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

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Powdermill Nursing Home &amp; Care Centre</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0004456</td>
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<tr>
<td>Centre address:</td>
<td>Gunpowdermills, Ballincollig, Cork.</td>
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<tr>
<td>Telephone number:</td>
<td>021 487 1184</td>
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<tr>
<td>Email address:</td>
<td><a href="mailto:personincharge.powdermill@gmail.com">personincharge.powdermill@gmail.com</a></td>
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<tr>
<td>Type of centre:</td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
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<tr>
<td>Registered provider:</td>
<td>JCP Powdermill Care Centre Limited</td>
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<tr>
<td>Lead inspector:</td>
<td>John Greaney</td>
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<tr>
<td>Support inspector(s):</td>
<td>Niall Whelton</td>
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<tr>
<td>Type of inspection</td>
<td>Unannounced Dementia Care Thematic Inspections</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>40</td>
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<td>Number of vacancies on the date of inspection:</td>
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About Dementia Care Thematic Inspections

The purpose of regulation in relation to residential care of dependent Older Persons is to safeguard and ensure that the health, wellbeing and quality of life of residents is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer and more fulfilling lives. This provides assurances to the public, relatives and residents that a service meets the requirements of quality standards which are underpinned by regulations.

Thematic inspections were developed to drive quality improvement and focus on a specific aspect of care. The dementia care thematic inspection focuses on the quality of life of people with dementia and monitors the level of compliance with the regulations and standards in relation to residents with dementia. The aim of these inspections is to understand the lived experiences of people with dementia in designated centres and to promote best practice in relation to residents receiving meaningful, individualised, person centred care.

Please note the definition of the following term used in reports:
responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).
Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor compliance with specific outcomes as part of a thematic inspection. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

<table>
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<tr>
<th>From</th>
<th>To</th>
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<tr>
<td>27 May 2019 09:00</td>
<td>27 May 2019 17:15</td>
</tr>
<tr>
<td>28 May 2019 09:30</td>
<td>28 May 2019 14:30</td>
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The table below sets out the outcomes that were inspected against on this inspection.

<table>
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<tr>
<th>Outcome</th>
<th>Provider’s self-assessment</th>
<th>Our Judgment</th>
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<td>Outcome 01: Health and Social Care Needs</td>
<td>Substantially Compliant</td>
<td>Non-Compliant - Major</td>
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<tr>
<td>Outcome 02: Safeguarding and Safety</td>
<td>Compliance demonstrated</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 03: Residents’ Rights, Dignity and Consultation</td>
<td>Compliance demonstrated</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 04: Complaints procedures</td>
<td>Compliance demonstrated</td>
<td>Compliant</td>
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<tr>
<td>Outcome 05: Suitable Staffing</td>
<td>Compliance demonstrated</td>
<td>Substantially Compliant</td>
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<tr>
<td>Outcome 06: Safe and Suitable Premises</td>
<td>Compliance demonstrated</td>
<td>Compliant</td>
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<tr>
<td>Outcome 07: Health and Safety and Risk Management</td>
<td></td>
<td>Non-Compliant - Major</td>
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Summary of findings from this inspection

As part of the thematic inspection process, providers were invited to attend information seminars given by the Office of the Chief Inspector. In addition, evidence-based guidance was developed to guide best practice in dementia care and to inform the inspection process.

Prior to the inspection, a provider self-assessment document had been completed and the service was assessed against the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.
Powdermill Nursing Home and Care Centre is located close to the town of Ballincollig and adjacent to a large public park. It is approximately nine kilometres west of Cork city. The centre offers 24 hour nursing care to both long term and respite residents that are predominantly over the age of 65 years. The centre accommodates forty residents on two floors in twenty three single bedrooms, one twin bedroom and five triple bedrooms.

There is a garden to the front of the centre, which is landscaped to a high standard with ornamental features and shrubs. On one side of the premises there is a patio area with garden furniture and shrubs, which is readily accessible to residents through a door that is alarmed to alert staff when it is opened. There is also a decking area located on the other side of the premises that also has garden furniture and seating.

The inspectors tracked the care pathways of residents with dementia and spent three periods of time observing how staff related to residents. A validated observational tool, the quality of interactions schedule (QUIS) was used to rate and record at five minute intervals the quality of interactions between staff and residents. The observations took place in the communal area on the ground floor where residents spent most of their day. The inspectors observed that staff interactions were person-centred, meaningful and were not rushed. Residents were observed to be treated with dignity and respect during all staff contacts.

The inspectors talked with residents, visitors and staff during the inspection. Residents and relatives were complimentary of the care provided and of staff. The inspectors saw that there was a varied activity schedule that included balance classes, pamper days, music, games and sensory activities that were aimed at the needs of people with dementia. There was information on residents’ backgrounds, lifestyles and hobbies to guide staff when planning the activity schedule. Residents had newspapers delivered during the morning. Closed circuit television (CCTV) cameras were located throughout the centre, including on corridors and in communal rooms. The policy governing the use of CCTV did not fully comply with guidance issued by the data protection commission and did not adequately address the placement of cameras in areas where residents would have a reasonable expectation of privacy, such as sitting rooms and dining rooms.

Each resident had a pre-admission assessment completed in order to ensure the service could meet their needs and to plan care. The health needs of residents were met to a good standard. There was good access to medical care and to allied health services such as physiotherapy, dietetics, speech and language therapy. Care plans were generally good and provide person-centred guidance on care to be delivered to residents. Approximately half of residents living in the centre on the days of the inspection either had a diagnosis of dementia or some level of cognitive impairment.

With respect to the centre from a fire safety perspective, inspectors reviewed the fire safety management practices in place, including the physical fire safety features of the building. The building was reviewed in the presence of the Person in Charge. Inspectors also examined records for maintenance, fire safety training of staff,
evacuation procedures and the programme of drills. Inspectors noted a positive and proactive response from the Person in Charge during the inspection to all fire related matters identified. Staff spoken with demonstrated a good understanding of fire prevention and evacuation procedures and this was evident from fire safety training records.

This report does not constitute a full fire safety assessment of the building and the Provider should seek the advice of a suitably qualified person with relevant experience in fire safety assessment, to fully meet their obligations under the Health Act 2007 as amended.

At the previous inspection, inspectors were not assured that adequate measures were in place to ensure a safe evacuation of residents with limited mobility from the first floor. While the Provider had put additional measures in place such as focused fire drills and training for this area, inspectors were still not assured in this regard.

Choice of food was offered to most residents and food appeared to be nutritious and available in sufficient quantities. Choice of food, however, was not always offered to residents that were prescribed modified texture diets. Discussions with staff and a review of records indicated that, at lunch time, there was only one option available for residents that were prescribed texture B (minced and moist) and texture C (smooth, moist and lump free) diets. Additionally, food was not always prepared in accordance with the prescribed food texture for all residents and some residents were provided with food that was modified beyond the texture prescribed.

A significant number of residents had their meals in their bedrooms. For some residents that had their meals in the dining room, the dining experience could be enhanced by providing more suitable seating arrangements. For example, inspectors observed that three residents had their meals served on a tray table. The design of the tray table meant that residents could not comfortably eat their meals from the tray, as it was not comfortably within their reach. These residents then proceeded to eat their lunch by placing the plate on their laps. Another resident, seated in an armchair at the end of a dining table, was seated in a manner that also meant that the plate of food was at the resident's side rather than in front.

The Action Plan at the end of this report identifies the areas where improvements are required to comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centre's for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland 2016.
Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

Outcome 01: Health and Social Care Needs

Theme:
Safe care and support

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

Findings:
This outcome sets out the inspection findings relating to healthcare, assessments and care planning. The social care of residents with dementia is discussed in Outcome 3. The inspector focused on the experience of residents with dementia and tracked the journey of a number of residents with dementia. Overall, while evidence of good practice was seen, inspectors identified a number of areas where significant improvements were required in supporting residents well being; smoking risk management; accurate provision of residents currently prescribed diets; adequate provision of choice for residents that were prescribed modified texture diets; improvements to enhance the dining experience; improvements in medication management.

Of the forty residents in the centre on the days of the inspection, nine had a formal diagnosis of dementia and nine others had a cognitive impairment, but did not have a confirmed diagnosis of dementia.

Catering staff made efforts to ensure residents were provided with food in accordance with residents' likes and dislikes. A discussion with catering staff indicated that they had a personal knowledge of individual resident’s preferences. While there were arrangements in place for communication between nursing and catering staff to support residents with special dietary requirements, the system required review to ensure that it accurately reflected each resident’s currently prescribed diet. Diet sheets used by catering staff did not accurately reflect each resident’s currently prescribed diet. For example, the diet sheet indicated that one resident should have texture B diet (minced and moist) whereas the actual prescribed diet for that resident was texture C diet (smooth, moist and lump free). This increased the potential risk of aspiration and choking for that resident. Residents were provided with drinks and snacks throughout the day. Thickened fluids were provided for residents at the consistency prescribed by the speech and language therapist.

Improvements were also required in relation to the provision of choice for residents that were prescribed modified texture diets. While most residents were offered choice of food at meal times, this was not the case for residents that were prescribed texture B
and C diets. There was usually only one option available for these residents and when staff were ascertaining the menu choice for each resident, the preferences of these residents was not recorded.

Residents' records were predominantly electronic. Comprehensive nursing assessments were carried out that incorporated the use of validated assessment tools for issues such as the risk of falling, risk of developing pressure sores and for the risk of malnutrition. Care plans were developed based on these assessments. A sample of care plans reviewed contained the required information to guide care delivery. Overall, care plans were person-centred and were updated regularly to reflect changing care needs. A review was required of care plans in relation to residents that smoked. There was a smoking shelter located at the side of the premises that contained a fire blanket and fire extinguisher. There was also a call bell for residents to alert staff should they require assistance. While each resident had a risk assessment completed and a care plan for smoking, it was not always evident that the care plan outlining the level of supervision required, reflected the findings of the risk assessment. For example, residents that had not fully complied with the smoking policy in the past were assessed as being suitable to smoke unsupervised. Additionally, some of the questions in the risk assessment were phrased in a manner that caused ambiguity among staff in relation to what question was being asked. Significant risks were previously found in this centre in relation to residents smoking, during an inspection conducted in June 2016.

A significant number of residents spent their day in their bedrooms and also had their meals in their bedrooms. The inspectors were informed that this was the choice of each resident. Inspectors observed that, on the days of the inspection, eighteen of the forty residents had their main meal in the dining room. The dining room was also used as a sitting room and many residents remained in this room throughout the day. For residents that had their meals in the dining room, improvements were required to enhance the dining experience. For example, inspectors observed that three residents had their meals served on a tray table. The design of the tray table meant that residents could not comfortably eat their meals from the tray, as the food was not comfortably within their reach. These residents then proceeded to eat their lunch by placing the plate on their laps. Another resident, seated in an armchair at the end of a dining table, was seated in a manner that also meant that the plate of food was at the resident's side rather than in front.

All nurses had completed medication management training. There were regular audits carried out of medication management practices. A review of a medication cupboard identified that there were some medications in the cupboard that had been discontinued. These drugs had past their expiry date by almost four months but had not yet been returned to the pharmacy. If administered to residents these medications could be ineffective. A review of the medication fridge identified that the fridge temperature was monitored and recorded. The inspectors noted that water was dripping internally into a container holding medications that are held for use in the event of an emergency situation for residents with diabetes. The packaging of these medicines were water damaged and could therefore be unusable when they were required. An assessment was required of the fridge to determine if it required repair or replacement.

There was a centre-specific medication policy with procedures for safe ordering,
prescribing, storing and administration of medicines. All residents had photographic identification in place. Medications in the centre were supplied in a monitored dosage system. There was a system of reconciliation to ensure that what was delivered matched the prescription.

The supply and administration of controlled drugs was checked and was correct against the drug register, in line with legislation. Two nurses checked the quantity of these medications at the start of each shift. The nurse, spoken with by the inspector, displayed a good knowledge of the requirements in the area of controlled drugs and the responsibilities of the registered nurse to maintain careful records.

Residents were predominantly admitted from acute hospitals. The person in charge carried out a pre-admission assessment of prospective residents with dementia to ensure that the centre could meet their needs. A care needs assessment, to ascertain if the person required long-term nursing care, was carried out by a healthcare professional and the result of this assessment was available in the centre in the form of a common summary assessment report (CSAR). Prospective residents and their families were welcomed into the centre to view the facilities and discuss the services provided before making a decision to live in the centre. This gave residents and their families information about the centre and also assured them that the service could adequately meet their needs.

Residents had access to general practitioners (GPs) of their choice. A review of records indicated that residents were reviewed regularly by their respective GPs. Residents with dementia were supported to attend out-patient appointments and were referred as necessary for care in the acute hospital services. There were records available showing that relevant information was shared by the centre, when residents were transferred to hospital, in the form of transfer letters and discharge summaries.

There was good access to allied health services. Dietetic, speech and language therapist (SALT) and wound care services were provided by a private nutritional supply company and there was good access. A physiotherapist visited the centre for three hours each week to carry out group exercises but also completed one-to-one assessments. Systems were in place for residents to have regular reviews by dental and optical services. Systems were also in place to ensure that residents that qualified for national screening programmes were facilitated to participate in the programme, should they so wish.

The inspector found that staff knew residents well and were knowledgeable regarding residents' likes, dislikes and their individual needs. Records of residents' assessments reviewed included comprehensive biographical details, medical history, and nursing assessments.

Staff provided end-of-life care to residents with the support of their GP and community palliative care services, as required. There were no residents at active end-of-life stage on the days of the inspection. There was evidence of preliminary discussions with residents around preferences for end of life care. Residents' relatives were facilitated to stay overnight with them when they became very ill. Religious and cultural needs were facilitated. Members of the local clergy provided pastoral and spiritual support to residents as they wished.
The nutrition and hydration needs of residents with dementia were assessed and monitored. Residents’ nutritional status was monitored through regular weights and also through the use of a validated assessment tool to screen residents for the risk of malnutrition. Residents' weights were checked routinely on a monthly basis and more frequently, if they experienced unintentional weight loss. Nutritional assessments and care plans were in place that outlined the recommendations of the dietician and speech and language therapists, where appropriate.

**Judgment:**
Non-Compliant - Major

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**Outcome 02: Safeguarding and Safety**

**Theme:**
Safe care and support

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

**Findings:**
Systems were in place to ensure that allegations of abuse were fully investigated and that residents were safeguarded during the investigation process. Staff had received training to guide them on the protection of vulnerable people and on how to identify and respond to an incident of abuse. There was a policy to guide staff on how to manage allegations of abuse. The person in charge and staff spoken to were knowledgeable of the different forms of abuse and all were clear on the reporting procedures. Residents told the inspector that they felt safe in the centre and spoke positively about the staff caring for them. All interactions by staff with residents observed by inspectors were kind and respectful.

There was a policy and procedure in place for the management of responsive behaviour. Inspectors were informed that a small number of residents with dementia were predisposed to experiencing responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). Staff were familiar with triggers to resident's behaviours and were observed using the most appropriate person-centred interventions to de-escalate behaviours.

A policy to inform management of restraint was available and reflected procedural guidelines in line with the national restraint policy. Inspectors were informed that 19 of the 40 residents living in the centre on the days of the inspection had bedrails in place when they were in bed. There was a risk assessment completed to ascertain the suitability and risk of using bedrails and to identify alternatives to bedrails. Safety checks were carried out for residents when bedrails were in place.
There were systems in place for the management of residents' finances. Inspectors were informed that the provider was pension agent for one resident. The procedures in place for managing finances were reviewed and the inspectors found that satisfactory records were maintained.

**Judgment:**
Compliant

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### Outcome 03: Residents’ Rights, Dignity and Consultation

**Theme:**
Person-centred care and support

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

**Findings:**
Inspectors found that residents, including residents with dementia, were consulted about how the centre was run and were enabled to make choices about their day-to-day life in the centre. There were adequate arrangements in place for consultation with relatives and families, who said they were regularly asked for their views in relation to their relatives’ care and the service provided.

Inspectors observed that staff interacted with residents throughout the day, while also respecting their privacy. Residents were able to exercise choice in relation to the time they got up and went to bed and told the inspector they were able to have breakfast at a time that suited them.

Inspectors spent three periods of time observing staff interactions with residents. A validated observational tool, the quality of interactions schedule (QUIS) was used to rate and record at five minute intervals the quality of interactions between staff and residents in the communal sitting areas. Inspectors observed that staff knew residents well and engaged with them in a personal, meaningful way by asking about their wellbeing, plans for the day, activities and meals. Inspectors observed that all residents had good levels of social engagement that appeared to provide them with enjoyment. Residents told inspectors that they had good relationships with staff and found them very helpful.

Social care opportunities were provided daily by designated activity staff. Inspectors reviewed the activity programme. The programme was varied and there were activities targeted to the needs of people with dementia. Exercise and discussion groups took place regularly throughout each week. There was a good emphasis on interactive activity and crafts where residents were supported to contribute to their maximum ability. There was a mix of group and individual activities available. Information on residents’ backgrounds, interests and hobbies had been collated by staff and the activity programme was reviewed regularly to ensure that the programme was relevant to residents’ interests.
During main meal times, staff were observed to offer assistance in a respectful and appropriate manner. All staff sat beside the resident they were assisting and were noted to encourage the resident throughout their meal. Independence was promoted and residents were encouraged to eat their meal at their own pace, with minimal assistance to improve and maintain their functional capacity. Adequate time was allocated to mealtimes and residents were observed to take as much time as they wished over their meals.

There were regular residents' meetings, which were used as an opportunity to get feedback from residents about life in the centre. The inspector viewed the minutes of these meetings. The meeting records provided assurances that residents were happy with the services provided, particularly the care and activities provided by staff and the catering arrangements. Residents were provided with updates on the service such as when the physiotherapist visited, and the programme of activities, including planned one-off activities.

There were closed circuit television (CCTV) cameras located throughout the premises, such as in hallways and sitting rooms. While there was signage located throughout the building, CCTV cameras were located in sitting rooms where residents would have a reasonable expectation of privacy. The policy on the use of CCTV was not signed or dated. The policy did not provide adequate detail to demonstrate that the use of CCTV in areas where residents would have a reasonable expectation of privacy was fully compliant with guidance issued by the data protection commission.

Inspectors were informed that the returning officer visited the centre and residents were facilitated to vote in local and European elections and in the referendum.

**Judgment:**
Substantially Compliant

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**Outcome 04: Complaints procedures**

**Theme:**
Person-centred care and support

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

**Findings:**
There was a complaints procedure in place. The inspectors found that any complaints made in the centre were listened to and acted upon in a timely manner. Information advising residents and others about how to complain was described in the residents' guide, the statement of purpose and the procedure was on display. The person in charge was responsible for addressing complaints.

Inspectors spoke with a number of residents who confirmed that they were aware of the procedure in relation to making a complaint and would feel confident to do so, if needed.
Inspectors reviewed the complaints log. A record was kept of all complaints. Complainants were updated promptly of the outcome of the investigation. All complaints were reviewed by the person in charge and areas for improvement and learning were identified and discussed at staff meetings.

**Judgment:**
Compliant

**Outcome 05: Suitable Staffing**

**Theme:**
Workforce

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

**Findings:**
On the day of inspection there were forty residents living in the centre. The dependency level of each resident was assessed using a recognised validated tool. Six of the residents were assessed as being maximum dependency, thirteen were high dependency, twelve were medium dependency and nine were assessed as having a low dependency level.

Inspectors were satisfied that there was an appropriate number and skill mix of staff on duty to meet the assessed needs of the residents living in the centre on the days of the inspection. Staff delivered care in a respectful, timely and safe manner. The inspectors reviewed staff rosters, which showed there was a nurse on duty at all times, with a regular pattern of rostered care staff. The staffing complement included the activities coordinator, catering, housekeeping, administration and maintenance staff. Residents said that staff were always available to attend to their needs and did so promptly when they requested help or rang the call bell.

The inspectors found that recruitment procedures were predominantly in compliance with the regulations. There was a comprehensive recruitment policy in place, based on the requirements of the Regulations. The inspectors reviewed a sample of four staff files, including recently recruited staff, which were found to contain most of the required documentation. Garda Síochána vetting was in place for all staff prior to commencing employment. Proof of current registration was in place for all nursing staff. A full employment history was in place for three of the four files reviewed, however, the employment history for one member of staff contained a gap of approximately fifteen months, for which a satisfactory explanation was not recorded. Details of induction, orientation and training certificates were contained in staff files.

Training for staff was scheduled throughout the year. Training records indicated that all staff had attended up-to-date training in mandatory areas such as fire safety, manual and people handling, safeguarding residents from abuse and responsive behaviour. Staff had also attended training in other areas, such as cardiopulmonary resuscitation,
medication management and dementia care.

**Judgment:**
Substantially Compliant

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### Outcome 06: Safe and Suitable Premises

**Theme:**
Effective care and support

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

**Findings:**
Powdermill Nursing Home is located close to the town of Ballincollig. Residents' accommodation is on the ground and first floors. Bedroom accommodation on the ground floor comprises nineteen single bedrooms, one twin bedroom and three triple bedrooms. Bedroom accommodation on the first floor comprises four single bedrooms and two triple bedrooms. For operational purposes the centre is divided into three sections; Millrace, which includes bedrooms one to nine; Cooperage, which includes bedroom ten to fifteen, and is on the first floor; and Barges, which includes bedrooms eighteen to twenty eight.

While the first floor can be accessed by both stairs and lift, there are multiple floor levels and not all of the bedrooms on the first floor are accessible directly, either from the stairs or from the elevator. The stairs leads to a hallway that is on a lower level to the hallway on which the elevator is located. The first hallway, located proximal to the elevator, provides access to bedrooms 12, 13, 14, and 15. These bedrooms accommodate eight residents in two triple and two single rooms. Rooms 12 and 13 are level with the hallway floor, however, rooms 14 and 15 are accessed via an upwards ramp. The second hallway, at the top of the stairs, is three steps lower than the hallway on which the elevator is located. Bedrooms 10 and 11, both single rooms, are located on this hallway. Bedroom 11 is level with the hallway floor but bedroom 10 is on a higher level and is accessed via four steps.

All of the bedrooms on the ground floor are en suite with toilet and shower. On the first floor one triple bedroom is en suite with toilet and shower and wash hand basin and the other triple bedroom is en suite with toilet and wash hand basin only. There are two communal bathrooms on the first floor, one with a toilet and shower and the other with a toilet only.

The centre is located close to the regional park and, weather permitting, residents are often taken for walks in the park, accompanied by staff. The garden to the front of the centre is landscaped to a very high standard with ornamental features and shrubs. On one side of the premises there is a patio area with garden furniture and shrubs, which is readily accessible to residents through a door that is alarmed to alert staff when it is opened. The smoking area is located here. There is also a decking area located on the
other side of the premises that also has garden furniture and seating.

There is adequate communal space that includes a comfortable sitting room and a family room, that is in the process of being refurbished but is not yet fully furnished with comfortable seating. There is a large dining room, which is also used as the main sitting room.

The centre was generally clean and bright throughout. There were records available demonstrating that equipment such as beds and hoists had preventive maintenance carried out at appropriate intervals.

**Judgment:**  
Compliant

**Outcome 07: Health and Safety and Risk Management**

**Theme:**  
Safe care and support

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

**Findings:**  
Overall, the provider was not taking adequate precautions against the risk of fire, such as, the storage of oxygen cylinders; the evacuation of residents with limited mobility who required the assistance of staff to evacuate from areas of the first floor; fire detection and alarm system did not meet the required L1 standard in line with current guidance for existing nursing homes; issues with fire containment; and, fire checks of adequate detail. It is acknowledged that the provider had put in place a comprehensive fire safety training programme including additional training sessions, and staff were knowledgeable of residents assessed needs.

There was poor practice in relation to the storage of oxygen cylinders in the centre. There was one cylinder on a stand and four loose cylinders in a cupboard, all located in the nurse station. When not in use, they should be appropriately stored in a well-ventilated area, remote from any possible ignition source. The cylinders were not adequately ventilated, nor were they sufficiently enclosed in fire rated construction. On day one of the inspection, the cupboard was found to be unlocked and open. Inspectors were not assured and found that these arrangements required review by a competent person with relevant experience, to determine the suitability of the oxygen storage arrangements.

Assurance was sought but not received in relation to the escape of residents with limited mobility, who require the assistance of staff to evacuate from areas of the first floor. Progressive horizontal evacuation was adopted as the primary evacuation method for the centre. The first floor was divided into compartments for evacuation and was provided with two designated escape stairways, each within a separate compartment. The rear stairs was identified as the main escape route from the first floor. Staff spoken
with, and drill records confirmed, that it was feasible to manoeuvre identified evacuation aids down this stairs. However, inspectors were not assured that if the rear stairs was not available in the event of a fire, that adequate arrangements were in place to evacuate residents with limited mobility from the first floor. The alternative escape stairs to the front was narrow and winding. Inspectors were not assured that this stairs would be suitable for use with the identified evacuation aids for some residents at first floor. There was no records to demonstrate that this stairs had been tested using the relevant evacuation aids. Inspectors sought assurance that the identified evacuation aids for residents who require them, were able to fit down the front stairs if required. The provider confirmed that consideration had been given to replacing this stairs, but there was no specific plan in place at the time of inspection.

At the time of inspection, there were four residents accommodated at first floor who were assessed as requiring assistance to evacuate. The person in charge said that the evacuation requirements of residents were considered when assessing residents prior to offering them accommodation at the first floor, however, there were no documented policies or procedures that supported this. The impact of this is that clear direction was not available to staff in relation to the evacuation needs of residents with limited mobility that were accommodated on the first floor.

The alternative external route from the bottom of the rear stairs required re-entry to the building, but there was no means of opening the door from the outside in this regard. This was brought to the attention of the registered provider and person in charge.

At first floor, there was a ramp providing access to and egress from, bedrooms 14 and 15. This ramp was found to be excessively steep and a recently installed fire door across the slope of the ramp created a potential risk. Doors on escape routes should be clear of any change of floor level.

The inspectors reviewed documentation in terms of regular in house fire safety checks in the centre. There were daily and weekly checklists which included checks for the fire detection and alarm system panel, escape routes, fire doors and so on and these were up-to-date. While this is considered good practice, improvement was required to ensure the checks were of adequate extent and detail. For example, inspectors noted some fire doors where smoke and heat seals were missing and others where the seals were painted over. Where smoke seals are painted over, it reduces the likely effectiveness of the door to contain the spread of smoke.

Inspectors found that improvements were required in terms of providing adequate containment of fire. Deficiencies were noted where services penetrated fire rated construction and were not adequately sealed to prevent the spread of fire and smoke. Breaches in the fire rated enclosure to a room or corridor that requires fire resistance, results in a passage for fire and smoke to compromise escape routes. For example, the door from the laundry room to the escape stairs was found to have a section of the door frame removed with a large number of wires passing through. The fire containment measures in the building required review to ensure their likely performance to prevent the spread of fire and smoke through the building.

The building was fitted with a fire detection and alarm system and this was being
inspected and tested at the required intervals, however the system did not meet the required L1 standard in line with current guidance for existing nursing homes.

Inspectors found that there was a fire procedure in place and evacuation drawings were displayed throughout the centre. The drawings showed the extent of the fire compartments to facilitate and assist progressive horizontal evacuation and the information was clearly portrayed and legible. Inspectors noted the plans did not reflect the recent alterations to the building. For example, the reception area was not correctly shown and a staff office and additional bedroom were not shown.

The registered provider had made arrangements for staff in the designated centre to receive suitable training in fire prevention and emergency procedures. Furthermore, the provider had arranged for focussed training sessions on evacuation from the first floor. Staff spoken with, who verified their training were found to be knowledgeable and competent in the identified methods of evacuation. In the main, inspectors found that the building was laid out a manner that provided residents and other occupants with an adequate number of escape routes and fire exits. Escape routes and exits were noted to be kept clear and well maintained.

Judgment:
Non-Compliant - Major

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

John Greaney
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Powdermill Nursing Home &amp; Care Centre</th>
</tr>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0004456</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>27/05/2019</td>
</tr>
<tr>
<td>Date of response:</td>
<td>27/06/2019</td>
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Requirements

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

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

Outcome 01: Health and Social Care Needs

Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
While each resident had a risk assessment completed and a care plan for smoking, it was not always evident that the care plan outlining the level of supervision required, reflected the findings of the risk assessment. For example, residents that had not fully complied with the smoking policy in the past were assessed as being suitable to smoke unsupervised. Additionally, some of the questions in the risk assessment were phrased in a manner that caused ambiguity among staff in relation to what question was being asked.

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

1. **Action Required:**
Under Regulation 05(1) you are required to: Arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2).

**Please state the actions you have taken or are planning to take:**
A. A risk assessment has been undertaken with a revised assessment document. The residents who smoke and their family (where authorised) were consulted. This is now used to guide the level of supervision required by each individual smoker.
B. The smoking risk assessment has been reviewed and the issue of any ambiguity has been removed.

**Proposed Timescale:** 29/05/2019

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
A review of records and discussions with staff indicated that a number of residents that were prescribed modified texture diets, did not receive food that was prepared to the recommended consistency. For example, some residents that were prescribed texture B diet (minced and moist) were provided with texture C diet (smooth, moist and lump free).

While there were arrangements in place for communication between nursing and catering staff to support residents with special dietary requirements, the system required review to ensure that it accurately reflected each resident’s currently prescribed diet. Diet sheets used by catering staff did not accurately reflect each resident’s currently prescribed diet.

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

**Please state the actions you have taken or are planning to take:**
A. Prescribed modified textured diets are now prepared in compliance with the resident’s care plan.
B. Updated diet sheets are communicated to the kitchen by the nurse as soon as any change occurs in the resident’s dietary requirements. This is also recorded in the nursing care plan.
C. Senior nursing staff will complete a weekly audit to ensure compliance.
Proposed Timescale: 29/05/2019

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
While most residents were offered choice of food at meal times, this was not the case for residents that were prescribed modified texture diets. There was usually only one option available for these residents and when staff were ascertaining the menu choice for each residents, the preferences of these residents was not recorded.

3. Action Required:
Under Regulation 18(1)(b) you are required to: Offer choice to each resident at mealtimes.

Please state the actions you have taken or are planning to take:
A. Residents who are prescribed textured diets are now given the choice of two options daily by the chef.

Proposed Timescale: 28/05/2019

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Inspectors observed that three residents had their meals served on a tray table. The design of the tray table meant that residents could not comfortably eat their meals from the tray, as it was not comfortably within their reach. These residents then proceeded to eat their lunch by placing the plate on their laps. Another resident, seated in an armchair at the end of a dining table, was seated in a manner that also meant that the plate of food was at the resident's side rather than in front.

4. Action Required:
Under Regulation 18(1)(c)(i) you are required to: Provide each resident with adequate quantities of food and drink which are properly and safely prepared, cooked and served.

Please state the actions you have taken or are planning to take:
A. The existing tray tables have been modified so that the resident’s legs can be placed comfortably under the tray tables. Residents can now eat comfortably from the tray table to avoid having plates on their laps.
B. The resident who sits in this armchair prefers her food to be served at her side. Residents choices and preferences are respected unless there is a risk to themselves or other residents.

Proposed Timescale: 06/06/2019
The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A review of a medication cupboard identified that there were some medications in the cupboard that had been discontinued. These drugs had past their expiry date by almost four months but had not yet been returned to the pharmacy.

5. Action Required:
Under Regulation 29(6) you are required to: Store any medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident in a secure manner, segregated from other medicinal products and dispose 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.

Please state the actions you have taken or are planning to take:
A. Out of date medication was returned to the pharmacy on the 29th of May.
B. The Director of Nursing has completed a root cause analysis to determine why the medication was not returned in a more timely manner. Learning outcomes implemented.

Proposed Timescale: 07/06/2019

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The inspectors noted that water was dripping internally in the medication fridge into a container holding medications. The packaging of these medicines were water damaged. An assessment was required of the fridge to determine if it required repair or replacement.

6. Action Required:
Under Regulation 29(4) you are required to: Store all medicinal products dispensed or supplied to a resident securely at the centre.

Please state the actions you have taken or are planning to take:
A. All medication with damaged packaging was removed and returned to the Pharmacy.
B. The fridge was assessed after the inspection and a new fridge was purchased.

Proposed Timescale: 29/05/2019

Outcome 03: Residents' Rights, Dignity and Consultation
Theme:
Person-centred care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
There were closed circuit television (CCTV) cameras located throughout the premises, such as in hallways and sitting rooms. While there was signage located throughout the building, CCTV cameras were located in sitting rooms where residents would have a reasonable expectation of privacy. The policy on the use of CCTV was not signed or dated. The policy did not provide adequate detail to demonstrate that the use of CCTV in areas where residents would have a reasonable expectation of privacy was fully compliant with guidance issued by the data protection commission.

7. Action Required:
Under Regulation 09(3)(b) you are required to: Ensure that each resident may undertake personal activities in private.

Please state the actions you have taken or are planning to take:
The CCTV policy has been reviewed and is detailed in relation to the use of CCTV cameras. CCTV has been used in the communal areas since 2000 to protect and ensure the quality and safety of all residents and does not compromise data protection guidelines or the privacy of residents.

Proposed Timescale: 14/06/2019

Outcome 05: Suitable Staffing

Theme:
Workforce

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
A full employment history was in place for three of the four files reviewed, however, the employment history for one member of staff contained a gap of approximately fifteen months, for which a satisfactory explanation was not recorded.

8. Action Required:
Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

Please state the actions you have taken or are planning to take:
The gap in the employees C.V. was queried and a valid reason for the gap was recorded on her file in accordance with Schedule 2.

Proposed Timescale: 30/05/2019
### Outcome 07: Health and Safety and Risk Management

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Inspectors noted that evacuation plans did not reflect the recent alterations to the building.

9. **Action Required:**
Under Regulation 28(3) you are required to: Display the procedures to be followed in the event of fire in a prominent place in the designated centre.

**Please state the actions you have taken or are planning to take:**
Floor plans will be updated to reflect any changes/additions to the building i.e., new room 7B, new director of nursing's office, new fire compartment outside the lift and outside room 14 on the first floor.

**Proposed Timescale:** 30/09/2019

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**Theme:**
Safe care and support

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
Inspectors found that improvements were required in terms of providing adequate containment of fire.

The fire detection and alarm system did not meet the required L1 standard in line with current guidance for existing nursing homes.

10. **Action Required:**
Under Regulation 28(2)(i) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

**Please state the actions you have taken or are planning to take:**
This compliance plan response from the registered provider did not adequately assure the office of the Chief Inspector that the actions will result in compliance with the Regulations.

**Proposed Timescale:** 30/09/2019

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**Theme:**
Safe care and support

**The Registered Provider (Stakeholder) is failing to comply with a regulatory**
requirement in the following respect:
Inspectors were not assured that if the rear stairs was not available in the event of a fire, that adequate arrangements were in place to evacuate residents with limited mobility from the first floor.

11. **Action Required:**
Under Regulation 28(2)(iv) you are required to: Make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and safe placement of residents.

**Please state the actions you have taken or are planning to take:**
This compliance plan response from the registered provider did not adequately assure the office of the Chief Inspector that the actions will result in compliance with the Regulations.

**Proposed Timescale:** 30/09/2019

**Theme:**
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
There was poor practice in relation to the storage of oxygen cylinders in the centre.

12. **Action Required:**
Under Regulation 28(1)(a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.

**Please state the actions you have taken or are planning to take:**
The storage of oxygen has been assessed by an external assessor with the view to achieve a balance between health and safety and the requirement to have oxygen available to the nurses when required in a medical emergency. Since the inspection the oxygen cylinders in the nurse’s station has been reduced to one cylinder from four. The remaining 3 cylinders are now being stored outside the building. The single cylinder is stored in a locked press in the nurses station. Storage of oxygen will again be reviewed as part of the L1 certification.

**Proposed Timescale:** 30/09/2019

**Theme:**
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The alternative escape stairs to the front of the building was narrow and winding. Inspectors were not assured that this stairs would be suitable for use with the identified
evacuation aids for some residents at first floor.

The alternative external route from the bottom of the rear stairs required re-entry to the building, but there was no means of opening the door from the outside.

At first floor, there was a ramp providing access to and egress from, bedrooms 14 and 15. This ramp was found to be excessively steep and a recently installed fire door across the slope of the ramp created a potential risk.

13. **Action Required:**
Under Regulation 28(1)(b) you are required to: Provide adequate means of escape, including emergency lighting.

**Please state the actions you have taken or are planning to take:**
This compliance plan response from the registered provider did not adequately assure the office of the Chief Inspector that the actions will result in compliance with the Regulations.

**Proposed Timescale:** 30/09/2019

**Theme:**
Safe care and support

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
the in-house fire safety checks required improvement to ensure they were of adequate extent and detail.

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

**Please state the actions you have taken or are planning to take:**
The in-house weekly fire safety check was introduced by the Centre in July 2016 and it involves activating the fire alarm, checking that all fire doors close properly and that all fire extinguishers are in place and fully serviced. A new checklist was implemented to include the smoke seals on all fire doors on the 5th of June and this has been added to the weekly fire check. Containment will also be included to the weekly check especially after any building work or contractor work has taken place.

**Proposed Timescale:** 05/06/2019