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:	Farranlea Road Community Nursing Unit
Name of provider:	Health Service Executive
Address of centre:	Farranlea Road, Cork
Type of inspection:	Unannounced
Date of inspection:	18 August 2021
Centre ID:	OSV-0000713
Fieldwork ID:	MON-0033839

About the designated centre

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

Farranlea Road Community Nursing Unit is a designated centre located near the suburban setting of Wilton, Cork. It is registered to accommodate a maximum of 89 residents. It is a two-storey facility with stairs and lift access to the first floor. Farranlea Road is set on a large site with enclosed courtyards and gardens for residents to enjoy. Residents' bedroom accommodation is set out in four units, Oak, Sycamore and Willow each are 25-bedded units accommodating older adults; and Cedar is a 14 bedded unit accommodating younger residents. Each unit is self-contained with a dining room, kitchenette, day rooms, a quiet sitting room and comfortable resting areas along corridors. The courtyards have garden furniture seating and tables, raised flower beds and shrubbery and paved walkways. Bedroom accommodation comprised single, twin and multi-occupancy wards, all with wash-hand basins, and en suite shower, toilet and wash-hand basin facilities. There were additional shower and toilets and a bath room in each unit. The Café Corner is located near the entrance to the centre for residents to meet with their visitors; the oratory is located alongside this. There is a well presented library on the ground floor. The atrium is a large communal space located on the first floor between Oak and Sycamore units with comfortable seating, where the group activities are held. Residents have access to facilities such as two activities rooms in Cedar unit, one with a therapeutic kitchen with laundry and cooking facilities to support independent living; physiotherapy gym, and occupational therapy room. There is an family room where people can stay, for example, when their relative is unwell or receiving end of life care. Farranlea Road Community Nursing Unit provides 24-hour nursing care to both male and female residents whose dependency range from low to maximum care needs. Long-term care, rehabilitation and palliative care is provided.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	78

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
Wednesday 18 August 2021	09:00hrs to 19:00hrs	Breeda Desmond	Lead
Wednesday 18 August 2021	09:00hrs to 19:00hrs	Siobhan Bourke	Support

What residents told us and what inspectors observed

Overall, inspectors found that the person in charge and staff were working to improve the quality of life and promote the rights and choices of residents in the centre. The inspectors met with the majority of residents present on the day of inspection and spoke with 12 residents in more detail. Inspectors also met with five relatives during the inspection. In general, residents spoken with gave positive feedback and were complimentary about the staff and the care provided in the centre. Visitors were delighted to resume visits with residents and inspectors saw a number of residents going out in the gardens with visitors.

On arrival to the centre the inspectors were guided through the infection control assessment and procedures by the receptionist. Following an opening meeting, inspectors were accompanied by the person in charge on a tour of the centre. It was evident that the person in charge was well known to the residents living in the centre and knowledgeable about the residents' care needs.

The centre was a large two storey building set out in four units over the two floors, with lift and stairs access between floors. Administration offices, the main kitchen and laundry were to the right of main reception. There was lovely seating by the main reception for visitors to rest. The person in charge said that they planned to have a large screen here welcoming people to 'Farranlea' and display a rolling montage of photographs of residents' activities and outings. The family room was by reception and was available to families whose relative was receiving end-of-life care. Recliner chairs, tea and coffee making facilities and a microwave provided comfort during a difficult time.

'Your Service, Your Say' complaints process, information on the complaints officer and suggestion box were displayed at reception. The hairdressers' room was located on the corridor leading into the Willow unit. Residents were observed throughout the day getting their hair up-styled. Many of the residents spoken with said they were delighted with the hairdresser and loved being complimented on their hair-styles. The oratory was located behind main reception on the corridor leading to Willow. In the afternoon of the inspection, a member of the clergy said prayers in the oratory where a number of residents attended these prayers, while others availed of the live streaming of the prayers on TV in their bedrooms. Tea and coffee making facilities and seating with coffee tables were available in front of the oratory. Relatives and residents were observed enjoying this quiet space during the afternoon. The patio door here opened to the secure garden and relatives were observed accompanying their relative into the garden and enjoy walking around and meeting other visitors and residents. Many of the bedrooms of Cedar and Willow had their own patio access to the garden and residents were seen to sit in their patio enjoying reading and the sunshine. One of the temporary visiting hubs created for visiting during the COVID-19 lock down, was located in this garden.

Cedar and Willow units were on the ground floor; Sycamore and Oak were on the

first floor. Cedar provided accommodation for up to 14 younger adults with complex neurological care needs and all bedroom accommodation was single occupancy bedrooms. Currently the occupancy there was maintained at 10 residents. The activity co-ordinators' rooms were within Cedar. Inspectors observed that 'Stella's Nail Bar' was well stocked for residents' nail treatments, colour and polish. The sensory room, located adjacent to the activity room had soft lighting and furnishings providing a relaxed atmosphere. This room had patio access to the outdoors. There was a beautiful enclosed garden within Cedar which was maintained by one of the residents in Cedar. He explained to inspectors that he was a gardener previously and loved gardening. He had an array of flowering plants, herbs and shrubs creating colour and texture throughout the space. He had painted all the garden furniture which looked really well in the garden. This unit had a therapeutic kitchen with laundry and cooking facilities. There was a schedule displayed here where people scheduled their time to use the room, for example, those residents who made their own breakfast, baking time, and other activities such as doing their own laundry. All of which was supported by the occupational therapist.

There was a large white board by the dining room in Cedar displaying the weekly activities, outings, personal assistants and staffing allocation. This provided current information to residents and empowered them regarding the supports in place for them to undertake their activities on a daily basis.

All units were self-contained with dining room, sitting room, sensory or quiet room, day room and pantry. Willow, Sycamore and Oak Units could each accommodate 25 older residents. Bedroom accommodation on these units comprised one four bedded multi-occupancy bedrooms, two twin bedrooms and 17 single bedrooms all with full en suite facilities. Inspectors noted that privacy screens in twin and multi-occupancy bedrooms did not ensure residents' privacy; in addition, they were difficult to use and residents would not be able to operate these independently should they wish to have privacy in their bedrooms. Some bedrooms were decorated with soft furnishings, colourful murals and mementos, however, twin and multi-occupancy bedrooms remained clinical.

The Atrium was an expansive space between Sycamore and Oak where larger group activities were held. On the day on inspection, the 3-man band were playing and singing for residents. They play every Wednesday morning and residents loved the music and craic. The activities staff gently encouraged residents to sing and clap along with the music. Residents said they enjoyed the band. Gorgeous murals were painted on the walls of resting areas along corridors; some had words of inspiration and encouragement as well as delicate paintings.

On the first floor a roofed terraced garden off Sycamore unit had been recently renovated with beautiful wall murals, raised beds with flowering plants, tables and chairs. These outdoor spaces were easily accessed by residents and their visitors on each unit. A number of residents were actively involved in the maintenance and painting of the gardens. One resident told an inspector how she loved to watch the plants she set bloom. Inspectors were informed that there was a multidisciplinary approach to gardening activities in the centre with the physiotherapist and occupational therapist along with the activities co-ordinators and care staff enabling

residents to remain active. All balconies had transparent storm-glass protection to ensure the safety of residents and relatives.

The library was a gorgeous room where resident came to read in quiet. There was a large display of book shelves laden with a selection of reading material. The person in charge explained that this room was used a lot during COVID-19 lock-down for skype and face-time calls with family and friends. There was a smoking balcony upstairs and inspectors were told that residents had their own fire retardant aprons. A fire blanket and suitable cigarette receptacle were installed during the inspection as additional fire safety precautions. All units had lovely displays of photographs of residents enjoying the garden club, outings, parties and activities. Large ornate clocks were hanging in communal areas to enable residents to easily see the time.

Mealtimes were observed in all units and appropriate assistance was seen to be provided to residents in a respectful manner. Nonetheless, trays were not removed from tables when residents were served their meals. One unit had lovely oil table clothes, little posy of flowers and condiments on tables. Here all residents were served together and staff actively engaged with residents in a normal social manner. In another unit, residents were returning from the music session. Residents were served as they returned rather than wait for their table companion to return. This meant that some residents sat alone for most of their meal when others joined them piecemeal. In another unit, staff talked loudly amongst themselves delegating jobs and serving duties in a task-oriented manner, which did not contribute positively to the dining experience for residents.

One unit had separate snack and meal menus displayed on each table for residents in accordance with their wishes. Later on in the day, the inspector observed the catering staff take time to explain to a resident the choices for their tea, how each choice was cooked and offered to cook whatever the resident would like. It was obvious they knew each other well and lovely kind interaction was observed; the atmosphere was relaxed and the resident was enabled to take their time to decide their menu choice.

A resident explained that they had access to several i-pads which were donated to the centre and they belonged to everyone; he said he got great use of it and used it to write poetry and research art as he loved to paint as well.

Visiting had resumed in line with the HSE 'COVID-19 Normalising Visiting in Long-term Residential Care Facilities' of July 2021. Visitors were observed visiting throughout the day and inspectors spoke with five families. They gave very positive feedback about the care their loved one received. They spoke of the dignity and respect their relative was shown; staff were friendly, kind and caring and always had a kind greeting for them. The praised the care their relative received and the special attention to their relative's skin care.

Emergency evacuation floor plans were displayed on each unit; these were colour coded and identified a point of reference. However, these had other units included in the display which made the plan quite small. Some of the evacuation plans displayed were not orientated relative to the position in the building, so the

evacuation route was not clear.

The laundry was in a cluttered state with a duvet cover in the hand-wash basin, curtains drying over the fire door, and a box of curtains on the ground. Laundry was segregated at source and alginate bags were in use when clinically indicated. Each unit had their own dirty utility room. While most were tidy and facilities accessible, the bedpan washer and sluicing sink in one of these rooms was inaccessible due to inappropriate storage of laundry skips and assisted shower chairs.

Improvement was noted since the last inspection regarding restricted access to clinical areas as these were now swipe-card access and were all maintained closed during the inspection.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted the quality and safety of the service being delivered.

Capacity and capability

Overall, this was a good service where a rights-based approach to care was promoted and there was a commitment to provide quality care. Improvements were noted in many aspects of care including the appointment of additional staff to ensure meaningful activation for residents.

Farranlea Road Community Nursing Unit was a residential care setting operated by the Health Services Executive (HSE). The person in charge held the post of interim director of nursing (DON); she was supported on-site by the recently appointed deputy DON, clinical nurse managers (CNMs) on each unit, CNM3 on night duty, senior nurses, care staff and administration. The governance structure was strengthened since the last inspection with the appointment of CNMs to cover the service on day duty at weekends. Nonetheless, the management structure in place (PIC, CNMs) continued to comprise of four acting posts and the vacant CNM3 night duty post. The CNM3 post remained vacant since the previous inspection; one administration staff was not replaced following retirement. While the post of general manager was an acting post for some time, inspectors were assured that the general manager was due to return to their substantive post within a fortnight following the inspection.

This centre was subject to a significant COVID-19 outbreak in December 2020 which was declared over by public health in February 2021. Inspectors acknowledged that staff, residents and families had been through a challenging time especially with the impact of losing friends and companions, degree of sickness and restricted visiting. The person in charge completed an evaluation of the outbreak management following the COVID-19 outbreak in line with Health Protection Surveillance Centre (HPSC) guidance. This report outlined 'what worked', what was effective' and the 'impact of residents and staff'. One of the actions arising from this report was the

need to provide support for residents and staff to deal with the impact of the aftermath of the outbreak. Inspectors were informed that the person in charge was arranging for workshops to be facilitated for residents and staff to talk about their experiences.

Monthly meetings were facilitated by the general manager with the other directors of nursing (DONs) in the HSE CH04 area to discuss and share ideas and learning from incidents and events. Quality and Patient Safety meetings were convened quarterly with set agenda items including infection prevention and control. Key performance indicators were maintained to provide oversight of quality of care delivered. These were fed back directly to each unit to provide oversight of clinical care, as well as informing monthly clinical meetings.

A variety of clinical audits were scheduled via the Viclarity audit programme and completed on a monthly basis and these results informed the monthly quality meetings. While quality of life audits were scheduled to be completed on a monthly basis, these were not comprehensive to provide robust information to influence outcomes for residents. Nonetheless, the person in charge showed inspectors the quality of life survey which 20 residents completed and results of these were due to be reviewed, information trended and followed up as part of residents' meetings.

Policies unavailable on the previous inspection (medication management and food safety) were available for staff to reference. Nonetheless, many policies were overdue review in line with regulatory requirements. The complaints policy did not reflect the current complaints' process.

The management team were aware of the legal requirement to notify the Chief Inspector regarding incidents and accidents. A sample of staff files examined showed that most documentation relating to Schedule 2 of the regulations pertaining to staff were in place, however the most recent vetting in accordance with the National Vetting Bureau (Children and Vulnerable Adults) Act 2012 for one staff member who was recently promoted to a new role, was not available on site.

Care staffing levels were adequate to the size and layout of the centre. Activities staffing levels and activities programme had improved since the last inspection, with two activities staff on duty every day to provide meaningful activation for residents. A multi-disciplinary approach was taken to the activation programme with consultation with activities, speech and language therapist, occupation therapist and physiotherapist all collaborating to improve the activity programme for residents.

At the time of inspection, the training matrix was being updated to provide better oversight and assurance that staff were up-to date with mandatory and required training. Inspectors found that staff were up-to-date with required training on safeguarding having completed both face-to-face sessions and online training. There was good uptake of training in infection prevention and control and one of the nursing staff provided face-to-face hand hygiene training sessions for staff one day a week. However gaps were found in uptake of annual fire safety training as outlined in Regulation 16.

Complaints, both written and verbal were recorded and the person in charge was

knowledgeable regarding the type and nature of complaints made, actions taken and consulting with the complainant when required. However the complaints procedure did not have the detail as required in the regulations.

Regulation 14: Persons in charge

The person in charge was full time and had the necessary experience and qualifications as required in the regulations. She facilitated the inspection in an open manner and demonstrated excellent knowledge regarding her role and responsibility, and was articulate regarding governance and management of the service, resident care and well-being and quality improvement initiatives required to enhance the service.

Judgment: Compliant

Regulation 15: Staffing

The number and skill mix of nursing and care staff was appropriate to meet the care needs of residents having regard for the size and layout of the centre. Additional activities staff were employed since the previous inspection, with two activities staff on duty each day to provide a resident-led activities programme. The impact of the increase in the number of staff to support and co-ordinate activities for residents was evident on the day of inspection.

Judgment: Compliant

Regulation 16: Training and staff development

The training matrix reviewed by inspectors on the day of inspection was in development so it was difficult to determine whether all training was up-to-date. Seven staff were not up to date with mandatory annual fire training.

Judgment: Substantially compliant

Regulation 21: Records

The most recent vetting in accordance with the National Vetting Bureau (Children and Vulnerable Adults) Act 2012 for one staff member, who was recently promoted

to a new role, was not available on site.

Judgment: Substantially compliant

Regulation 23: Governance and management

The management structure in place continued to have four acting management posts which did not support effective decision making; the CNM3 on night duty remained vacant since the last inspection; administration staff to support residents affairs was not replaced.

Some audit templates had five slots to be completed, for example, the care plan audit to enable five care plan documents be examined, five staff files, or five residents to give their feedback on quality of life staff. However, these were not comprehensively completed. Quality of life audits showed that just one resident's feedback was sought for each audit. Cognisant that this centre could accommodate 89 residents and this audit was undertaken on a monthly basis, it would take an inordinate amount of time to gain feedback from all residents.

A post falls review showed that the report did not accurately reflect the incident; consequently, a robust analysis could not be completed to enable learning to mitigate further such episodes.

Judgment: Not compliant

Regulation 31: Notification of incidents

The person in charge was aware of the regulatory requirement to submit notifications and these were submitted in a timely manner and in accordance with the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

The complaints procedure displayed was not in an easily accessible format to support people in making a complaint.

The complaints policy did not reflect the current complaints' officer or person deputising on occasions when the complaints' officer was not available; or identify the required personnel available to ensure records were appropriately responded to

and maintained.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

A number of policies and procedures set out in Schedule 5 of the regulations required review and updating.

Judgment: Substantially compliant

Quality and safety

Inspectors found that in general, residents were supported to have a good quality of life which was respectful of their wishes and choices. The person in charge was striving to promote a social model of care and to ensure residents were consulted about how the service was managed.

There was good evidence that residents had timely access to health care and review by health and social care professionals as required. Opportunities for social engagement had improved since the previous inspection and findings in relation to infection prevention and control and risks identified in the previous inspection had been addressed. However individual care plans and assessments and oversight of fire safety required improvement, these will be discussed under regulation 5 and 28.

Personal emergency evacuation plans for residents set out the assistance required for the resident during an emergency. Residents' health care needs were promoted by ongoing on-site access to their GP, and health and social care professionals as required. Residents had access to Headway services and Cork Independent Living with personal assistant services to support them. Residents living in the centre had access to a physiotherapist, dietician, speech and language therapist and occupational therapist who worked on site. Inspectors were informed that a consultant geriatrician was anticipated to commence at the centre in the coming weeks to further enhance the clinical care provided to residents. However, access to a clinical psychologist was still not available for the younger residents who were living in the Cedar Unit. Access to this service was via referral by GP, with waiting times of 2–3yrs.

A sample of seven care plans reviewed showed that validated assessment tools were used to inform care planning. Inspectors found that better oversight and auditing of care planning was required to ensure a more consistent approach to care plan records, as some of the care plans reviewed were person-centred and reviewed regularly as required by regulations, while some were not. In one of the care plans

reviewed, inspectors found gaps in nursing documentation which indicated a failure to respond to a resident's symptoms. Furthermore following a subsequent fall, there was no records available of immediate assessment or recording of neurological observations documented, despite several requests for these records. Documentation to support a resident when they were temporarily transferred to acute care was not evident on inspection on one unit.

Observation on inspection showed that staff had good insight into responding to and managing communication needs and provide support in a respectful professional manner. Care documentation included behavioural support plans and observational tools to help identify reasons for anxiety or upset, and controls to mitigate recurrences.

Improvement was noted regarding activities available to support resident with meaningful occupation as described earlier in the report. In addition, following from the ombudsman report 'Wasted Lives' relating to younger people in residential care, the person in charge had applied to be part of the pilot study associated with this and was accepted. Three residents were accepted to be involved in the study which was ongoing; a member of the team from the national office of the ombudsman had been on site with residents seeking their views and insights into their lives, hopes, dreams and aspirations.

Residents meetings were held on a quarterly basis and the person in charge and activities person facilitated these meetings. These were facilitated in each unit and showed good attendances. Minutes of these meetings demonstrated that the person in charge took the time to explain a rights-based approach and issues such as safeguarding, protection and reporting anything which made them feel uncomfortable were discussed. Following from these meetings, residents gave feedback on many aspects of care including meals and choices. A meeting was scheduled with the person in charge and catering manager along with two residents to discuss the menu, choices and enable residents to be actively involved in the process. This was just one example of the positive influence the person in charge had regarding enabling residents to have their voice heard.

The occupational therapist and physiotherapist supported residents in promoting independent living, rehabilitation and socialisation as well as supporting residents to remain active. The speech and language therapist was in the process of introducing a new programme, cognitive stimulation therapy with food, smells, tastes and memories. She will liaise with other members of the multi-disciplinary team, activities co-ordinators and pantry staff to enable maximum participation by residents, and knowledge of residents will be shared amongst the team members to further enhance the activities programmes.

Controlled drugs were maintained in line with professional guidelines. Drug administration records were examined and these were comprehensively maintained in line with professional guidelines. Crushing of medications were individually prescribed in accordance with best practice.

On the day of inspection inspectors saw that the centre was clean. Cleaning

schedules reviewed were consistently completed and unit managers maintained oversight of these records. Staff were observed to have good hygiene practices and were using PPE correctly. Staff training records found that staff were up-to-date on hand hygiene and infection prevention and control training. Issues identified in the previous inspection were observed to be addressed. However, monitoring and oversight of the laundry required review as inspectors found it was cluttered and untidy. In one unit, the bedpan washer and sink was inaccessible due to the level of equipment stored in the dirty utility room. Adequate precautions relating to prevention of legionnaires disease was not evident during six months (January - June 2021) of lock down.

There was a proactive approach to risk management in the centre. Risk assessments had been completed for actual and potential risks associated with COVID-19 and the provider had put in place many controls to keep all of the residents and staff safe. The risks identified on the previous inspection had been addressed by the management team.

Similar to the findings on the previous inspection, inspectors found fire safety precautions records were not comprehensively maintained. Relevant certification and maintenance records were not available on site to provide assurances regarding fire safety equipment.

Regulation 10: Communication difficulties

Observation on inspection demonstrated appropriate care, interaction and interventions with resident with communication needs. Assistive devises were available to residents to help with communication and residents had access to i-pads to help with their communication.

Judgment: Compliant

Regulation 11: Visits

Visits had resumed at the centre in line with updated national guidance for residential centres. Inspectors observed many visitors coming and going throughout the day with visits taking place in residents' rooms, out in the courtyard gardens or in designated areas of the centre. Staff guided visitors through appropriate COVID-19 safety checks at the centre. Residents and visitors who spoke with inspectors confirmed that there was sufficient time and space for residents to receive visitors at the centre.

Judgment: Compliant

Regulation 12: Personal possessions

Some residents had only access to a single wardrobe with some shelving, which was inadequate for people living in long-term residential care.

Judgment: Substantially compliant

Regulation 13: End of life

A sample of care plans reviewed showed that staff had actively engaged with residents to elicit their end-of-life care wishes.

Judgment: Compliant

Regulation 17: Premises

There was inadequate storage space to accommodate assistive and other equipment, for example, several specialised chairs, hoists and laundry bins were stored in the assistive bathrooms.

Multi-occupancy four-bedded rooms were clinical and lacked a homely feeling. The privacy screens available in the multi-occupancy rooms did not provide for adequate private accommodation for residents.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

The mealtime experience required review as the dining experience on some units was not resident-oriented; trays were not removed from tables when residents were served their meals. In one unit, residents were returning from the music session and were served as they returned rather than wait for their table companion to return. This meant that some residents sat alone for most of their meal when others joined them piecemeal. In another unit, staff talked loudly amongst themselves delegating jobs and serving duties in a task-oriented manner, which did not contribute positively to the dining experience for residents.

Judgment: Substantially compliant

Regulation 25: Temporary absence or discharge of residents

In the resident record examined it was not evident that relevant information about the resident was provided to the receiving designated hospital to ensure that the resident received appropriate care to their assessed needs.

Judgment: Substantially compliant

Regulation 26: Risk management

The risk management policy was up-to-date and contained the specified risks listed in the regulations.

Judgment: Compliant

Regulation 27: Infection control

While there was a flushing regime regarding precautions against legionella, this was not completed from January- June 2021 during the COVID-19 lock-down. Responsibility for this was not delegated to the units to be assured that legionella would not proliferate.

The laundry was not maintained in line with infection control protocols as there was a wet duvet cover in the hand-wash basin, curtains were drying over the fire door, and a box of curtains was on the ground. Each unit had their own dirty utility room. In one sluice room, it was not possible to access the bedpan washer or sluicing facilities due to the amount of equipment (laundry skips, assisted shower chairs and large waste bins) stored here.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Fire drills and evacuations records reviewed demonstrated that evacuations of rooms were undertaken, however, evacuation of a compartment was not undertaken to provide assurances that evacuations could be completed in a safe and

timely manner.

Daily fire safety checks were not comprehensively completed in the sample reviewed to be assured that adequate precautions against risk associated with fire.

The maintenance certificates were not held on site, so it could not be determined whether all the fire safety servicing was up-to-date.

Daily and weekly fire safety checks were not comprehensively completed.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Controlled drugs were maintained in line with professional guidelines. A sample of medication administration charts were examined and these were found to be comprehensive.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

On some units assessments and care plans were updated in line with regulatory requirements, and others were overdue.

One resident's care plan did not reflect the specific nutrition requirements associated with their medical diagnosis.

Judgment: Substantially compliant

Regulation 6: Health care

As found on a previous inspection, young residents with complex enduring needs did not have timely access to a clinical psychologist.

Although a resident presented with urinary symptoms, this was not investigated or followed up. The resident presented with symptoms which were outside their normal presentation, however, there was no nursing records for two nights to provide updates on the residents' condition. Following a fall, there was no indication that the residents observation were completed or that they were assessed for injury

immediately after the fall.

Judgment: Not compliant

Regulation 7: Managing behaviour that is challenging

While improvement was noted in the level of restrictive practice in place such as bed rail, there continued to be a large number in use with 34 of 78 residents with bed rails.

Judgment: Substantially compliant

Regulation 8: Protection

Staff had up-to-date training regarding protection. Good systems were evidenced to provide assurances that all appropriate measures were taken to safeguard residents and appropriate responses were seen to residents' feedback about the service.

Judgment: Compliant

Regulation 9: Residents' rights

Improvement was evidenced since the last inspection regarding residents access to meaningful activities. Additional activities staff were employed and two staff were on duty each day. The activities staff had developed activities in line with the wishes of residents. A multi-disciplinary team approach was taken to the activities programme to enable best outcomes for residents; included in this team were the activities staff, speech and language therapist, physiotherapist, occupational therapist, catering and care staff. The purpose was to share the information and further develop activities that would promote interaction, activation, interest, independence and cognition.

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 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Substantially compliant
Regulation 13: End of life	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 25: Temporary absence or discharge of residents	Substantially compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Not compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Farranlea Road Community Nursing Unit OSV-0000713

Inspection ID: MON-0033839

Date of inspection: 18/08/2021

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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: All staff are required to complete Fire Training annually. The Training records are maintained and monitored using an up to date Training matrix on EXCEL. This matrix includes all mandatory training. Progress has been made on the completion of training records onto Training Matrix (EXCEL) since inspection. Staff members identified as not having received fire training to date are now scheduled to attend the next Fire training in early November with the Fire Officer.	
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: Under Reg. 21 – ensure that the records set out in Schedule 2, 3, and 4 are all kept on site. Systems are now in place to ensure all Garda Vetting disclosures are available on site for all employees. The staff member identified during inspection has since made application to renew Garda Vetting on 01.09.21.	
Regulation 23: Governance and	Not Compliant

management	

Outline how you are going to come into compliance with Regulation 23: Governance and management:
A review of Care plans has been undertaken and areas for improvement identified. ViClarity Audit system that is in use is in paper format. The electronic ViClarity system is to be introduced following Training on 30.09.21. A care plan workshop with RGNs has identified the specific areas to be considered and addressed when documenting care. The deficit in administration staff has been addressed and these positions are now filled since 30.08.21.

Falls review and ward based hub meetings are now scheduled to take place fortnightly. An MDT approach to falls prevention and falls documentation is recommended best practice. Where a fall or near miss fall has been reported, the MDT will convene on that ward, review resident, review the falls risk, and identify and recommend appropriate safety measures to prevent further falls. A review of the post falls book with the ward staff will be included in all ward falls hub meetings. Falls are reported on NIMS system and form part of the discussions with QPS meetings on a monthly basis. Education Sessions on falls reduction, including falls documentation is planned for in the next Induction & Education day on 21.09.21.
QPS to provide training and education to staff nurses on incident reporting and risk documentation on 29.09.21.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
All residents are made aware of the complaints procedure on admission. The complaints policy is available and displayed prominently on notice boards throughout the building. The aim is to investigate and assist the complainant (complainant may be someone other than a resident) to understand the complaints process. All complaints are taken seriously and investigated thoroughly and acted on in a timely manner. Residents Forum meetings are held on a two monthly basis. Residents meet with P.I.C. also on a two monthly basis. Residents are informed at these meetings how to make a complaint and are given clear information as to how the complaints procedure operates. Minutes of these meetings are recorded and available.

An easy read version (one page document) of the Complaints procedure is to be designed and developed with resident participation. It will be a more visual document with fewer words, to include a photograph of the Designated Officer. A copy of this document (once prepared) will be given to each resident and explained to each resident individually.
Patient Advocacy Service (PAS) is due to meet Farranlea Residents on 07.09.21 to offer the support of a free, independent and confidential Patient Advocacy Service to residents

in making an informal complaint or in making a formal complaint.

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
The schedule 5 Policies are in line with the Cork Kerry Community Hospital Group. Schedule 5 Policies are currently being reviewed, to ensure all are in place and in date. The intention is to review, and update policies as necessary, to ensure the policies reflect the current practices and procedures in Farranlea CNU and are appropriate to residents care, health and well-being.

Regulation 12: Personal possessions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
Ensure resident has access to and retains control over their personal property. To ensure the residents rights are respected and personal property is safeguarded.

Following recent inspection, consideration is being given to additional shelving and wardrobe space in single rooms. The Occupational Therapist is to review the wardrobe space available and offer suggestions to improve. Residents are encouraged to 'de clutter' and 'spring clean' their rooms and wardrobes annually in Spring Time. Families and Care Staff are invited to assist residents with 'de cluttering' and removing unwanted, unused items as appropriate, to create a home from home environment.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Having regard for the needs of the residents, an inventory of equipment is being carried out to identify items no longer in use by the residents so they can be taken home by family members, or stored in a storage container on the premises. Unused beds have been removed since inspection. A filing room has been identified and re-assigned as an

area for additional storage. Management are liaising with maintenance to source and explore other suggestions and are actively exploring (i) storage capacity off site (ii) share equipment with other residential care facilities (iii) a track and trace community based system to loan equipment to Cork Community Hospitals is being considered similar to what is in place in Primary care.

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
Food and nutrition: mealtimes and meals should be an enjoyable experience with access to water, food choices, and adequate quantities, wholesome nutritious meals properly and safely prepared, cooked and served.

A review of the dining experience is being carried out in consultation with the residents. Their choice in location and preference for company shared will be taken into account. A Nutrition and Food meeting was held post Inspection on the 26.08.21.The outcome of this meeting included :(i) Complete the HIQA self-assessment questionnaire Food and Nutrition (baseline) (ii) Set up a Food and Nutrition subcommittee to include pantry staff representative, CNM, catering officer, dietician, Speech and language therapist, a Staff Nurse and HCA. Meet monthly (iii) Catering Officer to identify Training needs of pantry staff (iv) residents requested the staff assigned to each pantry, remain in each pantry, not to move staff from floor to pantry where possible. Catering Officer to provide practical training to pantry staff on food safety and food preparation, set up trays etc. Catering Officer agreed to provide a comprehensive Induction programme to pantry duties. A training manual for Pantry duties is to be developed. A communication diary is to be provided to pantry staff, to enable and improve communication between pantry staff on a daily basis. An audit of all 4 pantries to be completed in the coming two weeks to include (i) pantry staff training completed (ii) all staff are HACCP trained (iii) Food temperature checked (iv) rotation of stock (v) deep clean records maintained (vi) Fridge temp. Recorded (vii) appropriate and correct storage of food (viii) presentation of meals, (ix) timing of meals and (x) snacks available and supplied. The findings will be shared with committee members. Speech and Language therapist, to visit APHASIA Café in Cork city, to look at menu display, easy read Menus, the dining environment and experience. They will provide feedback to the committee. Residents agreed to discuss the refreshing and re decorating of dining rooms with their fellow residents and to feedback suggestions to committee. Next meeting agreed for 26.11.21. Sub group to meet on 26th October.

Regulation 25: Temporary absence or discharge of residents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 25: Temporary absence or discharge of residents:
Ensure that all relevant information is provided to the receiving hospital.
A meeting with all RGNs is scheduled to take place on 16.09.21.
The transfer letter (document) is to be discussed as is the feedback following HIQA Inspection 18.08.21. Staff Nurses will be advised to complete a transfer document prior to residents leaving Farranlea CNU and to retain a copy for care records.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
A Legionella Regime has been reviewed and a new template is now monitored weekly as required by legislation. The new template ensures that the correct temperatures are being reached 50 degrees for hot water and 20 degrees for cold water. Storage has been reviewed in the laundry room and additional shelving and storage boxes are now in place.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Farranlea CNU is obliged to comply with Fire safety regulations. Following the most recent inspection, Fire Maintenance Certificates are available – valid to 2022 (copies available on request). Daily Fire Checks and gaps identified in the daily fire checks have been addressed with CNMs and CNM3 Night Duty. An audit of the daily Fire Checks to be introduced on a monthly basis to ensure compliance with Fire Training, in Fire prevention, emergency procedures, building layout, escape routes, primary fire exit routes, fire evacuation points and firefighting equipment has been requested for the remaining 7 staff members. Compartment Fire Evacuation Drills have commenced at ward level and additional training on compartment evacuation have been requested from Fire Officer – date for next Fire Training on site has been confirmed for November 4th 2021.

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
As per Reg.5 the individual assessment is completed no later than 48hrs after admission. It is reviewed at intervals not exceeding 4 months. The individual care plan is evaluated and reviewed to reflect the changing needs of the residents. Support is identified to ensure and maximise the quality of life for each individual resident, while respecting their wishes. Meeting with RGNs is scheduled for 16.09.21. Discussion will be facilitated on care plans and documentation, in particular omissions identified by Inspector following inspection on 18.08.21. The importance of accurate and detailed care records will be addressed with RGNs. The gaps which were identified in documentation have been fed back to individual Nurses by the DON and this will be kept under ongoing review in order to ensure daily entries to care plans are accurate and up to date. This issue was also communicated and fed back to CNMs at meeting on 19.08.21 (post Inspection).

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
Quality of Life Audit is supplemented by using a resident's survey every 6 months. The assessed need for psychology input will be addressed on a case by case basis with the residents in Cedar Unit. Psychology input can be facilitated as required/requested through contracted services, which has occurred in the past, with positive outcomes.
The gaps and omissions in one specific care plan documentation has been fed back to the CNM2 and RGN on that ward. Care plan documentation and care plan audits will be scheduled on a monthly basis, to ensure compliance. This concern will be addressed daily at safety pause and will be addressed at RGN meeting scheduled for 16.09.21.
The privacy screens currently in place in 4 bedded rooms are being reviewed and a search on to identify more suitable screens to provide maximum privacy to the resident.

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
Arrangements are in place to protect residents from harm that promote body integrity,

personal liberty and a restraint free environment. A review of restrictive practices in Farranlea CNU is to be completed with an RGN working group over the month of October. The self-assessment questionnaire in relation to Restrictive Practices (HIQA) will form the baseline of this review and will identify areas for improvement.
Consultation with residents and their families will be ongoing in the review of the requirement and the changing needs of the residents in relation to the need for restraint.
MDT meetings are held on a monthly basis at ward level. Each resident is discussed and their individual care needs agreed.
Restraints that are in place are identified, reviewed, and an MDT decision is agreed as to whether or not to (i) continue, (ii) remove or (iii) replace restrictive measure with an alternative measure. Restrictive practice is captured on a risk assessment, specific to the individual resident and is documented with a clear review date.

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 12(c)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that he or she has adequate space to store and maintain his or her clothes and other personal possessions.	Substantially Compliant	Yellow	31/10/2021
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	31/10/2021
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the	Substantially Compliant	Yellow	30/11/2021

	residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.			
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	30/11/2021
Regulation 18(1)(c)(i)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are properly and safely prepared, cooked and served.	Substantially Compliant	Yellow	30/11/2021
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.	Substantially Compliant	Yellow	30/09/2021
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery	Not Compliant	Orange	31/10/2021

	of care in accordance with the statement of purpose.			
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	31/10/2021
Regulation 25(1)	When a resident is temporarily absent from a designated centre for treatment at another designated centre, hospital or elsewhere, the person in charge of the designated centre from which the resident is temporarily absent shall ensure that all relevant information about the resident is provided to the receiving designated centre, hospital or place.	Substantially Compliant	Yellow	30/09/2021
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the	Substantially Compliant	Yellow	30/09/2021

	Authority are implemented by staff.			
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	31/10/2021
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.	Not Compliant	Orange	30/09/2021
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	Substantially Compliant	Yellow	31/10/2021

	and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.			
Regulation 28(3)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place in the designated centre.	Substantially Compliant	Yellow	31/10/2021
Regulation 34(1)(b)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall display a copy of the complaints procedure in a prominent position in the designated centre.	Substantially Compliant	Yellow	31/10/2021
Regulation 34(3)(a)	The registered provider shall nominate a person, other than the person nominated in paragraph (1)(c), to be available in a designated centre to ensure that all complaints are appropriately responded to.	Substantially Compliant	Yellow	31/10/2021
Regulation 34(3)(b)	The registered provider shall	Substantially Compliant	Yellow	31/10/2021

	nominate a person, other than the person nominated in paragraph (1)(c), to be available in a designated centre to ensure that the person nominated under paragraph (1)(c) maintains the records specified under in paragraph (1)(f).			
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Substantially Compliant	Yellow	31/10/2021
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Not Compliant	Orange	30/09/2021
Regulation 6(1)	The registered provider shall,	Not Compliant	Orange	31/10/2021

	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.			
Regulation 7(3)	The registered provider shall 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.	Substantially Compliant	Yellow	31/10/2021