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:	13 July 2022
Centre ID:	OSV-0000713
Fieldwork ID:	MON-0036479

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 a 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 13 July 2022	09:00hrs to 17:00hrs	Breeda Desmond	Lead
Wednesday 13 July 2022	09:00hrs to 17:00hrs	Kathryn Hanly	Lead

What residents told us and what inspectors observed

Overall, inspectors found that, in general, staff were working to improve the quality of life and promote the rights and choices of residents in the centre. Inspectors met with many residents during the inspection, and spoke with 12 residents in more detail to gain insight into their experience of living there. All were very complimentary in their feedback and expressed satisfaction about the standard of care provided. One resident said they were anxious and worried in the earlier stages of the pandemic but staff reassured and supported them. Another resident said the pandemic had negatively impacted them and they no longer felt as sociable as they had been. They said they missed visiting residents within other units.

Inspectors arrived unannounced to the centre and reception staff guided the inspectors through the infection prevention and control measures necessary on entering the designated centre. This process included hand hygiene, face covering, wellness check and temperature. An opening meeting was held with the person in charge which was followed by a walk-about the centre.

The centre was a large two storey building set out in four units over the two floors (Cedar and Willow on the ground floor; Sycamore and Oak on the first floor), 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. There was 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 were available here.

'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. The oratory was located behind main reception. Tea and coffee making facilities and seating with coffee tables were available in front of the oratory. 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 resident had decorated her patio with an abundance of artwork, potted flowers and hedging and looked gorgeous. The resident had a visitor and they said they loved to spend time out there enjoying the fresh air and garden. The resident said that she was very happy with the care and service provided. Other residents had patio table and chair sets outside their bedrooms; one resident had set up their CD player and tall CD rack to enjoy their music while sitting outside in their patio.

All units were self-contained with dining room, sitting room, sensory or quiet room, day room and pantry. All units had small sitting rooms, and some had additional

sensory room or reading rooms. These were seen to be used by staff as part of the social distancing COVID-19 precautions. Willow, Sycamore and Oak Units each accommodated 25 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. Some bedrooms were decorated with soft furnishings, colourful murals, fairy lights and mementos, however, twin and multi-occupancy bedrooms remained clinical. Some bedrooms had private information displayed, for example, information regarding the assistance required for transfer, and other signage regarding return from the bathroom and use of a commode.

Cedar provided accommodation for up to 14 younger adults with complex neurological care needs and all bedroom accommodation was single occupancy with full en suite facilities. Currently the occupancy there was maintained at 10 residents. The activity co-ordinators' rooms were within Cedar. 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 resident's in Cedar. There was an array of flowering plants, herbs and shrubs creating colour and texture throughout the space. Garden furniture and props were painted different colours and looked really well in the garden. One resident was observed filling the water gallon from the sink and then watering the plants. 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 occupational therapy.

There were seating areas along corridors on each unit with colourful seating cushions; some had lovely delicate painted murals with words of inspiration and encouragement, others had art work displayed to brighten and uplift residents. Views of the enclosed gardens could be seen from many of the seating as the corridors were full-length glass windows giving a bright and airy ambiance.

Mitzi, the miniature schnauzer was on site during the inspection and was a regular visitor to the centre from the volunteer organisation, the 'Irish Therapy Dogs'. The tri-bike was in constant use and three staff undertook this activity with residents. Lots of photographs were seen with residents enjoying the outing on the bike and other social activities and parties.

The Atrium was an expansive space between Sycamore and Oak where larger group activities were held. The day of inspection was a gorgeous warm summer's day so the band relocated to the enclosed garden rather than the atrium. They played every Wednesday morning and residents loved the music and craic with three musician playing, two volunteers that visit the centre on a weekly basis and the thrid was a member of staff that played the guitar and sang. Residents had their 'party piece' and were encouraged to perform and enjoyed the fun and sing-along. Staff were seen to encourage residents to clap, tap their feet, wave, sing-along to the music to enhance their enjoyment. One resident observed that music makes people happy and it was lovely to watch and see people's enjoyment. There were lots of parasols available to provide shade from the hot sunshine. Residents also wore sun

hats and the inspector saw one of the HCA offering a resident suntan lotion and a facial spritzer to freshen up before going out to the music in the garden. When the inspector was trying to access Cedar, one of the residents came along and gave the access code to the inspector to gain entry.

Staff were observed to knock on residents' bedroom doors before entering and lovely social chat was heard, asking residents how they were; one resident was seen to have curlers in her hair following a member of staff up-styling her hair. Residents were seen to be well dressed and attention given to co-ordinating their attire including jewellery and make-up.

On the first floor a roofed terraced garden off Sycamore unit had 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. 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 enabling residents to remain active. All balconies had transparent storm-glass protection to ensure the safety of residents and relatives.

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 in place 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, day and date. Advisory signage was displayed at junctions throughout the centre directing residents to rooms such as the dining room, day rooms and bedrooms.

The dining room on Oak had been recently refurbished. Residents had chosen the colour scheme for the paintwork, table cloths, curtains and chairs and made the room warm, bright and inviting.

There were assisted bathrooms on each unit with specialist baths. These rooms were seen to be used as store rooms for large equipment such as hoists and could not be accessed by residents. One of these bathrooms had staff lockers. The baths were seen to be dusty and contained residual water as they had not been appropriately drained. The wooden railing on one balcony was worn and damaged; the protective coating on some low windowsills was worn away.

Clinical hand wash sinks were available within each bedroom for staff use. These sinks complied with the recommended specifications for clinical hand wash basins. Alcohol hand gel dispensers were readily available along corridors and within residents rooms; some were empty during the inspection.

Some rooms such as sluice rooms and household cleaners' rooms were unsecured and these contained clinical waste. Cleaners' trolleys were left unattended on corridors with free access to cleaning chemicals.

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, a rights-based approach to care was supported and there was a commitment to provide quality care where residents' independence was promoted.

Farranlea Road Community Nursing Unit was a residential care setting operated by the Health Services Executive (HSE). The general manager had returned to their substantive post since the last inspection and was the person nominated to represent the registered provider. The person in charge held the post of interim director of nursing (DON); she was supported on-site by the deputy DON (seconded), clinical nurse managers (CNMs) on each unit, CNM3 on night duty and weekend cover, senior nurses, care staff and administration. Nonetheless, the management structure in place (PIC, ADON, CNMs) continued to comprise six acting posts.

In general, inspectors found that residents received a good standard of care that met their assessed needs. Nonetheless, actions were issued on inspection regarding fire safety precautions relating to compartment evacuation as none had taken place other than for training purposes. A commitment was given by the person in charge that simulated evacuations would be completed on a weekly basis until such time as they were assured that all staff could safely and timely evacuate a compartment.

Actions from the previous inspection were followed up and actions completed included the mandatory training and vetting disclosures available on site for staff. Issues that remained outstanding from the last inspection included governance and management due to the ongoing number of acting management posts; Schedule 5 written policies and procedures, temporary absence transfer information not maintained on site, inadequate general storage in the centre, and residents' personal storage space in twin and multi-occupancy bedrooms as residents only had access to a single wardrobe which was inadequate in a long-stay residential care setting. Additional areas for improvement identified on this inspection included governance and management and aspects of infection control.

Previously, the service was supported by clinical practice development which the person in charge explained was invaluable to a service this size, along with the complexity of care such residents with spinal injuries and trachyostomy care for example. However, this support was no longer available to the centre. Resident care documentation was maintained on-line, however, there was just one computer per unit for staff to input all the daily care updates.

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. Audit results for January to July 2022 were examined and these showed a candid overview of the service with many scores under 50% demonstrating good insight into what an appropriate service should deliver. Associated quality improvement plans included a complete review of service provision relating to medication management and household cleaning for example, this was to ensure a better service for residents.

Inspectors found that that there were clear lines of accountability and responsibility in relation to governance and management arrangements for the prevention and control of healthcare-associated infection. The infection prevention and control programme was overseen by a hygiene and infection prevention and control committee. There was formalised and regular access to infection prevention and control specialists within CHO4. The provider had nominated a staff nurse, with the required training, to the role of infection prevention and control link practitioner, however, these hours were not protected.

Surveillance of healthcare associated infection (HCAI) and colonisation was routinely undertaken and recorded. Monthly monitoring of a minimum data set of HCAI, antimicrobial resistance (AMR) and antimicrobial consumption was undertaken through CHO4. This initiative provided ongoing assurance to management in relation to the quality and safety of services, in particular the burden of HCAI and AMR in the centre.

Infection prevention and control audits covered a range of topics including waste and linen management and environmental and equipment hygiene. Recent audits had identified issues with environmental hygiene and record keeping. The provider had acted to address the issues. An equipment cleaning checklist had recently been developed, however, this required further review to ensure all items of equipment were included and that it was consistently signed.

The management team were aware of the legal requirement to notify the Chief Inspector regarding incidents and accidents. The person in charge assured that documentation relating to Schedule 2 of the regulations pertaining to staff was in place including vetting in accordance with the National Vetting Bureau (Children and Vulnerable Adults) Act 2012.

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 speech and language therapist, occupation therapist and physiotherapist in conjunction with the activities co-ordinators 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 and follow-up with the complainant was evident from the records viewed.

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 continued to be

in development so it was difficult to determine whether all training was up-to-date. Nonetheless, there was a comprehensive programme of training, and staff were facilitated to attend training relevant to their role. Mandatory training was up-to-date for all staff in safeguarding and infection prevention and control. The majority of staff were due to attend fire training which had been scheduled for three dates in July and August. A small number of staff were due manual handling and children's first training. Further training and supervision was necessary in cleaning practices and processes.

Judgment: Substantially compliant

Regulation 21: Records

Schedule 2 information relating to staff files was available on site including vetting in accordance with the National Vetting Bureau (Children and Vulnerable Adults) Act 2012.

Judgment: Compliant

Regulation 23: Governance and management

Some of the management systems in place were not sufficiently robust to ensure that the service provided was appropriate, consistent, and effectively monitored as follows:

- the management structure in place continued to have six acting management posts which did not support effective decision making there is a condition on the registration of the centre requiring the registered provider to sustain a stable governance and management structure in the centre,
- the system to provide effective oversight of infection prevention and control was not robust as detailed under Regulation 27,
- the lack of oversight in relation to fire drills as outlined under Regulation 28.

There were inadequate resources to ensure the effective delivery of care:

- there was just one computer available on each unit for staff to update the daily care, including the daily narrative, care provided and assessment and care plan documentation for example, which lead to delays in recording care delivery.

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 4: Written policies and procedures

While most Schedule 5 policies were available, a policy relating to handling and disposal of unused or out-of-date medicines was not in place to inform staff on the appropriate measures to take when dealing with such medicines.

The policy relating to management of challenging behaviours did not reference the current national policy of the Department of Health so staff did not have the most up to date knowledge to assess, respond to and manage behaviours that challenge.

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 run.

There was ongoing improvement for opportunities for social engagement noted on inspection. The service continued to be part of the 'Wasted Lives' pilot study relating to younger people in residential care as part of the Office of the Ombudsman initiative. Several residents were involved in the study; members of the team from the national office of the ombudsman had been on site with residents engaging with them on their insights. Following from this, the HSE disabilities services engaged with this service and agreed to undertake an assessment of needs which was scheduled for August, and the person in charge said that this was welcomed as it may open up opportunities for additional personal assistant hours, vocational employment and day services for the 17 younger adults in the centre. The person in charge facilitated residents access other services such as Headway, Acquired Brain Injury (ABI), Irish Wheelchair association, Links and Cork Independent Living, Enable Ireland, promoting residents' independence and quality of life.

Residents' health care needs were promoted by ongoing on-site access to their GP, and timely referrals and access to allied health professionals such as on site physiotherapist, dietician, speech and language therapist and occupational therapist. Access to a consultant geriatrician was via the Integrated Care Programme for Older People (ICPOP). This was a relatively new initiative by the HSE which facilitated a care pathway for older people to have co-ordinated care planned around their assessed needs and choices. It comprised a multi-disciplinary team that included a consultant geriatrician to support individualised care. However, timely access to a clinical psychologist was still not available for the younger residents who were living in the centre. Access to this service was via referral by GP, with waiting times of 2–3yrs.

A sample of care plans were reviewed and these showed mixed findings. Consent was seen to be signed by residents and co-signed by the staff member gaining consent. Validated assessment tools were used to inform care planning. The new HSE 'quick screen' falls assessment tool was introduced and was found to be an additional support to assessing residents' care needs. Personal emergency evacuation plans for residents set out the assistance required for the resident during an emergency. However, 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. Occasionally, the daily narrative was included in the care plan which did not inform the care planning process. Documentation to support a resident when they were temporarily transferred to acute care was not evident on inspection. Care plans ensured that information about residents health-care associated infection status was accessible, however, further work was required to ensure that all resident files contained residents' current health-care associated infection status and history. Details of issues identified in care plans and transfer documentation were set out under Regulation 27.

Behavioural support plans were in place, however, these showed poor understanding of the complex communication needs of residents and showed little insight into the frustration and upset associated living in a designated centre as a young person or the assurances required for someone exhibiting communication needs. Some staff continued to refer to residents as patients in their narrative notes even though this was their home and were long-stay residents.

Monthly multi-disciplinary team meetings regarding restrictive practice were facilitated. Nonetheless, there continued to be a high level of bed-rail restrictive practice in use with 34 of 78 residents with bed-rails in-situ. Of the sample examined, assessments relating to restrictive practice were not comprehensively completed.

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, and protection were discussed. Following from these meetings,

residents gave feedback on many aspects of care including meals and choices.

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

Inspectors identified some examples of good practice in the prevention and control of infection. Staff spoken with were knowledgeable of the signs and symptoms of COVID-19 and knew how and when to report any concerns regarding a resident. A range of safety engineered needles were available. Waste and used laundry was segregated in line with best practice guidelines. Ample supplies of personal protective equipment (PPE) were available. Appropriate use of PPE was observed during the course of the inspection. However overall inspectors found that the provider had not taken all necessary steps to ensure compliance with Regulation 27 and the National Standards for infection prevention and control in community services (2018). Weaknesses were identified in equipment and environmental hygiene and oversight. The documentation reviewed relating to Legionella control did not provide the assurance that the risk of Legionella was being effectively managed. Findings in this regard were further discussed under the individual Regulation 27.

Regulation 11: Visits

There were no visiting restrictions in place and current public health guidelines of June 2022 on visiting were being followed. Visits were encouraged and practical precautions were in place to manage any associated risks. Inspectors were informed that visits continued to be scheduled to manage footfall within the multi-occupancy rooms.

Judgment: Compliant

Regulation 12: Personal possessions

Some residents had access to a single wardrobe with some shelving, which was inadequate for people living in long-term residential care. This was a persistent finding over a number of inspection reports.

Judgment: Substantially 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.

Judgment: Substantially compliant

Regulation 25: Temporary absence or discharge of residents

In the residents' records examined on two units, 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 in line with their current status and assessed needs.

Judgment: Substantially compliant

Regulation 27: Infection control

The environment was not managed in a way that minimised the risk of transmitting a healthcare-associated infection. This was evidenced by:

- a lack of appropriate storage space in the centre. For example equipment and staff belongings were observed in communal bathrooms of all four units. Staff belongings were observed within a clean linen store on one unit,
- excessive infection prevention and control signage on display throughout the centre. For example social distancing stickers were placed along all corridors and COVID-19 signage was displayed on the bedrooms doors of all residents within one unit inspected,
- there was no evidence of routine flushing of unused and infrequently used showers and outlets in resident's bathrooms
- clinical hand hygiene sinks were not kept clear of items such as clinical equipment
- washing machines in the centre were awaiting repair. The provider was not assured that cleaning textiles were being effectively and appropriately laundered off site,
- daily cleaning records were not consistently signed. This meant that the provider could not be assured that all areas were cleaned according to the schedule,
- the frequency of the bedroom deep cleans was insufficient. Inspectors were informed that four bedrooms were deep cleaned each month, which meant that each bedroom was scheduled to be deep cleaned every six months,
- clean flat mops were observed to be drying on the janitorial unit in one

housekeeping room. This practice increased the risk of cross contamination.

Equipment was not consistently decontaminated and maintained to minimise the risk of transmitting a healthcare-associated infection. For example:

- one bedpan washer was out of order; the detergent in two machines had expired. This impacted the efficacy of decontamination,
- heavy dust was observed on several bed frames. Bed frames were not included on the weekly cleaning schedule,
- the covers of a small number of mattresses and pillows were worn or torn. These items could not effectively be decontaminated between uses, which presented an infection risk,
- green labels to alert staff to when equipment was last cleaned were observed within one unit. However three labels were dated February 2021 which indicated that the system was not effectively used,
- individual moving and handling slings were stored on top of each other within a shared bathroom. This increased the risk of cross contamination.

Judgment: Not compliant

Regulation 28: Fire precautions

Fire drills and evacuations records reviewed demonstrated that evacuations of rooms only were undertaken, however, evacuation of a compartment was not undertaken to provide assurances that evacuations could be completed in a safe and timely manner. This was a repeat finding from the previous inspection where the provider had committed to undertaking these drills.

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. A daily record of CD patch checking formed part of the medication management to ensure the resident had continuous pain management. A thorough record was maintained of psychotropic medication administration and residents' response to the medication and whether it ameliorated their symptoms.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

While staff knew residents really well and some of the care plans viewed by inspectors were generally comprehensive and personalised, improvements were required in others. For example:

- some assessments were not updated in accordance with the regulations, for example, the last dates some assessment were completed were 07/07/21, 20/11/21, 14/09/21
- one resident admitted did not have their care plans written for three weeks, and some of the assessments were completed after the care plans
- care plans had comprehensive information detailed, however, the corresponding assessments did not have the equivalent details, so it was unclear where the information was obtained and the inspector found the assessment was not sufficiently robust
- the health-care associated infection status history and risk assessment had not been completed in two admission assessments reviewed
- the multi-drug resistant organism (MDRO) status of one residents was not recorded on their transfer documentation to ensure that the receiving facility had comprehensive information when caring for the resident
- one resident's wound care plan had not been reviewed since January 2022.

Judgment: Substantially compliant

Regulation 6: Health care

The inspector saw that timely access to a clinical psychologist was still not available for the younger residents who were living in the centre. Access to this service was via referral by GP; the person in charge reported that waiting times for this service was 2–3yrs.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

Behavioural support plans were in place, however, these showed poor understanding of the complex communication needs of residents and showed little insight into the frustration and upset associated living in a designated centre as a young person or the assurances required for someone exhibiting communication needs.

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. Of the sample examined, assessment relating to restrictive practice were not comprehensively completed to make an informed decision regarding implementing bed-rails, even though the resident had a bed rail in place. For example, one assessment was undertaken in October but some questions were not answered; a further re-assessed was undertaken in February 2022, however, just one page of the assessment was completed on that occasion.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Some staff continued to refer to residents as patients in their narrative notes even though this was their home and were long-stay residents.

Multi-occupancy twin and four-bedded rooms were clinical and lacked a homely feeling. They could not accommodate additional personal storage space fitting for people living in a long-stay residential care setting.

Some personal care information was displayed in residents' bedrooms which was not respectful of their privacy and dignity.

Some staff continued to refer to residents as patients in their narrative notes even though this was their home and were long-stay residents.

Judgment: Substantially 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	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Substantially compliant
Regulation 17: Premises	Substantially compliant
Regulation 25: Temporary absence or discharge of residents	Substantially compliant
Regulation 27: Infection control	Not 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	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Farranlea Road Community Nursing Unit OSV-0000713

Inspection ID: MON-0036479

Date of inspection: 13/07/2022

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: A comprehensive Training Matrix is being developed to include Mandatory Training and supplementary training records for all staff. Fire Training records have been reviewed and scheduled Fire Training dates have been confirmed for Aug. Oct. Nov. & Dec'22. Training on cleaning practices for staff at ward level is being out sourced and will be available for staff to attend. Plans are advanced to locate a 'virtual education hub' in Farranlea CNU. This facility will allow staff to join education sessions on a face to face basis or 'live streamed' from home. This facility will also enable the MDT on-site including the Allied Health professionals, Infection and Prevention Link Nurse Practitioner , record education sessions, and offer the appropriate 'links' to staff on demand. CNM's are to maintain staff training records at ward level, to identify staff education and training needs on a regular basis. CNM's are required to advise Nursing Admin. Office as to those staff who require the necessary training as it becomes available and this has been confirmed at meetings with the CNMs. The matter will remain as a standing order at meetings with the CNMs.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Following the development of the IGPOP, there now is a referral pathway for Older Residents in Farranlea to access appropriate Geriatrician Consultant services. This service is based in SFH. Where there is a difficulty in transporting a resident to SFH for	

consultation, a direct referral from DON Farranlea CNU to a named Geriatrician is facilitated in a timely manner. The Interim role of the Director of Nursing remains with HR CKCH with regard to permanent filling. The CNM 3 Post on Night Duty has been approved and is filled in a temporary capacity, while waiting on recruitment and selection process (HSE). The Outstanding CNM1 Posts x 3 have been approved by General Mangers Office, and have been filled in a temporary capacity, these posts are also waiting on recruitment and selection process (HSE) from panels permanent posts.

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
Review all current policies in place. Identify those 'out of date' and remove older versions. Each Ward to have an up to date Folder Schedule 5 Policies available. The absence of a reference to handling of and disposal of out of date medicines has been brought to Clinical Practice Development officer (SD) in Kerry Community Hospitals to advise and for CKCH policies to be updated as necessary. The most up to date National Policy on Challenging behaviours to be sourced and made available at ward level. An Advanced Nurse Practitioner (ANP) in Challenging Behaviour has agreed to support the staff in Farranlea CNU in relation to managing and care planning for those residents who exhibit behaviors that challenge. This person is due to provide this education in coming months.

Regulation 12: Personal possessions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
Provision of adequate storage space for resident's personal belongings and possessions is being reviewed as space is limited and wardrobes are 'built in' fixtures. Advice has been sought from maintenance Dept (carpentry) to share ideas on how to improve this space and to create opportunities for storage of non-personal items.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises: Off-site storage of large equipment is being considered as an appropriate solution for some items. Advice to be sought from other HSE facilities in relation to the availability of 'off site' storage space for large equipment .The freight container located on the grounds to be considered for storing some of the large bulky items and to assist with removal some equipment from ward bathrooms. Decluttering of all areas and spaces is to continue on a weekly (weekend) basis. The wooden railing on balcony has been referred for repair to Maintenance Dept. SFH. The protective coatings on some woodwork has also been referred to Maintenance Dept. SFH.	
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: The 'National Transfer Document and Health Profile (Jan 2020) had been removed from all wards, as a temporary measure, only, as a significant 'typo' had been identified in the printed document, related to residents food and nutrition safety. This 'typo' has since been corrected, by the Printers, and a new version of the booklets were distributed to each ward for each individual resident on 09.08.22.	
Regulation 27: Infection control	Not Compliant
Outline how you are going to come into compliance with Regulation 27: Infection control: A quality Improvement Infection Control and Prevention Plan has been developed to identify 'areas' of concern and to take a quality approach(PDSA) to making changes, implement change, with regular review dates. With the support of IPC Team (HSE) the areas of concern identified from a recent audit completed by IPC team in Farranlea in June '22 and the findings from the recent HIQA inspection report in August the areas of concern identified include: 1. Storage Space 2. Temporary staff changing rooms 3. Temporary Staff rest rooms 4. Remove Signage and Social Distancing Floor Stickers 5. Flushing records to include all unused shower and bathing facilities, include all unused sinks and water outlets	

6. Cleaning, Drying, Storage of Textiles.
7. Cleaning Records not consistently signed.
8. Frequency of deep cleans was insufficient.
9. Equipment 'out of order'.
10. The standard of cleaning unsatisfactory.
11. Detergents and products out of date.
12. Mattresses and pillows worn and torn
13. Regular weekly Weds. Meetings with PIC, ADON ,a nominated CNM ,Contract Cleaning Company (Area Manager and on site Supervisor)

QIP Plan :
1. Storage Space – Identify areas for staff changing. Temporary changing and staff rest rooms at ward level is to cease by 19.08.22
2. The Infection Control Link Practitioner to review all signage in place and to remove posters and signage not required .Completed 12.08.22.
3. Flushing records have been updated (18.08.22) to include all unused and infrequently used showers and outlets in resident's bathroom. The flushing record is completed weekly
4. Weekly Meetings (Weds.) have been convened with the current Cleaning Contractors (Area Manager) to discuss the following (i) appropriate laundering of Textiles (ii) daily cleaning records (iii) frequency of bedroom deep cleans, (iv) Cleaners rooms and trolleys and there upkeep (v) equipment and supplies issues and the general standard of cleaning throughout Farranlea CNU.
Contract Cleaning company have been requested to complete monthly audits and to provide the Audit findings to DON &ADON on a monthly basis.
Agreement made with Cleaning Contractor to clearly identify the role and responsibility of Contract Cleaning Staff, and Farranlea CNU staff in relation to cleaning all areas.
A room by room approach to be taken, from ceiling to floor, identifying every item that requires cleaning and then entered onto the appropriate cleaning schedule book.
A comprehensive Mattress and pillow audit is underway on all 4 Units, CNM is to present their findings to DON next Weds. 24.08.22. Infection Prevention Team have advised to complete a mattress and pillow audit every 3 months. Also recommended to introduce a 'tracking' identifier on each mattress to ensure checking is completed, recorded and when mattress is removed or replaced.
IPC to also enquire as to what is the recommended mattress checking system to use when checking mattresses and pillows for wear and tear.
5. Regular meetings are scheduled weekly, with current Cleaning Contractor Company area manager, supervisor, DON, ADON, and a CNM representative.
6. A Staff Information booklet on Environmental Cleaning for the Prevention and Control of Infections in Farranlea CNU is to be introduced in coming weeks.
7. A meeting with IPC CNS on 18/08/22 suggested several information 'links' with recommendations in relation to terminal cleaning, type bins recommended for dirty utility

rooms, waste management handbook, CORKKERRY handbook on laundry facilities etc..
IPC also recommended introducing onto flushing record room identifiers. Farranlea CNU to develop a Flushing 'tracker' List with Tracker numbers to cross check following Maintenance Dept. Service records 'going forward'.
The role of the Infection Control Nurse Link practitioner is to be reviewed and enhanced on site. Where possible protected time is to be given on a weekly basis to allow LINK practitioner time to review IPC practices, study audit findings, make recommendations, meet with CNM's provide feedback, 'share the learning . The IPC link practitioner Nurse is invited to attend a CNM Group meeting and give 'feedback' directly to CNM's on a regular monthly basis. Hand Hygiene assessments in progress, for both day and night staff
IPC to forward on links to information discussed, and will continue their support and commitment to improving the standards that relate to Infection prevention and control in Farranlea CNU.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Weekly Fire Evacuations drills have been completed per ward per week.
Records of room numbers and compartments evacuated, staff attendance are maintained, on a weekly basis.
These weekly records have been submitted to HIQA on a weekly basis since inspection on 13.07.22.
Weekly fire evacuation drills continue and a record of (i) the compartment evacuated, (ii) room numbers, and (iii) staff in attendance is maintained per ward.
Additional 'formal' Fire Training and Education has been scheduled for staff in Farranlea in August, October and November.

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:
A comprehensive review of care plan documentation is to be undertaken on each Ward. The CNM's have been met individually on a 1:1 basis and advised to (i) ensure a comprehensive audit on care plans is completed in August. This audit, to include (i) care assessment documentation, (ii) HealthCare associated infection status and history, (iii) transfer documents, and (iv) wound care plans (v) identify the use of 'patient' instead of resident in care plan. The findings from this audit will identify areas of concern and include action plan to address the specific areas. CNM2 1:1 meetings with DON have

commenced since date of Inspection. Care plan audit reports are requested and discussed at these meetings. Care plan documentation workshops are planned 'in house' for September '22.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
Following on from the Ombudsman Report: Wasted Lives (May 2021) engagement with Disability Services (HSE) has commenced. A number of meetings have been convened in past number of weeks, and a data base is being developed to identify all residents under the age of 65yrs living in Farranlea CNU, and to also identify the needs and supports required per individual resident. A Disability Services referral Form has been completed with each resident, under the age of 65yrs, in Farranlea CNU. Access to the appropriate level of psychiatry and psychology, has been prioritized. Access to Social Worker for all residents under age of 65yrs has also been prioritized with disability services. Disability Services have offered contact details and referral pathways to access these services as a matter of priority. Work on this data base, which includes comprehensive needs assessments, identifying all supports and services is to continue with interagency engagement and support, in coming weeks and months.

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:
A copy of the current National policy Doc. (DOH) on how to manage behaviors that challenge is being sourced (Practice Development Kerry, and the Disability Services HSE) and will be shared with CNM's, discussed and then distributed to all wards. Discussion has already taken place with disability services (HSE) in relation to supporting staff in managing behavior that is challenging An Advanced Nurse Practitioner (ANP) within the disabilities services has been approached, and has agreed to provide a series of education sessions and support for the RGN's in Farranlea CNU in the coming months. This education will provide valuable learning and opportunities for staff to engage with new interventions and to access new supports for working with residents who demonstrate these behaviors. This education will focus on (i) assessment (ii) response to and (iii) management and recording of behaviors that challenge and documentation in a recommended care plan document.
A comprehensive review on the use of bedrails has been requested since inspection on 13.07.22. A number of bed rails have since been removed.

The MDT meeting planned for Sept.13th will review the current restrictive practices in place. Each individual restraint risk will be assessed and deemed (i) appropriate (ii) continue or (iii) be removed. Each restraint individual to each resident will be documented clearly and risk assessment completed with a clear review date and be available in residents care plan.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: The CNM on each ward has been made aware of this finding and have been asked to communicate this unfortunate finding to the staff at ward level at handovers. All care plan documentation is to be audited and this audit to check if 'patient' is used in care plan documentation or in supporting documentation from Allied Health professionals who may at times cover Farranlea CNU from acute hospitals. CNM'S will be reminded at 1:1 meetings with DON to ensure this practice does not continue at ward level.

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	31/12/2022
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	31/12/2022
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises	Substantially Compliant	Yellow	31/12/2022

	which conform to the matters set out in Schedule 6.			
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Substantially Compliant	Yellow	31/12/2022
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	28/10/2022
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	31/08/2022
Regulation 27	The registered	Not Compliant	Orange	31/10/2022

	provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.			
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Orange	31/10/2022
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.	Substantially Compliant	Yellow	31/10/2022
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	Substantially Compliant	Yellow	30/11/2022

	event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.			
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.	Substantially Compliant	Yellow	30/09/2022
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Substantially Compliant	Yellow	30/09/2022
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	Substantially Compliant	Yellow	30/09/2022

	consultation with the resident concerned and where appropriate that resident's family.			
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.	Substantially Compliant	Yellow	31/12/2022
Regulation 7(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.	Substantially Compliant	Yellow	31/12/2022
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	Substantially Compliant	Yellow	31/10/2022

	to time.			
Regulation 9(3)(e)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise their civil, political and religious rights.	Substantially Compliant	Yellow	30/09/2022