Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Office of the Chief Inspector

Report of an inspection of a Designated Centre for Older People

Name of designated centre:	Sally Park Nursing Home
Name of provider:	Passage Healthcare International (Ireland) Limited
Address of centre:	Sally Park Close, Templeogue, Dublin 24
Type of inspection:	Unannounced
Date of inspection:	28 May 2019
Centre ID:	OSV-0005565
Fieldwork ID:	MON-0026706

About the designated centre

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

Sally Park Nursing Home can accommodate up to 44 residents. This will reduce to 43 as time allows. They can accommodate both female and male residents over the age of 18 including low / medium / high and maximum dependency levels with the following care needs, general care, respite care, dementia specific care, physical disability, intellectual disability, palliative care incorporating the services of the homecare team from our lady's hospice in Harold's Cross.

Sally Park Nursing Home provides 24hr nursing care in a period building set in extensive mature gardens with panoramic views of the Dublin Mountains. There are two purpose built extensions, and the home has 21 single en- suite rooms, 4 single rooms, 5 double rooms and 3 multi occupancy rooms. Rooms have TV and Telephone points. There are three large sitting rooms and a bright dining room for residents to use.

The centre is located in a local community, and is accessible by public transport. There is also parking for those travelling by car.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	43

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
28 May 2019	08:30hrs to 18:30hrs	Ann Wallace	Lead
28 May 2019	08:30hrs to 18:30hrs	Paul McDermott	Support
28 May 2019	08:30hrs to 18:30hrs	Deirdre O'Hara	Support

What residents told us and what inspectors observed

Overall the residents and families who spoke with the inspectors reported high levels of satisfaction with the care and services they received in the designated centre. The inspectors spoke with a number of residents some of whom had lived in the centre for a number of years and some who had moved into the centre within the last few months.

Those residents who had moved into the centre more recently told the inspectors that they had chosen the centre because it was homely and that the staff were kind and welcoming when they came to look around. These residents said that although it had taken some time to settle in that they were very comfortable and felt that they had made a good choice. They had been well supported by staff and managers and were enjoying their new friendships with other residents.

All the residents who spoke with the inspectors commented on how kind and caring the staff were in the centre. One resident said that she could ask for anything and staff would try to oblige. Residents said that they saw the person in charge regularly and that she was always available if they had any concerns or issues. Families told the inspectors that when they had raised a concern or complaint that they had been listened to and that the issue was dealt with promptly. The inspectors observed that the person in charge and the provider were well known to residents and their families and made themselves available to meet with residents and families throughout the day of the inspection.

Residents told the inspectors that they could trust the staff and that they felt safe in the centre.

Overall residents said that they were comfortable and that the premises met their needs. Residents were observed using the communal areas throughout the day to attend activities and meet with their families and friends. This helped to create a real sense of community and a pleasant atmosphere for residents some of whom did not join in with activities but were obviously enjoying watching what was going on.

Capacity and capability

Inspectors found that there was an absence of appropriate oversight systems in place to ensure that the centre was managed in line with the regulations and in line with the designated centre's own policies and procedures. This was seen in a number of areas including staffing, auditing, available policies and fire management

systems.

Significant improvements were also required to ensure that records were maintained in line with Schedules 2 and 4 of the regulations. In addition the provider had failed to adequately progress a number of actions to bring the centre into regulatory compliance following the last inspection.

There was a well established staff team who worked well together to provide care and services for the residents. There was a recruitment and selection process in place to ensure that suitable individuals were employed. Staff had access to appropriate training and updates.This helped to ensure that residents were cared for by staff who had appropriate knowledge and skills.

Managers were well known to residents and their families. Residents told the inspectors that they saw the person in charge most days. Residents and families said that staff and managers were approachable and that if they had raised any issues or complaints that these were dealt with promptly.

There were sufficient staff on duty on the day of the inspection to provide care and services in line with the statement of purpose. However staffing levels reduced after 22.00hours to two nurses and one carer and a review of the records of fire drills for night time staffing levels did not provide adequate assurance that these staffing levels would ensure the safety of residents in the event of a night time fire emergency. This is discussed further under Regulation 28.

Regulation 15: Staffing

Rosters showed that from 08.00hrs to 22.00hrs there were sufficient staff with the appropriate knowledge and skills to provide safe and effective care for residents taking into account the size and layout of the designated centre. However the inspectors were not assured that there were sufficient numbers of staff on duty between 22.00hrs and 08.00hrs to provide safe care in the event of a fire emergency. This addressed under Regulation 28.

The staff on duty matched the staff on the roster on the day of the inspection. Records showed that staffing levels were reviewed regularly and where a resident needs increased such as end of life care or increased supervision needs staffing levels were adjusted accordingly. There was a well established staff team a number of whom had worked in the centre for more than ten years. This helped to ensure continuity of care for residents from staff who knew them well.

There were two registered nurses on duty at all times in the designated centre.

Judgment: Not compliant

Regulation 16: Training and staff development

Training records showed that staff had access to appropriate training and updates to maintain their knowledge and skills.

Staff reported that they were encouraged to attend training and updates in line with the centre's mandatory training programme. This included the protection of older persons from abuse, fire safety procedures and moving and handling practices. In addition staff attended training in dementia care and the managements of responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

Inspectors found that care staff were supervised in their day to day work by nursing staff and the assistant director of nursing. All staff received a comprehensive handover of care information at the beginning of each shift and there was a clear allocation of care for each member of the team. Care and services were reviewed by the nursing staff and the assistant director of nursing (ADON) at regular intervals through the day. As a result staff were clear about what was expected of them in their role and demonstrated accountability for the quality of the care and services that they provided.

Some improvements were required in relation to the content and effectiveness of the fire safety training which is discussed under Regulation 28 and in the maintenance of staff training records which is addressed under Regulation 21.

Judgment: Compliant

Regulation 21: Records

Inspectors found that not all the records required in Schedules 2 and 4 of the regulations were available in the designated centre on the day of the inspection. These included;

- One member of staff did not have two written references in their staff file.
- A clear record of all staff training.
- A clear record of each fire practice, drill or test of fire equipment conducted in the designated centre and of any actions taken to remedy any defects found in the fire equipment.
- A record of the number and type and a clear maintenance record of all fire fighting equipment.

Judgment: Not compliant

Regulation 23: Governance and management

Significant actions were required on the part of the registered provider to ensure improved regulatory compliance and the provision of a safe and effective service for residents, particularly in terms of the arrangements for fire safety, personal accommodation and communal bathrooms and toilets. These were outstanding actions from the previous two inspections.

There was a clear management structure in place which outlined roles and responsibilities for all managers and staff working in the designated centre. Staff who spoke with the inspectors said that they were well supported in their work and that nursing staff and managers were available to them and that they were approachable. Inspectors also noted that the provider representative and the person in charge were well known to residents and to their families.

Overall there were sufficient resources in place to ensure that care and services were provided in line with the statement of purpose. However further assurances were required to ensure that staffing levels between 22.00hrs and 08.00hrs were adequate to keep residents safe in the event of a fire emergency.

There was a comprehensive range of clinical management systems in place to monitor the safety and efficacy of nursing and health care. These included regular audits in key areas such as falls, incidents, pressure sores, restraints and infections. Audit information was used to identify trends and areas for improvement, however there was no evidence of action plans in place to bring about the required changes; for example how the centre planned to reduce the use of bed rails and other restraints. In addition there was no evidence of oversight of these monitoring processes by the registered provider through an appropriate quality and safety framework.

Inspectors also found that there was an absence of appropriate oversight in key areas such as staff files, staff training records, fire safety processes and the general management of the centre in line with its own policies and procedures.

The provider had completed an annual review of the quality and safety of the service for 2018. The review included feedback from residents and their families.

Judgment: Not compliant

Regulation 3: Statement of purpose

The Statement of Purpose required updating to ensure that it contained

accurate information as required in Schedule 1 of the regulations. The document had not been updated to reflect the change in occupancy of some bedrooms.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The complaints procedure that was in place nominated the person in charge as the complaints manager in the centre.

The inspectors reviewed the complaints log and found that there was a clear record of complaints that had been made which included; how the complaint was investigated, what was the outcome, what changes had been made as a result of the investigation and the resident/families level of satisfaction with how the issue was resolved. Records showed that complaints were well managed and that a number of changes and improvements had been made as a result of complaints received from residents and families.

There was a comprehensive complaints procedure in place but this had not been updated to reflect the change of provider in 2017. This is addressed under Regulation 4, about written policies and procedures.

Judgment: Compliant

Regulation 4: Written policies and procedures

A number of policies in the centre had not been updated in line with the centre's own review dates and as a result did not include up to date information about the current provider and national best practice guidance. In addition the registered provider had not prepared, adopted and implemented a number of policies as required in Schedule 5 of the regulations;

- Staff recruitment and selection
- Information for residents
- Temporary absence or discharge of a resident.

Although these policies were subsequently submitted to the inspectors they were not in place at the time of the inspection and staff had not received training to

implement them in practice. In addition there were no clear management audit processes in place to ensure compliance with these policies.

Judgment: Not compliant

Quality and safety

The systems in place to monitor the quality and safety of care and services delivered to residents in the centre were not adequate. Significant improvements were required in the management of risk and hazards in the centre and in the processes that were in place to keep residents safe in a fire emergency. In addition the provider had not adequately addressed the regulatory non-compliances in relation to premises in line with the compliance plan submitted to the Office of the Chief Inspector following the last inspection.

Overall the premises provided a homely and comfortable environment for the residents. There was adequate communal space on the ground floor and residents spent much of the day in these areas. Residents took their meals in the spacious dining room with views over the garden. Those residents who preferred a quiet space were able to spend time and to take their meals in the quiet lounge. The main lounge, reception area and second lounge were well used by residents and their visitors on the day of the inspection.

Communal areas were used for musical entertainment, arts and crafts, board games and mass on the day of the inspection. Residents told the inspectors that they had plenty to do and that they enjoyed the activities that were on offer. Residents were encouraged to maintain their hobbies and interests such as knitting, crochet, painting, reading and playing music. Residents were also encouraged to try new activities and one resident had found they had a talent for watercolour painting.

There were a mixture of single, twin and three bedded rooms in the centre. All bedrooms on the ground floor were single en-suite and were of a good size. Bedrooms on the first and second floors varied in size and layout. Shared rooms had privacy curtains in place to ensure that residents could undertake activities such as personal care in private. A number of bedrooms were decorated with photographs and small items of furniture form the resident's home. This helped to personalise the bedroom and to orientate the resident to their personal space.

Although there were two well equipped wheelchair accessible shower rooms with toilets on the ground floor, at the time of the inspection one of these was allocated as a visitor's toilet and was not used by residents. The lack of appropriate bath and shower facilities in the designated centre was an outstanding action form the previous inspection.

Inspectors found that significant improvements were required in the identification and management of risks and hazards in the centre. This was a particular concern in relation to the management of fire safety risks as discussed under Regulation 28. In addition the records in relation to the identification of risks and the steps taken to mitigate these risks were not up to date in the risk register and inspectors were not assured that risks were being adequately managed.

Regulation 17: Premises

Significant actions were required on behalf of the registered provider to ensure improved regulatory compliance and ensure that the premises was appropriate for the number and needs of the residents who lived there. In addition the current premises did not conform to Schedule 6 in the following areas;

- suitable storage
- a sufficient number of toilets, baths and showers having regard to the dependency of the residents living in the centre.
- appropriate sluicing facilities.

The inspectors found that the planned extension and refurbishment of the current premises had not progressed in line with the plans that were submitted to the Office of the Chief Inspector for completion in 2019. The inspectors acknowledged that this was in part due to planning processes which were out of the provider's control; however the registered provider had not implemented a satisfactory interim plan to address the on-going non compliances.

As a result; there was no appropriate bath or shower facilities on the second floor where ten residents were accommodated and there was only one shower room available for 24 residents accommodated on the first floor Although there were three shower/bathrooms on the ground floor the layout of one of the shower rooms and an adjoining toilet did not ensure the privacy and dignity of high dependency residents using these facilities. A third shower room on the ground floor was of a suitable size and layout for higher dependency residents, however this had been designated as a visitor's toilet and was not used by residents at the time of the inspection.

Inspectors also observed that due to a lack of storage space in the designated centre large items of equipment such as hoists continued to be stored in resident's bedrooms when not in use. Other items such as laundry skips and personal care trollies were stored in bath/shower rooms when not in use.

The sluice room on the first floor was not of a suitable size and layout to facilitate good infection control practices.

Judgment: Not compliant

Regulation 26: Risk management

The registered provider had failed to include the following in the current risk management procedures;

- hazard identification and assessment of risks throughout the centre.
- the measures and actions in place to control the risk identified.

Records showed that there were arrangements in place for the identification, reporting,investigating and learning from incidents and adverse events that occurred in the centre.

Judgment: Not compliant

Regulation 28: Fire precautions

The inspectors were not assured that the fire precautions being taken in the centre were adequate. Significant improvements were required to comply with the requirements of the regulations and to ensure that residents and staff were protected from the risk of fire.

The service was non-compliant with the regulations in the following areas.

Inspectors were not assured that adequate precautions were being taken against the risk of fire. For example:

- There was no fire safety risk assessment, or similar risk identification system, in place to identify, record and plan the management of fire hazards and risks in the centre. The need to prepare a fire safety risk assessment was identified by the provider in August 2016.
- Fire fighting equipment, such as the automatic suppression system in the kitchen cooking area, identified in the (2016) fire safety strategy (current at the time of inspection) had not been installed.

The provider did not provide adequate means of escape throughout the centre. For example:

- The provider had not addressed the increased evacuation risk arising from

their decision to stop using the stairs leading from ground to first floor level in the original part the centre.
- Escape corridors and stairs were not adequately protected from the risk of fire.

The Emergency escape lighting, and emergency exit signage provided was inadequate.

- Adequate emergency exit signage had not been installed along the escape corridors to clearly indicate the route to be followed to the nearest final exit or to indicate a final exit door.

Adequate arrangements had not been made for maintaining all fire equipment or building services. For example:

- The inspection and certification of the Fire Detection and Alarm system was sporadic in nature, with up to 7 months between documented inspections and longer time periods between documented inspections of the emergency escape lighting system. In both cases the inspection and service intervals considerably exceed the 3 month intervals recommended by the appropriate Irish Standard Documents.

Arising from a combination of unsatisfactory record keeping, the irregularly updated fire safety log book and the lack of implementation the fire safety strategy the inspectors were not assured that adequate arrangements were in place for reviewing fire precautions.

Training records were provided that indicated that all members of staff had recently received fire training. However, the provider could not provide any details of the content of the training provided.

Inspectors were not assured that staff working in the centre were adequately prepared for the procedure to be followed in the case of fire and for the safe and timely evacuation of residents.

- Fire drills were not being carried out as often as was described in the Fire Strategy. The most recent fire drill took place on 20 May 2019, with the previous drill having taken place on 14 March 2018.
- The compartment evacuation procedure had not been practiced during fire drills.
- Fire Drill reports did not include enough information to provide assurance that staff were adequately prepared for the evacuation of the premises or to identify the need for additional fire training or revisions to the fire precautions or procedures.

Adequate arrangements had not been made for detecting fires.

- The fire strategy stated that detector coverage would be provided in all protected spaces. It was observed that fire detection was not provided in some store rooms, bathrooms, ensuites, shower rooms or along some of the

fire escape corridors.

Adequate arrangements had not been made for containing fires.

- Inspectors were not assured of the likely fire performance of all door sets (door leaf, frame, brush seals, intumescent strips, hinges, closers and ironmongery).It was observed that some doors along escape routes were not closing or catching properly, while intumescent strips, brush seals and cold smoke seals were missing from others.
- Automatic door closers had not been fitted to most bedroom and office doors.
- Fire stopping had not been provided where required i.e. around building services.
- Inspectors were not assured of the likely fire containment performance of the enclosures of the disused stairs, or of the stairs within the original part of the centre.

Inspectors were not assured that adequate arrangements had been made for evacuating all persons in the centre in a timely manner with the staff and equipment resources available.

- It was noted that there were only three staff on duty at night time. The fire procedure described how one staff member would stay in the reception area to coordinate the evacuation thereby reducing the number of staff conducting the evacuation to just two staff with up to eight residents to be evacuated from some compartments.

The Inspectors were not assured that adequate arrangements had been made for the safe placement of residents in the centre and for their evacuation from the centre should it become necessary.

- The inspectors were not assured that the personal emergency evacuation plans (PEEPS) for all residents are up to date. Changes in the assistance required by residents might impact on the fire evacuation procedures. The PEEPS for nine of the eleven residents in the second floor of the centre were undated, while others had a most recent review date of 28/11/2018.
- The first and second floor levels of the original building were complex in terms of their layout, evacuation requirements and the number of residents accommodated within them. The bedrooms for a significant number of residents who had high dependencies were in these parts of the building.

While it was observed that the fire procedures are prominently displayed a zone plan had not been displayed next to the fire alarm panel.

It was also observed that in some cases the escape routes indicated on wall mounted fire escape floor plans did not match the direction of escape indicated by the emergency exit signage.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

There were clear processes in place to ensure that each resident had a comprehensive assessment of their needs and that an up to date care plan was in place that addressed the resident's current needs.

Each resident had a pre-admission assessment completed by the Person in Charge or the assistant director of nursing prior to their admission to the centre. This helped to ensure that a good client/home fit was achieved and that centre was able to provide the services and equipment to meet the resident's ongoing needs.

Care plans were well written and detailed the specific care interventions that were required. For example those residents who required a care plan for responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment); detailed the potential triggers for behaviours, signs that the resident was becoming anxious and details of the appropriate distraction techniques and assurances that would support the resident.

Care plans were reviewed every three months or more often if there was a change in the resident's health or well being. Some improvements were required to ensure that where changes had been made such as instructions form the dietitian that these were clearly reflected in the resident's care plan. In addition a number of end of life care plans had not been completed and there was no evidence of a discussion with the resident or their family in relation to the resident's wishes at end of life.

There was clear evidence that the resident and/or their family were involved in the care planning process. Care plans included information about
each residents preferred daily routines and care interventions such as whether the resident preferred a morning or evening shower or a preferred gender of carer.

Judgment: Substantially compliant

Regulation 6: Health care

Inspectors found that residents had access to a high standard of evidence based nursing care and appropriate medical and specialist health services.

Nursing staff ensured that each resident had a medical practitioner of their choice. One new resident was in the process of choosing a general practitioner (GP) following their admission. The GPs visited the residents regularly to monitor and review their health needs. Each resident had a three monthly review of their

medications and there was clear evidence of residents' medications being reduced following GP review.

Records showed that residents had access to a wide range of health and social care practitioners to meet their ongoing needs. Consultations with physiotherapist, dietitian, speech and language therapy and specialist mental health services were arranged as required. Those residents who were eligible for national screening programmes were supported to participate if they wished to do so. For example a number of residents with diabetes were scheduled to attend the retinal screening programme in June. In addition regular chiropody and optician appointments were organised for residents in order to maintain their health and independence.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Overall the inspectors found that where a resident displayed responsive behaviours, (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment); this was dealt with in a positive manner that was not restrictive and upheld the resident's dignity and autonomy.

The centre had a policy on the management of responsive behaviours but the policy had not been updated and did not reflect best practice guidance. All staff had received training on the management of responsive behaviours. Staff knew the residents well and were knowledgeable about each resident's potential reasons and triggers for agitation and responsive behaviours. Staff offered discreet support and encouragement for residents at these times and were able to distract and reassure those residents who became agitated.

Although the designated centre was working towards a restraint free environment there had been a slight increase in the number of bed rails in use at night time. In addition the current record of the assessment for equipment such as bed rails did not provide sufficient information about the alternatives that had been trialled prior to the introduction of equipment that could be restrictive.

Judgment: Substantially compliant

Regulation 8: Protection

Inspectors found that overall the provider had appropriate measures in place to protect residents from abuse. There was a comprehensive policy on protecting residents from abuse but this policy had not been updated and did not

reflect the current national guidance.

All staff working in the centre had been through the centre's selection and recruitment procedures. Each member of staff had Gardai vetting in place. The inspectors reviewed a sample of staff files and found that two written references were in place for most staff but the person in charge had not followed up the telephone references supplied by one newly appointed member of staff. This was addressed by the person in charge following the inspection.

All staff had attended training in the protection of adults from abuse and staff who spoke with the inspectors were clear about their responsibility to keep residents safe. Staff were able to discuss the types of abuse to look out for and what to do if a resident raised a concern or made an allegation about abuse. Staff told the inspectors that nursing staff and managers were always available and that they could report any concerns that they might have.

Records showed that where a concern was raised that this was reported and investigated by the person in charge and appropriate steps were taken to protect the resident in line with the centre's policies and procedures.

Those residents who spoke with the inspectors said that staff were kind and caring and that they felt very safe in the designated centre.

Judgment: Compliant

Regulation 9: Residents' rights

Inspectors found that care and services were person centred and that residents' rights were upheld.

The daily routines and staff practices were found to support each person's autonomy and preferences for care and daily routines. Residents could choose when to get up, where to spend their day and what time to retire. During the day residents were offered appropriate choices at meal times, activities and entertainments and visiting arrangements. Inspectors observed that where a resident declined a care intervention or an activity that this was respected by staff. Staff were observed to address each resident by their preferred name or title and were respectful and kind in their interactions with the residents they cared for. Staff were observed knocking on bedroom doors and waiting for permission to enter. Staff closed doors and used privacy curtains when providing care for residents in shared rooms and staff were mindful of the need to maintain confidentiality when discussing residents with the inspectors.

There was a varied programme of activities and entertainments across seven days of the week. Most of which were provided by external providers which helped to bring the local community into the centre. On the day of the inspection the residents had been fostering a rescue dog from a local charity and members of the charity

were in the centre to collect the dog to go to his new home and were chatting with residents and discussing future visits from the dog with his new owner. During the morning the inspectors had met with a number of residents who told them how much they enjoyed the arts and crafts sessions that were held at weekends in the centre. One resident had discovered that they had a talent for artwork and had painted a number of watercolours which the centre had framed for them. Another resident proudly displayed their crochet work. Those residents who enjoyed playing music and singing were also encouraged to maintain these skills during the regular music and sing along sessions that were held each week in the centre.

Television, radios and newspapers were available for the residents. Residents said they particularly enjoyed the daily news discussion each morning during which a member of staff read items out of the newspaper to encourage discussion about local and national events. Visitors were observed coming and going throughout the day and many of them sat in the communal areas chatting with their own relatives and other residents.This helped to create a real sense of community in the centre and ensured that residents were able to stay in touch with the local community.

Residents had access to an independent advocate and were facilitated to contact the service if required. Resident meetings were held in the designated centre but improvements were required in relation to; how these were recorded and how any suggestions or improvements that residents made were followed up by managers and other staff. As a result it was not clear how residents were consulted in the overall organisation of the centre.

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 15: Staffing	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Sally Park Nursing Home OSV-0005565

Inspection ID: MON-0026706

Date of inspection: 28/05/2019

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 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: ***This compliance plan response from the registered provider did not adequately assure the Chief Inspector that the actions will result in compliance with the regulations.*** Staffing within the Nursing Home is adequate to meet the needs of the resident's both day and night, in the event of a fire; there can never be too many staff on duty to assist with an evacuation. However staffing levels cannot be assessed on the no of staff required to evacuate the nursing home and so to remedy this, we have been undertaking fire evacuation of compartments using just 2 staff and we have got this time down 45 seconds to locate and confirm fire and a further 3 minutes and three seconds to evacuate five residents to the next compartment in the old part part of the home (top floor). As part of the fire drill, staff that live the closest were contacted and were available to assist with evacuation, the earliest arriving 32 seconds and three further staff arrived in 2 minutes 6 seconds. A full staff list, with phone numbers has been devised with journey times to the nursing home included. This will be held in the emergency bag. When the extension is complete staffing levels throughout the home will be reviewed to ensure that all of the needs of the residents will be met consistently, which they are at the moment.	
Regulation 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: The Person In Charge's office has had a full revamp and systems are being put in place to ensure that all records are able to be accessed easily. This has commenced with timescale for completion 31 August 2019. A full audit of staff files has taken place – new folders have been purchased and staff	

personnel information has been ordered the same within each file.
A Training Matrix which was presented the following day after the inspectors visited has been assembled. The PIC is keeping this updated every time that training occurs.
A comprehensive overhaul has taken place of all fire records – going forward all tests will be recorded timely and accurately, with certificates to match the recordings where applicable. There have been a number of fire drills that have taken place with staff to facilitate safe evacuation methods, these have detailed lessons learned and actions for further drills. Drills will continue to take place until every member of staff that works in the Nursing Home has had a chance to evacuate a compartment with just one other colleague – (until the timing clicks in for the additional staff to arrive)
Where required new firefighting equipment has been purchased, there are complete logs of this held in the fire file.
Two sledges have been ordered to accommodate a swifter exit from rooms 8 and 9
We are looking at wheelchairs that can be wheeled downstairs and are currently deciding which is best for our residents, once decided upon they will be purchased.
There may be additions to this following a comprehensive Fire Risk Assessment that is being undertaken at the moment. If this is the case – records will be updated and maintained.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

A Management Framework Tool is being designed to facilitate oversight of the nursing home and all of its functions to the Registered Provider. This will be carried out every three months with feedback provided to the PIC following the audit. This will be ready to start on the 31 July 2019.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:

The statement of purpose is being redesigned to take into account the changes within the centre and the diagrams that need realigning. This will be complete by the 31 July 2019.

Regulation 4: Written policies and procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:

All policies and procedures will be reviewed and in place, and available to all staff for reading and understanding. This will be completed by the 31 August 2019

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
This compliance plan response from the registered provider did not adequately assure the Chief Inspector that the actions will result in compliance with the regulations.

The store rooms within the Nursing Home have been redesigned to house hoists and trolleys. There is one hoist that is stored on a large corridor – all of the rest are stored in cupboards.

Since the 28 May several conversations have taken place with the Landlord of the premises to add a further three bathrooms – this will comprise of adding two bathrooms onto the first floor and one shower room onto the top floor. A contractor finally visited the nursing home on the evening of Thursday 11 July 2019, (despite trying to get three contractors earlier to come and look at the job to quote and provide a time line). There is a further contractor scheduled to visit on Monday 15 July 2019. The contractor that visited on the 11 of July said he could commence the work on the 21 October 2019 with a completion date planned for 15 November 2019. Once finished this will equate to seven bathrooms in total for 43 residents.

This will commence prior to the extension and on completion will provide 3 bathrooms on the ground floor, 3 bathrooms on the first floor and one bathroom on the top floor. This will be in addition to the ensuite facilities currently within the home. When the extension is complete a further bathroom will be available on the top floor. When the extension/refurbishment commences a further bathroom will be added to the top floor. There will also be further bathrooms housed within the extension.

The Sluice room has been reorganised to enable efficient use upholding Infection Control procedures.

Regulation 26: Risk management	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management:
This compliance plan response from the registered provider did not adequately assure the Chief Inspector that the actions will result in compliance with the regulations.

A full review has commenced of risk management and the risk register. This will be completed by 30 September 2019

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
This compliance plan response from the registered provider did not

adequately assure the Chief Inspector that the actions will result in compliance with the regulations.

A fire Consultant has been employed to carry out a full Fire Risk Assessment. This is not fully complete and in order to complete it – we are awaiting the viewing of the files held by South Dublin County Council Fire Record Department. These have been requested and we are waiting for these files to be taken from archives.

Automatic Suppression System – A review of all fire safety requirements in the kitchen considered the need for an ansul suppression system, however in view of the fact that the cooking equipment consists of a steam oven and a gas cooker which are both located directly underneath the extraction duct that extracts directly to the open, with the ducts fully cleaned and maintained bi-monthly, it was deemed that there would be no positive benefit to such an installation.

A full review of the evacuation of the Nursing home has been carried out paying particular attention to the older part of the building. Additional signage is on order as per the instruction of the fire consultant and will be placed in the areas identified by them.

A full review of the emergency lighting system has been undertaken, however a lot of the additions are recommended rather than required and the consequence of this is that there are budgetary constraints – the emergency lighting quote alone came to €60,000, which is not achievable, so to this end the fire consultant is reviewing what is required to ensure that the lighting is adequate and safe. This will be completed by the 20 July and the Fire Company will be asked to provide a quote for same. Once the quote is received the same will be provided to the landlord and a date will be provided for completion.

Following a full overhaul of records all test certificates were ordered and placed in the one file together under specific headings.

All staff have been trained in fire Safety and the course contents have been sent to HIQA. Going forward a praise of course contents will be placed in the training file.

Six fire drills have been completed since the 28 May 2019, with each one having two staff doing evacuations of specific compartments to mirror the night staffing levels. Two of these have been carried out in the early morning with the night staff. Reports are detailing the drill along with lessons learned.

A full review of the fire detection system has been carried out, with planning decision being made on the 19 August 2019, if this is granted building will commence without delay and the project should be complete within 8 months. The fire detection will be updated at this point as part of the extension and refurbishment of the nursing home. If planning is not granted at this point the time line will be revisited.

A full review of all of the doors is in progress. As the records from the extension in 2007 are no longer available, the review includes an assessment of physical condition, location, operation and fittings. A number of issues have been identified for attention and remedial works are underway with a completion date of the 15 August.

Not all of the doors in the nursing home require automatic door closures, where these have been identified as being required these will be fitted. There are currently four residents who like to sleep with their bedroom doors open and these rooms will be fitted with closures. The peeps will determine who requires a closure and these will be reviewed at least yearly or earlier if any change to mobility or condition or a change in the residents choice occurs.

A full review of fire stopping around building services has commenced and where required fire rated foam will be used to fill any gaps. This will be complete by the 15 August.

The disused stairs are disused, further doors will be placed at the entrance to the lower staircase and if planning is achieved on the 19 August will be part of the refurbishment project, if this is delayed the timeline will be reviewed.

As stated above fire drills are being carried out with just two members of staff evacuating the compartments, going forward an additional member of staff will be introduced as per the timing schedule of staff attending the nursing home.

All Peeps have been updated (completed by the 10 July 2019) these will be reviewed at least yearly but if there is a change in the residents condition, mobility or choices, these will be updated at this point. Staff have ben reminded about ensuring accurate dates are recorded upon review.

A Zone Plan is being designed and will be in situ beside the fire panel in the nursing home from the 19 July 2019.

A full review of the signage has been undertaken and a number of recommendations made. An order for these has been placed and will be in situ by the 15 August 2019.

Maps with Zones and integrity of the compartments are in progress and will be complete by the 19 July 2019.

Travel distances to all exits from every compartment is being finalised and will be complete by the 19 July 2019.

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 full revision on care plans has been undertaken to ensure that all details regarding any professional's advice is reflected in the care plan. This is complete and will be checked by the ADON and PIC routinely.

All care plans in relation to End of Life Care are being updated. Families of residents previously not wishing to discuss end of life care for their loved ones have been contacted to re-discuss end of life care. Most of these have been updated but we are still

waiting on some families to come to discuss. This will be completed by the 31 July 2019.

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:
The policy on the management of responsive behaviours has been updated, to reflect best practice guidance, a copy of the same was sent to HIQA on the 29 May 2019, this has been made available for all staff to read and familiarise themselves with.

The increase in the number of bed rails has been due to a number of new admissions that had been used to using bed rails prior to their admission. These residents are being assessed using alternatives to test if the alternative is a better and safer option for the individual resident.

A new bed rail risk assessment has been introduced and is currently being trialled to ensure that sufficient information is recorded around alternatives being tried prior to the use of bedrails. The new form will be ready for implementation by the 31 July 2019.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Scheduled residents meeting will commence bi-monthly from the 31 July 2019 and will take place on the last Wednesday of the month. These will discuss issues ranging from daily activities, menus, management and any other issue that a resident may wish to discuss. These will be minuted and actions recorded and where possible acted upon. If the suggestions are not possible this will be relayed back to the individual.

The daily discussion that is held in the nursing home that outlines daily occurrences and goings on will still be held and any actions arising from these will be noted and followed up (previously these have been acted upon without evidence of same)

Notice boards are in place in each sitting room detailing, day, date, weather and activities for the day.

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 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	11/07/2019
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.	Not Compliant	Orange	02/07/2019
Regulation 17(2)	The registered provider shall,	Not Compliant	Orange	

	having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.			
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Not Compliant	Yellow	31/08/2019
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Not Compliant	Yellow	31/08/2019
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	31/07/2019
Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated	Not Compliant	Orange	30/09/2019

	centre.			
Regulation 26(1)(b)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the risks identified.	Not Compliant	Orange	30/09/2019
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Orange	15/08/2019
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	20/07/2019
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	20/07/2019
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	
Regulation 28(1)(d)	The registered provider shall	Substantially Compliant	Yellow	15/08/2019

	make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, firefighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.			
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	15/08/2019
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and	Not Compliant	Orange	19/08/2019

	extinguishing fires.			
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.	Not Compliant	Orange	08/07/2019
Regulation 28(3)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place in the designated centre.	Substantially Compliant	Yellow	12/07/2019
Regulation 03(2)	The registered provider shall review and revise the statement of purpose at intervals of not less than one year.	Substantially Compliant	Yellow	31/07/2019
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.	Not Compliant	Yellow	31/08/2019
Regulation 04(2)	The registered provider shall make the written policies and procedures referred to in paragraph (1) available to staff.	Not Compliant	Yellow	31/08/2019
Regulation 04(3)	The registered provider shall review the policies	Not Compliant	Yellow	31/08/2019

	and procedures referred to in paragraph (1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.			
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Substantially Compliant	Yellow	31/07/2019
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.	Substantially Compliant	Yellow	31/07/2019
Regulation 9(3)(c)(ii)	A registered provider shall, in so far as is reasonably practical, ensure that a resident	Substantially Compliant	Yellow	12/07/2019

	radio, television, newspapers and other media.			
Regulation 9(3)(c)(iii)	A registered provider shall, in so far as is reasonably practical, ensure that a resident telephone facilities, which may be accessed privately.	Substantially Compliant	Yellow	
Regulation 9(3)(c)(iv)	A registered provider shall, in so far as is reasonably practical, ensure that a resident voluntary groups, community resources and events.	Substantially Compliant	Yellow	
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned.	Substantially Compliant	Yellow	31/07/2019