

# eDeposit Ireland

**Lusk Community Unit, Station Road, Lusk, Co. Dublin.**

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**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Lusk Community Unit
<b>Centre ID:</b>	OSV-0000505
<b>Centre address:</b>	Station Road, Lusk, Co. Dublin.
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<b>Type of centre:</b>	The Health Service Executive
<b>Registered provider:</b>	Health Service Executive
<b>Provider Nominee:</b>	Sheila Marshall
<b>Lead inspector:</b>	Leone Ewings
<b>Support inspector(s):</b>	None
<b>Type of inspection</b>	Announced
<b>Number of residents on the date of inspection:</b>	49
<b>Number of vacancies on the date of inspection:</b>	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.

**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 Quality Standards for Residential Care Settings for Older People in Ireland.**

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration renewal decision. This monitoring inspection was announced and took place over 2 day(s).

**The inspection took place over the following dates and times**

From:	To:
27 January 2015 09:30	27 January 2015 16:30
28 January 2015 10:00	28 January 2015 16:00

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

Outcome 01: Statement of Purpose
Outcome 02: Governance and Management
Outcome 03: Information for residents
Outcome 04: Suitable Person in Charge
Outcome 05: Documentation to be kept at a designated centre
Outcome 06: Absence of the Person in charge
Outcome 07: Safeguarding and Safety
Outcome 08: Health and Safety and Risk Management
Outcome 09: Medication Management
Outcome 10: Notification of Incidents
Outcome 11: Health and Social Care Needs
Outcome 12: Safe and Suitable Premises
Outcome 13: Complaints procedures
Outcome 14: End of Life Care
Outcome 15: Food and Nutrition
Outcome 16: Residents' Rights, Dignity and Consultation
Outcome 17: Residents' clothing and personal property and possessions
Outcome 18: Suitable Staffing

**Summary of findings from this inspection**

This inspection was announced following an application by the provider to renew the registration of the centre. As part of the inspection, the inspector met with residents and staff, observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files.

Prior to the inspection, all documents submitted by the nominated person on behalf of the provider, for the purposes of application to register were found to be satisfactory. One outstanding document relating to a fire compliance template from a suitably qualified person had not been received for review. However, evidence of compliance with planning legislation had been received and reviewed.

The centre is registered to accommodate 50 residents' and there were 49 residents on the day of inspection, with one bed vacant. Five of the beds were used on a rolling programme of temporary respite stays for residents in the locality.

The provider and the person in charge were found to be operating in compliance with the conditions of registration and in compliance with twelve of the eighteen outcomes inspected against. The inspector confirmed that the nominated person on behalf of the provider had fully addressed the one non compliant outcome from the last monitoring inspection which took place on July 2014.

The inspector found that the governance structure had changed since the time of the last inspection whilst the new director of nursing was recruited.

The six non compliances not met on this inspection related to follow up from incidents and fall, maintenance of mandatory training records, provision of prescribed food supplements, and review of the use of restraint. Additionally the provider has not provided an annual report on quality and safety and quality of life. The provider has not submitted evidence of fire compliance as required by the Regulation 4 of the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2009.

The action plans at the end of this report reflect these non-compliances.

**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 Quality Standards for Residential Care Settings for Older People in Ireland.**

***Outcome 01: Statement of Purpose***  
***There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.***

**Theme:**  
Governance, Leadership and Management

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

**Findings:**  
The inspector reviewed the statement of purpose submitted for the purposes of renewal of registration. The document was detailed, informative and easy to follow and contained all of the required information required by Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

The statement of purpose was clearly implemented in practice relating to provision of services which were to be provided to residents.

**Judgment:**

Compliant

***Outcome 02: Governance and Management***

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

**Theme:**

Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

The Inspector found that overall there were good systems of clinical governance in the centre which resulted in good outcomes for residents. There were enough resources to ensure the effective delivery of care, as described in the statement of purpose.

There were clear lines of accountability for decision making and responsibility for the delivery of services to residents. Changes which had taken place and been properly notified to the Authority since the last inspection; the named person in charge had retired from her post at the end of May 2014, and an interim arrangement proposed and agreed with the Authority that two persons participating in management would take on this role on a temporary basis. The recruitment process was not yet complete to date, and one of the senior managers had been nominated as person in charge by the provider. She was interviewed as part of this registration process and found satisfactory. The roles of nurse managers, nursing staff and care staff were clearly set out in the job descriptions.

The inspector found that the management systems in place ensures that services provided were safe, appropriate to residents' needs, consistent and effectively monitored. For example, the risk register and safety statement had been updated on 2 January 2015 to include all risks, and measures to mitigate risk.

There was evidence of consultation with residents and their representatives, and there were some systems in place to review and monitor the safety and quality of care provided. However, no written report for 2014 had been collated or made available to residents or the Chief Inspector.

The provider had not submitted evidence of fire compliance, completed on the template

provided by the Authority with the application to renew registration.

**Judgment:**  
Non Compliant - Major

***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:**  
There was a guide to the centre available to residents, a copy of which was submitted and reviewed prior to this inspection. The detailed document known as the information directory included a summary of services and facilities provided, outlined the terms and conditions of a residents stay, the complaints procedure and arrangements for visitors to the centre. There was a copy available to residents' living in the centre, and details of how feedback on service provision could be made to management.

A written contract of care was in place for each long term resident and was agreed on admission; which included details of the care and welfare and services provided. Each contract also included details of the fees charged to the resident each week and outlined any additional fees that may be added for services that the resident may request or require.

**Judgment:**  
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 person in charge had changed since the time of the initial application for registration. A new person in charge had been nominated by the provider whilst the recruitment process for a full time post holder was completed.

The inspector was satisfied that the current person in charge and deputy manager at the centre were suitably qualified and experienced to fulfil their roles, and the required supports were in place. The person in charge was supported by an assistant director of nursing, two clinical nurse managers, and a clinical nurse specialist.

A supportive organisational structure and management arrangements were found to be in place for the person in charge. The person in charge reported into the provider nominee, a general manager based in the local health office. They meet on a formal basis regularly, and all relevant issues are discussed, including budgets, staffing, complaints and risk management at the centre. Other supports included allied healthcare, activities, portering, catering, household and administrative staff.

**Judgment:**

Compliant

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

**Theme:**

Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

The majority of the records outlined in schedule 2, 3, 4 and 5 were available for review. However, the person in charge did not have a full training matrix containing information about staff mandatory training in fire, moving and handling and safeguarding older people. She agreed to forward this information to the inspector after the inspection. This information was not found to be fully complete relating to all staff working at the centre and required review, this was communicated to the person in charge.

Overall, the inspector found records were kept secure and were easily retrievable. Residents could access their records if they wished. There was a policy in place which reflected practice in relation to retention of records in the centre. That is, that all records were retained for a minimum of seven years.

The centre-specific policies outlined in schedule 5 reflected the centre's practices. The protection of residents from elder abuse and the fire policy had been updated and implemented since the last inspection. Policies, procedures and practices were reviewed at a minimum every three years to ensure the changing needs of residents were met.

The inspector reviewed insurance documents which showed the centre was adequately insured against injury to residents and other risks were insured against, including loss or damage to a resident's property. The directory of residents contained all the required details of each resident including the date, time, cause and place of those who had died.

Three staff files reviewed contained all documents outlined in schedule 2.

**Judgment:**

Substantially Compliant

***Outcome 06: Absence of the Person in charge***

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

**Theme:**

Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

The Chief Inspector was notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during her absence. A shared arrangement for covering the role of the person in charge has been ongoing since June 2014 while the recruitment process was ongoing.

As part of the application procedure the assistant director of nursing has been nominated in this role as an interim arrangement until the post of person in charge is filled by the provider and commences in the role. The assistant director of nursing was not on duty at the time of this inspection but has the required skills, knowledge and experience and has participated in previous inspection and monitoring events.

**Judgment:**

Compliant

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***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:**

Robust measures were in place to protect residents from being harmed or suffering any form of abuse. A report had been made by the person in charge of an allegation of abuse which was currently under investigation and review. The inspector reviewed actions taken following the report and found policy had been followed with regard to immediate steps taken to safeguard the resident.

The policy and procedure in place for, the prevention, detection and responding to allegations of abuse was in place. Staff interviewed by the inspector were clear on procedures to follow if they witnessed any form of abuse and clear working knowledge of the policy as it relates to them.

Residents spoken with told the inspector they felt safe in the centre. The inspector saw that all main entry/exit doors were kept secure and reception desk was manned during the day. There was a visitor's sign in book at the main entrance.

The inspector saw evidence that all staff had up-to-date training in relation to the prevention, detection and response to abuse. Staff spoken with had a good, clear understanding of what constitutes abuse and knew what to do in the event of an allegation, suspicion or disclosure of abuse, including who to report any incidents to. Their knowledge reflected that outlined in the policy and procedure.

There were systems in place to safeguard residents' money. It was covered by a clearly outlined policy. There was a policy on, and procedures in place, for managing behaviour that may be challenging.

There was a policy on, and procedures in place, for the use of any form of restraint. For example, one resident had been identified as having exit seeking behaviours, and had additional measures implemented and wore an alarm bracelet which did not restrict them in any way from moving around the premises. This was kept under review and another resident had recently no longer required this measure and it had been discontinued.

However, as mentioned under outcome 5, while documentation had improved since the last inspection, a recent audit of the use of bed rails in use was not fully in line with best practice and had identified the need to undertake further review in this area. The person in charge has undertaken to implement additional training and review relating to the use of bed rails.

**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, visitors and staff was promoted and protected. However, some improvements relating records of auditing and monitoring quality and safety at the centre. For example, follow up from incidents at the centre and a small number of residents who have had frequent falls or incidents, was not adequate and did not have the details of measures to mitigate risk fully addressed by the person in charge.

The centre had a risk management policy, an emergency plan and an up-to-date health and safety statement in place. The risk register was comprehensive and identified all potential risks and specific measures put in place to reduce the level of risk. Infection control practices were good with hand washing and drying facilities available by each wash hand basin and hand sanitizers available throughout the centre. The centre had notified the Authority of an outbreak of a respiratory viral illness, which had been contained and infection control measures fully implemented. The person in charge gave an update relating to this outbreak and actions taken to mitigate risk which were in line with best infection prevention and control practices. The public health specialist nurse had been notified of the outbreak and visiting had been curtailed for the time of the outbreak.

The emergency plan gave staff clear guidance on what to do in the event of all types of emergencies. The inspector saw that there was adequate means of escape and fire exits were unobstructed. Records reviewed on inspection showed that the fire alarm was serviced on a quarterly basis and fire safety equipment and emergency lighting was serviced on an annual basis. Records of staff confirmed that staff completed fire safety and participated in fire drills. Records reviewed were not comprehensive to include dates for all staff, and maintenance of records was identified as an issue where improvement was required in Outcome 5 of this report. There was a floor plan showing the nearest

fire exit displayed in corridors throughout the centre.

Manual handling practices observed were in line with best practice and all assistive devices were available to facilitate moving and handling. A request was made to submit records of staff who had training in place, although staff who were interviewed told the inspector about their last training session. The inspector was informed that moving and handling training took place on site by a FETAC Level 6 trained instructor.

**Judgment:**

Non Compliant - Moderate

***Outcome 09: Medication Management***

***Each resident is protected by the designated centre's policies and procedures for medication management.***

**Theme:**

Safe care and support

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

Medication management was found to be in line with best practice, reflected the centres policy and reflected An Bord Altranais agus Cnáimhseachais na hÉireann "Guidance to Nurses and Midwives on Medication Management" (July 2007) guidelines. The written operational policies relating to the ordering, prescribing, storing and administration of medicines reflected current practices observed by the inspector.

The inspector noted that food supplements were now prescribed on a separate prescription sheet however, stock of some supplements had not been available for three days, the person in charge confirmed that the stock had been ordered but had not yet arrived to replenish stock. The pharmacy provider was not involved with supply of these supplements as they came from a central source in the organisation. The person in charge undertook to review the current arrangements to ensure availability of the required food supplements to residents as prescribed by the dietician, and assured the inspector that she would address this issue forthwith.

The system in place for reviewing and monitoring safe medication management practices was in place, and medication errors are recorded and actioned in line with best practice. A medication audit on medication management practices had taken place during 2014, and further review was planned for in 2015.

**Judgment:**

Substantially Compliant

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***Outcome 10: Notification of Incidents***

***A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.***

**Theme:**

Safe care and support

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

Clear and concise records of all incidents occurring in the centre were maintained and made available for review.

The inspector found that all notifiable incidents had been notified to the Chief Inspector within three days. Quarterly reports had been provided to the authority to notify the Chief Inspector of any incident which did not involve personal injury to a resident.

**Judgment:**

Compliant

***Outcome 11: Health and Social Care Needs***

***Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.***

**Theme:**

Effective care and support

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

Each resident's wellbeing and welfare was maintained by a high standard of evidence-based nursing care. Systems were in place to complete pre-admission assessment in line with the admissions policy. Each resident had their right to refuse treatment documented where applicable, and this was respected. Care plans were reviewed on a three monthly basis by nursing staff and were comprehensive and generally reflective of care needs identified by each assessment. A number of residents at the centre had inputs from psychiatry for older person's team, and access to specialist review is in place. A small number of residents were identified as having behaviours which required

closer levels of supervision and review and this review was clearly documented.

Each resident had an assessment in place which was updated every three months. The inspector reviewed four residents' files and saw that each identified need had a care plan in place. There was evidence that residents' were involved in their assessment and care plan and any further reviews. The inspector saw evidence that residents' received appropriate medical and allied health care without delay. Residents were seen by their general practitioner (GP) and the medical officer on a frequent basis and had their medications reviewed every three months or more frequently as required. Recommendations from healthcare professionals were linked into each residents care plan where applicable.

**Judgment:**

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 single storey premises were purpose built, and opened in December 2001 and has resident accommodation for 50 people. The designated centre is located in the village of Lusk approximately 20 miles from Dublin city. Access to the building is controlled and all visitors are asked to sign in at reception and undertake hand hygiene.

The provider has completed three separate phases of improvements to the premises over the last two years to reduce multiple occupancy rooms and the opening of a new extension to facilitate resident needs. The design and layout of the premises is suitable for the stated purpose as outlined in the Statement of Purpose. There were adequate toilet, shower and bathroom facilities for resident use, including five assisted bath/shower rooms. The new extension has rooms which have been commissioned with ceiling track hoists and had been well designed to meet resident needs, and facilitate assistive equipment.

The community unit also accommodates a day centre facility, physiotherapy and other community based services. An oratory, hairdressing salon, snoezelem room and fine dining (visitor's area). The person in charge and assistant director of nursing had an

office near the front door. The dining room was also recently been extended as part of the changes to the premises. The main kitchen is located adjacent to the dining room. The kitchen was an adequate size in relation to numbers of residents at the centre.

Two large communal sitting rooms are available and a further smaller quiet sitting room, with additional seating on large wide corridors. Outdoor landscaped courtyard gardens are appropriately furnished and level walking areas and paths around the building. An outdoor smoking space had been designated for residents use.

The resident bedrooms are as follows:

Rush Side:

- 12 single bedrooms with en-suite facilities
- 5 single bedrooms with hand washing facilities
- 4 twin bedrooms with hand washing facilities

Lusk Side:

- 11 single bedrooms with en-suite facilities
- 4 single bedrooms with hand washing facilities
- 4 twin bedrooms with hand washing facilities

The inspector noted that the standard of ongoing maintenance was well managed, the premises were well maintained and there was an ongoing maintenance programme in place. There was adequate lighting, ventilation and heating in place throughout the building.

The laundry facilities were reviewed on previous inspections found to be adequate and were well equipped with appropriate washing and drying machines and facilities to iron linens and clothing. Hot water was thermostatically controlled to wash hand basins and shower/bath facilities, and the hairdressing room.

Storage facilities were adequate and corridors were spacious, wide and had handrails in place to facilitate movement throughout the building.

**Judgment:**

Compliant

***Outcome 13: Complaints procedures***

***The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.***

**Theme:**

Person-centred care and support

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

Complaints were found to be well managed, and the person in charge was the nominated complaints officer. The complaint's policy was in place and the inspector noted that it met the requirements of the Regulations. The complaints procedure was on display at in the centre. Relatives and residents who spoke with the inspector knew the procedure if they wished to make a complaint. Residents and relatives were aware of the name of the current person in charge and her deputy and could readily access them for feedback purposes.

Two complaints had been documented by the person in charge since the time of the last inspection and reviewed by the inspector. The complaints were found to have been investigated and responded to by the person in charge. The inspector was satisfied that all the complaints made to the person in charge had been documented and investigated in line with the policy. Complaints and feedback from residents were viewed positively by the provider and the person in charge. Feedback came from individuals and through the resident's meetings facilitated by the advocate.

**Judgment:**

Compliant

***Outcome 14: End of Life Care***

***Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.***

**Theme:**

Person-centred care and support

**Outstanding requirement(s) from previous inspection(s):**

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

**Findings:**

Improvements had taken place since the last inspection. The end of life policy was now fully reflective of practices at the centre and required review relating to assessment time frames, staff supports in place, provision of written information and documentation of return of personal property and effects. The policies had been updated since this time, and practices in place ensured that each resident received care at the end of their life which met their physical, emotional, social, psychological and spiritual needs and respected their privacy, dignity and autonomy.

A thematic monitoring inspection took place in July 2014 and all lines of enquiry were completed and reviewed in detail. The inspector was satisfied the a high standard of care was in place and family meetings were planned and documented to discuss any palliative care or end of life matters which required review. A relative confirmed to the inspector that careful and sensitive discussion took place about this area of care and that all residents and relatives views were considered as part of the overall discussion in

family meetings.

The inspector reviewed a resident's end of life preferences which were recorded and there was an end of life care plan in place. Residents could choose their preferred place of death. All spiritual, religious and cultural practices were facilitated by staff. Respect was shown for the remains of a deceased resident and arrangements for the removal of remains occurred in consultation with deceased resident's family.

**Judgment:**

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:**

The inspector confirmed that the provider and person in charge were found to be compliant relating to this outcome, and there were no areas for improvement identified. The thematic inspection relating to food and nutrition undertaken in July 2015 was also in full compliance and all lines of enquiry were reviewed at this time.

Food and drink were provided in quantities adequate for residents needs, and available on a regular and as required basis. Menus were reviewed by the dietician who visited each week for one day, and food options gave choice and variety. For example, a recommendation was made about inclusion of an oily fish option in the overall menu choices.

The main dining room was attractively decorated, and well ventilated, with space to move wheelchairs and mobility aids between the tables. The inspector observed mealtimes at the centre and found that food was attractively presented and very much a social occasion. Residents were offered a choice of food at each meal time and individual preferences were readily accommodated. The nursing and care staff monitored the meal times closely. Residents who required their food to be modified in any way, were served this food in individual portions and had the same choice of food at the main meal which was presently separately on the plate. A fine dining option was available to residents who could arrange to have a family meal, or with a significant other in the visitor's room, where tea, coffee and refreshments were readily available.

Drinks were provided during the day and with meals, and at other regular times during

the day. Portion sizes were appropriate and second helpings were offered. All residents expressed satisfaction with their meals to the inspector on the day of the inspection. The inspector observed the dining room and visited residents and found that the dining experience was dignified, pleasant and relaxed for the residents. The inspector observed staff seated beside residents assisting them with a meal and assisting one resident at a time with their meal. The meal time provided opportunity for social interaction between staff, residents and relatives.

Relevant information pertinent to the meal time was in place and was reviewed by the catering manager and person in charge. Snacks were provided at any time as requested, a variety of snacks, such as yoghurt, scones, crackers and fruit were available.

Inspectors found that weight records showed that residents' weights were checked monthly or more regularly if required. Nutrition risk assessments were used to identify residents at risk and were also repeated on a regular basis. Records also showed that a small number of residents had been referred for and received a recent dietetic and speech and language (SALT) review. The treatment plans for residents was recorded in the residents' records. Evidence of review and regular input from the dietician were well documented in residents' records.

**Judgment:**

Compliant

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

**Theme:**

Person-centred care and support

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

The inspector was satisfied that all staff treated residents with respect, with regard to each individuals' privacy and dignity and that strong emphasis was placed on these values by the provider and person in charge. A good response to the pre-inspection was acknowledged, and assistance with completion of residents' questionnaires had been provided by two independent advocates.

Staff were observed knocking on bedroom, toilet and bathroom doors and waiting for a response to enter and this was confirmed by residents. The inspector observed staff

interacting with residents in a friendly and courteous manner. There was an open visiting policy and contact with family members was encouraged and facilitated. The person in charge and all staff were seen to interact well with residents during the inspection.

Residents' meetings took place within the centre, where a committee has been established since 2005. Residents told the inspector they had opportunities to discuss issues as they arose with the person in charge, provider or any staff member. The committee meets each month to discuss any issues, and minutes of the meetings are displayed on the information board. A volunteer advocate facilitates this meeting. The person in charge told the inspector that any issues raised by residents for example, in relation to food were addressed at local level or at management meetings where additional measures (if any) to address were required.

Relatives confirmed that if they had any query it was addressed immediately. They also said they were kept up to date with any changes in health or social care, and valued family meetings and their involvement with care.

The inspector found that most residents said they had flexibility in their daily routines, for example, residents could decide whether to participate in activities available to them. They chose when to go to bed and the time they got up. Residents also confirmed that they can opt not to participate in activities if they chose.

The inspector noted that televisions had been provided in residents' bedrooms. Residents had access to newspapers daily and there was access to the internet.

Residents had opportunities to participate in meaningful activities, appropriate to their interests and preferences every day at the centre with a varied resident led programme on view. There were two activity staff employed in the centre and the benefits to residents were apparent. A schedule of activities was available each day and the inspector noted that various activities were being provided throughout the centre.

The hairdresser visited regularly and residents also planned trips and outings with the activities staff. Residents commented they enjoyed their lifestyle and access to local shops and activities such as quizzes, dancing, singing and exercise/fitness sessions. There was evidence that residents engaged in activities such as music, SONAS (a therapeutic programme specifically for residents with dementia), hand massage and could access a fully equipped snoezelem room. Social care assessments were in place in respect of all residents and residents, which included individual likes and dislikes and each resident had a care plan to guide the social care services delivered.

**Judgment:**  
Compliant

**Outcome 17: Residents' clothing and personal property and possessions**  
**Adequate space is provided for residents' personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.**

**Theme:**

Person-centred care and support

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

Residents could have their laundry attended to within the centre, laundry services were provided on site. Residents and relatives expressed satisfaction and were complimentary about the laundry service provided. However, in practice a number of relatives confirmed that residents had their laundry completed by relatives. Adequate storage space was provided and there were procedures in place for the management of laundry that required additional infection control procedures. Residents admitted under the Nursing Homes Support Scheme had laundry services included in the overall fee and this was outlined in the contract of care, and resident's guide.

Residents had access to a locked space in their bedroom if they wished to store their belongings. There was a policy in place of residents' property in line with the Regulations and a list of residents' property was maintained by staff, and kept up to date.

**Judgment:**

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 sufficient numbers of staff with the appropriate skills, qualifications and experience to meet the assessed needs of all the residents.

There was an actual and planned staff rota. The inspector saw that there was a minimum of one staff nurse on duty at all times and the numbers of staff rostered during the day and night took into account the statement of purpose and size and layout of the building. The roster showed that staff were supported by two clinical nurse managers. Residents spoken with confirmed that staffing levels were good. Feedback from written questionnaires confirmed that residents were overall satisfied with staffing levels and did not have to wait excessive for a call bell to be answered or their requested needs to be met.

Staff spoken with told the inspector their learning and development needs were being met and they demonstrated a good knowledge of policies and procedures relating to the general welfare and protection of residents. However, records of mandatory staff training requested and submitted by the provider post inspection were not comprehensive. Following review of these records the inspector could not fully determine that all staff had mandatory education and training in place.

A review of three staff files confirmed that effective recruitment procedures were in place, all three files contained the required documents outlined in Schedule 2, including evidence of up-to-date registration with the relevant professional body for staff nurses for 2014.

**Judgment:**

Substantially 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:***

Leone Ewings  
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<sup>1</sup>

<b>Centre name:</b>	Lusk Community Unit
<b>Centre ID:</b>	OSV-0000505
<b>Date of inspection:</b>	27/01/2015 and 28/01/2015
<b>Date of response:</b>	18/03/2015

### 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:

Evidence of fire compliance on template supplied by the Authority has not been submitted as part of the application to renew registration.

#### Action Required:

Under Regulation 4 of the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 you are required to: Provide all documentation

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

prescribed under Regulation 4 of the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015

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

Please find attached letter from HIQA outlining that after 1/3/2015, that these documents will no longer be required as agreed with HSE fire officer/Estates and HIQA.

**Proposed Timescale:** 01/03/2015

**Theme:**

Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Annual report of a review of quality and safety and quality of life not completed to date.

**Action Required:**

Under Regulation 23(d) you are required to: Ensure there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.

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

The annual review will be completed and sent to the department.

**Proposed Timescale:** 09/03/2015

**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:**

Records of staff mandatory training were not fully maintained by the provider, or available for inspection.

**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:**

Mandatory training records have been sent to the department. The PPIM will be responsible for the planning of all mandatory training and records of same will be maintained by administrative staff. This will be held on an excel spreadsheet. We have inhouse trainers who deliver the CPR and Man Han training, Fire training is organised with a private company contracted by the HSE who deliver the training to all staff for one week in November. Elder protection will be organised with the local Trainer and

infection control training is delivered by the community CNS for infection control.

**Proposed Timescale:** 17/02/2015

### **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:**

Policies and procedures relating to restraint are in place but some gaps are evident relating to the use of bedrails which is not fully in line with best practice.

**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:**

Training updates have been planned for 4/3/2015. This training will incorporate best practise, national policies and alternatives to bed usage. Evidence of this training and reduction of bed rail usage should be reflected in the next quarterly returns.

**Proposed Timescale:** 28/04/2015

### **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:**

Arrangements for investigation and learning from serious incidents or adverse events involving resident were not robust or specific to fully mitigate risk.

**Action Required:**

Under Regulation 26(1)(d) you are required to: Ensure that the risk management policy set out in Schedule 5 includes arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.

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

Case conference/MDT has taken place for one resident and the second resident's MDT has been planned for early march 2015. Learning from MDT and action plans have been implemented

**Proposed Timescale:** 28/04/2015

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## 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:**

Prescribed food supplements were not available for three days as they were found to be out of stock.

**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:**

CNM's have been given the responsibility to ensure that stocks are checked every Sunday. Requests are sent to the central store on Monday and delivery occurs on Tuesday. The Dietician has identified how many products are required for each resident per month. We have allowed for extra requirements when managing our stock control. This procedure has been implemented with support the dietician.

**Proposed Timescale:** 17/02/2015

## Outcome 18: Suitable Staffing

**Theme:**

Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Mandatory training records are not accurately maintained by the person in charge.

**Action Required:**

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

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

Mandatory training records have been sent to the department. The training records are now being maintained by the administrative staff under the governance of the PPIM.

**Proposed Timescale:** 17/02/2015