the assessed needs of the residents.</td>
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There was an actual and planned staff rota. Inspectors saw that there was a minimum of one staff nurse on duty at all times and the numbers of staff rostered during the day and night took into account the statement of purpose and size and layout of the building. Residents spoken with confirmed that staffing levels were good and their requested needs to be met.

Residents spoken with told inspectors that staff were kind, patient and they felt well looked after. The feedback received on residents’ questionnaires was extremely positive.

Records reviewed confirmed that all staff had mandatory manual handling, protection of vulnerable residents' training in place and all had attended refresher fire training within the past year. Inspectors found that the practice of moving staff from one role to another without the provision of suitable training required review.

All qualified staff were registered to practice in 2018 with Bord Altranais agus Cnáimhseachais na hÉireann.

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**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:**

Sheila McKeivitt  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority
Health Information and Quality Authority
Regulation Directorate

Provider’s response to inspection report

<table>
<thead>
<tr>
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<th>Seanchara Community Unit</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000515</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>29/01/2018</td>
</tr>
<tr>
<td>Date of response:</td>
<td>21/02/2018</td>
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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 01: Statement of Purpose

Theme:
Governance, Leadership and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The statement of purpose dated November 2017 did not reflect the current make-up of bedrooms in use in the centre.

1. Action Required:
Under Regulation 03(1) you are required to: Prepare a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Welfare of

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Residents in Designated Centres for Older People) Regulations 2013.

Please state the actions you have taken or are planning to take:
The statement of purpose has been updated to reflect the current bed usage in Seanchara and will be sent to HIQA within the specified time frame.

Proposed Timescale: 22/02/2018

Outcome 02: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The management systems in place were not strong enough to ensure the service provided was safe, appropriate, consistent and monitored effectively.
These included:
• two incidents of inappropriate behaviours by a resident had not been recorded as an incident and therefore the risk associated with such behaviours escalating had not been identified in the risk register
• one fire drill been carried out in centre in 2017 which was not in line with the centres policy
• there was no evidence that complaints were being overviewed
• not updating and submitting a revised statement of purpose to reflect the change of use of a single bedroom being used as a twin bedroom
• one staff member had changed role. There was no evidence that a competency assessment, an appraisal or the provision of suitable training was provided to the member of staff to support them in their new role. This left both the staff member and residents in a vulnerable place.

2. 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.

Please state the actions you have taken or are planning to take:
1. Two fire drills will take place yearly. This has been requested to the fire training company which conducts the yearly training. This will include a simulated evacuation for night staff. A Fire drill has taken place on 6th February 2018 which included staff that rotates onto nights. Another fire drill is planned for April 2018 which will involve the night staff only.
2. The Statement of purpose has been updated and submitted on 22nd February 2018.
3. There is now a system in place to ensure that both the informal complaints as well as formal complaints in line with the HSE and local complaints procedure are overseen and reviewed by a senior member of staff not involved in the complaint. This will allow for the tracking of trends and identification of areas of improvement. The local policy will be updated to reflect this change. Complaints, both management and reviews of same
will be a standing item on the bi-monthly senior management meetings to ensure greater governance of same.

4. A Professional Development Plan has now been completed on said member of staff on 20/02/18. Contact had been made with Central Nurse Education and said member is booked to attend the FETAC L5 training in September 2018. Staff member in the interim period is been enrolled in a care skills programme to commence in April 2018. The staff member has received Manual handling, Hand Hygiene, Dementia training and Safeguarding prior to the transfer to his new temporary position. The change of role has been documented along with the Professional Development Plan in the staff members personnel file.

5. The resident continues to have a care plan identifying the potential for behaviours that concern towards staff and actions to be implemented and this remains under regular review including MDT involvement. A risk assessment has been completed on resident and staff informed. All staff have been reminded to report all such incidents as per local policy. CNM2 and ADON will ensure greater governance of incidents by attending daily handovers and auditing of incident forms. Senior management will ensure staff has all relevant support. CNM2 and ADON are visible on the wards on a daily basis for advice, guidance and support. In service training continues re management of behaviours that concern for all staff via our Practise Development personnel.

Proposed Timescale:
1: 6th February 2018
2: 22nd February 2018
3: 20th February 2018
4: 20th February 2018 to 12 March 2019
5: 21 February 2018

Proposed Timescale: 12/03/2019

Outcome 05: Documentation to be kept at a designated centre

Theme:
Governance, Leadership and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Some policies had not been updated to reflect the "National standards for Residential Care Settings for Older People in Ireland (2016)".

3. Action Required:
Under Regulation 04(3) you are required to: Review the policies and procedures referred to in regulation 4(1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.

Please state the actions you have taken or are planning to take:
All policies will be reviewed as per recommended timelines as is the current practise but will include/reference the latest recommendations/standards found in the National Standards for Residential Care Settings for Older People in Ireland (2016) and Regulations (2013). This process will begin immediately, however the policies will be reviewed as per their due date.

**Proposed Timescale:** 20/02/2018  
**Theme:** Governance, Leadership and Management  

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:  
Documents outlined in schedule two were not available in one staff file.

4. **Action Required:**  
Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

Please state the actions you have taken or are planning to take:  
All staff files are currently being reviewed and updated with required documentation as per Schedule Two.

**Proposed Timescale:** 28/02/2018  
**Theme:** Governance, Leadership and Management  

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:  
The resident's guide displayed in the centre did not contain up-to-date information.

5. **Action Required:**  
Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

Please state the actions you have taken or are planning to take:  
The residents guide will be reviewed and updated.

**Proposed Timescale:** 26/03/2018  
**Theme:** Governance, Leadership and Management
The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
All fire records were not kept filed in a manner that was safe or easily retrievable.

6. Action Required:
Under Regulation 21(6) you are required to: Maintain the records specified in paragraph (1) in such manner as to be safe and accessible.

Please state the actions you have taken or are planning to take:
All documentation regarding fire safety/evacuation etc, will be kept together in one file located at the porters desk.

Proposed Timescale: 01/03/2018

Outcome 08: Health and Safety and Risk Management

Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Inappropriate behaviours displayed by a resident had not been recorded in the incident book and therefore had not been identified as a risk in the risk register.

7. Action Required:
Under Regulation 26(1)(b) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the risks identified.

Please state the actions you have taken or are planning to take:
The resident continues to have a care plan identifying the possibility of behaviours that concern towards staff and actions to be implemented and this remains under regular review including MDT involvement. A risk assessment has been completed on resident and staff informed. All staff have been reminded to report all such incidents as per local policy. CNM2 and ADON will ensure greater governance of incidents by attending daily handovers and auditing of incident forms. Senior management will ensure staff have all relevant support. CNM2 and ADON are visible on the wards on a daily basis for advice, guidance and support. In service training continues re management of behaviours that concern for all staff via our Practise Development personnel.

Proposed Timescale: 21/02/2018

Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The practice of storing dirty linen in open top laundry bins in multi-occupancy bedrooms required review.

8. Action Required:
Under Regulation 27 you are required to: Ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.

Please state the actions you have taken or are planning to take:
The practise of storing linen in multi occupancy rooms will be reviewed and where appropriate bins with lids (peddle) will be introduced.

Proposed Timescale: 01/04/2018

Theme: Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Fire drills were only taking place once per year and there was no evidence that one was practiced at night time when there was a significant reduction of staff available to evacuate residents.

9. Action Required:
Under Regulation 28(1)(e) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and residents are aware of the procedure to be followed in the case of fire.

Please state the actions you have taken or are planning to take:
Two fire drills will take place yearly. This has been requested to the fire training company which conducts the yearly training. This will include a simulated evacuation for night staff. A Fire drill has taken place on 06/02/18 which included staff that rotates onto nights. Another fire drill is planned for April 2018 which will involve the night staff only.

Proposed Timescale: 30/04/2018

Outcome 12: Safe and Suitable Premises

Theme: Effective care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Inadequate number of bathrooms in centre for number of residents
One of the two assisted baths was not working
The paint work on corridors was chipped and cracked
Residents’ accommodated in three and four bedded shared rooms had a lack of private space
The plans submitted to HIQA to address deficiencies in premises had not been commenced to date

10. **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 refurbishment of the Seanchara facility has been designed and subsequently tendered to building contractors. The returned tender prices were significantly higher than the estimated budget cost. A submission to HSE Estates has been made to provide an uplift to the project funding based on a value engineered format of the works for both Seanchara and Clarehaven’s refurbishment. Subject to funding availability within the tender validity period, the works will be carried out during the relevant period of registration.

Should the funding uplift not be approved, then the individual maintenance actions identified within the inspection will be priced and funding sought for their implementation, again for delivery within the period of registration.

**Proposed Timescale:** 31/12/2018

**Outcome 13: Complaints procedures**

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

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
There was no independent person named in the complaints policy to review or audit the complaints process.

11. **Action Required:**
Under Regulation 34(3) you are required to: Nominate a person, other than the person nominated in Regulation 34 (1)(c), to be available in a designated centre to ensure that all complaints are appropriately responded to and that the person nominated under Regulation 34 (1)(c) maintains the records specified under in Regulation 34 (1)(f).

**Please state the actions you have taken or are planning to take:**
There is now a system in place to ensure that both the informal complaints as well as formal complaints in line with the HSE and local complaints procedure are overseen and reviewed by a senior member of staff not involved in the complaint. This will allow for the tracking of trends and identification of areas of improvement. The local policy will be updated to reflect this change. Complaints, both management and reviews will be a
standing item on the bi-monthly senior management meetings. This will ensure greater governance of same.

**Proposed Timescale:** 20/02/2018

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

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

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
Maximum dependent residents living in shared bedrooms could not receive visitors in private.

Visitors to residents in shared bedrooms had a negative impact on the privacy of the resident receiving visitors and on the other residents in these rooms.

12. **Action Required:**  
Under Regulation 11(2)(b) you are required to: Make suitable communal facilities available for a resident to receive a visitor and a suitable private area which is not the resident’s room, if required.

**Please state the actions you have taken or are planning to take:**  
We have a number of communal rooms which are available for residents to receive visitors (Sitting rooms on both units, the sunroom, outdoor courtyards and enclosed gardens and visitors dining room). The sunroom is often utilised by families should they wish to have private family gatherings such as birthday celebrations, this enhances the living experience for the resident and families have expressed their gratitude at being able to avail of this service. We also have a private ensuite visitors room that can be used by families as required day or night. We also have three seating areas available off corridors. To date we have not received any complaints that there are not adequate private areas to entertain family, should this arise we will endeavour to accommodate the request as best we can. Any requests for a private area can be facilitated by booking the visitors room in advance.

**Proposed Timescale:** 20/02/2018

### Outcome 17: Residents' clothing and personal property and possessions

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

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
Residents' in shared bedrooms had a limited amount of storage space to store and maintain his/her clothes and other possessions within their private space.
13. **Action Required:**
Under Regulation 12(c) you are required to: Provide adequate space for each resident to store and maintain his or her clothes and other personal possessions.

**Please state the actions you have taken or are planning to take:**
Each resident has a bedside locker and wardrobe available to them, where extra clothing and personnel effects need to be stored we have facilitated the use of an extra chest of drawers where appropriate space is available for individual residents which is beside their bed space. We are currently seeking newer models of wardrobes/lockers which would allow for more storage space.

**Proposed Timescale:** 31/12/2018

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**Outcome 18: Suitable Staffing**

**Theme:**
Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Staff did not have access to suitable training prior to transfer from one role to another.

14. **Action Required:**
Under Regulation 16(1)(a) you are required to: Ensure that staff have access to appropriate training.

**Please state the actions you have taken or are planning to take:**
A Professional Development Plan has now been completed on said member of staff on 20/02/18. Contact had been made with Central Nurse Education and said member is booked to attend the FETAC L5 training in September 2018. Staff member in the interim period is been enrolled in a care skills programme to commence in April 2018. The staff member has received Manual handling, Hand Hygiene, Dementia training and Safeguarding prior to the transfer to his new temporary position. The change of role has been documented along with the Professional Development Plan in the staff members personnel file.

**Proposed Timescale:** 20 February 2018 -12 March 2019

**Proposed Timescale:** 12/03/2019