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:	Cluain Lir Community Nursing Unit
Centre ID:	OSV-0000739
Centre address:	Old Longford Road, Mullingar, Westmeath.
Telephone number:	041 6871500
Email address:	cho8.socialcare@hse.ie
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Jude O'Neill
Lead inspector:	Catherine Rose Connolly Gargan
Support inspector(s):	Leanne Crowe
Type of inspection	Announced
Number of residents on the date of inspection:	45
Number of vacancies on the date of inspection:	3

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 announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
02 November 2017 09:00	02 November 2017 17:30

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

Outcome	Our Judgment
Outcome 02: Governance and Management	Non Compliant - Moderate
Outcome 05: Documentation to be kept at a designated centre	Compliant
Outcome 07: Safeguarding and Safety	Substantially Compliant
Outcome 08: Health and Safety and Risk Management	Compliant
Outcome 09: Medication Management	Non Compliant - Moderate
Outcome 11: Health and Social Care Needs	Substantially Compliant
Outcome 12: Safe and Suitable Premises	Non Compliant - Moderate
Outcome 13: Complaints procedures	Non Compliant - Moderate
Outcome 16: Residents' Rights, Dignity and Consultation	Substantially Compliant
Outcome 18: Suitable Staffing	Compliant

Summary of findings from this inspection

This was an announced inspection completed over one day to monitor ongoing compliance with the regulations. Inspectors followed up on progress with completion of 12 actions required from the last inspection in October 2016. Six actions were satisfactorily completed. Actions in relation to provision of sufficient communal accommodation and activities for residents with one to one and small group needs were progressed but were not satisfactorily completed on the day of inspection. An action regarding medication procedures and facilitation of the pharmacist to meet their obligations had not been progressed. These actions are restated in the action plan with this inspection. The details of unsolicited information received by the Health Information and Quality Authority (HIQA) in January 2017 were assessed on this inspection. HIQA requested the provider to complete a provider led investigation into the areas identified in this information and areas for improvement were identified and implemented. Inspectors also found that the complaints management process required improvement.

Inspectors met with the person in charge, members of the staff team and residents

and their relatives during the course of the inspection. Documentation records such as the centre's policies, risk management (including fire safety) procedures and records, audits, staff training records and residents' records were reviewed.

Residents and relatives spoken with during this inspection and feedback from pre-inspection questionnaires completed by ten residents and six relatives referenced general satisfaction with the service provided, care given and the staff team in the centre. Some dissatisfaction with the laundry service was identified in a small number of questionnaires. The person in charge confirmed she was already aware of the issues with the laundry service and was taking action to correct them. Residents confirmed that they felt safe and were well-cared for in the centre.

The provider and person in charge held responsibility for the governance, operational management, and administration of services and provision of sufficient resources to meet residents' needs. There were appropriate systems in place to manage and govern the service; however sufficient resources were not provided to ensure actions were completed regarding provision of sufficient communal space for residents on Brosna unit. There were arrangements in place to ensure residents were appropriately safeguarded and all staff was appropriately vetted. While residents' views were valued by staff and their choices were respected, residents did not attend the quarterly meetings of the residents' forum and their views did not inform a decision to cut back on hairdressing services. Residents did not have access to a pharmacist as required by regulations.

Residents' accommodation was arranged over two floor levels. The inspector found that residents had sufficient space for their personal belongings in their bedrooms. The centre was visibly clean and was maintained to a good standard. While interim arrangements had reduced the impact of limited communal facilities on residents residing in Brosna unit, additional accommodation was necessary to ensure the centre met its stated purpose. Recreational activities available for residents were interesting and meaningful. However, limited communal facilities did not support activity provision for residents with one-to-one or small group needs.

Residents' healthcare needs were met to a satisfactory standard. Staff were knowledgeable regarding residents and their needs. Staff were facilitated to attend mandatory and professional development training to enhance their skills and knowledge.

The Action Plan at the end of this report identifies improvements that must be made to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland 2016.

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

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

Theme:
Governance, Leadership and Management

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

Findings:
There was a clearly defined governance and management structure in place that identified lines of authority and accountability. The roles and responsibilities of all members of the management and staff team were outlined. An arrangement was in place where the provider representative or deputy met with the person in charge on a monthly basis. All key aspects of the service including risk management was discussed at this meeting. A regional governance meeting was held on a quarterly basis. The person in charge met with the heads of the various departments in the centre. The minutes from meetings demonstrated a comprehensive review of the service was completed at these meeting forums. While areas requiring improvement were discussed at these meetings and many were satisfactorily progressed, findings from this inspection also indicated that some actions from the last inspection in October 2016 referencing non-compliance with the regulations were not progressed. For example practices in relation to medication management, insufficient communal space on Brosna unit and a failure to facilitate the pharmacist to meet their obligations. The person in charge advised inspectors that progression was hindered by a lack of funding.

There was a system in place to monitor the quality and safety of the service. An auditing and review schedule was in place and information collated was analyzed and trended. Action plans were developed to progress areas identified as requiring improvement. The person in charge and staff in the centre took a proactive approach to ensuring the service was safe and met residents' needs. They demonstrated that residents' quality of life in the centre was important to them and had worked to make the environment comfortable and accessible for residents.

While capital funding was not provided to increase available communal space in Brosna unit, the interim arrangements implemented by the person in charge and staff to reduce negative outcomes from the confined space available are welcomed. Prior to the

previous inspection in Oct 2016 a pharmacist attended the centre, provided advice, conducted audits and was available to meet with residents. This service was withdrawn in Sept 2016 and had not been reinstated. This non compliance is re-stated in this inspection report.

Judgment:
Non Compliant - Moderate

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

Theme:
Governance, Leadership and Management

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

Findings:
All information in staff files as required by Schedule 2 of the Regulations was made available.

All records to be maintained in respect of each resident and otherwise as described by Schedules 3 and 4 of the Regulations were in place. They were held securely and were easily retrieved

All of the written operational policies including a policy to inform admission of residents as required by Schedule 5 of the Regulations were available and up to date. These policies were accessible to staff to inform their practice.

Judgment:
Compliant

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

Theme:

Safe care and support

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

Findings:
Inspectors found that there were measures in place to protect residents being harmed or suffering abuse. Appropriate action was taken in response to allegations, disclosures or suspected abuse. All staff had recently completed training in the prevention, detection or response to abuse. Staff spoken with were able to describe what action they would take in response to an allegation or incident of abuse and were aware of their reporting responsibilities.

There was a policy and procedure in place for managing responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). Due to their complex medical conditions, some residents showed responsive behaviours. Inspectors saw that assessments had been completed and these had been used to inform the development of behavioural support plans for each resident that required one. A number of staff who spoke with inspectors were aware of possible triggers of responsive behaviours for residents and could describe the interventions that they would use.

A restraint-free environment was promoted in the centre. On the day of inspection, 14 residents were using forms of restraint such as bedrails, and these were documented in the centre's restraint register. Risk assessments were undertaken and the care plans reviewed detailed the use of restraint. While risk assessments were reviewed by staff, residents' care documentation did not confirm that these assessments were reviewed every four months as required. While inspectors were informed that safety checks were completed when bed rails were in use, however these checks were not been documented. Additionally, there was no evidence that alternatives to bedrails had been trialled prior to the implementation of bedrails.

The provider was not managing finances on behalf of any residents at the time of the inspection.

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):
No actions were required from the previous inspection.

Findings:
The health and safety of residents, staff and visitors was promoted and protected. There was evidence of proactive management of risk identified in the centre. The centre's risk management policy was available and included the required information and controls to manage the risks specified by regulation 26 (1). Risk management documentation examined and the practices and procedures observed in the centre confirmed that all areas of risk was identified, assessed and occurrence mitigated with implementation of effective controls. The controls implemented to mitigate risks were considered to ensure they were sensitive to residents' needs, rights and quality of life.

Inspectors examined the arrangements in place and associated documentation to ensure fire safety in the centre and found that there were satisfactory fire safety management procedures in place. Frequent and detailed local fire safety checking procedures were completed and an external provider serviced fire safety equipment at regular intervals. Personal evacuation risk assessments were completed for all residents that took account of the staffing and equipment resources necessary to ensure their safe evacuation in the event of an emergency incident. Any issues that might hinder timely evacuation of individual residents was identified in this documentation such as cognitive impairment. A copy of each resident's evacuation plan was kept in a folder in the nurses' station for ease of access and reference in the event of an emergency and to assist the emergency services if necessary. Inspectors reviewed the records of fire evacuation drills completed and found that comprehensive records were maintained. A simulated day-time drill was completed and a simulated night-time drill was scheduled in the days following the inspection. This process ensured participation by all staff and facilitated assessment of adequacy of staffing levels available to safely evacuate residents in an emergency. The inspectors observed that the information recorded in the review of simulated drill procedures provided assurances that timely evacuation of residents in the event of an emergency could be achieved. While a small number of staff required up-to-date training in fire safety, the person in charge confirmed that this training was scheduled to take place within a month of the inspection.

Records of accidents and incidents involving residents or others were completed and areas. There was evidence of identification and implementation of learning from monthly accident/incident reviews. Each resident was assessed on admission and regularly thereafter for risk of falls. Residents who experienced a fall had their falls risk assessment reviewed and were referred for specialist assessment and care strategies as necessary to ensure their risk was controlled and their independence was optimized. Procedures were put in place to mitigate risk of further falls and residents at risk of falling were appropriately risk assessed with controls such as hip protection and sensor alarm equipment put in place. There was a low incidence of resident falls in the centre resulting in injury requiring hospital care. The inspectors observed that all residents were appropriately supervised by staff on the day of inspection. Each resident had a moving and handling risk assessment completed. Staff had completed safe moving and handling training and all procedures observed by inspectors were completed safely by staff.

There was policy and procedural information available to guide staff on infection prevention and control in the centre. This reference documentation also advised staff on the management and prevention of communicable infection including outbreak

procedures. Environmental cleaning procedures reflected best practice in infection prevention and control standards and the centre was visibly clean. Hand hygiene facilities and personal protective equipment (PPE) was located at various points throughout the premises. Staff carried out hand hygiene procedures as recommended.

Judgment:
Compliant

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

Theme:
Safe care and support

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

Findings:
There were written operational policies informing ordering, prescribing, storing and administration of medicines to residents. Inspectors' findings confirmed that residents' medicines were stored appropriately, including medicines controlled under Misuse of Drugs legislation and medicines requiring refrigeration. Checks were consistently completed of balances of controlled medicines twice every 24 hours and refrigerator temperatures were recorded on a daily basis. Residents' prescribed medicines were reviewed by the centre's medical officer. There were procedures in place for return of out-of-date or unused medicines to the dispensing pharmacy.

Inspector's findings did not provide sufficient assurances that residents were protected by safe medication management practices in relation to the following;
- documentation of maximum dosage of PRN (a medicine only taken as the need arises) medicines permissible over a 24 hour period on residents' prescription records was not completed. This was an action not completed from the last inspection in October 2016.
- medicines administered to residents in a crushed format were not individually prescribed for administration in that format.
- the name and route of medicines administrated by subcutaneous route were incompletely documented. These findings are actioned in outcome 11.
- the pharmacist who supplied residents' medications was not facilitated to meet their obligations to residents. This was an action not completed from the last inspection in October 2016.

Audits were completed by the person in charge at regular intervals to monitor medicine management procedures in the centre and the areas identified for improvement in these audits concurred with inspectors' findings on this inspection. While the person in charge demonstrated that she had made efforts to progress areas identified for improvement, these were not successful to date.

Judgment:
Non Compliant - Moderate

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:
Inspectors' findings confirmed that residents healthcare needs were met. The centre provided accommodation for 48 residents with varying care needs and dependency levels. Residents received timely access to health care services including emergency out-of-hours general practitioner (GP) care, community psychiatry and palliative care services. Residents in the centre had regular access to a medical officer. Residents had access to allied healthcare professionals. Physiotherapy, occupational therapy and speech and language therapy services were based on-site and reviewed residents in the centre on referral. Dietician, dental, Ophthalmology and chiropody services were also provided for residents. Residents' positive health and wellbeing was promoted with regular exercise as part of their activation programme, an annual influenza vaccination programme, monthly review of their vital signs, regular blood profiling and medication reviews by the centre's medical officer.

Staff spoken with by inspectors were knowledgeable regarding residents' likes, dislikes and needs. However inspectors' findings in relation to medication administration practices did not reflect practices that were in line with professional nursing guidelines. These findings are described in outcome 9.

An assessment of each resident's needs was carried out within 48 hours of their admission. Care plans were developed based on their assessments of need and thereafter in line with changing needs. The assessment process involved the use of validated tools to determine each resident's risk of malnutrition, falls, level of cognitive function and skin integrity among others. Care plans were updated routinely on a four-monthly basis or to reflect changes in each resident's care needs. The inspectors found that there were systems in place to optimize communications between residents and their families as appropriate regarding their care. A record of consultations with residents and their families regarding care plan reviews was maintained. Residents care

plans examined were person-centred and clearly described the care interventions to be completed to meet each need identified including behaviour support and end-of-life wishes and care. An assessment tool was available to assist staff with measuring and monitoring residents experiencing pain. Blood glucose level parameters for residents with diabetes were stated in their care plan to optimize their health. Although staff were aware of the optimal fluid intake over 24hours for residents assessed as being at risk of dehydration, these clinical parameters were not stated in their care plans. Monitoring records were available to ensure prescribed clinical care parameters were achieved. Residents were screened for nutritional risk on admission and reviewed regularly thereafter. Residents' weights were checked routinely on a monthly basis and more frequently when residents experienced unintentional weight loss. Nutritional assessment and care plans were in place that outlined the recommendations of the dietician and the speech and language therapist where appropriate.

There were care procedures in place to prevent residents developing pressure related skin injuries. Each resident had their risk of developing pressure related skin damage assessed on admission and regularly thereafter. Pressure relieving mattresses, cushions and repositioning schedules were used to mitigate risk of skin injury developing. There were no residents with a pressure related skin ulcer in the centre on the days of inspection. Inspectors observed where immediate and comprehensive was implemented to prevent one resident with symptoms of pressure related damage to their heel developing an ulcer. A policy document was available to inform wound management in line with evidence based practice procedures. Tissue viability specialist services were available as necessary to support staff with management of any residents' wounds that were deteriorating or slow to heal. Inspectors examined the procedures in place for care of one resident with a chronic wound and found that care reflected evidence-based best practice.

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

Findings:
The centre has accommodation for 48 residents over two floors arranged into two

residential units. Brosna unit was located on the ground floor and Inny unit on the first floor. Residents' bedroom accommodation was provided in mostly single room accommodation in addition to some twin bedrooms. The size and layout of bedrooms met the needs of the residents including accommodation of their personal equipment and devices. Privacy screening was available in two twin rooms and was designed to close fully around each resident's bed.

The location, design and layout of the centre was suitable for its stated purpose and met residents' individual and collective needs in a comfortable environment with the exception of communal space provided in Brosna unit. There was one communal room available for 24 residents on Brosna unit. The provider stated in their action plan response to the last inspection in October 2016 that additional communal accommodated would be provided by June 2018. In the interim, the person in charge and the staff team on Brosna unit had implemented improvements to optimize residents comfort in the unit. Specially designed assistive tables with varying seating capacities were provided to ensure all residents including residents in large support seating could comfortably access and sit at a table to eat their meals and participate in table based activities. A small annexed area off a circulating was furnished with seating and fitted with a facility to provide refreshments. This area enabled residents to meet their visitors in private outside of the communal room or their bedrooms and enabled residents to rest in an alternative area other than the communal room or their bedroom. However this arrangement did not meet the required standard and did not meet the needs of one resident with assessed needs best met in an area with less noise and stimulation. In contrast, residents accommodated on Inny unit had access to a number of communal areas. Residents could rest in a comfortable quiet room as an alternative to the noisier large communal room. In addition some residents choose to dine together in an additional small dining room.

Inspectors found the centre to be visibly clean, warm and well-ventilated. Residents had access to safe and secure outdoor areas on both floors. Due to cooler weather conditions on the day of inspection, residents did not choose to access these areas. The inspector was told that residents enjoyed the outdoor areas in warmer weather conditions. The external grounds were well maintained. Natural lighting was optimized throughout the centre and floor coverings were bright and did not have any bold designs which supported residents with dementia to access the centre with ease. Corridors and door entrances used by residents were wide and spacious to facilitate residents' safe mobility and assistive equipment. Internal painting had been completed on corridors since the last inspection and each resident's bedroom door was framed in a different colour. This improved the décor and supported residents' familiarity with accessing their environment. Painting of hand rails on circulating corridors and grab rails in toilets/showers was planned. Both units were well furnished with familiar pieces of domestic furniture and traditional memorabilia which made the environment therapeutic for residents. There was a seated area and a visitor's room for residents' use located on the ground floor outside of the units. There was a spacious lift to the first floor provided. There was a spacious chapel on site and was used regularly by residents.

Residents' bedrooms were personalised according to their preferences and in many cases reflected their interests. Each bedroom had a shelved display unit fixed to the wall, which were fully used by residents to display their family photographs and

favourite ornaments. Residents' safety and accessibility was promoted by hand rails to corridors and grab rails in toilets/showers. Furniture and equipment including high support wheelchairs used by residents was in good working condition. Mobility aids that included remote control beds and ceiling hoists were available in each resident's bedroom to promote safe moving and handling practices.

Judgment:
Non Compliant - Moderate

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:
There was a policy and procedure in place for the management of complaints, but required review to ensure that it reflected the practices within the centre. Inspectors found that there were systems in place to ensure that residents and their representatives were supported to make complaints.

A summary of the complaints' process was displayed within the centre, but this did not reflect recent changes to the appeals' process. Management informed inspectors that this document would be amended after the inspection. All other information accurately reflected the management of complaints.

There was a person nominated to manage complaints, and all complaints were recorded in the complaints' log. Complaints were found to be managed appropriately in a timely manner, and complainants were informed of the outcome of their complaint. For the most part complaints were recorded in line with the regulations; however inspectors noted that the satisfaction of the complainant with the outcome of the complaint was not consistently recorded. An additional person had not been nominated to ensure that complaints were appropriately recorded and responded to.

Judgment:
Non Compliant - Moderate

Outcome 16: Residents' Rights, Dignity and Consultation
Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to

exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

Theme:
Person-centred care and support

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

Findings:
Inspectors found that residents' privacy and dignity was respected. Residents were facilitated to communicate and exercise control over their lives and to maximise their independence. Staff were observed providing care in a sensitive and discreet manner, and were respectful in their interactions with residents. A person-centred approach was evident, with several examples of residents being supported by staff to pursue their individual interests. One resident was facilitated by staff to visit a café on the day of the inspection, and inspectors were informed that this occurs on a regular basis. A small number of residents were also supported to attend day care services on a weekly basis.

Inspectors found that since the last inspection, improvements had been made in the provision of activities to residents. The quality of life for many residents in the centre was enhanced by their engagement with visitors on a regular basis and participation in meaningful activities. One staff member is assigned to activities on a daily basis, and two staff members had recently completed specialist training in providing activities to residents. Large notice boards in each unit outlined the schedule of activities on a weekly basis, and photos from a recent Halloween party were displayed throughout the centre. On the day of the inspection, group activities such as chair exercises, board games, art and reminiscence therapy had been planned, and were observed by inspectors. However, improvement was required in ensuring all residents had opportunities to participate in meaningful activities and participate in the organisation of the centre. The occupational therapist supported staff with facilitating activities for residents with one to one or small group activation in a room outside the unit two days each week. Inspectors also found that while efforts to make room visits for one-to-one activities with residents were evident. However, further improvements were required to ensure that residents on Brosna unit with one to one or small group activation needs had access to appropriate facilities to meet their needs. Assessments of residents' interests were completed on admission to inform activity programmes for residents, and were updated as required. However, while inspectors were informed that individual records of residents' participation in activities were maintained, evidence of this could not be located on either unit on the day of the inspection.

Inspectors found that the systems in place were inadequate to ensure that each resident is consulted about and participates in the organisation of the designated centre concerned. Residents did not attend the residents form. A forum for residents was held once every quarter, and minutes of these were provided to inspectors for review. Topics discussed included activities, plans for refurbishment of the centre and upcoming

events. However, inspectors noted that no residents attended these meetings. A member of management informed inspectors that only residents' relatives or representatives attended the meetings to date, but that residents were also invited. While there was evidence that residents had some opportunity to provide feedback about the service, inspectors were not assured that residents were supported to be consulted about and participate in the organisation of the centre.

While visiting was not restricted in the centre, an initiative was in place at mealtimes to ensure that residents could take their meals undisturbed. .

Hairdressing services were available to residents in the centre, but this had recently decreased from a number of days per week to one day every six weeks. The person in charge informed inspectors that an additional day could be scheduled within this six week period if required. However, there was no evidence that residents were consulted about this arrangement and a number of residents expressed dissatisfaction with the reduction in the service.

Residents were facilitated to exercise their civil, political and religious rights. Weekly mass was held in the centre's chapel, communion was administered daily and rosary prayers were recited regularly. The person in charge outlined to inspectors how residents were supported to practice their respective faiths. Voting could be held in the centre, and residents could also vote in their electoral area if they chose to do so.

Residents' communication needs were outlined in care plans and these were reflected in practice by staff. Residents had access to telephones, and management were currently assessing how internet access could be made available to residents.

Residents had access to independent advocacy services, which could be contacted as required.

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):
No actions were required from the previous inspection.

Findings:
There were appropriate staff numbers and skill-mix on duty to meet the assessed clinical needs of residents. However, inspectors found that the social needs of residents requiring 1:1 activation were not met. This finding is discussed in further detail and actioned under Outcome 16.

On the day of the inspection, an actual and planned staffing roster was in place and reflected the actual number of staff on duty. Any changes to the roster were clearly indicated. Inspectors observed that there were sufficient staff on duty on the day of the inspection. Staff were seen to respond to residents' needs and requests quickly, and residents were well-supervised throughout the day.

A staff induction checklist was in place for newly-recruited staff and evidence of completed checklists were visible in staff files.

Training records were provided to inspectors and indicated that all staff had completed training in safe moving and handling procedures and the prevention, detection and response to abuse. While a small number of staff required up-to-date training in fire safety, the person in charge confirmed that this training was scheduled to take place within a month of the inspection. A large portion of staff had also completed training in infection control, medication management, and dementia care among other training to maintain their professional development and skills. Staff spoken with by inspectors were knowledgeable regarding the training that they had completed.

A sample of staff files were reviewed by inspectors and these were found to contain the majority of information required by the regulations. While An Garda Síochána vetting disclosures were not being held in the centre, these were forwarded to HIQA following the inspection. The person in charge told inspectors that all staff in the centre had An Garda Síochána vetting disclosures in place. Inspectors reviewed records confirming that all nursing staff were registered with An Bord Altranais agus Cnáimhseachais na hÉireann.

Staff appraisals were completed by the person in charge on an annual basis, and evidence of the appraisals completed in the previous year were provided to and reviewed by inspectors. Actions following these appraisals had been recorded where required. The person in charge informed inspectors that appraisals for this year were planned for December 2017.

There were no volunteers operating in the centre at the time of the inspection.

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:

Catherine Rose Connolly Gargan
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:	Cluain Lir Community Nursing Unit
Centre ID:	OSV-0000739
Date of inspection:	02/11/2017
Date of response:	15/12/2017

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:
A number of actions from the last inspection in October 2016 referencing noncompliance with the regulations were not progressed. For example practices in relation to medication management, insufficient communal space on Brosna unit and a failure to facilitate the pharmacist to meet their obligations. The person in charge advised inspectors that progression was hindered by a lack of funding.

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

1. Action Required:
Under Regulation 23(a) you are required to: Ensure the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.

Please state the actions you have taken or are planning to take:
The Provider has reviewed the Statement of Purpose and has ensured that adequate resources are in place for effective delivery of care as set out in the Statement of Purpose dated 1/12/17.

See action 3 / 4 / 5 & 9 which provides further information on each issue individually.

Proposed Timescale: 15/12/2017

Outcome 07: Safeguarding and Safety

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no evidence that alternatives to bedrails had been trialled prior to the implementation of bedrails.

While inspectors were informed that safety checks were completed when bed rails were in use, this had not been documented.

Bedrail risk assessments were not reviewed every four months as required.

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

Please state the actions you have taken or are planning to take:
Under Regulation 07(3) you are required to: Ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.

Please state the actions you have taken or are planning to take:

Evidence on alternatives to bed rails will be recorded in multi disciplinary enabler and restraint assessment form.

Safety checks will be recorded in restraint release form.

Bed rail risk assessments will be reviewed every four months as required.

Proposed Timescale: 16/02/2018

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:** The pharmacist who supplied residents' medications was not facilitated to meet their obligations to residents. **3. Action Required:** Under Regulation 29(2) you are required to: Facilitate the pharmacist concerned in meeting his or her obligations to a resident under any relevant legislation or guidance issued by the Pharmaceutical Society of Ireland. **Please state the actions you have taken or are planning to take:** A permanent Pharmacist is being processed from panel to fill vacant position. It is expected that this person will be in place in January 2018. Once in position the PIC will be enabled to facilitate a Pharmacist to meet the requirements of the Pharmaceutical Society of Ireland. Nursing staff in the Centre are fully compliant with safe medicines management procedures and pending filling of the Pharmacist position they maintain linkages with the dispensing pharmacist in Regional Hospital for advice.
Proposed Timescale: 31/01/2018

Outcome 11: Health and Social Care Needs
Theme: Effective care and support **The Registered Provider is failing to comply with a regulatory requirement in the following respect:** Although staff were aware of the optimal fluid intake over 24hours for residents assessed as being at risk of dehydration, these clinical parameters were not stated in their care plans. Documentation of maximum dosage of PRN (a medicine only taken as the need arises) medicines permissible over a 24 hour period on residents' prescription records was not completed. Medicines administered to residents in a crushed format were not individually prescribed for administration in that format. The name and route of medicines administrated by sub-cutaneous were incompletely documented.

4. Action Required:
Under Regulation 06(1) you are required to: Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

Please state the actions you have taken or are planning to take:
A policy on the administration of sub-cutaneous fluids in residents at risk of dehydration including clinical parameters for use is complete.

The Provider shall confirm in writing to the Medical Officer the requirement to:
• Document the maximum dosage of PRN medication permissible in 24 hour period.
• Medicines to be crushed to be individually prescribed for administration in that format.
• Ensure that all prescriptions are completely documented.

New format drug administration charts have been sourced which will assist with effective documentation. It is expected that these will be on site by 31/01/18

Proposed Timescale: 31/01/2018

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 layout and design of Brosna unit required improvement to provide residents with sufficient communal accommodation to meet their dining, recreational and relaxation needs.

5. 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:
A detailed submission/proposal has been sent to the Head of Older Persons Services on the requirement to provide/create additional day spaces in the Brosna unit. This proposal has not been approved to date. The Provider and the PIC will review the submission options from a cost saving perspective and re-submit the enhanced proposal for progression.

Provision is currently in place for 1:1 sessions in the Snoezlen room and for small group activities in the OT group room or Activities room located in the Therapy Dept of Centre. 1:1 social care provision hours have been approved for one individual resident as required in his personal care plan.

Residents needs on 1:1 or in small group activities will be on agenda in governance / resident / ward meetings and will be included in their personal care plans.

Proposed Timescale: 31/03/2018

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:
The satisfaction of the complainant with the outcome of the complaint was not consistently recorded.

6. 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:
The nominated person (action 6) will ensure all complaints are recorded appropriately including details of any investigation, the outcome of the complaint and whether or not the complainant is satisfied with the outcome.

Proposed Timescale: 15/12/2017

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
An additional person had not been nominated to ensure that complaints were appropriately recorded and responded to.

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

Please state the actions you have taken or are planning to take:
The nominated person (action 6) will ensure all complaints are recorded appropriately including details of any investigation, the outcome of the complaint and whether or not the complainant is satisfied with the outcome.

Proposed Timescale: 15/12/2017

Outcome 16: Residents' Rights, Dignity and Consultation

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Improvements were required to ensure that residents on Brosna unit with one to one or small group activation needs had access to appropriate facilities to meet their needs.

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

Please state the actions you have taken or are planning to take:
Provision is currently in place for 1:1 sessions in the Snoezlen room and for small group activities in the OT group room or Activities room located in the Therapy Dept of Centre.

1:1 social care provision hours have been approved for one individual resident as required in his personal care plan.

Residents needs on 1:1 or in small group activities will be on agenda in governance / resident / ward meetings.

Proposed Timescale: 15/12/2017

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
As the residents' forum was not attended by residents, inspectors were not assured that residents were consulted about and participated in the organisation of the centre.

Hairdressing services had recently decreased from a number of days per week to one day every six weeks. The person in charge informed inspectors that an additional day could be scheduled within this six week period if required. However, there was no evidence that residents were consulted about this arrangement and a number of residents expressed dissatisfaction with the reduction in the service.

9. Action Required:
Under Regulation 09(3)(d) you are required to: Ensure that each resident is consulted about and participates in the organisation of the designated centre concerned.

Please state the actions you have taken or are planning to take:

Residents will be encouraged and assisted to participate in Resident Forum meetings going forward. All issues relating to the service are discussed at this Forum.

Hairdressing is provided to residents without charge at a minimum of once in every six weeks. This is the same number of hours which were provided by staff member prior to retirement. The allocation of hairdressing hours is now fair and equitable for each resident.

A resident survey re satisfaction with hairdressing service provided was conducted this week and 2 residents are unhappy with service to date. These residents were unhappy because they like to have their hair done twice a week. These residents can be facilitated on an individual basis directly with the hairdresser.

The PIC is in discussion with hairdressers to provide hairdressing service once every four weeks from Jan 2018. Residents are free to maintain linkages with their community and use their own hairdresser if they wish at any other time.

Proposed Timescale: 31/01/2018