Health Information and Quality Authority
Regulation Directorate

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

Centre name:	Farranlea Road Community Nursing Unit
Centre ID:	OSV-0000713
Centre address:	Farranlea Road, Cork.
Telephone number:	021 492 7671
Email address:	bernadette.oleary@hse.ie
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Richard Buckley
Lead inspector:	John Greaney
Support inspector(s):	Michelle O'Connor
Type of inspection	Announced
Number of residents on the date of inspection:	85
Number of vacancies on the date of inspection:	15

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 2 day(s).

The inspection took place over the following dates and times

From:	To:
12 June 2017 11:30	12 June 2017 18:00
13 June 2017 08:30	13 June 2017 18:30

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

Outcome	Our Judgment
Outcome 01: Statement of Purpose	Compliant
Outcome 02: Governance and Management	Non Compliant - Moderate
Outcome 03: Information for residents	Non Compliant - Moderate
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Non Compliant - Moderate
Outcome 06: Absence of the Person in charge	Compliant
Outcome 07: Safeguarding and Safety	Substantially Compliant
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 09: Medication Management	Substantially Compliant
Outcome 10: Notification of Incidents	Compliant
Outcome 11: Health and Social Care Needs	Substantially Compliant
Outcome 12: Safe and Suitable Premises	Substantially Compliant
Outcome 13: Complaints procedures	Non Compliant - Moderate
Outcome 18: Suitable Staffing	Non Compliant - Major

Summary of findings from this inspection

Farranlea Road CNU is located on the suburbs of Cork City. The centre comprises four units, Willow and Cedar on the ground floor, and Sycamore and Oak on the first floor. The first floor can be accessed by stairs and a large lift. Three of the units, Willow, Sycamore and Oak provide continuing care beds for the older person and Cedar accommodates younger adults with complex high support needs. Each unit was originally designed to accommodate 25 residents, however, Cedar unit has been reconfigured to support residents to participate in activities and to promote independence with the development of a therapeutic kitchen, an activities room, a sensory room, an office and a nurses station. As a result of this, the capacity of Cedar was reduced to 14 beds. On the days of inspection there were 25 residents in each of Willow, Sycamore and Oak, and there were 10 residents in Cedar.

This registration inspection was announced and took place over two days. As part of the inspection process, inspectors met with residents, relatives, staff members, the person in charge. assistant director of nursing and the provider. The inspectors observed practices and reviewed documentation such as care plans, medical records, complaint records, accident logs, policies and procedures and staff files.

Overall the inspectors were satisfied that care was provided to a good standard. Residents and relatives spoken with were mostly complimentary of the care provided, the food available and the programme of activities. Residents independence was supported and promoted. Residents spoken with by inspectors stated that they felt safe in the centre and were complimentary of the care provided.

Some improvements, however, were required. For example, significant improvements were required in relation the management of complaints. Some complaints were rerecorded on incident forms, there was not always adequate detail contained in the complaint record, there was not always adequate detail of the investigation of the complaint and there was not always adequate detail of the outcome of the complaint. Additionally, the policy and procedure in relation to the management of written complaints was not always adhered to.

Additional staffing hours had been allocated to meet the needs of residents since the last inspection, particularly in the evening time. Due to the changing condition of residents, a further review of staffing was required to meet the needs of residents and to ensure they were at all times safe, particularly in relation to the supervision of residents that were at risk of falling.

Improvements were also required in relation to the management structure. The person in charge was also the person in charge for one other designated centre, Heather House Community Nursing Unit, which is a 50 bedded centre and is located approximately four kilometres from Farranlea Road CNU. Based on the on-going findings on this and previous inspections, and discussions with nurse managers, the inspectors were not satisfied that the person in charge could adequately oversee the quality and safety of care in two large centres that were not co-located and were home to a significant number of residents with complex care needs.

Other required improvements included:
• contracts of care did not always contain adequate detail
• all personnel files did not contain two written references
• personnel file contained a report of Garda vetting but not the actual disclosure form
• not all staff had attended training in responsive behaviour
• the risk management policy did not address all of the requirements of the regulations
• the local emergency plan did not identify emergency alternative accommodation
• fire safety checks were not always completed
• the reconfiguration of a bathroom was not yet complete
• roles and responsibilities of volunteers were not always described and Garda vetting was not completed for all.

The action plan at the end of this report identifies where improvements are needed

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 Standards for Residential Care Settings for Older People in Ireland.

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 detailed Statement of Purpose was available to both staff and residents at the nurses' station on each unit. It contained a statement of the designated centre's aims, objectives and philosophy of care. It accurately described the facilities and services available to residents, and the size and layout of the premises. Farranlea Community Nursing Unit (C.N.U.) provides 75 continuing care beds for the older person and 10 beds for younger adults with complex high support needs.

Recent changes to the management structure were also outlined in an organisational chart. This identified lines of authority and reporting relationships for staff.

Judgment:
Compliant

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

Theme:
Governance, Leadership and Management

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

Findings:
There was a clearly defined management structure. The person in charge reported to an acting General Manager. The person in charge was supported in her role by an acting assistant Director of Nursing (ADON). The ADON only started in this post on the first day of this inspection.

There was a programme of audits that included audits of issues such as care plans, medication management, restraint, waste management and hygiene. There was an annual review of the quality and safety of care, which was available to residents and relatives.

The person in charge was also the person in charge for one other designated centre, Heather House Community Nursing Unit, which is a 50 bedded centre and is located approximately four kilometres from Farranlea Road. Based on the on-going findings on this and previous inspections, and discussions with nurse managers, the inspectors were not satisfied that the person in charge could adequately oversee the quality and safety of care in two large centres that were not co-located and were home to a significant number of residents with complex care needs.

Judgment:
Non Compliant - Moderate

Outcome 03: Information for residents
A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

Theme:
Governance, Leadership and Management

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

Findings:
A guide to the centre was given to residents and relatives prior to admission to Farranlea Road CNU. A copy was also available at each nurses' station. The resident's guide contained a summary of services and facilities, terms and conditions relating to residence, the procedure relating to complaints and arrangements for visits.

A contract of care was provided for residents, as required under Regulation 24 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. The contract outlined services included in the overall fee charged by the nursing home and general exclusion costs. Arrangements for or receipt of financial support under the Nursing Homes Support Scheme were also included. However, a sample of contracts reviewed by inspectors had not always been provided to residents on admission. Some were signed some months post admission. Dates were not always accurately recorded and details of room occupancy for residents, whether single, double

or four-bedded, were not always clarified.

Judgment:
Non Compliant - Moderate

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

Theme:
Governance, Leadership and Management

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

Findings:
The person in charge had recently taken up the role. Based on a review of documentation, interview and observations of the inspectors, the centre was managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.

The person in charge demonstrated sound clinical knowledge and a good knowledge of the legislation and her statutory responsibilities. She was engaged in the governance, operational management and administration of the centre on a regular and consistent basis. Residents and relatives could identify the person in charge. Staff felt supported by the person in charge.

As discussed in more detail under Outcome 2, the person in charge was also the person in charge for one other designated centre, Heather House Community Nursing Unit,

Judgment:
Compliant

Outcome 05: Documentation to be kept at a designated centre
The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:
Governance, Leadership and Management

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

Findings:
Inspectors found that the designated centre had all of the written operational policies as required by Schedules 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. Policies were regularly reviewed, centre-specific and reflected the centre's practice. Policies were available to all staff at each nurses' station in addition to national policies, guidance and guidelines. However, staff confirmed it could be difficult to find time to read polices and sign off as having read and understood them.

Inspectors saw that all records were securely stored and easily retrievable. Copies of HIQA inspection reports and statutory notifications were available in the centre. A Directory of Residents was maintained in line with Regulation 19.

Inspectors viewed a selection of staff files and found that not all the requirements of Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, had been met. Some staff files contained just one written reference and one had no photo ID. The centre had in place HSE Garda Vetting Liason Officers Garda vetting report confirmation forms for staff. However, this is not a disclosure in accordance with the National Vetting Bureau Act 2012 as required by schedule 2 of the 2013 care and welfare regulations.

Judgment:
Non Compliant - Moderate

Outcome 06: Absence of the Person in charge
The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:
Governance, Leadership and Management

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

Findings:
The person in charge had recently taken up post. The required notification was submitted to HIQA informing of the absence of the previous person in charge and included details of the new person in charge. There were adequate arrangements in place for when the person in charge was absent from the centre.

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

Findings:
There was a policy in place for the prevention, detection and response to abuse. All staff members had received up-to-date training on recognising and responding to abuse. Staff members spoken with by inspectors were knowledgeable of what constituted abuse and what to do in the event of suspicions or allegations of abuse.

There were adequate systems in place for the management of residents' finances. The centre acted as pension agent for two residents and adequate arrangements were in place for the management of this money. The centre held small sums of money for safekeeping on behalf of residents and adequate records were maintained of all transactions for and on behalf of residents.

There was a policy in place for managing responsive behaviour (also known as behavioural and psychological signs and symptoms of dementia). There were a number of residents in the centre on the days of inspection that presented with responsive behaviour. Based on discussions with members of staff, they had the knowledge and skills to appropriately respond to and manage incidents of responsive behaviour. However, while staff had adequate knowledge of how to respond to individual residents behaviour this was not adequately documented in care plans. This is addressed in more detail under Outcome 11. A significant number of staff had not attended training in responsive behaviour.

There was a policy on the management of restraint. A small number of residents had lap belts in place and these were only in place following review by relevant allied health professionals and were used for the purpose of postural support. A number of residents had bedrails in place. Residents were risk assessed prior to the use of bedrails and there were records to indicate that alternatives were explored prior to the use of bedrails. There were records of safety checks in place while bedrails were in use.

Judgment:
Substantially 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:
During the previous inspection, inspectors saw that some fire doors were being wedged open or locks disengaged, which presented a risk to the safety of residents. During this inspection, inspectors found that incidents where these practices occurred had been reduced, but not eliminated. A kitchenette door was held open with a wooden wedge, a relatives' rooms was held open with a bin and a sluice room combination lock had been disengaged. There was still unrestricted access to the kitchen, staff tea room and nurses' office on one unit but plans were in progress to fit keypad locks to these doors.

A risk management, quality and safety committee met quarterly to discuss corporate, departmental, clinical and organisational risks. Agenda items included incident/accident quarterly trends, HIQA notifications, safeguarding incident reports and quality initiates. Inspectors saw that a recently discussed agenda item had been actioned. Guidance posters, devised in conjunction with the dietician, were displayed throughout the centre, advising caution to visitors bringing sweet treats for residents on special diets.

Farranlea CNU had policies and procedures relating to health and safety and identified risks were addressed in a risk register. Recent risk assessments covered issues such as absconsion, nosocomial infection, smoking, the storage of chemicals and access to certain rooms. Each risk assessment included a description of the risk, impact/vulnerabilities, existing control measures, additional controls required, the person with responsibility and revision dates. However, the risk management policy did not include all of the items set out in regulation 26(1). The health and safety statement was based on a template with incomplete sections and appendices. The evacuation and emergency response plan did not detail alternative emergency accommodation for residents in the event of a major incident.

Inspectors found suitable fire equipment was available throughout the centre and that bedding and furnishings were made of fire retardant material. Fire evacuation plans and procedures were prominently displayed. Personal emergency evacuation plans (PEEPs) had been devised for all residents and were available in care plans. All staff had participated in mandatory annual fire safety training and regularly practiced drills. A record of drill details was kept, such as the time taken to complete a drill and any remedial action taken. A manual call point was tested on a weekly basis. A list of in-house checks was kept at each nurse's station for each of the four units. However,

inspectors found that some of these checks had not been signed off as completed and not all checks as outlined in HIQA guidance, Fire Precautions in Designated Centres 2016, were included.

Policies and procedures on infection control were consistent with national guidelines, including the safe handling and disposal of clinical waste, dealing with spillages, the provision of protective clothing, hand washing and cleaning of equipment in order to prevent cross infection. Alcohol rub and hand washing facilities were present throughout the centre, in addition to awareness raising posters on the importance of hand hygiene. Separate hand wash sinks were available in areas where infected material or clinical waste was handled.

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

Findings:
There were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents. The processes in place for the handling of medicines, including controlled drugs, were generally safe and a random sample of controlled drugs counted indicated they were correct. The controlled drug cupboard was a locked cupboard within a locked cupboard. Medication requiring refrigeration were stored appropriately, however, the fridge temperature was not always monitored and recorded.

Medication administration was observed and staff were seen to adhere to appropriate medication management practices. Medication and prescription charts were legible. Where crushed medications were required this was appropriately prescribed in this format. There were appropriate procedures for the handling and disposal for unused and out of date medicines. At the time of inspection no residents were responsible for their own medication.

A system was in place for reviewing and monitoring safe medication management practices. Medication audits were conducted by the pharmacist. Medication errors were recorded. The pharmacist was facilitated to meet their obligations to residents. Staff reported receiving good support and a good service from the pharmacist.

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 incidents which occurred in the designated centre was maintained. All incidents requiring notification to the Authority and quarterly reports were submitted on time. The centre's incident reporting system was paper based. Two different incident forms were in circulation. In addition to a near miss and incident form, a falls incident form had been devised to more specifically capture relevant information in relation to falls. Details recorded included; situation description, trip hazards, resident's account, risk factors, medications, assessment and recommendations. Incidents were audited on a quarterly basis, discussed at management level and results circulated to staff.

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:
Overall the inspector was satisfied that residents' health care needs were met to a good standard through appropriate medical and nursing care. Residents received a comprehensive assessment on admission and at regular intervals thereafter using

recognised evidence-based tools.

Residents were regularly reviewed by a general practitioner (GP) and there was also evidence of access to out-of-hours GP services. There was evidence of referral and review by allied health/specialist services, which were available on-site, including speech and language therapy, dietetics, physiotherapy, and occupational therapy.

Only a small number of residents had wounds and records indicated the use of evidence-based tools for assessment, including the use of photographs. Records indicated consultation with a tissue viability specialist for advice in the care and treatment of wounds, when indicated.

The centre had recently changed over to a new style of care plan. Different staff were assigned the responsibility of transferring information and updating new care plans for a specific number of residents. Inspectors viewed a sample of care plans and found a large time lag (more than four months) between the review of older care plans and the implementation of newer care plans. Newer care plans were often sparsely detailed and full advantage had not been taken of narrative notes sections. While core care plans and risk assessments were complete, sections such as 'My day, my way' and 'A key to me' were often left blank. Some care plans were comprehensive and provided adequate detail of the care to be provided while others provided limited details of the care to be delivered.

Where a resident presented with responsive behaviour, specific care plans had not always been created to identify how best to meet the needs of these residents. For example, the care plan for one resident stated that staff should read minutes of a meeting that were contained in the resident's medical notes. While regular staff were able to explain triggers and de-escalation techniques, this information would be difficult for new or agency staff to locate. Risk assessments dealing with responsive behaviour were available at the nurses' station and were updated annually.

There were adequate processes in place to ensure that when a resident was admitted, transferred or discharged to and from the centre, that appropriate information about their care and treatment was shared between providers.

Judgment:
Substantially Compliant

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):
No actions were required from the previous inspection.

Findings:
Farranlea Road CNU is located on the suburbs of Cork City. The centre comprises four units, Willow and Cedar on the ground floor, and Sycamore and Oak on the first floor. The first floor can be accessed by stairs and a large lift. Three of the units, Willow, Sycamore and Oak provide continuing care beds for the older person and Cedar accommodates younger adults with complex high support needs. Each unit was originally designed to accommodate 25 residents in 17 single bedrooms, 2 twin-bedrooms and one four-bedded room; all of the bedrooms were en suite with shower, toilet and wash-hand basin. Cedar unit has been reconfigured to support residents to participate in activities and to promote independence with the development of a therapeutic kitchen, an activities room, a sensory room, an office and a nurses station. As a result of this, the four bedded room, the two twin bedrooms and three single rooms were no longer designed to accommodate residents and the capacity of Cedar was reduced to 14 beds. On the days of inspection there were 25 residents in each of Willow, Sycamore and Oak, and there were 10 residents in Cedar.

On the days of inspection the centre was bright, clean and decorated to a good standard. Many of the bedrooms were personalised with residents' personal possessions, and there was adequate storage facilities for personal belongings, including a secure lockable cupboard.

Communal space in each unit consisted of a sitting room, a quiet room, a dining room and a number of seated alcoves along corridors. Additional communal space was provided in link areas between units. The corridors were wide and had handrails throughout, facilitating easy access for residents with mobility aids. A risk assessment had been carried out in relation to the absence of handrails at the entrance to the centre and in the enclosed gardens and it was determined they were not required.

Overall inspectors were satisfied that the design and layout of the centre met the needs of residents, for example:
• clear signage along corridors, using colours, arrows and images.
• seated alcoves looked out onto enclosed gardens. These contained patio stone and green areas with trees, bushes, flowers and shrubs. Some residents had also cultivated vegetables and herbs.
• upstairs balcony areas were open to the air but securely cordoned off with plastic screens. Some areas had brightly coloured tiles, potted plants and wooden benches for residents to sit out.
• a library was stocked with books, old photographs and a gramophone.
• dining areas on each unit were bright, cheerfully decorated and serviced by a small adjoining kitchenette.
• a four bedded unit had been converted on Cedar unit to create a therapeutic kitchen. This was used by residents for breakfast clubs. Recipe books were used to guide residents when partaking in cooking activities. Routine chores such as washing clothes could also be built into the activities program.

• an activities room on Cedar was seen to be well utilised by residents. It was used for Sonas, art sessions, board games and listening to music.

In addition to en suite facilities in each of the bedrooms, each unit contained an assisted bathroom with an assisted bath, a shower trolley, a toilet, standing and chair weighing scales and a ceiling-mounted electronic hoist system. The bathrooms, however, did not meet the needs of all residents living in the centre and plans were in place to reconfigure one of the bathrooms. This was not yet complete.

There were adequate sluicing and laundry facilities, however, residents' personal property is primarily laundered by relatives or by an external contractor and the laundry is only used for household items such as mop heads.

Judgment:
Substantially Compliant

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:
The centre had an up-to-date policy and procedure on the management of complaints. The person in charge was the nominated person for managing complaints and the provider was identified as the person responsible for independent appeals. External advocates were identified as being responsible for overseeing the complaints process to ensure that all complaints were adequately addressed. The complaints process was on prominent display in the centre.

The inspector viewed a sample of complaints in the complaints log and identified a number of required improvements. Some complaints were recorded in on a complaints form while others were recorded on incident forms. The incident form was not designed to record relevant details in relation to complaints. Additionally, there was inadequate records of the specifics of each complaint, inadequate detail of the investigation of each complaint and there was not always adequate detail of the outcome of the complaint. The record for one complaint made reference to a written complaint, however, a copy of this was not contained in the log. The policy in relation to the management of complaints was not always followed, as there was no written acknowledgement of the complaint, as required by the centre's own policy.

Judgment:

Non Compliant - Moderate

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

Theme:
Workforce

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

Findings:
Inspectors were satisfied that the registered provider had reviewed staffing and skill mix levels as required following the previous inspection, to ensure adequate care was provided to residents with increased dependency needs at particularly busy times during the day and evening. However, since the previous inspection the residents' profile had changed and some newer residents required supervision with respect to clinical care needs and prevention of falls. The centre was also heavily reliant on agency staff. On one unit, the staffing roster and a senior staff nurse confirmed that two or three agency staff were on duty most days. One agency nurse had recently been involved in a series of medication errors which the centre had picked up on and dealt with appropriately.

All new staff received induction training and underwent a progress review every three months during their first year. Following this, annual performance reviews were to take place. However, this system of appraisal had not been rolled out to some of the longer serving staff. Staff meetings were held regularly at both unit level and for specific disciplines. Management highlighted relevant issues to staff and staff had the opportunity to feedback.

Volunteers were supervised appropriate to their level of involvement in the centre, however, a description of their specific role and responsibilities within the centre was not available and some volunteers had no Garda vetting in place.

Farranlea CNU employed a core staff of nurses, healthcare assistants, multi-task attendants, activities, catering, security, clerical staff and management. The centre also employed allied health professionals such as a physiotherapist, occupational therapist, speech and language therapist and dietician. Maintenance and supplies staff were shared with other designated centres. Cleaning and laundry staff were provided by an external contractor. Inspectors found that some of the cleaning, maintenance, administration and allied health professionals were not included in mandatory training,

or other training relevant to their positions. Nursing, healthcare assistants and multi-task attendants were up-to-date with respect to manual handling and safeguarding training but gaps existed in fire, responsive behaviour and hand hygiene/infection control training.

Judgment:
Non Compliant - Major

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:

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

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	Farranlea Road Community Nursing Unit
Centre ID:	OSV-0000713
Date of inspection:	12 and 13 June 2017
Date of response:	25 July 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:
Based on the on-going findings on this and previous inspections, and discussions with nurse managers, the inspectors were not satisfied that the person in charge could adequately oversee the quality and safety of care in two large centres that were not co-located and were home to a significant number of residents with complex care needs.

1. Action Required:

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

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:
A business case has been submitted to senior management, seeking approval to upgrade a position in Heather House to Director of Nursing or Assistant Director of Nursing level, this appointee will be designated Person in Charge for Heather House

Proposed Timescale: 30/09/2017

Outcome 03: Information for residents

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A sample of contracts reviewed by inspectors had not always been provided to residents on admission. Some were signed some months post admission. Dates were not always accurately recorded and details of room occupancy for residents, whether single, double or four-bedded, were not always clarified.

2. Action Required:
Under Regulation 24(1) you are required to: Agree in writing with each resident, on the admission of that resident to the designated centre, the terms on which that resident shall reside in the centre.

Please state the actions you have taken or are planning to take:
All new contracts have the requested information added and are distributed to the resident or their nominated next of kin within 1 week of admission. If contracts are not returned Clerical Admin follow up with the respective parties to return within one month following admission. The contracts will reflect the initial location of a resident, whether double, single occupancy etc, but this may be subject to change dependent on care needs.

Proposed Timescale: 30/06/2017

Outcome 05: Documentation to be kept at a designated centre

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors viewed a selection of staff files and found that not all the requirements of Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated

Centres for Older People) Regulations 2013, had been met. Some staff files contained just one written reference and one had no photo ID. The centre had in place HSE Garda Vetting Liason Officers Garda vetting report confirmation forms for staff. However, this is not a disclosure in accordance with the National Vetting Bureau Act 2012 as required by schedule 2 of the 2013 care and welfare regulations.

3. 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 personnel files are currently being reviewed and all outstanding documentation has been requested from the staff.
Garda Vetting disclosures on all staff will be completed, and retained on site.
Garda Vetting disclosures will be completed on the PIC, and PPIM's prior to each renewal of registration, and will be held centrally by the CHO Data Controller.

Proposed Timescale: 30/09/2017

Outcome 07: Safeguarding and Safety

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A significant number of staff had not attended training in responsive behaviour.

4. Action Required:
Under Regulation 07(1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.

Please state the actions you have taken or are planning to take:
A staff member has been trained in "Train the Trainer" and will roll out responsive behaviour training and Positive behaviour management, in conjunction with the other in house facilitator. Dates commencing in July 2017 have been identified. Eight staff per session will be facilitated and the target is all staff will have received training in behaviours by end Oct 2017.

Proposed Timescale: 31/10/2017

Outcome 08: Health and Safety and Risk Management

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risk management policy did not include all of the items set out in regulation 26(1). The health and safety statement was based on a template with incomplete sections and appendices.

5. Action Required:
Under Regulation 26(1) you are required to: Ensure that the risk management policy set out in Schedule 5 includes all requirements of Regulation 26(1)

Please state the actions you have taken or are planning to take:
All Risk Management policies have been reviewed and now contain all the requirements set out in Regulation 26 (1).
The Health and Safety Statement has been reviewed, updated, and be centre specific.

Proposed Timescale: 30/06/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
During the previous inspection, inspectors saw that some fire doors were being wedged open or locks disengaged, which presented a risk to the safety of residents. During this inspection, inspectors found that these practices still occurred. A kitchenette door was held open with a wooden wedge, a relatives' rooms was held open with a bin and a sluice room combination lock had been disengaged.

6. 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:
A number of locks have been installed with automatic closure which will assist in preventing this practice. There is on-going education of staff to raise awareness of safe practices in relation to fire doors.

Proposed Timescale: 30/06/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The evacuation and emergency response plan did not detail alternative accommodation

for residents in the event of a major incident.

7. Action Required:
Under Regulation 26(2) you are required to: Ensure that there is a plan in place for responding to major incidents likely to cause death or injury, serious disruption to essential services or damage to property.

Please state the actions you have taken or are planning to take:
The Evacuation and Emergency Plan has been amended and the alternative accommodation has been identified and included in the policy.

Proposed Timescale: 30/06/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors found that some fire safety checks had not been signed off as completed and not all checks as outlined in HIQA guidance, Fire Precautions in Designated Centres 2016, were included.

A record of servicing was seen by inspectors for hoists and assistive equipment, however, a preventative maintenance record for two lifts could not be located. This was particularly relevant in the context that one lift had been broken during the current and previous inspection.

8. Action Required:
Under Regulation 28(1)(a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.

Please state the actions you have taken or are planning to take:
There has been a review of the daily fire checklist to include all checks as outlined in the guidance documentation.
The contract for preventative maintenance for the 2 lifts within the facility is held centrally and a copy of same has been requested and is awaited from Head of Maintenance.

Proposed Timescale: 14/07/2017

Outcome 09: Medication Management

Theme:
Safe care and support

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

in the following respect:
Medication requiring refrigeration were stored appropriately, however, the fridge temperature was not always monitored and recorded.

9. Action Required:
Under Regulation 29(4) you are required to: Store all medicinal products dispensed or supplied to a resident securely at the centre.

Please state the actions you have taken or are planning to take:
All nurses have been advised of the need to check fridge temperatures and record same. An audit system of checking the recording of temperatures has been put in place to monitor compliance, and this will be checked by the night CNM3.

Proposed Timescale: 30/06/2017

Outcome 11: Health and Social Care Needs

Theme:
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Improvements were required in relation to the development of care plans. For example:
• the centre had recently changed over to a new style of care plan and inspectors found a large time lag (more than four months) between the review of older care plans and the implementation of newer care plans
• newer care plans were often sparsely detailed and full advantage had not been taken of narrative notes sections
• some care plans were comprehensive and provided adequate detail of the care to be provided while others provided limited details of the care to be delivered
• while core care plans and risk assessments were complete, sections such as 'My day, my way' and 'A key to me' were often left blank
• where a resident presented with responsive behaviour, specific care plans had not always been created to identify how best to meet the needs of these residents.

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

Please state the actions you have taken or are planning to take:
Care plan audits by CNM2's have been scheduled monthly to ensure compliance with a four monthly review.
Families (when available), of residents, who are unable to engage will be consulted in the completion of "A key to me/ My Day my Way".

Proposed Timescale: 31/07/2017

Outcome 12: Safe and Suitable Premises

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The bathrooms, however, did not meet the needs of all residents living in the centre and plans were in place to reconfigure one of the bathrooms. This was not yet complete.

11. 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:
One resident's bathroom within the centre did not meet their care needs however there are on-going plans in relation to this refurbishment. The residents hygiene and toilet care needs are facilitated in an assisted bathroom.

Proposed Timescale: 31/08/2017

Outcome 13: Complaints procedures

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some complaints were recorded in on a complaints form while others were recorded on incident forms. The incident form was not designed to record relevant details in relation to complaints.

12. Action Required:
Under Regulation 34(1)(f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.

Please state the actions you have taken or are planning to take:
Staff education is on-going in the appropriate recognition, documentation and management of complaints. This will facilitate the management of complaints as a separate entity from incidents.

Proposed Timescale: 30/08/2017

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was inadequate records of the specifics of each complaint, inadequate detail of the investigation of each complaint and there was not always adequate detail of the outcome of the complaint. The record for one complaint made reference to a written complaint, however, this was not contained in the log. The policy in relation to the management of complaints was not followed as there was no written acknowledgement of the complaint as required by the centre's own policy.

13. Action Required:
Under Regulation 34(2) you are required to: Fully and properly record all complaints and the results of any investigations into the matters complained of and any actions taken on foot of a complaint are and ensure such records are in addition to and distinct from a resident’s individual care plan.

Please state the actions you have taken or are planning to take:
Staff will comply with the local policy in replying in writing to a complainant , acknowledging the complaint and setting out a time frame for investigation and possible resolution.

Proposed Timescale: 30/06/2017

Outcome 18: Suitable Staffing

Theme:
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Since the previous inspection the residents’ profile had changed and some newer residents required additional one to one care with respect to clinical care needs and safeguarding against falls. The centre was also heavily reliant on agency staff. This requires a review of staffing and skill mix levels.

14. Action Required:
Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

Please state the actions you have taken or are planning to take:
The staffing has been reviewed to meet the inspection finding, the residents identified have had a review of their care need and extra care is being provided at specific times when the residents were noted to be at greatest risk. Extra hours in the am and from 5.30 to 8pm have been introduced during the week along with Saturday and Sunday day hours, this has led to a significant reduction in falls and behaviours that challenge

Proposed Timescale: 30/06/2017

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Inspectors found that some of the cleaning, maintenance, administration and allied health professionals were not included in mandatory training, or other training relevant to their positions. Nursing, healthcare assistants and multi-task attendants had gaps in fire, responsive behaviour and hand hygiene/infection control training.

15. 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:
All staff training records have been reviewed and a training programme is being created to ensure compliance.

Proposed Timescale: 30/09/2017

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Volunteer files did not include a description of their specific role and responsibilities within the centre.

16. Action Required:
Under Regulation 30(a) you are required to: Set out in writing the roles and responsibilities of people involved on a voluntary basis with the designated centre.

Please state the actions you have taken or are planning to take:
A volunteer agreement and job description with role and responsibilities defined , has been developed and activity staff will provide same to all volunteers and ensure its completion.

Proposed Timescale: 30/06/2017

Theme:
Workforce

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

in the following respect:
Some volunteers had no Garda vetting in place.

17. Action Required:
Under Regulation 30(c) you are required to: Provide a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 for people involved on a voluntary basis with the designated centre.

Please state the actions you have taken or are planning to take:
Currently one volunteer's Garda Vetting is outstanding, this has been sent for processing and we are awaiting its return. This volunteer will be accompanied at all times by a staff member until confirmation of vetting has been received.

Proposed Timescale: 31/07/2017