<table>
<thead>
<tr>
<th>Centre name:</th>
<th>St Conlon’s Community Nursing Unit</th>
</tr>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000666</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Church Road, Nenagh, Tipperary.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>067 31 893</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:elainej.flynn@hse.ie">elainej.flynn@hse.ie</a></td>
</tr>
<tr>
<td>Type of centre:</td>
<td>The Health Service Executive</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>Health Service Executive</td>
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<tr>
<td>Lead inspector:</td>
<td>Mary Costelloe</td>
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<tr>
<td>Support inspector(s):</td>
<td>None</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Unannounced Dementia Care Thematic Inspections</td>
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<td>Number of residents on the date of inspection:</td>
<td>27</td>
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<td>Number of vacancies on the date of inspection:</td>
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About Dementia Care Thematic Inspections

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

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

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

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

**The inspection took place over the following dates and times**

From: 10 July 2019 09:00  
To: 10 July 2019 17:00  
11 July 2019 09:00  
11 July 2019 15:00  

The table below sets out the outcomes that were inspected against on this inspection.

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<th>Outcome</th>
<th>Provider’s self assessment</th>
<th>Our Judgment</th>
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<td>Compliance demonstrated</td>
<td>Non Compliant - Moderate</td>
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<tr>
<td>Outcome 02: Safeguarding and Safety</td>
<td>Substantially Compliant</td>
<td>Non Compliant - Moderate</td>
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<td>Outcome 03: Residents' Rights, Dignity and Consultation</td>
<td>Compliance demonstrated</td>
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<td>Compliance demonstrated</td>
<td>Compliant</td>
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<td>Outcome 06: Safe and Suitable Premises</td>
<td>Non Compliant - Moderate</td>
<td>Non Compliant - Moderate</td>
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<td>Outcome 07: Health and Safety and Risk Management</td>
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<td>Non Compliant - Major</td>
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<tr>
<td>Outcome 08: Governance and Management</td>
<td></td>
<td>Non Compliant - Major</td>
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**Summary of findings from this inspection**

This inspection report sets out the findings of a thematic inspection which focused on specific outcomes relevant to dementia care.

Issues of concern relating to health and safety and risk management, governance and management were also reviewed.

The findings from this inspection indicated a lack of support and oversight by the Health Service Executive (HSE) senior management team in regard to staffing.
arrangements, staffing levels and management of risk and fire safety in the centre. It was of serious concern that the governance and management systems in place had not appropriately identified and addressed these issues which are further discussed further under Outcome: 5 Suitable staffing and Outcome 7: Health and safety and risk management. On foot of these findings an urgent compliance letter was issued to the registered provider representative following this inspection.

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

While this centre does not have a dementia specific unit, the inspector focused on the care of residents with a dementia during this inspection. Ten residents were diagnosed with dementia or cognitive impairment. The inspector met with residents, relatives and staff members during the inspection. The inspector tracked the journey of a number of residents with dementia within the service, observed care practices and interactions between staff and residents who had dementia using a validated observation tool (QUIS). The inspector also reviewed documentation such as care plans, medical records, staff files and relevant policies.

The centre was single storey, well maintained and nicely decorated. There was a good variety of communal day spaces including the dining room, day room, conservatory, family room and relaxation room. The communal areas had a variety of comfortable furnishings and were domestic in nature.

Accommodation was provided for residents in five twin en suite bedrooms, two single en suite bedrooms and fifteen single bedrooms without en suite facilities. There was a longstanding non-compliance with the design and layout of the premises as the 15 single bedrooms did not offer sufficient space for residents living in these rooms. The person in charge had continued to assess all residents prior to admission as outlined in the statement of purpose to ensure that only residents with low dependency needs, requiring minimum nursing care and with no need of assistance with healthcare equipment were accommodated in these bedrooms.

On this inspection the centre was found not to be operating in line with its own statement of purpose. On exploring this situation, the inspector found that the instruction to move outside the statement of purpose resulted in the non compliance detailed under Outcome 7: Health and safety and risk management. This instruction was issued in the absence of any additional measures to the risks associated with it being put in place.

Senior HSE management had also failed to respond to their own fire safety risks on foot of a fire risk assessment report dated December 2018.

Despite the shortcomings in relation to the size of some bedrooms, the overall atmosphere was homely, comfortable and in keeping with the overall assessed needs of the residents who lived there. The inspector found the residents were enabled to move around the centre as they wished. Signs and colours had been used in the
centre to support residents to be orientated to where they were. Resident's had independent access to a secure outdoor space. Many of the residents and relatives commented on the homely feel of the centre.

The inspector found that residents’ overall healthcare needs were met and they had access to appropriate medical and allied healthcare services. The quality of residents’ lives was enhanced by the provision of a choice of interesting things for them to do during the day and an ethos of respect and dignity for residents was evident. All staff fulfilled a role in meeting the social needs of residents and the inspector observed that staff connected with residents as individuals. Improvements were required to the nursing and care planning documentation to ensure that residents up to date care needs were always reflected.

Residents were observed to be relaxed and comfortable in the company of staff. Staff had paid particular attention to residents dress and appearance. The inspector noted that staff assisting residents with a diagnosis of dementia were particularly caring and sensitive.

The collective feedback from residents and relatives was one of satisfaction with the service and care provided.

Areas for improvement are discussed in the body of the report and in the action plan at the end of the report.
Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

**Outcome 01: Health and Social Care Needs**

**Theme:**
Safe care and support

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

**Findings:**
The inspector found that residents’ overall healthcare needs were met and they had access to appropriate medical and allied healthcare services and each resident had opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

There were 27 residents accommodated on the days of the inspection. Four residents were assessed as having maximum dependency needs; three had high dependency needs, 12 had medium dependency and four were assessed as having low dependency needs. Ten residents were identified as having dementia or cognitive impairment.

Residents had access to general practitioner (GP) services of their choice and could retain their own GP if they so wished. There was an out-of-hours GP service available. The inspector reviewed a sample of files and found that GPs reviewed residents on a regular basis.

A full range of other services was available including speech and language therapy (SALT), occupational therapy (OT), dietetic services, tissue viability and psychiatry of later life. A physiotherapist visited weekly. Chiropody, dental, audiology and optical services were also provided. The inspector reviewed residents’ records and found that while residents had been referred to these services, regularly reviewed, the recommendation’s were not consistently recorded in the resident’s care plans.

There was a policy in place that set out how resident’s needs would be assessed prior to admission, on admission, and then reviewed at regular intervals. All residents had a care plan that was developed on admission, and this was added to as the staff got to know the resident better. However, a review of records showed inconsistencies in the care planning documentation. There was evidence of relative and resident involvement in the review of care plans.

The person in charge continued to assess all residents prior to admission to ensure that their needs could be met as outlined in the statement of purpose. She confirmed that
the size of single bedrooms placed restrictions on the acceptance and placement of some residents. The assessment process involved the use of validated tools to assess each resident's risk of falls, malnutrition, level of cognitive impairment, manual handling requirements and skin integrity.

Nursing staff spoken with were familiar with and knowledgeable regarding residents up to date needs but this was not always reflected in the nursing documentation. While care plans in place were found to be individualised and person centered, inconsistencies were noted in the care planning and nursing documentation. For example:
- Some care plans had not been updated to reflect the professional advice of allied health service professionals such as the dietitian.
- Some care plans lacked guidance for staff on the specific care needs for some residents, for example, the nutritional care plan for a resident who had lost weight was not informative.
- There was no care plan in place for a resident with restrictive practices in place such as a bedrail.
- There were no care plans in place for a resident with infections.
- Some risk assessments were completed inaccurately for example, a risk assessment for use of a bed rail was not accurate.
- Some risk assessments were not accurately linked with the care plan, for example a moving and handling assessment was not accurately linked with the mobility and safety care plan.
- Meaningful activities assessments were not completed for all residents.
- Social care plans were not in place for all residents.

The inspector was satisfied that residents' weight changes were closely monitored. All residents were nutritionally assessed using a validated assessment tool. All residents were weighed regularly. Nursing staff told the inspector that if there was a change in a resident's weight, nursing staff would reassess the resident, inform the GP and referrals would be made to the dietitian and speech and language therapy (SALT). Files reviewed by the inspector confirmed this to be the case. All staff were aware of residents who required specialised diets or modified diets and were knowledgeable regarding the recommendations of the dietician and SALT.

Meals were served to residents in a large bright dining room. The majority of residents had their meals in the dining room but could have them in their bedrooms if they wished. There were large written and colourful pictorial menu boards in the dining room which clearly displayed what food choices and dishes were available for each meal. Meals appeared to be wholesome and nutritious and served in an appetising manner. Staff strived to ensure that mealtimes were unhurried, social occasions. Staff were observed to engage positively with residents during meal-times, offering choice and appropriate encouragement while other staff sat with residents who required assistance with their meal. The inspector noted that staff assisting residents with dementia were caring and sensitive. Nursing staff supervised the mealtimes. Residents spoken with were complimentary of quality and choice at mealtimes. A variety of hot and cold drinks, as well as snacks and fruit were offered and encouraged throughout the day. Residents told the inspector that they could have something to eat or drink at any time including night time.
There was a reported low incidence of wound development and the inspector saw that the risk of same was assessed regularly and appropriate preventative interventions including pressure relieving equipment were in use. The inspector noted adequate wound assessment and wound care charts in place.

The inspector reviewed the files of residents who had recently fallen and noted that the falls risk assessments and care plans had been updated post falls. The person in charge reviewed falls on a regular basis. The physiotherapist visited and was available to review residents as required. Low-low beds and crash mats were in use for some residents. Residents at high risk of falls were accommodated in bedrooms near to the nurses' station for additional supervision. The inspector noted that the communal day areas were supervised by staff at all times.

The inspector was satisfied that caring for a resident at end of life was regarded as an integral part of the care service provided in centre. Staff provided end-of-life care to residents with the support of their GP and the homecare palliative team. The inspector reviewed a number of 'end-of-life' care plans that outlined the individual wishes of residents and their families including residents' preferences regarding their preferred setting for delivery of care. The resuscitation status of residents was noted. Religious sacraments were available to all residents as desired. Facilities were available for relatives who wished to stay overnight.

Staff continued to provide meaningful and interesting activities for all residents including residents with dementia. However, as discussed previously, the social care needs of each resident were not consistently assessed, life histories and 'Key to me' documents had not been recorded for all residents. There was a dedicated staff member who facilitated a variety of activities each day. Some staff had completed training in the provision of meaningful activities, imagination gym and Sonas (therapeutic programme specifically for residents with Alzheimer’s or dementia). The daily and weekly activities schedule was displayed and the inspector observed residents enjoying a variety of activities during the inspection. Residents were encouraged and supported to attend other activities taking place locally in the community. Some residents regularly attended physical exercise, computer classes and other activities in the neighbouring pastoral centre. Some residents mentioned that they would like to avail of day trips to places of local interest, however, the person in charge advised that it was difficult to organise at present due to the lack of suitable transport and limited staffing resources.

**Judgment:**  
Non Compliant - Moderate

**Outcome 02: Safeguarding and Safety**

**Theme:**  
Safe care and support
Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
The provider and person in charge had taken measures to safeguard residents from being harmed and from suffering abuse; however, improvements were required to ensure that all staff had completed safeguarding training. Inconsistencies in the recording of information relating to the administration of PRN 'as required' psychotropic medications had still not been fully addressed.

The person in charge advised that all staff and persons who provided services to residents had An Garda Síochána vetting in place. A sample of staff files reviewed by the inspector confirmed this to be the case.

There was a comprehensive safeguarding policy in place. The person in charge had attended safeguarding officer training and was qualified to train staff in house; however, all staff had not completed safeguarding training. The person in charge stated that it was difficult at present to schedule training due to lack of nursing management support staff and also to release staff to attend training due to limited staffing resources.

Residents with dementia were provided with person-centred support that promoted a positive approach to the behavioural and psychological symptoms of their dementia. Staff spoke with demonstrated an awareness of recognising the underlying causes of these symptoms. Care staff knew the residents well and were observed to use life history and family information when conversing with residents. Staff were knowledgeable about and could outline person-centred strategies for dealing with individual residents' responsive behaviour. Nursing staff spoken with were clear they needed to consider the reasons people's behaviour changed, and would also consider and review for issues such as infections, constipation, and changes in vital signs.

The inspector observed that residents appeared relaxed, calm and content during the inspection. Staff spoke of the importance of maintaining a calm, noise free environment and allowing residents choice of daily routines. The inspector observed this taking place in practice. Residents also had access to support and advice from the community psychiatric team who visited the centre.

Staff continued to promote a restraint-free environment. There were six bed rails in use at the time of inspection some at the residents own request. A review of a sample of residents files indicated that risk assessments and regular checks were documented, however, care plans were not in place for all residents using bedrails. The inspector saw that alternatives such as low low beds and crash mats were in use for some residents.

A small number of residents were prescribed psychotropic medicines on a PRN 'as required' basis and these were administered occasionally. Staff spoken with informed the inspector that these were always administered as a last resort only when other strategies had been trialled and possible underlying causes had been eliminated. However, as outlined at the previous inspection, there were still discrepancies and inconsistencies in how this information was recorded. Records did not always indicate the rationale for administration of these medicines, what other interventions had been
tried to manage the behaviour and the effect and outcome for the resident following the administration of the medicine.

Staff spoken with and training records reviewed indicated that some staff had attended training on managing actual and potential aggression (MAPA) and some staff had attended training workshops on enhancing and enabling well being for people with dementia. The person in charge had completed a post graduate diploma in dementia care.

The inspector was satisfied that robust systems were in place for the management of residents finances. The provider acted as pension agent for nine residents and all money was paid into an interest bearing resident account. Residents were invoiced and charges were clearly set out on a monthly basis. Receipts were available for any purchases made on behalf of residents and bank balancing statements were available at the request of residents. Small amounts of money were kept for safekeeping on behalf of some residents. The inspector was satisfied they were managed in a clear and transparent manner. Individual balance sheets were maintained for each resident and all transactions were clearly recorded and signed by two signatories. There were regular reviews of accounts carried out by internal and external auditors. All residents had access to a secure lockable locker in their bedrooms should they wish to securely store any personal items.

Judgment:
Non Compliant - Moderate

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

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

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

**Findings:**
The inspector was satisfied that residents were consulted in the organisation of the centre, and that their privacy and dignity was respected.

Residents' committee meetings continued to be held on a regular basis. Family members were invited to attend to represent the views of residents with cognitive impairment. Minutes of meetings were recorded. Issues discussed at recent meetings included catering, activities and fire policy. There was evidence that some issues raised by residents had been acted upon. A food, meals and dining quality improvement survey had been completed in February 2019, the results of which indicated high satisfaction. Residents had access to advocacy services and the contact details for the local SAGE (support and advocacy service for older people) advocate were displayed.
The inspector noted that the privacy and dignity of residents was well respected. Bedroom and bathroom doors were closed when personal care was being delivered. Staff were observed to knock and wait before entering bedrooms. Adequate screening curtains were provided in shared bedrooms. Residents spoken with confirmed that their privacy was respected. Many residents spoken with praised the staff stating that they were kind, caring and treated them with respect.

The inspector heard staff addressing residents by their preferred names and speaking in a clear, respectful and courteous manner. Staff paid particular attention to residents’ appearance, dress and personal hygiene and were observed to be caring towards the residents. Residents choose what they liked to wear. The hairdresser visited as required and some residents availed of the service, other residents were supported to attend their own hairdresser locally.

Residents’ religious and political rights were facilitated. The local priest visited and said Mass weekly. Daily mass, rosary and other church services were relayed by video link from the local parish to a large television screen in the main dayroom. Many of the residents spoke of enjoying this facility. Eucharistic ministers visited daily and offered Holy Communion to residents. Arrangements were in place for residents of different religious beliefs.

Residents were facilitated to vote. The person in charge advised that the majority of residents had voted in-house during recent elections and some residents had been supported to vote in their local constituency.

The inspector found the management style of the centre maximised residents’ capacity to exercise personal autonomy and choice. The inspector observed that residents were free to join in an activity or to spend quiet time in their room and being encouraged and supported to follow their own routines. Residents were seen to be walking about independently, going in and out of the garden area and coming and going from the centre during the two days of inspection.

There was an open visiting policy in place. The inspector observed visitors coming and going throughout the inspection. There were two family rooms available should residents wish to meet visitors in private. The family room in the palliative care suite had facilities for families to stay overnight if they wished.

Residents had access to information and news, daily and weekly local newspapers, notice boards, radio, television and Wi-Fi were available. There was access to the internet and residents were observed to enjoy listening to, joining in and dancing to YouTube music videos on the large screen television in the day room. Residents also had access to a computer tablet.

As part of the inspection, the inspector spent periods of time observing staff interactions with residents. The inspector used a validated observational tool (the quality of interactions schedule, or QUIS) to rate and record at five minute intervals the quality of interactions between staff and residents in the communal areas. The scores for the quality of interactions are +2 (positive connective care), +1 (task orientated care), 0 (neutral care), -1 (protective and controlling), -2 (institutional, controlling care). An
overview of the observations is provided below:

The inspector found that for 100% of the observation period (total observation period of 60 minutes) the quality of interaction score was +2 (positive connective care). Staff knew the residents well and they connected with each resident on a personal level. Staff made eye contact and greeted residents individually by their preferred names, staff offered choice such as choice of preferred drinks and food and choice of preferred place to sit. Residents were observed to enjoy the company of staff, some smiling, laughing and being affectionate towards staff. Staff sat beside residents and were observed offering assistance in a respectful and dignified manner to residents who required assistance with eating.

Judgment:
Compliant

Outcome 04: Complaints procedures

Theme:
Person-centred care and support

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

Findings:
The inspector was satisfied that complaints were managed in line with the centre’s complaints policy.

There was a comprehensive complaints policy in place which clearly outlined the duties and responsibilities of staff. The complaints procedure was clearly displayed and contained all information as required by the Regulations including the name of the complaints officer, details of the appeals process and contact information for the Office of the Ombudsman. There was a comment box also available.

There was a complaints log available to record complaints. There were no open complaints at the time of inspection.

Judgment:
Compliant

Outcome 05: Suitable Staffing

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

**Findings:**
Staffing arrangements and staffing levels required review to ensure that residents' assessed needs including their assessed evacuation needs in the event of an emergency could be met.

The inspector had significant concerns regarding the safety of residents particularly in the event of fire at night time. There were three staff on duty at night time and the inspector was not assured that they would be able to conduct a safe and effective phased evacuation of the building in the event of fire taking into consideration the assessed evacuation needs of residents. This was brought to the attention of the registered provider representative on day one of the inspection who agreed to provide an additional staff member on night duty forthwith. The registered provider representative was advised that the additional staff member on night duty was required until such time as the Chief inspector was satisfied that all residents were accommodated in a safe environment.

A vacancy had arisen for the post of clinical nurse manager in November 2018. The registered provider representative advised that the post was currently being advertised. In the interim, the person in charge had no nursing management supports available on a day to day basis in the centre and there were no suitable deputising arrangements in place in the absence of the person in charge. The inspector was advised that due to lack of nursing management supports over the past number of months, many quality care audits had not been completed and there had been limited oversight of nursing documentation and care plans.

Staffing levels in the centre had reduced since the previous inspection. The inspector was informed that there was a cap on the hiring of agency staff and that staff on short term sick leave were not being replaced. On both days of inspection, there were rostered staff on sick leave who had not been replaced. On the days of inspection a staff member allocated to cleaning duties had to replace a staff member allocated to direct resident care and a staff member allocated to facilitating activities and supervision of residents in the day room had to assist with the tea round which was normally carried out by a care staff member. The current staffing levels were not in accordance with those set out in the centre's statement of purpose.

Mandatory training of all staff was not up-to-date. The person in charge advised that due to lack of staffing resources it was difficult to release staff to attend training. The person in charge had completed 'train the trainer' in safeguarding but stated that due to lack of nursing management supports it had not been possible for her to facilitate in-house training with staff.

The person in charge had identified the current staffing arrangements as posing a risk to residents and this was identified as a risk on the centre’s risk register. The staffing arrangements impacted on both residents and staff, and impacts included:
- inadequate staff on duty to meet the assessed needs of residents which impacted on for example, the safe evacuation of residents.
- supervision of residents in the dayroom at times during the day as staff allocated to facilitating activities with residents had to leave the dayroom to assist with the tea rounds.
- inadequate oversight of nursing documentation and care planning documentation.
- mandatory training of staff not completed for example all staff had not completed safeguarding training.
- staff training matrix was not up-to-date.
- day trips requested by residents as evidenced in the minutes of the last two residents meetings were not facilitated due to inadequate staffing resources.
- infection control and cleaning schedules were not fully adhered to on some days due to designated cleaning staff being allocated to resident care.

Staff files reviewed were found to contain all the required documentation as required by the Regulations. Nursing registration numbers were available and up-to-date for all staff nurses. Details of induction and orientation received and training certificates were noted on staff files. There were no volunteers attending the centre.

Trainings certificates observed in staff files reviewed indicated that some staff had recently completed training in infection control, dementia and person centred care, restraint management and clinical supervision. However, the person in charge was unable to provide evidence of all training completed by staff. The training matrix had not been updated to include all training completed. The person in charge advised that all staff had completed mandatory training in fire safety and people moving and handling. As discussed under Outcome 2: Safeguarding, some staff had not completed safeguarding training, other staff had not completed MAPA training (management of actual and potential aggression) and some nursing staff had not completed recent medicines management training. Further training was planned in infection control, food safety, clean pass and person-centred care.

The inspector found that staff delivered care in a respectful manner. The centre was person orientated and not task focused, and all staff provided care to the residents.

**Judgment:**
Non Compliant - Moderate

**Outcome 06: Safe and Suitable Premises**

**Theme:**
Effective care and support

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.
**Findings:**
The centre was single storey, well maintained and nicely decorated. It was warm, clean and odour free throughout. There was a good variety of communal day spaces including the dining room, day room, conservatory, family room and relaxation room. The communal areas had a variety of comfortable furnishings and were domestic in nature. Many of the residents and relatives commented on the homely feel of the centre.

Private accommodation was provided for residents in five twin en suite bedrooms, two single en-suite bedrooms and 15 single bedrooms without en-suite facilities. There was a longstanding non-compliance with the design and layout of the premises as the 15 single bedrooms did not offer sufficient space for residents and did not comply with the size set out in the National Standards for Residential Care Settings for Older People in Ireland. For example, it was not possible to place bedside lockers beside some beds and within residents reach. There was minimal floor space available which was insufficient to allow for the use of large pieces of specialised equipment including hoists. The person in charge had continued to assess all residents prior to admission as outlined in the statement of purpose to ensure that residents with low dependency needs, requiring minimum nursing care and with no need of assistance with healthcare equipment were accommodated in these bedrooms. A new 50 bed unit was planned.

There were an adequate number of toilets and assisted showers. There was a separate bathroom with specialist bath. Contrasting coloured grab-rails had been fitted to bathrooms to help residents with dementia orientate better.

The corridors were wide and bright and allowed for freedom of movement. Corridors had grab rails, and were seen to be clear of any obstructions. Residents were seen to be moving as they chose within the centre. The floor covering was consistent in colour and non slip.

The inspector noted good signage and sign posting throughout the centre. Appropriate signage was provided on doors, there was a sign with a word and a picture for bathrooms and other rooms residents would use. The inspector noted that some bedroom doors were provided with visual cues to assist residents recognise their own bedroom. Residents were encouraged to personalise their rooms and many had photographs and other personal belongings in their bedrooms. Residents spoken with stated that they liked their bedrooms.

Residents had access to a large well-maintained and landscaped external garden courtyard area. The outdoor space was easily accessible and many residents were observed coming and going from the garden area independently. The inspector also observed that staff supported other residents to go for walks in the garden and to partake in activities which were held in the garden area.

There was a range of equipment in the centre to aid mobility. Overhead ceiling hoists were provided in some bedrooms and bathrooms. Hoists and other equipment seen in the centre were in working order, and records showed they had been regularly serviced.

The building was secure. The entrance door was fitted with an automatic locking system and all fire exit doors were alarmed.
**Judgment:**
Non Compliant - Moderate

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

**Theme:**
Safe care and support

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

**Findings:**
Systems in place for the identification and management of fire safety risk in the centre were not effective. The inspector was particularly concerned about the level of fire safety risks that had not been assessed and proactively managed.

There was evidence of regular fire safety checks being carried out and all staff had received on-going fire safety training which included evacuation and use of equipment. The servicing of the fire alarm and fire equipment was up to date. All fire exits were observed to be free of any obstructions. However, the inspector had significant concerns regarding the safety of residents particularly in the event of fire at night time. There were three staff on duty at night time and the inspector was not assured that they would be able to conduct a safe and effective phased evacuation of the building in the event of fire taking into consideration the assessed evacuation needs of residents. This was brought to the attention of the registered provider representative on day one of the inspection who agreed to provide an additional staff member on night duty forthwith.

Fire drill records reviewed did not provide assurances that residents could be evacuated safely in a timely manner in the event of fire. Records reviewed showed that while fire drills were being carried out and had simulated the evacuation of one resident, there was no recorded evidence of simulated full compartment evacuation drills conducted to take account of staffing levels and all residents' evacuation requirements.

The inspector was not assured about the effectiveness of fire containment throughout the building which could result in uncontrolled fire and smoke spread throughout the premises. The inspector noted that some fire doors did not have smoke brushes and intumescent strips fitted to prevent the spread of smoke. A risk assessment of fire doors had been carried out by a fire safety engineer in December 2018 and had identified a large number of fire doors to be replaced. This identified risk had not been addressed. The management team was advised that an urgent compliance letter in respect of these issues would be issued following the inspection.

‘Fire plans’ displayed in various locations throughout the premises did not reflect the layout of the building and all exits from the building.
The personal emergency evacuation needs of all residents were not up to date and did not always reflect the level of assistance or equipment required.

Risk assessments for individual residents who smoked were not completed consistently.

**Judgment:**
Non Compliant - Major

### Outcome 08: Governance and Management

**Theme:**
Governance, Leadership and Management

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

**Findings:**
The findings from this inspection indicate a lack of support and oversight by the Health Service Executive (HSE) senior management team in regard to staffing arrangements, staffing levels and management of risk and fire safety in the centre. It was of serious concern that the governance and management systems in place had not appropriately managed these issues. These issues are discussed further under Outcome 5: Suitable staffing and Outcome 7: Health and safety and risk management.

There was a lack of support for the PIC to carry out her duties and responsibilities. There was a vacancy for the post of clinical nurse manager which had not been filled. The impact was that there were no nursing management supports available on a day to day basis in the centre and there were no suitable deputising arrangements in place in the absence of the person in charge. The person in charge had planned to commence a management training course in September 2019 pending suitable deputising arrangements and supports being put in place in the centre.

While there were systems in place to review the quality and safety of care in the centre, the inspector found that many quality care audits had not been completed and there had been limited oversight of nursing documentation and care plans. This was attributed to the lack of nursing management supports in place.

Staffing levels in the centre had reduced since the previous inspection. There was a cap on the hiring of both nursing and care agency staff. Staff on short term sick leave were not being replaced. The current staffing levels were not in accordance with those set out in the centre's statement of purpose.

**Judgment:**
Non Compliant - Major
**Closing the Visit**

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

**Acknowledgements**

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

**Report Compiled by:**

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

Centre name: St Conlon's Community Nursing Unit
Centre ID: OSV-0000666
Date of inspection: 10/07/2019
Date of response: 26/08/2019

Requirements

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

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

Outcome 01: Health and Social Care Needs

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Inconsistencies were noted in the care planning and nursing documentation. For example:
- Some care plans had not been updated to reflect the professional advice of allied health service professionals such as the dietitian.
- Some care plans lacked guidance for staff on the specific care needs for some residents, for example, the nutritional care plan for a resident who had lost weight was

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
not informative.
- There was no care plan in place for a resident with restrictive practices in place such as a bed rail.
- There were no care plans in place for a resident with infections.
- Some risk assessments were completed inaccurately for example, a risk assessment for use of a bed rail.
- Some risk assessments were not accurately linked with the care plan, for example a moving and handling assessment was not accurately linked with the mobility and safety care plan.
- Meaningful activities assessments were not completed for all residents.
- Social care plans were not in place for all residents.

1. **Action Required:**
   Under Regulation 05(3) you are required to: Prepare a care plan, based on the assessment referred to in Regulation 5(2), for a resident no later than 48 hours after that resident’s admission to the designated centre.

Please state the actions you have taken or are planning to take:
The inspector has reviewed the provider compliance plan. The actions proposed to address the regulatory non-compliance does not adequately assure the office of the chief inspector that the actions will result in compliance with the regulations.

Care planning and nursing documentation

- Meetings have been held with staff in relation to care planning inconsistencies
- Each resident has an assigned key nurse who is responsible for the residents individualised care planning and documentation.
- The residents care plan is prepared based on the assessment no later than 48hrs after the resident’s admission to the Designated Centre.
- Following revision and evaluation, health, personal and social care plans reflect the current care needs of the resident.
- A ‘Care Plan Development and Implementation Policy’ (2019), has been issued and discussed with staff nurses at the shift to shift handover, daily safety pause and via email correspondence.
- Any recommendations from Allied Health Professionals are now documented and communicated to staff at shift to shift handover, including staff who have been absent from work due to leave.

For example, when a resident has been reviewed by the dietitian, the recommendations made are documented in the care plan. A copy of the recommendations is issued to the Catering department. The catering department ensures that they are also aware of the changes with regard to dietary needs.
- The care plan review focused on the assessments, care plan documentation, with specific attention to nutrition and hydration, restrictive practices, infection prevention and control, all risk assessments and meaningful activity, with the review of social care plans for all residents.
- Care plans are now more detailed and provide guidance for all staff.
- The individual risk assessments followed by interventions inform the care planning process for each individual resident.
• This is reviewed at a minimum 4 monthly or as required.
• The Quality Care Metrics was completed by 2 external auditors for July 2019. Findings were analysed by the external auditors and feedback report provided to the Person in Charge. A time-lined Quality Improvement Plan has been developed by the Person in Charge and has been reported to the Registered Provider.

Actions to be completed by: 30 September 2019
• The Quality Care Metrics has been scheduled to be completed by 2 external auditors in August 2019. Findings will be submitted to the Person in Charge and reported to the Registered Provider. Planned date of completion, 30th August 2019
• The meaningful activity assessment with the Care planning tools’ A Key to Me’, My day, my way’, ‘Calendar of events’ are under review in consultation with each resident/nominated representative. Planned date of completion, 30th September 2019.

Proposed Timescale: 30/09/2019
Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Some risk assessments were completed inaccurately for example, a risk assessment for use of a bed rail was inaccurate.
Some risk assessments were not accurately linked with the care plan, for example a moving and handling assessment was not accurately linked with the mobility and safety care plan.
Meaningful activities assessments were not completed for all residents.

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

Please state the actions you have taken or are planning to take:
The inspector has reviewed the provider compliance plan. The actions proposed to address the regulatory non-compliance does not adequately assure the office of the chief inspector that the actions will result in compliance with the regulations.

• Following revision and evaluation, a ‘Care Plan Development and Implementation Policy’ (2019) has been issued and discussed with staff nurses at the shift to shift handover, daily safety pause and via email correspondence.
• All risk assessments for the use of bed rails have been reviewed, evaluated, update, completed and communicated to staff.
• The Quality Care Metrics was completed by 2 external auditors for July 2019. Findings were analysed by the external auditors and feedback report provided to the Person in Charge. A time-lined Quality Improvement Plan has been developed by the Person in Charge and has been reported to the Registered Provider.
• Following the completion of the Quality Care Metrics for July an action plan has been developed to ensure that all risk assessments, interventions and actions are accurately
linked to the appropriately care plan.
• The Residents Forum Agenda has been reviewed and revised to include meaningful activities as an agenda item.

Proposed Timescale: 30/09/2019

Outcome 02: Safeguarding and Safety

Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Records did not always indicate the rationale for administration of psychotropic medicines administered on a PRN basis, what other interventions had been tried to manage the behaviour and the effect and outcome for the resident following the administration of the medicine.

3. Action Required:
Under Regulation 07(3) you are required to: 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.

Please state the actions you have taken or are planning to take:
• Following revision and evaluation, the National Policy 'Policy on the Use of Physical Restraints in Designated Residential Care Units for Older People' (2011), has been issued and discussed with all staff at the shift to shift handover, daily safety pause and via email correspondence.
• Following revision and evaluation, A 'Care Plan Development and Implementation Policy' has been issued and discussed with staff nurses at the shift to shift handover, daily safety pause and via email correspondence.
• Following the completion of the Quality Care Metrics for July an action plan has been developed by the Person in Charge and communicated to nursing staff, to ensure the rationale for administration of psychotropic medicines administered on a PRN basis is recorded, other interventions, which include the management of the behaviour and psychological symptoms of the resident requiring alternative management are explored and actioned prior to the administration of PRN psychotropic medicine.

Actions to be completed by: 30th October 2019.

• The Quality Care Metrics has been scheduled to be completed by 2 external auditors in August 2019. Findings will be submitted to the Person in Charge and reported to the Registered Provider. Planned date of completion 30th August 2019.
• Psychotropic medicines management and administration training has been planned for October 2019
Proposed Timescale: 30/10/2019

Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
All staff had not completed safeguarding training.

4. Action Required:
Under Regulation 08(2) you are required to: Ensure staff are trained in the detection and prevention of and responses to abuse.

Please state the actions you have taken or are planning to take:
The inspector has reviewed the provider compliance plan. The actions proposed to address the regulatory non-compliance does not adequately assure the office of the chief inspector that the actions will result in compliance with the regulations.

Actions completed:
• Three dates for Safeguarding training facilitated by the Safeguarding team has been planned for September 2019, dates to be finalised.

Actions to be completed by: 30th October 2019
• All staff will have completed safeguarding training. Planned date for completion, 30th September 2019.
• All staff personnel files will be audited to determine compliance with mandatory safeguarding training. This will be evidenced in the training matrix. Planned date for completion, 30th October 2019

Proposed Timescale: 30/10/2019

Outcome 05: Suitable Staffing

Theme:
Workforce

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Staffing levels required review to ensure that residents assessed needs including their assessed evacuation needs in the event of an emergency could be met.

5. Action Required:
Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

Please state the actions you have taken or are planning to take:
The inspector has reviewed the provider compliance plan. The actions proposed to address the regulatory non-compliance does not adequately assure the office of the
chief inspector that the actions will result in compliance with the regulations.

Actions completed:
• Following revision and evaluation, Standard Operating Procedure for, “Allocation of Staff according to Occupancy and Dependency levels for Older Person’s Services in CHO3 Area” (2019), has been issued and discussed with all staff at the shift to shift handover, daily safety pause and via email correspondence.
• An additional staff member has been assigned to night duty to ensure safe evacuation of residents based on fire drills completed which encompasses size and layout of the designated centre.
• All staff have attended Fire Safety training and the Training Matrix now reflects full compliance.
• Fire evacuation drill by Fire Safety Training Manager was carried out on 8th August 2019.
• A fire drill report has been completed by the Fire Safety Training Manager and submitted to the Regulatory Authority.

Evacuation and fire drills.
• Daily fire drills have taken place for a period of time since 11th July 2019 to test fire evacuation procedure
• Learning has been identified from carrying out regular drills and actioned to improve procedure.
• All residents can be safely evacuated to a safe zone.
• PEEPs for all residents have been updated.

Number of staff on duty
• Daily review of rosters takes place to ensure that there are adequate staffing levels at all times to ensure safe evacuation of residents. The Person in Charge is informed if staff are unable to attend for work unexpectedly e.g. sick leave. The Person in Charge arranges for cover via agency or staff members that are available.
• Dependency levels of residents are reviewed three monthly or if their status alters. Their needs are then accommodated accordingly.

**Proposed Timescale:** 22/08/2019

**Theme:**
Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The person in charge was unable to provide evidence of all training provided to staff. The training matrix had not been updated to include all training completed. Some staff had not completed safeguarding training, other staff had not completed MAPA training (management of actual and potential aggression) and some nursing staff had not completed recent medicines management training.

**6. Action Required:**
Under Regulation 16(1)(a) you are required to: Ensure that staff have access to
appropriate training.

Please state the actions you have taken or are planning to take:

**Actions completed:**
- The training matrix has now been updated to include all training which is completed.
- Three dates for Safeguarding training has been planned for September 2019, dates to be finalised.
- Responding to Behaviours that Challenge training programme was arranged for 15th May 2019, five staff members were released to attend.
- The Person in Charge has completed a Post Graduate in Dementia Care, in UL. The Person in Charge provides oversight, direction, knowledge, skills and information sharing to staff, residents and their families. The Person in Charge instils the ethos of a Person Centred approach for caring for people with Dementia and Cognitive Impairment.
- Nursing staff have been requested to complete Medicines Management e-Learning training by 30th August 2019, and issue evidence of certification to the Person in Charge.

**Actions to be completed by:** 30th October 2019.
- All staff will have completed safeguarding training. Planned date for completion, 30th September 2019.
- Psychotropic medicines management and administration training has been planned for October 2019.
- All staff personnel files will be audited to determine compliance with mandatory training. This will be evidenced in the training matrix. Planned date for completion, 30th October 2019.

**Proposed Timescale:** 30/10/2019

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**Outcome 06: Safe and Suitable Premises**

**Theme:**
Effective care and support

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
The 15 single bedrooms did not offer sufficient space for residents and did not comply with the size set out in the National Standards for Residential Care Settings for Older People in Ireland

**7. Action Required:**
Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

**Please state the actions you have taken or are planning to take:**
Actions completed:
Admission criteria in the Statement of Purpose sets out that all residents admitted to the designated centre are needs assessed and the single rooms are only used for those residents that are considered low dependency, and have no need of assistance with healthcare equipment.

Actions to be completed:

Designated Centre’s 50 Bed Replacement Project

The existing facility at the designated centre will be replaced with a new build. The unit, which currently has 27 beds, will comprise of two 25 bed residential unit wards in a two storey block. The current status is that the Planning Permission and Fire Certificate have been submitted. The design team have commenced the detailed design. The completed 50 bed replacement project will meet the National Quality Standards for Residential Care Settings for Older People.

**Proposed Timescale:** 31/12/2021

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

**Theme:**
Safe care and support

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
Fire safety risks had not been assessed and proactively managed.

There were three staff on night duty and the inspector was not assured that they would be able to conduct a safe and effective phased evacuation of the building in the event of fire taking into consideration the assessed evacuation needs of residents.

Fire drills had not taken place to provide assurances that residents could be evacuated safely in a timely manner in the event of fire.

A risk assessment of fire doors had been carried out by a fire safety engineer in December 2018 and had identified a large number of doors to be replaced. This had not been addressed.

The personal emergency evacuation needs of all residents were not up to date and did not always reflect the level of assistance or equipment required.

Risk assessments for individual residents who smoked were not completed consistently.

**8. Action Required:**
Under Regulation 26(1)(a) you are required to: Ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.
Please state the actions you have taken or are planning to take:

The inspector has reviewed the provider compliance plan. The actions proposed to address the regulatory non-compliance does not adequately assure the office of the chief inspector that the actions will result in compliance with the regulations.

Actions completed:

- Fire safety risks have now been assessed and are been proactively managed.

Staffing & Training:

- Following revision and evaluation, the Standard Operating Procedure, “Allocation of Staff according to Occupancy and Dependency levels for Older Person’s Services in CHO3 Area” (2019), has been issued and discussed with all staff at the shift to shift handover, daily safety pause and via email correspondence.
- Daily review of rosters takes place to ensure that there are adequate staffing levels at all times to ensure safe evacuation of residents. The Person in Charge is informed if staff are unable to attend for work unexpectedly e.g. sick leave. The Person in Charge arranges for cover via agency or staff members that are available.
- An additional staff member has been assigned to night duty to ensure safe evacuation of residents based on fire drills completed which encompasses size and layout of the designated centre.
- Weekly fire evacuation drills determine the level of staff that are required to ensure the safety of residents, particularly at night.
- Dependency levels of residents are reviewed three monthly or if their status alters and their needs are accommodated accordingly.

Evacuation and fire drills.

- All staff have attended Fire Safety training and the Training Matrix reflects full compliance.
- Daily progressive horizontal compartmental fire evacuation drills took place from 12 July to 26 July 2019.
- Bi-weekly progressive horizontal compartmental fire evacuation drills have been scheduled from 27 July 2019
- Learning has been identified from carrying out regular drills and actioned to improve procedure.
- Fire evacuation drill by external Fire Training Manager was carried out on 8th August 2019.
- A fire drill report has been completed by the Fire Safety Training Manager and submitted to the Regulatory Authority.
- An update on actions carried out specifically in relation to fire safety was submitted to the Regulatory Authority on 9th August 2019
- All residents can be safely evacuated to a safe zone.
- PEEPs for all residents have been updated.

Integrity of fire rated door sets

- Considerable remedial works have been carried out by Maintenance Dept under the supervision of the Building Services Officer. These works included such as the replacement of intumescent strips, smoke brushes, screws, hinges, signage etc.
- Smoke brushes and intumescent strips have been fitted to all fire doors
- Repairs fully carried out to all doors that required repairs with the exception of doors that require replacing.
• Specific doors have been fitted with drop down fire seals.

Building Services/ Maintenance
• Installed fire detection and alarm system is an L1 system and that there is coverage throughout the centre including the roof spaces.
• Most recent quarterly inspection certs for Fire detection and Alarm System and Emergency Lighting System are available.
• An ETCI Test Report in relation to the Designated Centre has been commissioned and completed.

Residents who smoke:
• Risk assessments for individual residents who smoke have been completed, care plans reviewed, revised and updated accordingly.

Actions to be completed
Fire doors will be reviewed as part of fire risk assessment

Proposed Timescale: 30/04/2020

Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The inspector was not assured about the effectiveness of fire containment throughout the building which could result in uncontrolled fire and smoke spread throughout the premises. A risk assessment of fire doors had been carried out by a fire safety engineer in December 2018 and had identified a large number of doors to be replaced.

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

Please state the actions you have taken or are planning to take:
The inspector has reviewed the provider compliance plan. The actions proposed to address the regulatory non-compliance does not adequately assure the office of the chief inspector that the actions will result in compliance with the regulations.

Actions completed:
Integrity of fire rated door sets
• Considerable remedial works have been carried out by Maintenance Dept under the supervision of the Building Services Officer. These works included such as the replacement of intumescent strips, smoke brushes, screws, hinges, signage etc.
• Smoke brushes and intumescent strips have been fitted to all fire doors
• Repairs fully carried out to all doors that required repairs with the exception of doors that require replacing.
• Specific doors have been fitted with drop down fire seals.
Building Services/ Maintenance

- Installed fire detection and alarm system is an L1 system and that there is coverage throughout the centre including the roof spaces.
- Most recent quarterly inspection certs for Fire detection and Alarm System and Emergency Lighting System are available.
- An ETCI Test Report in relation to the Designated Centre has been commissioned and completed

Residents who smoke:

- Risk assessments for individual residents who smoke have been completed, care plans reviewed, revised and updated accordingly.

Evacuation and fire drills.

- All staff have attended Fire Safety training and the Training Matrix reflects full compliance.
- Daily progressive horizontal compartmental fire evacuation drills took place from 12 July to 26 July 2019.
- Bi-weekly progressive horizontal compartmental fire evacuation drills have been scheduled from 27 July 2019.
- Learning has been identified from carrying out regular drills and actioned to improve procedure.
- Fire evacuation drill by external Fire Training Manager was carried out on 8th August 2019.
- A fire drill report has been completed by the Fire Safety Training Manager and submitted to the Regulatory Authority.
- An update on actions carried out specifically in relation to fire safety was submitted to the Regulatory Authority on 9th August 2019.
- All residents can be safely evacuated to a safe zone.
- PEEPs for all residents have been updated.

Actions to be completed

- Fire doors will be reviewed as part of fire risk assessment.

**Proposed Timescale:** 30/04/2020

**Theme:**

Safe care and support

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**

Fire drill records reviewed did not provide assurances that residents could be evacuated safely in a timely manner in the event of fire particularly at night time. Records reviewed showed that while fire drills were being carried out, there was no recorded evidence of simulated full compartment evacuation fire drills conducted to take account of night time staffing levels and residents evacuation requirements.
10. **Action Required:**
Under Regulation 28(2)(iv) you are required to: Make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and safe placement of residents.

**Please state the actions you have taken or are planning to take:**

**Actions completed:**

**Staffing & Training:**
- Following revision and evaluation, the Standard Operating Procedure, “Allocation of Staff according to Occupancy and Dependency levels for Older Person’s Services in CHO3 Area” (2019), has been issued and discussed with all staff at the shift to shift handover, daily safety pause and via email correspondence.
- Daily review of rosters takes place to ensure that there are adequate staffing levels at all times to ensure safe evacuation of residents. The Person in Charge is informed if staff are unable to attend for work unexpectedly e.g. sick leave. The Person in Charge arranges for cover via agency or staff members that are available.
- An additional staff member has been assigned to night duty to ensure safe evacuation of residents based on fire drills completed which encompasses size and layout of the designated centre.
- Weekly fire evacuation drills determine the level of staff that are required to ensure the safety of residents, particularly at night.
- Dependency levels of residents are reviewed three monthly or if their status alters and their needs are accommodated accordingly.

**Evacuation and fire drills:**
- All staff have attends Fire Safety training and the Training Matrix reflects full compliance.
- Daily progressive horizontal compartmental fire evacuation drills took place from 12 July to 26 July 2019.
- Bi-weekly progressive horizontal compartmental fire evacuation drills have been scheduled from 27 July 2019
- Fire evacuation drill by external Fire Training Manager was carried out on 08 August 2019. Report available upon request.
- An update on actions carried out specifically in relation to fire safety was submitted to the Regulatory Authority on 9th August 2019
- The external Fire Trainer executed a fire drill on the 08 August 2019, to ensure the safe evacuation of all residents from Room 14 through to Room 20 evacuating 11 residents with night time staffing levels of four staff. This area is classified as two full compartments. The fire drill has been submitted to the Regulatory Authority.
- All residents can be safely evacuated to a safe zone.

**Proposed Timescale:** 22/08/2019

**Outcome 08: Governance and Management**
**Theme:**
Governance, Leadership and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
On this inspection the centre was found not to be operating in line with its own statement of purpose. On exploring this situation, the inspector found that the instruction to move outside the statement of purpose resulted in the non compliance detailed under outcome 7: health and safety and risk management. This instruction was issued in the absence of any additional measures to the risks associated with it being put in place.

There were inadequate nursing management supports in place to assist the person in charge in her role. There was no suitable deputising arrangements in place in the absence of the person in charge.

Staffing arrangements and staffing levels required review to ensure that residents assessed needs including their assessed evacuation needs in the event of an emergency could be met.

Staffing levels in the centre had reduced since the previous inspection. There was a cap on the hiring of both nursing and care agency staff. Staff on short term sick leave were not being replaced.

The current staffing levels were not in accordance with those set out in the centre's statement of purpose.

11. Action Required:
Under Regulation 23(a) you are required to: Ensure the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.

Please state the actions you have taken or are planning to take:
The inspector has reviewed the provider compliance plan. The actions proposed to address the regulatory non-compliance does not adequately assure the office of the chief inspector that the actions will result in compliance with the regulations.

Actions completed:

Vacant CNM2 Post:
• Local recruitment campaign for vacant CNM 11 post has already taken place, the interviews yielded no successful candidate for the vacant CNM 11 position in the Designated Centre.
• A further recruitment campaign has taken place; closing date for applications was 12th July 2019. Planned interviews are scheduled to take place on 29th August 2019

Staffing:
• Following revision and evaluation, Standard Operating Procedure “Allocation of Staff according to Occupancy and Dependency levels for Older Person’s Services in CHO3 Area” (2019), has been issued and discussed with all staff at the shift to shift handover, daily safety pause and via email correspondence.
• Daily review of rosters takes place to ensure that there are adequate staffing levels at all times to ensure safe evacuation of residents. The Person in Charge is informed if staff are unable to attend for work unexpectedly e.g. sick leave. The Person in Charge arranges for cover via agency or staff members that are available.
• An additional staff member has been assigned to night duty to ensure safe evacuation of residents based on fire drills completed which encompasses size and layout of the designated centre.
• Dependency levels of residents are reviewed three monthly or if their status alters and their needs are accommodated accordingly.
• Senior staff nurses are available for duty
• The Person in Charge receives support externally from the General Manager, staff of the General Manager office and from a Director of Nursing colleague.
• Monthly governance / business meetings are convened by the General Manager and attended by the Person in Charge.
• Monthly quality, risk and safety meetings are convened by the General Manager and attended by the Person in Charge. The minutes indicate that key aspects of the quality and safety of the service including risk management are reviewed by the senior management team at this forum.
• One to one business meetings are held quarterly between the Provider Representative and the Person in Charge.

Statement of Purpose:
• The Statement of Purpose has been reviewed and updated to reflect the current staffing levels.

Proposed Timescale: 31/10/2019

Theme:
Governance, Leadership and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The findings from this inspection indicate a lack of support and oversight by the Health Service Executive (HSE) senior management team in regard to staffing arrangements and staffing levels in the centre and management of risk and fire safety. It was of serious concern that the systems in place had not appropriately managed these issues.

While there were systems in place to review the quality and safety of care in the centre, the inspector was advised that due to lack of nursing management supports over the past number of months, many quality care audits had not been completed and there had been limited oversight of nursing documentation and care plans.

12. Action Required:
Under Regulation 23(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

Please state the actions you have taken or are planning to take:
The inspector has reviewed the provider compliance plan. The actions proposed to address the regulatory non-compliance does not adequately assure the office of the chief inspector that the actions will result in compliance with the regulations.

Actions completed:

Vacant CNM11 Post:
- Local recruitment campaign for vacant CNM11 post has already taken place, the interviews yielded no successful candidate for the vacant CNM11 position in the Designated Centre.
- A further recruitment campaign has taken place; closing date for applications was 12th July 2019. Planned interviews are scheduled to take place on 29th August 2019.

Quality Care Metrics
- The Quality Care Metrics was completed by 2 external auditors for July 2019. Findings were analysed by the external auditors and feedback report provided to the Person in Charge. A time-lined Quality Improvement Plan has been developed by the Person in Charge and has been reported to the Registered Provider.
- Following the completion of the Quality Care Metrics for July an action plan has been developed by the Person in Charge and communicated to nursing staff.

Additional Audits:
- Monthly Infection Prevention Control Surveillance audits have been scheduled.
- Quarterly review of the Risk Register has been scheduled, with oversight provided by the Quality, Risk and Safety Officer.
- Unannounced Environmental Health Audits have been conducted on a yearly basis.
- Unannounced Medication Management and Administration Audit was conducted on 26th June 2019. A time lined quality improvement plan has been developed and actioned.

Oversight of nursing documentation and care plans:
- Meetings have been held with staff in relation to care planning inconsistencies.
- Each resident has an assigned key nurse who is responsible for the residents individualised care planning and documentation.
- The residents care plan is prepared based on the assessment no later than 48hrs after the resident’s admission to the Designated Centre.
- Following revision and evaluation, a ‘Care Plan Development and Implementation Policy’ (2019), has been issued and discussed with staff nurses at the shift to shift handover, daily safety pause and via email correspondence.
- Care plans are now more detailed and provide guidance for all staff.

Actions to be completed

- The Quality Care Metrics has been scheduled to be completed by 2 external auditors in August 2019. Findings will be submitted to the Person in Charge and reported to the Registered Provider. Planned date of completion, 30th August 2019.

Governance and Leadership Training
- MBTI Training facilitated by NMPDU for the Person in Charge has been scheduled for 16th September 2019.
**Proposed Timescale:** 16/09/2019