Health Information and Quality Authority
Regulation Directorate

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	Lusk Community Unit
Centre ID:	OSV-0000505
Centre address:	Station Road, Lusk, Co. Dublin.
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Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Paula Keating
Lead inspector:	Ann Wallace
Support inspector(s):	Shane Walsh
Type of inspection	Unannounced
Number of residents on the date of inspection:	49
Number of vacancies on the date of inspection:	1

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
18 July 2017 09:00	18 July 2017 18:30

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

Outcome	Our Judgment
Outcome 02: Governance and Management	Compliant
Outcome 03: Information for residents	Substantially Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Substantially 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 11: Health and Social Care Needs	Substantially Compliant
Outcome 12: Safe and Suitable Premises	Substantially Compliant
Outcome 15: Food and Nutrition	Substantially Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Substantially Compliant
Outcome 18: Suitable Staffing	Compliant

Summary of findings from this inspection

This was an unannounced inspection by the Health Information and Quality Authority (HIQA). The purpose of the inspection was to inform an application to renew registration of the centre.

As part of the inspection the inspectors met with residents, relatives, the person in charge (PIC), the assistant director of nursing (ADON), clinical nurse managers (CNM) and members of staff who were present in the centre. The inspectors also observed practices and reviewed documentation such as policies and procedures, staff files, health and safety documents, clinical governance and audit documents, care plans, medical records and the records from allied healthcare professionals.

The feedback from the residents and the relatives who spoke with the inspectors was positive and there were high levels of satisfaction reported for the care and services provided by the centre.

During the inspection residents were seen to be offered choice in how they went about their day and were spending time in different areas of the centre. Inspectors found that residents were empowered and supported to maintain their independence and were able to participate in the running of the centre.

The person in charge (PIC) had management responsibility for three other centres in the HSE area. This arrangement had been reviewed since the last inspection and it was planned that one of the assistant directors of nursing (ADON) who was currently based in the centre would be taking up the role of PIC in August 2017. During the inspection the PIC and ADON were seen to be easily accessible to residents, relatives and staff.

Inspectors found that there were adequate staffing levels and skill-mix to meet the residents' assessed needs. Residents had access to medical and allied health care professionals including specialist services where required.

The centre had effective governance and management arrangements in place to ensure the quality and safety of the service provided to residents. Regular reviews and audits were carried out. The inspectors found evidence of improvements being introduced as a result of audits and other feedback.

The centre was seen to be clean and tidy on the days of the inspection. Communal areas were well used by residents and their visitors which gave the centre a homely atmosphere. The central garden area provided a peaceful outdoor view from various vantage points around the centre including the dining room and there was a further enclosed garden to the rear of the building. Garden areas were well laid out and suitably furnished for the residents who lived at the centre. Several bedrooms were decorated with photographs and artifacts from the resident's life at home giving the bedrooms a personal feel. Residents took a real pride in their personal space and were happy to show the inspectors around their rooms.

Following the inspection the inspectors were satisfied that the actions identified in the previous report had been addressed by the centre. However some areas for improvement were identified in relation to fire doors and fire safety training for staff, documentation, care planning and medications. These are detailed in the report and set out in the action plan at the end of the report.

Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

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

Theme:
Governance, Leadership and Management

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

Findings:
The service provided in the centre was seen to be in line with the statement of purpose. The inspectors found that there were sufficient resources made available to provide safe and effective care and services for residents and that the centre had appropriate systems in place to monitor the quality and safety of care for the residents.

There was a clearly defined management structure that identified the lines of authority and accountability, and all staff with whom the inspector spoke were clear about the reporting structure. The person in charge [PIC] was supported in her role by two assistant directors of nursing [ADON]. The ADONs worked a weekend rota to ensure that a senior member of staff was available in the centre across seven days of the week. The centre had recently employed a clinical nurse manager [CNM] to support the nursing and care staff on each of the units.

Documentation showed that the quality of care and the experience of residents were monitored and reviewed on an ongoing basis. There was a residents forum which was chaired by an independent advocate and an annual resident survey was completed in 2016 and was reported in the centre's annual report. There was clear evidence of changes being made in response to audit and quality reports and to resident feedback. These included improvements to the activities programme and menus.

As part of the ongoing governance within the centre the senior nursing team carried out a range of monthly nursing metrics audits on practice in each unit and used the findings to identify areas for improvements. Areas audited included; care plans, medications, use of bedrails, pressure sores and falls. In addition the centre monitored resident dependencies, incidents and complaints. The inspectors found clear evidence of changes being implemented in response to incidents and other clinical risks identified within the centre. Complaints were followed up in line with the centre's complaints

procedures and the complainant's satisfaction with the outcome was recorded.

The inspectors found that the centre had appropriate arrangements in place to supervise staff in their work. Nursing and care staff were supported and supervised in their day to day work by the clinical nurse manager and the ADONs.

Support staff in catering and administration were supervised by the heads of departments for those areas. Housekeeping and security were outsourced to agencies who were engaged through the HSE procurement processes. Staff working in these departments were managed by their relevant agency line managers.

Some staff in the centre had personal development plans and this process was being rolled out across the staff groups. Staff demonstrated responsibility and accountability in their roles and were clear about what was expected of them in their work. There were regular staff meetings including staff handover meetings at the beginning of each shift. All meetings were minuted. Staff told the inspectors that they had regular contact with the PIC and senior nurses in the centre and that senior staff were approachable.

Judgment:
Compliant

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:
The inspectors did not look at this outcome in its entirety. A sample of residents' contracts of care was reviewed and all services that may result in an additional charge were not outlined.

The inspectors reviewed a sample of three residents' contracts. The contracts were signed by both a representative of the provider entity and the resident or their next of kin. They also outlined how the care and welfare of the residents would be provided and maintained in the centre. The weekly fee that would be charged to the residents and services that would be provided under the fee were listed.
The contract outlined that some additional fees could be charged for additional services, however what these services were or how much the charges could be were not listed in the contract.

Judgment:

Substantially Compliant

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

Theme:
Governance, Leadership and Management

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

Findings:
The inspector found that 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 (PIC) and the assistant directors of nursing (ADON) were suitably qualified and experienced to fulfil their roles and had appropriate supports in place. The PIC had senior management responsibility for two other HSE centres in the region and informed the inspector that she spent approximately 50% of her time in the centre. The PIC was supported by the two assistant directors of nursing who acted into the role in her absence. The centre had reviewed the PIC role since the last inspection and had appointed one of the ADONs to move into the role full time in August 2017. Two clinical nurse managers were responsible for the support and supervision of nursing and care staff on the units.

The PIC reported to the provider nominee who she met with regularly to discuss relevant issues including budgets, staff issues, complaints, incidents and clinical governance.

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

Findings:
All the documents required to be kept and maintained in the centre were in place. The inspectors found that records required to be kept in the centre were kept secure and were easily available for review.

The inspectors reviewed a sample of six staff recruitment files and found that all contained the requirements as listed in Schedule 2 of the regulations.

The directory of residents was up to date.

The inspectors reviewed a sample resident's nursing and medical records and found that in most cases the records contained all the requirements of Schedule 3 of the regulations. However inspectors found that some care plans did not adequately document the interventions required to meet needs such as communications and responsive (challenging) behaviours and that two medication administration records had not been signed by the administering nurse. This is discussed under outcomes 9 and 11.

The centre maintained all polices as listed in Schedule 5. The policies reviewed by the inspector were up-to-date, comprehensive and included current best practice guidance. The Safeguarding policy had been developed with multi-disciplinary team and gave clear guidance on how agencies must work together to ensure that residents in the centre were protected.

Inspectors found that records as listed in Schedule 4 were in place.

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

Findings:
Inspectors found that procedures were in place to safeguard and protect residents from abuse. Inspectors found clear evidence that the centre was working towards a restraint-free environment.

There was a policy in place that set out clear procedures for the prevention, detection and response to elder abuse. The staff training records documented that staff had attended training on safeguarding and elder abuse. Staff who spoke with the inspectors were able to articulate the policy and procedure to follow in the event of an allegation, suspicion or disclosure of abuse. Staff were also clear about who to go to report concerns regarding abuse. Inspectors were satisfied that the person in charge knew how to respond to an allegation of abuse if it was reported to them. Residents told the inspectors that they felt safe at the centre.

The centre had clear systems in place to keep residents' money safe. All transactions were signed for by two people. Money and valuables kept on behalf of a resident were stored securely.

Inspectors reviewed the centre's policy on the management of responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social of physical environment). The policy described the types of responsive behaviours and the approaches that should be used for identifying causes of responsive behaviours. Staff had attended training on the management of responsive behaviours. Inspectors found that residents were referred to specialist services including mental health for investigation or management of responsive behaviours when required.

Inspectors noted that the care provided in the designated centre was person centred. Staff interviewed by the inspectors knew the residents who might display responsive behaviours and were able to describe the triggers for such behaviour and the most appropriate way to respond to reassure and support the resident. Inspectors found that in most cases this was documented in individual resident's care plans. However one care plan reviewed did not provide sufficient information regarding potential triggers for behaviours or clear guidance on the agreed management of the behaviours should they occur.

There was a policy in place setting out the procedures relating to the use of restraint (physical, chemical or environmental). Where restraints were being used, inspectors found that a risk assessment had been completed that identified the risks and the options that had been considered prior to the decision to use restraint. The decision to use restraint and the resident's and or family's consent were documented. Restraints were used for the least time possible to manage the identified risks. All restrictions were recorded and reviewed monthly or more often if a resident's needs changed.

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

Findings:
The centre had policies and procedures in relation to health and safety in the centre. However promotion of fire safety and the management of risk within the centre required improvement.

The centre had suitable fire equipment in place which had been serviced in October 2016. The emergency exits throughout the building were unblocked and well signposted. Daily visual checks were carried out to ensure that fire exits were clear. The centre was compartmentalised through double fire doors positioned at regular intervals along the corridors. The doors had hot fire seals and smoke seals in place to slow the spread of fire and smoke. The doors were held open by magnetic locks which would automatically release if the fire alarm sounded. The inspectors tested four of the corridor doors and found that they closed with no notable gaps in between the doors.

Doors into rooms were also fire doors consisting of a main door and a smaller panel door which could be opened to allow access for a bed or large piece of equipment. The main door was on a self closing mechanism which would shut the door if the fire alarm sounded. The inspectors noted that on a significant number of bedroom doors the smaller panel was not securely closed. These panels were not on self closing mechanisms and as such leaving them open would compromise the effectiveness of the fire door to slow the spread of smoke or fire. On one door to a communal room the inspectors noted that a hot fire seal was missing from the small panel door. Two fire doors were observed to be held open with chairs, which would prevent them from closing if the fire alarm sounded. This was corrected during the inspection.

There was a policy in place for the prevention of fire and for what actions to take during a fire. The procedure to be followed on the sounding of the fire alarm was displayed at each nurses' station and it matched the procedure outlined in the policy. The inspectors reviewed the records of fire drills and noted that fire drills were held infrequently. A drill had been held in May 2015 and the most recent drill in May 2016. During both drills significant issues had been identified and the recorded improvement action in both records was that drills were to be carried out every three months until staff were competent in the process and once this competence had been achieved then subsequent drills should be carried out six monthly. These actions had not been implemented.

Records showed that all staff had attended the centre's mandatory fire safety training.

The inspectors spoke to a number of staff about what procedure should be followed if the fire alarm sounded. Inspectors found that not all staff were able to articulate the centre's fire safety procedure in the event of a fire alarm sounding.

Service records confirmed that the fire alarm and emergency lighting in the centre was serviced on a quarterly basis.

The centre had a health and safety statement and a risk register in place. The risk register documented a small number of risks identified in the centre including verbal abuse, depreciated equipment, and the risk of airborne infection spreading during the use of therapeutic vaporisers. The risk register outlined the mitigating factors and actions to reduce these risks but was not a comprehensive record of the management of all risks identified in the centre. The PIC informed the inspectors that a comprehensive CHO9 (community area 9) risk register was in place which covered several centres within the HSE area and was not site specific.

Incidents were clearly recorded in the centre's incident record books. Inspectors found that serious incidents were investigated through the centre's incident reporting and clinical governance processes and that the learning from these incidents was communicated to relevant staff. Individual risk assessments in residents files were comprehensive and reflected current best practice guidance.

In most areas the inspectors observed good infection control procedures by staff. Hand wash basins were available in appropriate areas and alcohol handgel was located throughout the centre. However inspectors observed that one treatment room had a handwash basin but no soap or paper towels in place. Staff confirmed that they used the handwash basin in the corridor outside the room to wash their hands. This was not in line with best practice guidance and the centre's own policies and procedures.

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

Findings:
The inspectors found that there was a comprehensive medication management policy in place which provided guidance to staff on all aspects of medication management from ordering, prescribing, storing and administration. The centre had implemented clear stock management procedures in relation to prescribed nutritional supplements in line

with the improvements required from the previous inspection.

Photographic identification was available on the drugs chart for each resident to ensure the correct identity of the resident receiving the medication and reduce the risk of medication error in the sample reviewed. The prescription sheets reviewed were legible and clear. The maximum amount for (PRN) medication (a medicine only taken as the need arises) was indicated on the prescription sheets examined. Drugs being crushed were signed by a doctor as suitable for crushing. Residents' medications were reviewed regularly by their general practitioner (GP).

The inspectors observed part of a medication round and found that some practices were not in line with the centre's own medication policies and best practice guidance. Two medication records reviewed by the inspector were found to be incomplete as they had not been signed by the administering nurse and the medications for three residents were administered outside of the acceptable time scales for prescribed medications.

Medicines were being stored safely and securely in the clinic room on each unit. Medicine trolleys were kept locked and stored in the clinical rooms when not in use. The drugs fridge in each clinical room was clean and tidy and temperatures were recorded daily. The inspector found in one drugs fridge that a topical cream had been left open and was not stored appropriately. The opened product did not have a date of opening recorded.

Medications that required strict control measures were kept in a secure cabinet which was double locked. Nurses kept a register of controlled drugs. Controlled drugs were checked by two nurses at the change of each shift. The inspector checked a selection of the medication balances and found that one record had not been signed by two nurses.

Nursing staff had completed training in medication management and audits were completed monthly by the management team. Medication errors were recorded, however the inspector found that the learning outcomes were not always recorded.

Although medication administration practices in the centre had improved in line with the requirements from the previous inspection the inspectors found that further review and improvement was required.

Judgment:
Substantially 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):
No actions were required from the previous inspection.

Findings:
Inspectors found that each resident had an assessment of their needs and a written care plan and that individual resident's care needs were reviewed on a regular basis.

A selection of resident's records were reviewed during the inspection and inspectors spoke with residents and their families about the health and social care services provided in the centre. Residents and their families reported that care needs were met and that they were kept informed about care plans and any changes that occurred.

Resident's needs were assessed prior to admission and again on admission. A comprehensive care plan was developed following admission.

Records showed that in general there was a good standard of risk assessment and care planning for example nutritional risks, pressure sore risk and falls risks were completed for each resident. Care plans identified resident's self-care abilities as well as their needs for care and support. Risk assessments were in place to ensure that care was delivered safely whilst promoting individual resident's independence. However inspectors noted that the standard of documentation varied and some records did not include all of the details required to support safe and effective care. For example one care plan for a resident who displayed responsive (challenging) behaviours did not identify potential triggers for such behaviours or the appropriate actions that staff would need to take to support and reassure the resident. Staff knew the resident and were able to articulate this information to the inspector but this information was not documented. This is actioned under outcome seven. Care plans relating to residents' communication needs varied and did not always specify individual resident's needs and appropriate interventions. This is actioned under outcome 16.

The resident record included the care plan and daily progress record including a record of when care staff delivered specific aspects of care such as repositioning a resident or supervising individual residents with fluids and diet. These were completed by care staff and checked by the nurse in charge of each shift. Weekly and monthly base line observations and weights were recorded for individual residents in line with their levels of risk or changes in condition. These records were monitored in the centres monthly clinical audit calendar. Inspectors found that one resident who had been identified as being at nutritional risk had not been weighed the previous month due to responsive behaviours and that no alternative monitoring action had been recorded.

Resident care plans were reviewed four monthly or more frequently if a residents condition changed. There was evidence that residents and their families were involved in the reviews if they chose to do so.

Records showed that resident's had access to the centre's medical officer and general practitioner [GP] services. GPs visited the centre on a regular basis and there were

arrangements in place for out of hours GP services should a resident need an urgent medical review.

A range of allied health care professionals attended the centre and records showed that relevant allied health professionals were contacted as required including dietician, speech and language therapy, palliative care services and mental health services. The centre organized optical and dental services for residents when required. Where recommendations were made for individual residents they were put into place for example mobility aids/adaptations and modified diets.

Feedback from residents and their relatives during the inspection was positive about the quality of healthcare that they were provided with in the centre.

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:
The design and layout of the centre met the needs of the residents. The centre was well lit, adequately heated and was visibly clean throughout. Most of the requirements of Schedule 6 were met, but some improvements were identified.

The centre was situated in a purpose built single story building that was owned by the HSE. The centre was divided into two units,Rush Unit and Lusk Unit. Each unit consisted of 25 beds, with a mixture of single and twin bedrooms. The centre also accommodates a day service, a physiotherapy service and other community based health services. The staff for these services are on a separate roster to the centre's staff.

All bedrooms were of a suitable size to meet the residents' needs and provided sufficient personal space. Each resident had a bedside locker, a lockable wardrobe, and a chair. Many rooms had an additional wardrobe installed to provide residents with additional storage if they requested it. Residents were facilitated to personalise their rooms. Most bedrooms had pictures and personal belongings that residents and families had brought into the centre. In the twin rooms there was screening in place around beds to provide

residents with privacy. The screening went all the way around each bed and did not impact on the other resident's personal space when it was closed. There was space in most bedrooms for a hoist if required. In some bedrooms overhead hoists had been installed to meet residents' needs. Call bells were installed above every resident's bed. Some bedrooms had en-suite facilities. Nurse call bells and hand rails were installed in all en-suite facilities.There was a wash hand basin for each bed in the rooms that did not have an en-suite.

There were sufficient communal toilets and showers. Some communal bathrooms had both showers and accessible baths in place, while others contained showers. Call bells were in place in all communal bathrooms and toilets, however it was noted that not all of the communal bathrooms had grab rails installed at the sink areas.

The minutes of the residents' committee meetings outlined that there was an ongoing issue in relation to the heat of showers. The inspectors spoke to the PIC about this and it was explained that this was an ongoing issue that management were trying to resolve. Plumbers had repeatedly reviewed the system. The cause of the intermittent fluctuating temperature was unknown at the time of the inspection and was under review.

The centre had a suitable amount of communal space. Each unit had a day room and there was also a large dining room area. The Rush day room was organised into two areas. One area was decorated in a homely manner with leather couches, pictures and a piano and opened out onto the internal courtyard garden. The second area was a larger and brighter space where the inspectors observed activities taking place. The furniture in this space was not as homely as the smaller area in the room. There was a day room/area in the Lusk unit that also opened out onto an internal courtyard area.

The centre had three secure garden areas, two courtyards and a large garden to the rear of the centre. The doors to these areas were unlocked and accessible to all residents. Inspectors observed residents and relatives socializing in the courtyard areas throughout the inspection including a birthday tea party for one resident during the afternoon. The centre also had an oratory, and hairdressing room, a snoezelen room and a fine dining room. The fine dining room was a smaller communal space decorated elegantly and was often used by residents and their relatives.

The corridors in the centre were well lit, sufficiently wide to allow free access for wheelchair dependent residents and visitors and were free from trip hazards. There were handrails in place on all the corridors. Equipment such as hoists and wheelchairs were stored in designated areas on the corridor. Although the equipment was stored tidily and safely in the designated areas the equipment remained in sight and gave a more institutional feel to those areas of the building. The service records documented that the hoists had been serviced within the last 12 months.

Judgment:
Substantially Compliant

Outcome 15: Food and Nutrition
Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.

Theme:
Person-centred care and support

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

Findings:
Resident were provided with food and drinks regularly, or whenever requested. Food was prepared safely and meals were observed to be served hot and looked appetizing. Care staff and staff working in the catering team were aware of individual residents' nutritional needs. Inspectors found that in most cases these were recorded in both care plans and in the kitchen records. However the record for one resident who required a special diet was not available in the kitchen records.

The daily menus for the centre worked on a four week rolling cycle to ensure residents had a varied diet, and options. Menus were displayed on the tables in the dining rooms. There were at least two choices provided for each meal. Residents were individually asked what they would like to have for their meals the evening before, however the inspectors were informed that often residents may change their mind and this could easily be facilitated. Residents on a modified consistency diet also had the same options for meals as all other residents. Meals were prepared on site in the dedicated kitchen located beside the dining room.

The inspectors observed one meal time. The tables were laid out in a pleasant way. Residents were observed to be talking to each other and it seemed to be a social experience. Two new specialised tables had recently been purchased to aid in assisting some residents to eat. The specialised tables allowed staff to sit beside residents, allowing for assistance to be provided in a discrete, relaxed and dignified manner. Noise had been identified as a problem during mealtimes and efforts had been made to reduce this. Signs had been put on the doors into the dining room to inform staff and visitors not to pass through during meal times as noise was disturbing the residents. Also the doors to the kitchen were kept closed as much as possible to minimise noise.

Between meals a tea trolley visited day rooms and all bedrooms to offer residents tea, coffee, juice, water or a snack. The inspectors observed the tea trolley serving residents on two occasions.
There was a small kitchenette area which contained a microwave, a toaster, fridge and hot water boiler to allow staff to get residents tea or snacks whenever they wished. Staff explained that the kitchen staff prepare sandwiches and snacks to be left in the kitchenette during the evening times.

Judgment:
Substantially Compliant

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

Theme:
Person-centred care and support

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

Findings:
The inspectors found that there was a person centred approach to the residents in the centre that respected their privacy and dignity.

Throughout the inspection residents were seen to be making choices about their day to day life at the centre. For example when to get up, what to eat and drink at meal times, where to spend time in the centre and what activities to take part in during the day. There were televisions, radios and newspapers available for residents to access.

In most care records where residents had communications needs these were identified in their assessment and care plans. However inspectors found that some resident records did not include a clear communications care plan which identified the resident's specific needs and appropriate interventions to support that resident. Staff who spoke with the inspectors knew the residents well and were familiar with the most effective way to engage with residents when providing care and support. Staff demonstrated empathy and respect in their dealings with individual residents.

Residents were offered a range of recreational activities to meet their needs and preferences. The centre had a planned activities programme which was organised by two dedicated activities coordinators. The programme included 1:1 and group activities Monday to Friday including some evening activities. At weekends care staff continued activities with the residents on a more informal basis. During the inspection residents were seen mobilizing around the unit on their way to the various activities on offer. Residents told the inspectors that they enjoyed the activities that were on offer at the centre.

There were regular residents meetings and records showed that topics such as meal choices and activities in the centre were discussed.

Residents were supported to engage in religious activities of their choice. Mass and

communion were available in the centre. Staff were aware of individual residents religious preferences and needs and were respectful of same.

There was access to advocacy in the centre and details were provided in the resident's guide.

Residents were supported to vote in elections if they wished to do so.

Judgment:
Substantially Compliant

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

Theme:
Workforce

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

Findings:
There was suitable staff numbers and skill mix to meet the needs of the residents. Staff were recruited appropriately and mandatory training was up to date.

The centre had a planned and actual rota in place. The inspectors noted that there was a qualified 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 that they did not have to wait long periods for staff to attend to their needs.

Agency staff was sometimes used in the centre. The person in charge informed the inspectors that they used the same two agencies and where possible requested the same staff in order to provide continuity of care for residents with someone who was familiar with the centre. Staff who spoke with the inspectors confirmed this. Staff reported that if an agency nurse or carer was new to the centre they worked closely with an assigned member of the staff for the duration of the shift.

Staff who spoke with the inspectors were clear that their learning needs were being met through the centre's training programme and that they received adequate support and supervision in their roles.

The inspectors reviewed a sample of seven staff files and found that staff were recruited as per the requirements of Schedule 2 of the regulations including up to date registration with the relevant professional body for qualified nursing staff. A vetting disclosure from the Garda Vetting Unit was documented in four staff files. Three further disclosures were held by the HSE centrally off-site. Copies of these three vetting disclosures were reviewed by the inspectors post inspection and found to be satisfactory. The inspectors also reviewed the files of volunteers in the centre and they outlined their job descriptions and contained copies of their Garda vetting. The person in change confirmed to the inspectors that all staff and volunteers working in the centre were Garda vetted.

Inspectors reviewed the records relating to professional registrations and found that all nurses working in the centre were registered with the Nursing and Midwifery Board of Ireland.

Judgment:
Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

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Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	Lusk Community Unit
Centre ID:	OSV-0000505
Date of inspection:	18/07/2017
Date of response:	06/09/2017

Requirements

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

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

Outcome 03: Information for residents

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The contracts of care did not clearly outline what additional services that may be provided in the centre, or what fees may be associated with them.

1. Action Required:
Under Regulation 24(2)(a) you are required to: Ensure the agreement referred to in regulation 24 (1) relates to the care and welfare of the resident in the designated

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

centre and includes details of the services to be provided, whether under the Nursing Homes Support Scheme or otherwise, to the resident concerned.

Please state the actions you have taken or are planning to take:
Updated contracts of care in process of being issued outlining what additional services provided in Lusk and fees associated with them.

Proposed Timescale: 8 Weeks – 6th November 2017

Proposed Timescale: 06/11/2017

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:
1) Some care plans did not adequately document the interventions required to meet needs such as communications and responsive (challenging) behaviours.

2) Two medication administration records had not been signed by the administering nurse.

2. 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:
Care plans have been reviewed and additional information has been inputted.

Omission of signature on the drug chart has been managed under the Medication management policy.

Proposed Timescale: 06/09/2017

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:
One responsive behaviours care plan did not identify potential triggers for behaviours and did not clearly specify the appropriate interventions to be taken in the event of such behaviours.

3. Action Required:
Under Regulation 07(2) you are required to: Manage and respond to behaviour that is challenging or poses a risk to the resident concerned or to other persons, in so far as possible, in a manner that is not restrictive.

Please state the actions you have taken or are planning to take:
Care plans have been reviewed and additional information has been inputted.

Proposed Timescale: 06/09/2017

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 register in the centre was not comprehensive or specific enough to identify all risks in the centre.

4. Action Required:
Under Regulation 26(1)(a) you are required to: Ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.

Please state the actions you have taken or are planning to take:
The risk register has been updated and is now unit focused.

Proposed Timescale: 06/09/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
One treatment room had a handwash basin but no soap or paper towels in place. Staff confirmed that they used the handwash basin in the corridor outside the room to wash their hands. This was not in line with best practice guidance and the centre's own policies and procedures.

5. 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:

Reported to maintenance to fit required items

Proposed Timescale: 5 weeks – 16th October 2017

Proposed Timescale: 16/10/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Fire drills were not occurring at regular intervals, despite the centre identifying deficits in the evacuation procedure.

6. 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 have taken place on 28th July 2017 and the 1st August 2017 for both day and night staff. Fire drills will continue to take place twice yearly in 2018 and then onwards.

Proposed Timescale: 06/09/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A high number of bedroom doors had the small panel door left open which seriously reduced the effectiveness of the fire doors in containing fire. Two fire doors were also found to be wedged open by chairs.

7. Action Required:
Under Regulation 28(2)(ii) you are required to: Make adequate arrangements for giving warning of fires.

Please state the actions you have taken or are planning to take:
Staff have been informed that side doors must be kept in the closed position if not in use. Porters will be requested to observe during their daily walk around.

Proposed Timescale: Completed/Ongoing

Proposed Timescale: 06/09/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A hot fire seal was missing on one door.

8. Action Required:
Under Regulation 28(1)(c)(i) you are required to: Make adequate arrangements for maintaining all fire equipment, means of escape, building fabric and building services.

Please state the actions you have taken or are planning to take:
Reported to maintenance as urgent to comply with a regulatory requirement

Proposed Timescale: 5 weeks – 16th October 2017

Proposed Timescale: 16/10/2017

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:
Some medication administration records were not completed fully and signed by nursing staff.
Opened topical cream was not stored with lid on and did not have a date of opening.
A signature was missing from one entry in MDA book.

9. Action Required:
Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.

Please state the actions you have taken or are planning to take:
Staff have been reminded re: Medication policy and legal requirements. Omissions of signature were managed under the medication management policy. All staff that have not completed the in-house training have been requested to complete the HSEland medication management training before year end.

Medication rounds will be reviewed and prescription times altered if possible to reduce length of morning medication round.

Proposed Timescale: Completed and Training will be completed by 31st December 2017

Proposed Timescale: 31/12/2017

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:
There was an ongoing issue in relation to the heat of showers. Plumbers had repeatedly reviewed the system. The cause of the intermittent fluctuating temperature was unknown at the time of the inspection and was under review.

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:
There have been no further complaints received from the staff or residents. Any further complaints will be referred to the maintenance departure for futher investigation.

Proposed Timescale: Completed/Ongoing observation

Proposed Timescale: 06/09/2017

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Grab rails were not installed at the sink areas in all communal bathrooms.

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:
All grab rails now fitted at sink areas in all communal bathrooms

Proposed Timescale: Completed 26th & 27th July 2017

Proposed Timescale: 27/07/2017

Outcome 15: Food and Nutrition

Theme:
Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The record for one resident who required a special diet was not available to catering staff in the kitchen records.

12. Action Required:
Under Regulation 18(1)(c)(iii) you are required to: Provide each resident with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional assessment in accordance with the individual care plan of the resident concerned.

Please state the actions you have taken or are planning to take:
Catering staff were provided with the required documentation on the day of the inspection. Catering/Ward staff have been informed of the importance of sharing information. Catering Manager and CNM2 will meet weekly to discuss any changes.

Proposed Timescale: Completed/Ongoing

Proposed Timescale: 06/09/2017

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:
Not all residents had a clear care plan relating to their communication needs.

13. Action Required:
Under Regulation 10(2) you are required to: Where a resident has specialist communication requirements record such requirements in the resident's care plan prepared under Regulation 5.

Please state the actions you have taken or are planning to take:
All resident's communication needs are assessed on admission and 3 monthly thereafter. Any deficits which are identified as requiring care are documented in a care plan. All communication care plans are reviewed every 3 months. Some residents do not have communication care plans as they have no identified specialist communication requirements.

All assessments will be reviewed again to identify any gaps.
Proposed Timescale: 23/10/2017