Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	Fennor Hill Care Facility
Name of provider:	Blockstar Building Limited
Address of centre:	Cashel Road, Urlingford, Kilkenny
Type of inspection:	Unannounced
Date of inspection:	15 April 2021
Centre ID:	OSV-0007180
Fieldwork ID:	MON-0031471

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

Fennor Hill Care Facility is situated on the outskirts of Urlingford in County Kilkenny and within walking distance from the village centre. Residents' accommodation is situated on two floors of the facility and accommodates 56 residents. It is a newly built facility opened in September 2019. Accommodation comprises 48 single rooms and 4 twin rooms, all of which have spacious ensuite bathrooms with a toilet, hand sink and shower facilities. The centre has communal sitting and dining rooms on both floors. The centre can accommodate both female and male resident with the following care needs: general long term care, palliative care, convalescent care and respite care. The age profile of each resident maybe under or over 65 years but not under 18 years with low to maximum dependency levels.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	50

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 15 April 2021	10:00hrs to 18:00hrs	Caroline Connelly	Lead
Thursday 15 April 2021	10:00hrs to 18:00hrs	Catherine Furey	Support
Thursday 15 April 2021	10:00hrs to 18:00hrs	Sean Ryan	Support

What residents told us and what inspectors observed

The overall feedback from residents and relatives was that this was a nice place to live, with plenty of communal and private space and easy access to the external gardens. Residents identified staff as being kind and caring and they enjoyed the activities provided. The inspectors spoke with a large number of the residents during the inspection and met two visitors who were in visiting their relatives.

The inspectors arrived unannounced to the centre and on arrival they were met by a staff member who ensured that all necessary infection prevention and control measures, including hand hygiene and temperature checking were implemented prior to accessing the centre. Following an opening meeting inspectors were guided on a tour of the centre. Inspectors saw that the centre was a modern well maintained building which was decorated to a high specification with a lovely entrance foyer adorned by a large chandelier. This foyer contained couches and a decorative fire for residents to relax beside and watch the world go by. Day and dining rooms opened off the foyer where residents were observed to be social distancing in various groups. An oratory provided another area where residents could use for prayer, reflection and quiet times. There was also a meeting room on the ground floor which doubled up as a visitors room, this room was also used for window visiting. The first floor had its own day and dinning room but a number of residents told the inspectors that they came downstairs for activities and to go into the garden. The inspectors noted that many of the resident's bedrooms were personalised with soft furnishings, ornaments and family photographs. Residents in the centre were complimentary about the building stated that they had big en-suite bedrooms and loved the space afforded to them.

The centre was observed to be bright and very clean. However, inspectors saw that infection control practices particularly in an area upstairs which was classed as the isolation area required immediate review. Clinical waste bins were missing, hand washing sinks were not working and the area used for donning and doffing of PPE was not appropriate. These issues around are discussed further in the report.

Inspectors saw that there was a comprehensive activities programme in place and residents were aware of the day's programme to enable them choose whether to attend or not. There was a staff member allocated to the role of activity co-ordinator. The inspectors saw a number of lively, fun filled activities taking place. Inspectors were informed that a second activity co-ordinator was to be on duty upstairs but this post is currently vacant and recruitment is underway for a replacement. Although some activities did take place upstairs, the lack of activity provision was evident with a large number of residents in the upstairs sitting room sitting in the room without meaningful activities for parts of the day. The person in charge assured the inspector this role would be filled as soon as possible. Staff on the first floor were also observed executing an unsafe moving and handling practice which is discussed in the report. Downstairs the inspectors saw a sing song session with residents singing their favourite songs, inspectors observed that staff

encouraged residents to partake in the singsong and some good humoured banter was heard. Residents told the inspector that the activities were really important to them and they had kept them going during the period of no visitors and when they were not seeing family members. Residents were delighted that they can have visitors again and cherished the time with them. One resident told the inspectors that they had attended a medical appointment, following which they went into town for the first time in months. The resident was accompanied by family and was delighted to come back with some new clothes. The inspectors saw visiting taking place in the centre and noted there was a separate entrance for the visitor and all infection control procedures were complied with. Although the visitors told inspectors they were thrilled to be back visiting, inspectors noted the visiting area was in a very high traffic area and privacy for visiting was difficult to maintain.

Inspectors saw that the centre had a residents' committee and residents reported that their views were listened to and records of residents' meetings showed that any issues or suggestions made by the residents were generally acted upon. Residents told inspectors that they enjoyed living in the centre. Staff were kind and attentive and the food was varied and served nicely. Residents felt that their complaints or concerns would be addressed and they enjoyed the resident council meetings. They had been informed of the importance of hand washing because of COVID-19 and they were understanding of why staff and their relatives had to wear masks. The activity co-ordinator had created designated areas in the centre for different activities such as a relaxation area and an area for yoga. She discussed her plans and showed the inspectors an area upstairs that contained a football table, a snooker table, darts board and the maintenance man had installed a bar. The plan is that this will be an area where men could do activities, work and enjoy games together. Throughout the day inspectors saw that residents had unrestricted access to the garden either alone or when accompanied by staff. A new smoking shelter had been installed in a corner of the garden which contained a electric cigarette lighter, a fire blanket and an extinguisher, however it did not contain a way of alerting staff such as a call bell system.

Overall residents and relatives spoken to were very complimentary about the staff. However, a few residents commented on the frequent changes to the management team. Residents relatives said they were very grateful to the staff who had worked so hard during the pandemic who kept their spirits up and kept the centre COVID-19 free. Inspectors saw lovely interactions between residents and staff during the inspection and one residents' face was seen to light up the minute she heard one of the staff members voices. One resident described the staff as "the finest" you can discuss anything with them and they will do everything to help you. Residents had access to telephones, IT communications and newspapers and enjoyed religious services via the television.

Overall, the residents expressed feeling content in the centre. The next two sections of the report will present the findings of this inspection in relation to the governance and management arrangements in place, and how these arrangements impact on the quality and safety of the service being delivered.

Capacity and capability

Immediate improvements were required in the overall governance and management of the service to ensure effective oversight of this centre. The centre has an ongoing history of poor compliance with the regulations found over the last number of inspections. Following this inspection a precautionary provider meeting was held on the 16 April 2021 and the provider agreed to cease taking admissions and committed to spending a minimum of two days per week in the centre to provide oversight of the service to assure safe, suitable and quality care was provided to the residents. The governance and management required strengthening, governance systems implemented and a number of other areas for improvement were identified during the inspection included staff training, staff supervision, robust recruitment, staff files, and overall oversight of the service.

The centre is owned and operated by Blockstar Buildings Limited who is the registered provider. The company is made up of four directors who are all involved in the operation of other designated centres. One of the directors had committed to being in the centre on a weekly basis. The centre was registered in August 2019 for 56 beds to accommodate residents on the ground floor and first floor. In July 2019 and at a subsequent meeting in November 2019, inspectors expressed concerns about the governance and management of the centre. The centre was inspected in February 2020 and in September 2020 the inspectors found that the provider did not have adequate oversight of the service and there was a lack of systems and processes in place to monitor the safety and quality of the service. There had been three different persons in charge in the centre since it was first registered who have subsequently left the centre and the current person in charge had commenced in the centre in December 2020. A consultant was employed and took responsibility for all aspects of fire safety, health and safety and risk management. However due to level 5 restrictions they had only recently recommenced visiting the centre. The governance arrangements put in place following the previous inspection which included a second consultant supporting clinical care were no longer in place. The inspectors found the improvements noted on the previous inspection in September 2020 were not sustained. Repeated non- compliance's in a number of areas of the services including governance and management were found on this inspection as outlined throughout the report.

This unannounced inspection was triggered by a number of pieces of unsolicited information raising concerns about care of residents and poor communication with families and issues with management of responsive behaviours. Some of this information was also sent to the Chief Inspector via the notification process from the centre. Inspectors found evidence to support some of the concerns raised which is discussed in the report and actions taken to prevent issues happening again in the future. The inspectors also followed up on actions required from the previous

inspection. An immediate action plan was also issued on the day of the inspection in relation to the assurances required around the evacuation of the centre in the case of fire. Following the inspection evacuation drill records were submitted demonstrating good evacuation times. The inspectors acknowledged that residents and staff living and working in centre has been through a challenging time and they have been successful to date in keeping the centre COVID-19 free. Regular swab tests had confirmed all staff to be negative for COVID-19 and residents and staff had received COVID-19 vaccinations. There was a plentiful supply of PPE. However, not all staff had received full infection prevention and control training.

Whilst there was evidence of some quality improvement strategies and a system of audit was in place, for example; audits were carried out in relation to, medication management, care planning, infection control and health and safety. Following completion of audits, there was evidence of recommendations. However, there were no action plans following on from the audits and issues were not allocated to responsible staff for action and completion. The inspectors also identified a number of issues in these areas that were not identified in the audits. A comprehensive record of all accidents and incidents was maintained. However, there was no trending of accidents and incidents for patterns or trends, the person in charge said she would commence same.

Whist the provider assured the inspector that staff were recruited in line with best practices gaps were seen in staff files. This lack of oversight could lead to clinical and other issues being missed in relation to staff recruited.

Regulation 15: Staffing

On the day of the inspection there were three nurses, plus the person in charge, ADON, an administrator, seven care staff, three catering staff member, two cleaning staff and an activity staff member to provide care to the 49 residents present. There were also two pre registration nurses on induction in the centre. Whilst the inspectors found there appeared to be adequate staffing numbers supervision of staff appeared to be lacking which is outlined under training and staff development.

Judgment: Compliant

Regulation 16: Training and staff development

Training records seen on the day of the inspection did not provide evidence that all staff had received mandatory training. Gaps were evident in moving and handling, safeguarding training, infection control and responsive behaviours. A number of new staff had commenced in the centre and they had not undertaken HSE land training

on hand hygiene and donning and doffing which is essential training during the current pandemic. Staff who also did not have moving and handling training were seen to use incorrect manual handling techniques, which posed a risk to both residents and staff. A member of household staff who commenced working in the centre in September 2020 did not receive cleaning training and only undertook infection control training in February 2021.This meant appropriate cleaning measures and infection control procedures may not have been in place during this time.

Overall despite good staffing levels there appeared to be a lack of a cohesive system of staff communication, supervision and development. This was evidenced by poor practices seen on inspection in relation to moving and handling, infection control and knowledge of some staff in relation to correct procedures to be followed in these areas.

Judgment: Not compliant

Regulation 21: Records

A sample of staff files viewed did not provide assurance around robust recruitment. There were a number of key documents missing from staff files such as references and a CV for senior staff, and no record of current registration with the nursing body for one nursing staff member. The files were not kept in accordance with schedule two of the regulations.

Judgment: Not compliant

Regulation 23: Governance and management

A large number of issues were identified with the governance and management of the centre that did not provide assurances that the registered provider had adequate oversight of the service. The governance arrangements did not ensure the effective delivery of a safe, appropriate and consistent service in the centre. Issues with the governance arrangements and lack of effective systems included:

- The roles and responsibilities of the senior team were not clearly defined and there was a lack of communication between the senior team which impacted on the delivery of care to the residents. Staff reported that they received mixed instructions from different senior managers.
- Key information was not collected and analysed to monitor the safety and quality of the service. The senior team were unable to give the inspectors accurate information around what residents had pressure sores, what residents were in precautionary isolation or how many residents were using

bedrails. This information was essential to provide good care and have oversight of the centre
- There was evidence of a lack of of effective systems in place to monitor infection control procedures, staff training, care planning and medication management and theses are all outlined further under the specific regulations.
- There was a lack of evidence the audits were used to inform service improvements. Audits undertaken did not have action plans for corrective actions required.
- There was no trending of accidents and incidents to improve safety for residents.
- There was a lack of oversight of staff files therefore, robust recruitment could not be assured which could lead to safeguarding issues for residents.

Judgment: Not compliant

Regulation 31: Notification of incidents

Notifications had been submitted for incidents specified in the regulations in a timely manner.

Judgment: Compliant

Regulation 34: Complaints procedure

Records were maintained of complaints and the outcome was recorded. The complaints process was seen to be displayed in the entrance hall of the centre. The appeals process was outlined in this document as well as the contact details of the ombudsman.

There was only one complaint on file since the previous inspection and documentation was available to inspectors in relation to this matter.

There were suggestion boxes located on each floor which meant that residents or visitors could raise a concern or make a suggestion anonymously, if they wished.

Judgment: Compliant

Quality and safety

Overall, residents were supported and encouraged to have a quality of life which was generally respectful of their wishes and choices. Opportunities for social engagement were evident. However, inspectors found that the quality and safety of resident care was compromised by lack of oversight by management, inadequate management of infection control, inconsistent access to healthcare services, and a care planning system that did not fully direct residents specific care needs. Improvements were required to ensure that all residents had their individual medical, social, spiritual and psychological needs clearly documented to ensure that the care provided is person-centred and respectful of each residents wishes. Improvements were also required in infection control and medication management.

The design and layout of the centre promoted an unrestricted environment for residents who were encouraged to mobilise freely and had access to an enclosed garden from the large ground floor sitting room. The activities schedule in the centre continued to be of a high quality, with a number of engaging and varied activities was on offer seven days a week. Staff were seen to be supportive and encouraging in their interactions with residents. There was sufficient communal space for residents to partake in group activities, and privately if they wished. Residents with diagnosis of dementia were predominantly accommodated on the first floor. Due to a vacant position for an activities coordinator, health care staff working on this floor assisted in the daily provision of activities but the inspectors found that further activities in this area were required .

Residents were offered choice at every meal and mealtimes were seen to be a relaxed and unhurried social occasion. Residents were offered visits in line with current COVID-19 visiting guidelines and were encouraged to maintain contact with families through various means such as video calls and telephone.

There was evidence that residents had access to medical and other allied healthcare professionals such as dietitian, specialist wound care and chiropody. These were available both in person and remotely. On the day of inspection, residents were being reviewed by the visiting physiotherapist and the local psychiatry team. However, inspectors found evidence that specific instructions from medical and allied health professionals were not consistently followed. The management of residents with behavioural and psychological symptoms of dementia required review. Inspectors found that the root cause of the behaviour was not identified and medications were used to de-escalate these behaviours without any other alternatives being trialled first. An overall review of medication management practices was required as a number of non-compliance's were found in this area. Some of the issues that inspectors identified were repeat non-compliance's from the previous inspection in September 2020.

Up-to-date service records were in place for the maintenance of the fire equipment detection, fire alarm system and emergency lighting. Residents all had Personal Emergency Evacuation Plans (PEEPs) in place and these were updated regularly. This identified the different evacuation methods applicable to individual residents for day and night evacuations. Fire training was completed in 2020 and some had recommenced for 2021. Fire drills had not been undertaken since July 2020 and a lot of new staff had not undertaken a fire drill. The person in charge confirmed they

had not simulated a drill of a full compartment with minimal staffing levels since she had commenced her role the inspector requested a drill of same following the inspection. This was conducted following the inspection and further drills are recommended.The centre had a risk management policy in place and risk register identified clinical and environmental hazards and risks. However, aspects of risk management required review to ensure that all risks in the centre were identified and responded to.

The centre continued to remain free from COVID-19 infection. Despite having some measures in place to minimise the risk of infection being introduced to the centre, inspectors identified a number of issues which had the potential to severely impact on infection prevention and control. These collective risks are discussed in detail under Regulation 27: Infection Control.

Regulation 11: Visits

Indoor visiting had recommenced in line with the HPSC guidelines. A visiting area had been set up which enabled safe visiting abiding by social distancing guidelines. Visitors booked in advance and went through a screening process and infection control guidelines with appropriate PPE wearing prior to visiting. The inspectors met a number of visitors who were delighted to be able to get in to visit their family member again. The centre also facilitated visiting for compassionate reasons and window visits. Residents also kept in touch with their families via telephone video conferencing, mail and other technological means. One of the visiting areas was in a high traffic area of the centre which interfered with the privacy of the visit and the person in charge said she would review and change same.

Judgment: Compliant

Regulation 26: Risk management

The risk registrar required updating to include risks identified during the inspection and actions required to mitigate these risks.

- The outdoor smoking area for residents was not fitted with a call bell. As a result, residents were unable to call for help when using this area independently.
- Inspectors observed a large hoist battery with a trailing cable being charged in a resident's room. The use of this equipment in a this area was not risk assessed.

Judgment: Substantially compliant

Regulation 27: Infection control

Inspectors found a number of infection control risks throughout the centre. There was a lack of clarity amongst management and staff about the isolation status of residents. At the commencement of the inspection the management team told the inspectors that there were no residents in isolation. However, inspectors later saw that there were three residents in precautionary isolation, due to being newly admitted to the centre, or returning from an acute hospital stay. The designated isolation area in use was not effective in minimising the risk of infection and did not adhere to the Health Protection Surveillance Centre (HPSC) *Interim Public Health, Infection Prevention & Control Guidelines on the Prevention and Management of COVID-19 Cases and Outbreaks in Residential Care Facilities* guidance.

Inspectors identified the following issues, which posed a risk of transmission of infection to residents and staff:

- The isolation area comprised a number of bedrooms. In three bedrooms residents were in precautionary isolation but other bedrooms accommodated long-term residents who were not in isolation. Inspectors saw that this was a high traffic area where many residents and staff were seen walking in the corridors and in and out of rooms.
- There were no dedicated staff for residents in isolation. The same staff were seen to attend to residents in precautionary isolation as well as other residents.
- Donning and doffing (putting on and taking off) of personal protective equipment (PPE) was carried out in the same room and there were no segregation of these functions which could lead to cross contamination. There were no clinical waste bins either inside or directly outside of the designated isolation rooms to allow for immediate disposal of potentially infected PPE
- Three hand hygiene sinks on the corridors were not working, including the sink on the isolation unit.
- Household staff finished at 3pm. There was no evidence of cleaning of high-touch areas after this time.
- Large containers of cleaning products used by household staff were inappropriately stored in the sluice rooms. Domestic staff topped up smaller bottles from this supply. There was a risk of cross contamination from an unclean area.
- There was no holder for a toilet brush in a resident's ensuite, as a result it was placed directly on the ground next to the toilet.

Judgment: Not compliant

Regulation 28: Fire precautions

At the time of inspection, the registered provider had not taken adequate precautions to ensure that residents were protected from the risk of fire.

There was no fire drills undertaken in the centre since July 2020. Many new staff had not taken part in a fire drills in the centre. The inspector was not assured that residents could be safely evacuated in the event of a fire, as there was no evidence that full compartment evacuations having been completed. Drill reports were submitted following the inspection and further drills were required to ensure the competency of all staff.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

Inspectors found evidence that staff were not adhering to medication management guidance for nurses set out by the Nursing and Midwifery Board of Ireland. A number of these findings were repeat non-compliance's from the previous inspection as follows:

- Inspectors were not assured that eye drops were instilled as prescribed. Three bottles with eye-drops were signed with a date of opening on the outer box, however, the eye-drop bottles within the box were sealed. These eye-drops had been signed as administered.
- A number of insulin pens in current use were not labelled with a date of opening. This was important as the medication was required to be disposed of 28 days after opening.
- The count of controlled drugs was not accurate. A medication that had been administered had not been recorded in the controlled drug count. In addition, another controlled medication stored in the controlled drugs cupboard was not recorded as part of the daily count.

Further issues identified included:

- Medications that had been discontinued by the general practitioner remained on the administration record sheet. This could potentially lead to an error in administration.
- There were gaps in the medication administration record, with a number of medications not signed for by the nurse. It was unclear whether these medications had been omitted by the nurse, or refused by the resident.
- Where it was identified that residents refused medications, the rationale for this was not documented on the administration record. This made it difficult to ascertain the reason for the refusal and whether further action was

required.

- Medications were being administered to a small number of residents in an altered format such as crushed. The inspector noted that these medications had not been individually prescribed to be crushed by the general practitioner. As a result a high-risk medication which was unsuitable for crushing was being administered in this form. A full review of the prescription of medications in altered formats was required.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Inspectors found evidence of repeated non-compliance from the previous inspection as follows:

- There was a lack of clear direction around end of life care preferences. A separate folder contained the resident's end of life care decisions. These were not consistently recorded in the resident's individual care plan, resulting in a lack of clarity amongst staff with regard to each resident's wishes and preferences at end of life.
- The "It's about me" assessment which details relevant information to inform person-centred care planning such as the resident's specific preferences, important facts and life story was referred to in a resident's care plan. However, this document was not completed and therefore, important details were not captured.

Further issues identified were:

- A resident who had been recently admitted did not have a comprehensive assessment or care plan completed within the required time frame of no later than 48 hours after admission. As a result, there was no specified plan in place to guide the health, personal and social care needs of the resident.
- A number of residents had incomplete or blank assessments and care plans.These included a resident with no mobility, no dependency or skin care assessments or care plans in place. Therefore there were not appropriate assessments and care plans in place to direct the residents care.
- The identification and management of clinical risks required review. For example, a resident was identified in their care plan as being at risk of wandering and absconsion, however the corresponding wandering and absconsion risk assessments were not completed. It was unclear from the documentation what level of risk was posed and what strategies were in place to mitigate the risk.

Judgment: Not compliant

Regulation 6: Health care

Inspectors found that recommended medical treatment and professional expertise from allied health professionals were not consistently followed. This could potentially lead to poor outcomes for residents. For example:

- A nutritional supplement prescribed by the hospital medical officer upon discharge had not been transcribed to the residents medication kardex and therefore it was not clear if the resident was receiving the prescribed supplement.
- A direction from an acute hospital discharge summary stated that a resident's wound was to be reviewed by a Tissue Viability Nurse. This was not completed. In addition, the aforementioned wound dressing had sporadic, inconsistent clinical measurements documented in the wound assessment chart.

Judgment: Not compliant

Regulation 7: Managing behaviour that is challenging

The centre had a local restraint policy in place which stated that a comprehensive assessments would be undertaken and recorded prior to the use of any restraint. However, inspectors identified that a newly-admitted resident had bedrails in place, with no assessment or rationale for their use documented.

Inspectors examined documentation including care plans and behaviour charts for residents identified as displaying behaviours that challenge and found that alternative interventions and de-escalation techniques were not fully outlined to direct the care of the resident.

A record of the number of restraints used in the centre was not available. Inspectors were not assured that the systems in place and oversight of restraint use reflected a commitment to restraint reduction and an aim towards a restraint free environment. The numbers were not in line with what was reported to HIQA in the quarterly notifications.

Judgment: Not compliant

Regulation 9: Residents' rights

Residents meetings were held on a regular basis and meeting minutes confirmed that residents were consulted with and participated in the organisation of the centre.

Individual choice was promoted where practicable. Residents could undertake activities in private. Inspectors observed that there were appropriate facilities and opportunities for residents to participate in a range of activities. There was a weekly activity schedule offered seven days a week.

Overall, residents' right to privacy and dignity were respected and respectful interactions were seen between staff and residents. The residents had access to newspapers, telephones, broadband and television. Independent advocacy services were available to residents and contact details of these were displayed in the main reception area.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 26: Risk management	Substantially compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Fennor Hill Care Facility OSV-0007180

Inspection ID: MON-0031471

Date of inspection: 15/04/2021

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant 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 document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Training is being put in place and the training matrix kept under review to ensure that all staff have completed mandatory and other such training as identified on or before July 31st 2021. Supervision of staff is being carried out to ensure they provide safe and effective care and in line with the relevant training provided to them.	
Regulation 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: A review of staff files has been undertaken to ensure all necessary documents and other such information is in place accordance with the regulations. Staff files will continue to be monitored to ensure robust recruitment practices within the centre.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Governance and management at the centre has been strengthened and enhanced by the	

following:
1. In addition to daily engagement with the management team, the RPR is onsite in the centre two days each week to provide additional support, guidance and assistance to all team members;
2. Roles and responsibilities of the senior management and all other team members have been reinforced and the necessity to have robust communication at all levels of the organization has been revised and promulgated to all staff;
3. The centre has recommenced trending and analysis of key performance indicators (KPIs) to drive continuous improvements in the service.

Regulation 26: Risk management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management:
Ongoing risk management practices are being carried out in the centre to mitigate risks to all stakeholders. An IP rated emergency call button has been installed in the outdoor smoking shelter. The identified hoist battery trailing cable has been secured.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
The following has been put in place with regard IPC:
1. An isolation area on the ground floor has been put in place to mitigate issues identified on the 1st floor;
2. Provision of IP&C systems identified have been addressed;
3. Corridor hand hygiene sinks are now in working order with non-sensor lever handles installed and training updated to ensure staff are familiar with recommended hand hygiene practices and frequency;
4. Cleaning schedules for high touch areas is in place throughout the centre including after 3pm;
5. Chemicals not related to the sluice room(s) have been relocated and a toilet brush replacement programme has been organized.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
A designated employee has been appointed to assist, coordinate and support the senior management team in relation to fire precautions to include that fire drills are practiced regularly by all staff in the centre. Fire drills will be integrated into the centres risk management and fire precaution practices to ensure al staff are familiar with the centres fire emergency procedures.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
Issues identified in the inspection report have been reviewed by the RPR, senior management team and nursing staff collectively. A concerted and determined team effort has been implemented to improve and mitigate issues that have been identified and robust procedures have been put in place in relation to medication management to prevent future reoccurrences.

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
The following has been implemented in relation to resident care plans:
1. All care plans have been designated to individual nursing staff with oversight by senior team;
2. Care plan examples and teaching with nursing staff is ongoing with the necessity to have person centered care planning, which meets the individual needs of the resident, completed in a timely manner and updated where appropriate;
3. Care planning has been revised to ensure compliance and that individual care plans meet regulation criteria.

Regulation 6: Health care	Not Compliant
Outline how you are going to come into compliance with Regulation 6: Health care: The following has been put in place in relation to healthcare; 1. Any identified healthcare needs will be assessed at pre-admission stage and acted on by senior nurse team; 2. Allied health personnel are actively engaged at the centre at present with recognition by nursing staff of the importance of referral and acting upon any recommendations made to enable improved outcomes for residents.	
Regulation 7: Managing behaviour that is challenging	Not Compliant
Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging: The following has been put in place in relation to Responsive Behaviours; 1. Responsive Behavior training is scheduled to be completed by an external facilitator with all staff completing training on or before 15th June 2021; 2. Care plans of residents that may present with behaviors' that challenges have been reviewed and de-escalation techniques in place with noted documentation and communication by staff on the needs of these residents; 3. Behavioral support committee introduced to support staff in managing residential group presenting with responsive behaviors.	

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	15/06/2021
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	18/05/2021
Regulation 21(1)	The registered provider shall 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.	Not Compliant	Orange	30/05/2021
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and	Not Compliant	Orange	18/05/2021

	details responsibilities for all areas of care provision.			
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	15/06/2021
Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.	Substantially Compliant	Yellow	18/05/2021
Regulation 26(1)(b)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the risks identified.	Substantially Compliant		18/05/2021
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated	Not Compliant	Orange	18/05/2021

	infections published by the Authority are implemented by staff.			
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	18/05/2021
Regulation 29(4)	The person in charge shall ensure that all medicinal products dispensed or supplied to a resident are stored securely at the centre.	Not Compliant	Orange	18/05/2021
Regulation 29(5)	The person in charge shall 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	Not Compliant	Orange	18/05/2021

	the product.			
Regulation 29(6)	The person in charge shall ensure that a medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident shall be stored in a secure manner, segregated from other medicinal products and disposed of in accordance with national legislation or guidance in a manner that will not cause danger to public health or risk to the environment and will ensure that the product concerned can no longer be used as a medicinal product.	Substantially Compliant	Yellow	18/05/2021
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Not Compliant	Orange	18/05/2021
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care	Not Compliant	Orange	30/05/2021

	plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.			
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.	Not Compliant	Orange	30/05/2021
Regulation 6(2)(c)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the care referred to in paragraph (1) or other health care service requires additional professional expertise, access to such treatment.	Not Compliant	Orange	18/05/2021
Regulation 7(3)	The registered provider shall ensure that, where	Not Compliant	Orange	18/05/2021

	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.			