



SUMMARY OF HEALTH INFORMATION AND QUALITY AUTHORITY (HIQA) INSPECTION FINDINGS IN DESIGNATED CENTRES FOR OLDER PEOPLE

Inspections completed during November 2018 to February 2019

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1.0 EXECUTIVE SUMMARY

This report by HCI highlights the trends in inspection findings, those being 'Compliant' and 'Not Compliant' as detailed by the Health Information and Quality Authority (HIQA) in reports for residential care settings for older people. The inspections were against the requirements as outlined in the following:

- Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (S.I.No. 415 of 2013).
- Health Act 2007 (Registration of Designated Centres for Older People) Regulation 2015 (S.I.No. 61 of 2015).

HCI completed a review of seventeen (17) randomly selected HIQA Inspection Reports. All inspections were completed during November 2018 to February 2019.

The review highlighted that Regulation 21: Records and Regulation 28: Fire Precautions had findings that carried a Not Compliant Red Risk. Issues identified under these Regulations included:

- Regulation 21: Records (75% Services Not Compliant of the 16 Services reviewed against this Regulation). Issues included:
 - Records were not stored securely.
 - Failure to ensure all staff had a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 and 2016.
- Regulation 28: Fire Precautions (75% Services Not Compliant of the 16 Services reviewed against this Regulation). Issues included:
 - Strong smell of gas from the cooker/oven in the kitchen which required urgent action.

Other areas recognised as requiring improvement included:

- Regulation 23: Governance and Management (94% Services Not Compliant of the 17 Services reviewed against this Regulation). Issues included:
 - Management roles and responsibilities were not clearly defined.
 - Inspectors were not satisfied that the governance arrangements were sufficiently

robust to ensure the service provided is safe, appropriate, consistent and effectively monitored.

- Regulation 9: Residents' Rights (93% Services Not Compliant of the 15 Services reviewed against this Regulation). Issues included:
 - A person-centred approach to care was not observed.
 - Appropriate arrangements were not in place to ensure the rights of residents were respected in relation to privacy, dignity and their ability to exercise personal choice.
 - The language used in some care plans was not appropriate.
- Regulation 17: Premises (87% Services Not Compliant of the 15 Services reviewed against this Regulation). Issues included:
 - The layout and design of the residential home was not fit for purpose.
 - General maintenance of the premises was required.
- Regulation 27: Infection Control (73% Services Not Compliant of the 11 Services reviewed against this Regulation). Issues included:
 - Standard of cleaning within the residential home was not monitored appropriately.
 - Hand hygiene practices were not in compliance with best practice guidelines.
 - The lack of auditing practices could not ensure that infection prevention and control practices were in compliance with best practice and National Standards.
- Regulation 26: Risk Management (70% Services Not Compliant of the 10 Services reviewed against this Regulation) Issues included:
 - Risk management policy and procedure did not contain the requirements of the Regulations.
 - There were inadequate arrangements to identify, assess, mitigate, monitor and report all risks.
 - The risk register was not updated and reviewed on a regular basis.

Enhanced Authority Monitoring Approach Summary of HIQA Inspection Findings in Designated Centres for Older People completed during November 2018 to February 2019

An area of good practice was identified in relation to Regulation 14: Persons In Charge (100% of the 7 services reviewed against this Regulation were deemed compliant).

The following Regulations were not inspected in the reports reviewed and were therefore not included in the analysis:

- Registration Regulation 4 – Application of Registration or Renewal of Registration.
- Registration Regulation 6 – Changes to Information Supplied for Registration Purposes.
- Regulation 25 – Temporary Absence or Discharge of Residents.

2.0 BACKGROUND

Effective from the 1st of January 2018, Health Information and Quality Authority (HIQA) implemented the use of the Enhanced Authority Monitoring Approach (AMA) to the regulation of designated centres. This approach implemented changes to the inspection report format, which now reflects:

- Views of the people who use the service (as provided through resident questionnaires and Inspectors communications on-site with residents).
- Capacity and capability of the Registered Provider to deliver a safe quality service (addresses governance, leadership and management arrangements in the centre and how effective they are in assuring that a good quality and safe service is being provided).
- Quality and safety of the service (addresses the care and support people receive and whether it was of a good quality and ensured people were safe).

Another enhancement includes the risk-rating of regulations deemed Not Compliant within the designated centres. The inspection report format is regulation driven rather than the previous template which presented the findings under outcomes.

The findings of all monitoring inspections are set out under the four (4) Registration Regulations as detailed within S.I.No. 61 of 2015 and the thirty-two (32) Regulations as detailed within S.I.No. 415 of 2013. The number of regulations inspected by HIQA in each residential care setting is dependent on the purpose of the inspection.

The compliance descriptors are outlined as follows:

- **Compliant:** A judgment of compliant means the Registered Provider and/or the Person in Charge is in full compliance with the relevant legislation.
- **Substantially Compliant:** A judgement of substantially compliant means that the Registered 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 judgement of not compliant means the Registered Provider or Person in Charge has not complied with a regulation and that 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 will identify the date by which the Registered Provider must comply. Where the non-compliance does not pose a significant risk to the safety, health and welfare of residents using the services, it is risk rated orange (moderate risk) and the provider must take action *within a reasonable time frame* to come into compliance.

Once a judgement of 'Not Compliant' is made, Inspectors will review the risk to residents and will report on this risk as:

- **Red:** There is a high risk associated with the non-compliance.
- **Orange:** There is moderate risk associated with the non-compliance.
- **Yellow:** There is low risk associated with the non-compliance.
- **Green:** There is no risk.

3.0 AREAS OF GOOD PRACTICE

Table 1 details the Regulation(s) where good practice was identified, i.e. services inspected against the Regulations were deemed fully compliant. Caution is advised when interpreting Table 1 below, as not all of the 17 services reviewed were inspected against each Regulation.

Table 1: Regulations where Good Practice was identified

Dimension	Regulation	No. of Services Inspected against this Regulation of the 17 sample reports
Capacity and Capability	Registration Regulation 7: Application by Registered Providers for the Variation or Renewal of Conditions of Registration	1
	Regulation 14: Persons In Charge	7
	Regulation 22: Insurance	4
	Regulation 32: Notification of Absence	2
	Regulation 33: Notification of Procedures and Arrangements for periods when Person In Charge is absent from the designated centre	1
Quality and Safety	Regulation 20: Information for Residents	4

4.0 RESIDENT FEEDBACK

Resident questionnaires were sent in advance of announced Inspections to allow residents and their representatives to provide feedback regarding living in the residential home. Also, during inspections, HIQA Inspectors, where possible, spoke with residents to discuss their experience of the service.

Overall, the majority of the feedback received within the seventeen (17) reports reviewed was positive. Feedback included:

- **Daily Living/Social Activities:**
 - o A number of residents believed there was not enough activities and the activities which were on offer did not interest them.
 - o A number of residents felt that the range and availability of meaningful activities in the residential home could be improved.
 - o Some residents appreciated the oratory in the residential home.
- **Space/Premises in the Residential Homes:**
 - o Residents felt they did not have enough space to store clothing and belongings as the wardrobes were too small.
 - o Some residents felt their privacy and lack of space made living in multi-occupancy rooms difficult.
 - o Some residents highlighted that the outdoors of the residential home was inaccessible.
- **Identifying a member of staff where issues, concerns or complaints arise:**
 - o Residents communicated that they were aware of who the Person In Charge was and would have no hesitation to make a complaint to them.
 - o Residents knew how to make a complaint and they felt it would be addressed.
 - o Some residents made complaints in relation to the noise from other residents and from staff who were providing care.
 - o A small number of residents said they would inform their family if they were unhappy about anything in the residential home.
- **Food and Nutrition:**
 - o Residents appeared happy with the food and meals they received.
- **Care Provided in the Residential Home:**
 - o The majority of residents communicated that they were happy with the care they received in the residential home.
- **Safety in the Residential Home:**
 - o Residents said they felt safe and well supported in the residential home.

5.0 OVERALL REVIEW FINDINGS

The inspection reporting framework used by HIQA is organised into two dimensions. Dimension 1 focuses on Capacity and Capabilities (detailed in Tables 2 and 3 below) with Dimension 2 focusing on Quality and Safety (detailed in Table 4 below). The tables show the percentage of the Services in compliance, or in breach of, the requirements per Regulation for the 17 reports. Key areas that were deemed Not Compliant are highlighted within the tables.

Table 2: Capacity and Capability – Registration Regulations

Dimension	Regulation	Regulation Description	No. of Services inspected against this Regulation of the 17 samples	Fully Compliant	% of Services Not Compliant	Substantially Compliant	Not Compliant Red	Not Compliant Orange	Not Compliant Yellow
Capacity and Capability	7	Application by Registered Providers for the Variation or Renewal of Conditions of Registration	1	100 %	0 %	0 %	0 %	0 %	0 %

5.0 OVERALL REVIEW FINDINGS Continued...

Table 3: Capacity and Capability

Dimension	Regulation	Regulation Description	No. of Services inspected against this Regulation of the 17 samples	Fully Compliant	% of Services Not Compliant	Substantially Compliant	Not Compliant Red	Not Compliant Orange	Not Compliant Yellow
Capacity and Capability	3	Statement of Purpose	12	58 %	42 %	17 %	0 %	17 %	8 %
	4	Written Policies and Procedures	10	60 %	40 %	0 %	0 %	20 %	20 %
	14	Persons In Charge	7	100 %	0 %	0 %	0 %	0 %	0 %
	15	Staffing	16	50 %	50 %	13 %	0 %	31 %	6 %
	16	Training and staff Development	16	31 %	69 %	31 %	0 %	32 %	6 %
	19	Directory of Residents	5	80 %	20 %	20 %	0 %	0 %	0 %
	21	Records	16	25 %	75 %	6 %	12 %	44 %	13 %
	22	Insurance	4	100 %	0 %	0 %	0 %	0 %	0 %
	23	Governance and Management	17	6 %	94 %	41 %	0 %	53 %	0 %
	24	Contract for the Provision of Services	7	57 %	43 %	43 %	0 %	0 %	0 %
	30	Volunteers	5	60 %	40 %	0 %	0 %	20 %	20 %
	31	Notification of Incidents	10	70 %	30 %	0 %	0 %	20 %	10 %
	32	Notification of Absence	2	100 %	0 %	0 %	0 %	0 %	0 %
	33	Notification of Procedures and Arrangements for periods when Person In Charge is absent from the designated centre	1	100 %	0 %	0 %	0 %	0 %	0 %
	34	Complaints Procedure	15	53 %	47 %	33 %	0 %	7 %	7 %

5.0 OVERALL REVIEW FINDINGS Continued...

Table 4: Quality and Safety

Dimension	Regulation	Regulation Description	No. of Services inspected against this regulation of the 17 samples	Fully Compliant	% of Services Not Compliant	Substantially Compliant	Not Compliant Red	Not Compliant Orange	Not Compliant Yellow
Quality and Safety	5	Individual Assessment and Care Plan	16	31 %	69 %	31 %	0 %	32 %	6 %
	6	Healthcare	14	71 %	29 %	14 %	0 %	15 %	0 %
	7	Managing Behaviour that is Challenging	13	62 %	38 %	15 %	0 %	23 %	0 %
	8	Protection	12	50 %	50 %	17 %	0 %	25 %	8 %
	9	Residents' Rights	15	7 %	93 %	53 %	0 %	33 %	7 %
	10	Communication Difficulties	3	67 %	33 %	0 %	0 %	33 %	0 %
	11	Visits	9	89 %	11 %	0 %	0 %	11 %	0 %
	12	Personal Possessions	6	33 %	67 %	0 %	0 %	67 %	0 %
	13	End of Life	7	29 %	71 %	28 %	0 %	43 %	0 %
	17	Premises	15	13 %	87 %	27 %	0 %	60 %	0 %
	18	Food and Nutrition	9	78 %	22 %	11 %	0 %	11 %	0 %
	20	Information for Residents	4	100 %	0 %	0 %	0 %	0 %	0 %
	26	Risk Management	10	30 %	70 %	20 %	0 %	50 %	0 %
	27	Infection Control	11	27 %	73 %	0 %	0 %	64 %	9 %
	28	Fire Precautions	16	25 %	75 %	19 %	6 %	50 %	0 %
	29	Medicines and Pharmaceutical Services	8	50 %	50 %	25 %	0 %	12 %	13 %

6.0 DETAILED FINDINGS

The following provides examples of the 'Not Compliant' findings (including 'Not Compliant Yellow, Orange and Red') and 'Substantially Compliant' findings as detailed within the HIQA Inspection Reports under each of the report dimensions. The numbers in brackets following the finding, e.g. (2) detail the frequency of the finding across the services inspected.

Dimension 1: Capacity and Capability

Regulation 3: Statement of Purpose

(42% of Services Not Compliant of the 12 assessed against this Regulation)

- **Not Compliant Orange:**

- Statement of Purpose:

- The Statement of Purpose required review as it did not contain all the information as set out in Schedule 1 of the Regulations, including:
 - The identity of the Registered Provider.
 - The reporting structure within the organisation to assist residents and family when reading this information booklet.
 - An accurate description (either in narrative form or a floor plan) of the rooms in all parts of the residential home including their size and primary function.
 - The criteria used for admissions to the residential home, including the residential home's policies and procedures (if any) for emergency admissions.
 - The total staffing complement, in whole time equivalents, for the residential home with the management and nursing complements.
 - The emergency procedures in the residential home.
 - The arrangements made for consultation with, and participation of, residents in the operation of the residential home.

- The service provided did not reflect the aims, objects and philosophy of person-centred advocated in the Statement of Purpose evidenced by the degree of institutional practices observed.
- The Statement of Purpose stated that all practices were to be informed by policies, procedures and guidance, whenever possible. A qualified commitment to adhering to the policies and procedures was not in compliance with Regulation 4 which states that matters set out in Schedule 5 are adopted and implemented.
- Some information included in the Statement of Purpose did not protect specific residents' privacy and dignity.
- Information on complaints management required review as the Office of the Chief Inspector does not have a role in responding to individual complaints

- **Not Compliant Yellow:**

- Statement of Purpose:

- The Statement of Purpose did not contain all the information set out in Schedule 1 of the Regulations. The information did not reflect the current status of the residential home, for example, staffing levels described the residential home as having a half a post specifically for activities when in fact there were eight hours a week allocated.

Regulation 4: Written Policies and Procedures

(40% of Services Not Compliant of the 10 assessed against this Regulation)

- **Not Compliant Orange:**

- Written Policies and Procedures:

- Schedule 5 policies were not signed off as read by staff or approved by the Person In

6.0 DETAILED FINDINGS Continued...

Charge and Registered Provider.

- Policies were not consistently implemented in practice. For example, policies on the end of life, use of restraint, recruitment of staff and volunteers, and staff training and development were not implemented in full.
- The Management Team were in the process of upgrading the policies and procedures.

• **Not Compliant Yellow:**

○ Written Policies and Procedures:

- The residential home was not following their own policy on safeguarding, incident reporting and care planning.
- Policies and procedures required under Schedule 5 of the Regulations were in the process of being updated, however, this process had not been completed.

Regulation 15: Staffing

(50% of Services Not Compliant of the 16 assessed against this Regulation)

• **Not Compliant Orange:**

○ Staffing:

- A review of staff numbers, skill mix and allocation were required to ensure the needs of residents were met in a person-centred manner and the social care needs of residents who are unable to participate in group activities provided were met (2).
- The number of vacancies was unclear on the day of the inspection.
- Residents' and staff told the Inspectors there were not enough staff to take residents out as normal.
- Staffing levels did not reflect those described in the residential home's Statement of Purpose.
- A part time activities person had been recruited to work eight hours per week in the residential home but was on leave for

over a month with no replacement.

- Inspectors were informed that the residential home were utilising their own staff to cover vacancies and were not currently using agency staff. The residential home's staff were working extra hours to cover vacancies and leave in order to provide continuity of care. According to the rosters viewed two staff were rostered to work an average of just over 62 hours and 63 hours respectively over a four-week period.
- Supervision of residents with high dependency needs in the communal sitting room on the ground floor required improvement.
- Cleaning staff were rostered from Monday to Friday and there was no designated cleaning staff at weekends. Responsibility for cleaning at weekends fell upon care staff in addition to their care and support duties.
- The staffing arrangements in place in the residential home were not appropriate to meet the care needs and dependency levels of residents. Inspectors observed that residents were sitting in the sitting room for most of the day unsupervised.
- Other indicators that staffing levels were not adequate included:
 - The Person In Charge did not have sufficient time to carry out management duties as she was the only registered nurse on duty on the days she was working.
 - The nursing roster comprised of a variety of nurses working a minimum of 7 and a maximum of 20 hours per week, an arrangement which was seen to adversely impact on continuity of care.
 - There was no dedicated cleaning, laundry or activity staff employed. Care staff were engaged in laundry, kitchen, catering, activities and cleaning duties on any given day.
 - The chef was only on duty from 10.00am to 2pm each day.
 - Activities were scheduled to be provided by a person from the community who had not been available for six months.

6.0 DETAILED FINDINGS Continued...

- Some records required and maintained by staff were unreliable and this was attributed to a lack of available time to complete records.

Regulation 16: Training and Staff Development

(69% of Services Not Compliant of the 16 assessed against this Regulation)

• **Not Compliant Orange:**

○ Training:

- An analysis of all staff members training had not been sufficiently completed or updated since the previous inspection.
- Gaps within staff training were identified and a complete record of training was not known or available for all rostered staff.
- A record of each staff members commencement date, induction, probation and appraisal was not available on all files examined.
- Cleaning staff were not provided with appropriate training for their role.
- Education to ensure best practice relating to cleaning, cleaning products and infection prevention and control relating to cleaning was not facilitated.
- There was no method to determine if learning was understood and implemented in practice.
- Refresher courses to ensure staff knowledge was up to date were not in place, for example, the last documentary evidence for food safety related course for chefs was 2013.
- The Inspector observed staff going in and out of the kitchen and this was not in keeping with food hygiene safety best practice guidelines.
- Appropriate staff supervision was not evidenced:
 - To enable and ensure the safe delivery of

care.

- To ensure practice was in accordance with their policies.
- Ensure residents were protected from institutional practices.
- Not all staff had the required up-to-date training in:
 - Fire safety.
 - Moving and handling.
 - Infection prevention and control.
 - Food hygiene.

• **Not Compliant Yellow:**

○ Training:

- A review of staff supervision was required to ensure care was consistently delivered in line with the Statement of Purpose. The Inspector observed staff supervision at mealtimes would improve outcomes for residents.

• **Substantially Compliant:**

○ Training:

- Staff were not appropriately supervised to ensure the training received was then put into place. For example, the supervision of the quality of cleaning.
- A number of staff numbers had yet to attend the updated medication management training.
- Staff appraisals for 2018 had not been completed due to a reduction in nursing management support.
- Supervision of staff at weekends was found to be inconsistent.

6.0 DETAILED FINDINGS Continued...

Regulation 19: Directory of Residents

(20% of Services Not Compliant of the 5 assessed against this Regulation)

- **Substantially Compliant:**

- Directory of Residents:
 - Some improvement was required to the Directory of Residents as there were some minor gaps noted in the information required by the Regulations.

Regulation 21: Records

(75% of Services Not Compliant of the 16 assessed against this Regulation)

- **Not Compliant Red:**

- Schedule 2, 3 & 4 Documents:
 - The Registered Provider failed to ensure all staff had a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 and 2016 available for inspection. In the absence of the required documentary proof of vetting, the Registered Provider was issued with an immediate compliance plan in this regard. A response was received which was accepted by the Inspector (2).
 - Available records were not stored securely in the residential home. For example, the Inspector observed that resident files held in one communal room were not securely locked.

- **Not Compliant Orange:**

- Schedule 2, 3 & 4 Documents:
 - There were no individual resident

assessments or care plans for residents who needed support with moving and handling manoeuvres. In the sample of care files reviewed, some assessments were not at quarterly intervals as required.

- Weekly checks to assess if the fire detection and alarm system were operating effectively were not carried out.
- A record of all correspondences in relation to each resident's care was not available or held in the residential home, as required.
- The Inspector noted there was a staff member rostered and had previously worked in the residential home prior to a declaration of Garda clearance being obtained.
- Some documents were missing, it was not known where these documents were located.
- An Bord Altranais nurse registration personal identification numbers were not in place for two nurses.
- The nurse signature list dated from 2012 contained names of several nurses who had left the residential home. As a result, it was impossible to tell the current nurse complement.
- Controlled drugs records were not maintained in line with best practice professional guidelines to ensure the safety of residents and mitigate the potential for errors.
- Inspectors found that not all documents in respect of each staff member as required by the Regulations were in place in the sample of staff files examined.
- The records of emergency evacuation drills seen by Inspectors lacked detail and as such did not provide sufficient assurances regarding staffing resources available to safely evacuate residents in the event of an emergency, especially at night when there was less staff on duty.
- A record of visitors had not been maintained by the residential home.
- Not all medication incidents were recorded as errors, for example, when a syringe driver containing medicines had been interfered

6.0 DETAILED FINDINGS Continued...

with by a resident.

- Records required as listed in Schedules 2, 3 and 4 were not comprehensive. For example:
 - A vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 was not in place for some staff members (Schedule 2).
 - Drug administration records were incomplete in the sample reviewed, so it could not be determined whether residents had received their prescribed medication.
 - Medication errors were not recognised as such and so they were not recorded (Schedule 3).
 - Lack of a full employment history of staff recruited (3).
 - The actual commencement date of staff members.
 - No job description available.

• **Not Compliant Yellow:**

○ Schedule 2, 3 & 4 Documents:

- Records of each fire practice, drill and test of fire equipment were incomplete.
- The records of simulated emergency evacuation drills completed lacked sufficient detail to provide assurances that residents could be safely evacuated in the event of a fire in the residential home. For example, the records were inconsistent regarding the staffing resources, location of the simulated fire, area evacuated, time taken to complete evacuation and any areas identified as needing improvement.
- Some improvements were required in relation to documents required to be obtained for members of staff prior to recruitment. From a sample of staff files reviewed, not all files contained two written references, including a reference from the person's most recent employer. Additionally, not all CVs included explanations for gaps

in employment.

- The Registered Provider and Person In Charge were requested to revise the planned roster to reflect any changes to the actual hours worked by staff.

Regulation 23: Governance and Management

(94% of Services Not Compliant of the 17 assessed against this Regulation)

• **Not Compliant Orange:**

○ Management:

- The arrangements for the governance and administration oversight for the residential home required improvement.
- Formal and minuted meetings with staff and between management were described as infrequent but occurring occasionally. This did not assure the inspector that robust governance and management arrangements were in place.
- Adequate resources were not provided to ensure the effective delivery of care in accordance with the Statement of Purpose and to implement the residential home's policies. Gaps were found within staff recruitment, appraisal and training, and in the arrangements to manage risk, maintain records, agree and implement policies and in the communication systems.
- The lines of authority and accountability required review and improvement to ensure residents' safety and welfare. For example, staff and volunteers worked in the delivery of direct care and support to residents in the absence of a record of Garda Clearance and without confirmation of appropriate training.
- Issues with the roles and responsibilities not being clearly defined and outlined in relation to numerous staff in acting positions:
 - Interim governance and management arrangements in place did not empower

6.0 DETAILED FINDINGS Continued...

local managers with the necessary authority to effect the substantive cultural change required in the residential home.

- The new management systems put in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored required further implementation.
 - Regular formalised management meetings between the general manager and the Person In Charge and management team had not happened since the previous inspection and these are required to be recommenced.
 - A detailed governance and management plan clearly identifying roles and responsibilities was required to be submitted to the office of the Chief Inspector.
 - There has been a repeated failure to take all necessary action to improve the privacy and dignity of residents.
 - There was a lack of involvement of and oversight by senior managers in plans to address both of the above issues.
 - There were findings of repeated regulatory non-compliance over three inspections.
 - The inspector was not assured that there was sufficient supervision and oversight by management in the area of infection control practices.
 - The management team were unsure as to how many vacant posts existed.
 - Systems were in place to monitor clinical aspects of care and included key performance areas such as falls, restraint, and pressure sores. There were areas of care and day to day operational management that were not being consistently or effectively monitored, therefore quality improvements were not reliably informed.
 - There was insufficient management oversight of the following areas:
 - Care planning.
 - Notifications.
 - Complaints management.
 - Records management.
 - Governance and management communication.
 - Audit and quality improvement.
 - Supervision of staff out of hours and on weekends.
 - The managements systems in place did not ensure that the service provided was safe, appropriate, consistent and effectively monitored as evidenced by:
 - Delays in addressing identified fire safety issues.
 - A failure to take all necessary action to improve the privacy and dignity of residents.
 - A lack of involvement of and oversight by senior managers in plans to address both of the above issues.
 - Findings of repeated regulatory non-compliance over four inspections.
 - The arrangements for management support in the absence of the assistant Person In Charge had not been clarified.
 - Due to staffing vacancies, the roles and responsibilities of vacant positions had been reassigned. During this inspection, Inspectors were not satisfied that the residential home had sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.
 - Arrangements were not in place to ensure an effective and regular cleaning routine was in place to maintain appropriate hygiene standards.
 - There was a lack of oversight to ensure the premises was kept in a good state of repair.
- Annual Review:
- An annual review completed had not been prepared in consultation with residents (2).
 - The Person In Charge sought feedback and established the satisfaction levels of residents or their relatives within a survey. However, there was no analysis, action or quality improvement plan described or developed as a result.
 - The annual review of the quality and safety

6.0 DETAILED FINDINGS Continued...

of care delivered to residents to ensure that such care was in accordance with relevant standards set by the Authority under Section 8 of the Act was not undertaken in accord with the National Standards.

○ Audits:

- An improvement plan as a result of all audits was not evident to ensure adequate resources were provided for an effective service in line with the residential home's policies and Statement of Purpose.
- Action plans to address deficits found were not consistently developed. Therefore, the system in place was not informing a continuous quality improvement process. For example, infection prevention and control audits were completed every three months but were not picking up on the non compliant findings.

Regulation 24: Contract for the Provision of Services

(43% of Services Not Compliant of the 7 assessed against this Regulation)

Substantially Compliant:

○ Contract of Care:

- The contracts of care for residents in shared bedrooms did not identify the bedroom occupancy of residents.
- The contract of care did not specify the number of other residents, if any, of that bedroom.
- The contract of care did not identify the room to be occupied by the resident.

Regulation 30: Volunteers

(40% of Services Not Compliant of the 5 assessed against this Regulation)

• Not Compliant Orange:

○ Volunteers:

- A sample file reviewed did not contain a suitable written agreement and official Garda vetting clearance document.

• Not Compliant Yellow:

○ Volunteers:

- Volunteers attended the residential home and enhanced the quality of life of residents living there. Roles and responsibilities were not set out in writing for some volunteers and vetting disclosures were not available.

Regulation 31: Notifications of Incidents

(30% of Services Not Compliant of the 10 assessed against this Regulation)

• Not Compliant Orange:

○ Notification of Incidents:

- Institutional practices were not recognised, and notifications were not submitted in accordance with the Regulations.
- Notifications required to be submitted to the Office of the Chief Inspector in relation to injuries requiring medical attention were not submitted as required.

• Not Compliant Yellow:

○ Notification of Incidents:

6.0 DETAILED FINDINGS Continued...

- Two incidents that require notification to the Chief Inspector within three working days as per Schedule 4 had not been submitted.
- Quarter three notifications as set out in Schedule 4 had not been submitted to the Chief Inspector in the time frame required. The residential home did not have a copy of the notifications they stated were sent to the Office of the Chief Inspector and were unsure of what had actually been sent.

Regulation 34: Complaints Procedure

(47% of Services Not Compliant of the 15 assessed against this Regulation)

• **Not Compliant Orange:**

○ Complaints:

- A 'complaints, concerns and compliments' log was maintained in the residential home, with the majority of issues raised with staff being recorded as concerns. However, inspectors found that the complaints policy did not refer to concerns, and therefore a formal process had not been set out for managing such items. Inspectors noted that details of concerns were recorded, as well as any action taken, but records did not consistently include the date of resolution or the satisfaction or dissatisfaction of the complainant with the outcome of the complaint.

• **Not Compliant Yellow:**

○ Complaints:

- There were no complaints recorded for 2018, however, residents told Inspectors they had made complaints. The Registered Provider acknowledged that issues had been reported but did not see these as complaints as they had been dealt with at the time.

• **Substantially Compliant:**

○ Complaints:

- The recording of the investigation, actions taken and the satisfaction or otherwise of the complainant were inconsistently recorded.
- There was no trending of complaints for patterns or trends.
- The complaints policy and procedure and the notice outlining the procedure for making complaints required review as they did not adequately outline the independent appeals process.

6.0 DETAILED FINDINGS Continued...

Dimension 2: Quality and Safety

Regulation 5: Individual Assessment and Care Plan

(69% of Services Not Compliant of the 16 assessed against this Regulation)

• **Not Compliant Orange:**

○ Care Plans:

- The sample of assessments and care plans viewed showed that these were not comprehensively completed or updated in a timely manner as set out in the Regulations (3).
- Improvement was needed in relation to the level of detail within care plans following assessments, changes in conditions and recommendations by Allied Health Care Professionals.
- The dates of assessment outcomes and the specifics of the interventions or measures agreed or decided were not consistently reflected or updated. For example, changes in a diabetic medicine regime and diet, and decisions regarding active or comfort measures agreed were not adequately reflected in the sample of residents' care plans reviewed.
- Further development was required as the care plans were not person centered. The Inspector reviewed multiple care plans and found standard statements that featured in all care plans.
- The guidance in a number of the care plans was not related to the issue identified. For example, the guidance on a care plan for the management of a residents hearing impairment was to give medication as prescribed. There was no medication charted in the medicines record for hearing impairment.
- There was poor evidence that care plan reviews are conducted every four months

and done in consultation with the resident. The Inspector found multiple examples of care plans that had not been reviewed since June 2018.

- The Inspector reviewed a care plan of a resident that had been admitted to the acute hospital. There was no reassessment of need on return to the residential home.
- Information gleaned on assessments did not always inform risk assessments, consequently, the degree of risk associated with the resident and their care needs was under-scored. This had the potential to negatively impact quality of care and quality of life of residents.
- While there was a monthly weight chart for each resident, weights were not done routinely even though this would inform care and support. For example, some residents were on significant cardiac support medication and oversight of their weight could inform care and possibly improve outcomes for residents.
- Dementia care plans were not updated following incidents of challenging behaviour. Furthermore, incidents of challenging behaviour were not supported by records of behavioural support to enable learning and possibly mitigate recurrence of behaviours.

• **Not Compliant Yellow:**

○ Care Plans:

- Care plans did not contain enough information to guide staff on how to care for individuals' complex needs.
- Some residents' files did not contain any information on residents' end of life care needs and one 'Do not resuscitate' order was located in a separate file and signed by the resident's next of kin.
- Some individual care plans contained two different care plan formats and it was not clear which format was to be followed to guide staff.
- Some care plans were not dated.
- Recommendations made by the MDT were

6.0 DETAILED FINDINGS Continued...

not consistently recorded in the care plan to guide staff on changes to the resident's needs.

Regulation 6: Healthcare

(29% of Services Not Compliant of the 14 assessed against this Regulation)

• Not Compliant Orange:

○ Healthcare:

- Residents did not have appropriate access to a General Practitioner (GP). For example, within one file the last recorded entry by a medical practitioner was March 2017.
- Medication management was reviewed, and documentation and practice showed the drug administration records were set out in a way that facilitated staff to dispense from the pharmacy sheet rather than from the prescription. This was not in keeping with best practice professional guidelines.
- The medication administration folder contained a lot of documents, some of which were obsolete, and others needed updating to ensure they contained information that was current.

Regulation 7: Managing Behaviour that is Challenging

(38% of Services Not Compliant of the 13 assessed against this Regulation)

• Not Compliant Orange:

○ Bedrails:

- The Inspector confirmed the provision of alternative equipment such as ultra-low or low-low beds was limited to 15% of beds available in one unit which likely attributed to the continued high level of bedrail usage

by 60% of residents.

- A small number of residents had bed rails in place at night-time. Improvements were required in relation to the use of bed rails. For example:
 - Bed rails were in place for one resident when the risk assessment indicated that they were not appropriate.
 - A review was required of the bed rail risk assessment tool to ensure that it supported the assessor to make an objective decision of the risks associated with bed rail usage.
 - A review was required of bed rails to establish that they complied with relevant guidance in relation to safety.

○ Documentation:

- The documentation in place did not guide care. Observations made by the Inspector indicated that residents did not receive care that supported their physical, behavioural and psychological well-being.

○ Restraint:

- Staff had not received up to date training to update their knowledge and skills appropriate to the use of restraint.
- The Management Team did not ensure that, where restraint is used, that it is only used in accordance with the national policy.

• Substantially Compliant:

○ Care Plans:

- It was not clear what alternatives to restraint were trialled before the restraint was applied to residents.

6.0 DETAILED FINDINGS Continued...

Regulation 8: Protection

(50% of Services Not Compliant of the 12 assessed against this Regulation)

• Not Compliant Orange:

○ Safeguarding:

- There was insufficient evidence to confirm that all staff had received training in relation to the detection and prevention of and responses to abuse.
- Training in relation to the detection and prevention and responses to abuse had not resulted in improved outcomes for residents. This lack of protection was evidenced in the exposure of residents to institutional practices on a daily basis.
- The Registered Provider was requested to review banking arrangements for residents for whom they were pension agents to ensure they were in compliance with Department of Social Protection guidance.

• Not Compliant Yellow:

○ Safeguarding:

- One recent incident of peer to peer abuse was not responded to appropriately. The residential home failed to follow its own policy on recognising and responding to incidences of abuse. The residential home failed to inform the office of the Chief Inspector and other appropriate agencies. While steps had been made to prevent a recurrence there was no evidence of an internal incident report or investigation.

Regulation 9: Residents' Rights

(93% of Services Not Compliant of the 15 assessed against this Regulation)

• Not Compliant Orange:

○ Privacy and Dignity:

- Institutional practices were observed throughout the inspection and following review of care documentation.
- Inspectors observed some normal human interactions that respected people's human rights; however, this was not always seen. Some staff members showed kindness, offered choice, while others performed their duties in a perfunctory manner.
- Inspectors observed that just four residents came to the dining room for their lunch, all other residents had their meal either in bed or by their bedside.
- Some residents were not assisted with their meal in a respectful manner.
- Residents were impacted on by noise from other residents.
- Residents' dignity could not be protected when receiving intimate care in the multioccupancy room where their only privacy protection was a curtain.
- Language used in care plans was not appropriate to older adult care, for example, the use of "nappy", "bibs" and "patients" was not dignified to residents who were living in the residential home as their home.
- The Inspectors identified a number of areas where residents' rights continued to not be upheld:
 - The use of multi-occupancy rooms for up to seven residents did not support the receipt of personal care and communication in a manner that protected privacy and dignity. Privacy screens provided visual protection but did not adequately protect the privacy of residents in relation to the conduct of personal activities and communication. These screens provided little or no protection from the noise and odours that a resident might experience in multi-occupancy accommodation.
 - Residents were limited in their choice of bedroom due to a lack of private accommodation available.
 - Residents were limited in their choice of

6.0 DETAILED FINDINGS Continued...

sitting area during the day due to a lack of communal space available.

- As there was not enough dining space on all units, residents on those units did not always have choice in dining areas.
- Residents were unable to receive visitors in private and the rights of other residents to privacy was not respected when visiting took place in the multioccupancy rooms.
- The residential home has failed to carry out a comprehensive review of occupancy levels to inform the profile and number of residents who could appropriately be accommodated in the residential home.

○ Activities:

- A review of the activities programme had not been completed to enable change and improve outcomes for residents.
- There appeared to be an over-reliance on the activities coordinator to socially engage with residents.
- There were no dedicated hours or staff allocation to the co-ordination of activities which led to inconsistent documentation.
- Significant improvements were required in relation to the provision of activities for residents, including access to amenities and activities in the community.

• **Not Compliant Yellow:**

○ Activities:

- Opportunities for some residents to participate in activities was limited due to current staffing levels. Residents who normally went out for shopping or a walk were not going out as often as they usually did due to reduced staffing levels.

○ Resident Involvement:

- The minutes of a recent resident meeting were not available for inspectors to view.

Regulation 10: Communication Difficulties

(33% of Services Not Compliant of the 3 assessed against this Regulation)

• **Not Compliant Orange:**

○ Communication Difficulties:

- Records and information in relation to communications and a meeting held between external professionals and parties with a resident's representatives were not available. The resident or a staff member involved in the resident's care planning had not attended case review meeting/s and the rationale for this was unclear.

Regulation 11: Visits

(11% of Services Not Compliant of the 9 assessed against this Regulation)

• **Not Compliant Orange:**

○ Visits:

- Inspectors noted that many visitors continued to visit residents in the multi-occupancy bedrooms as there were limited private or communal rooms for visiting. These visiting arrangements did not promote or protect the dignity of the residents in the other beds who may require personal care or be trying to sleep/rest watch television while visitors were in their bedroom.

6.0 DETAILED FINDINGS Continued...

Regulation 12: Personal Possessions

(67% of Services Not Compliant of the 6 assessed against this Regulation)

- **Not Compliant Orange:**

- Storage of Personal Belongings:

- There was a lack of storage space in the multi-occupancy bedrooms for residents to adequately store their clothes or personal memorabilia (5). Residents used the following to store personal belongings:
 - The clothing of one resident was stored on the only chair beside their bed space.
 - Some personal possessions were stored in bags and on chairs.
 - Residents were unable to personalise and decorate their surroundings with mementos and photographs in keeping with a homely environment (2).
 - Some residents did not have access to independently locked rooms located outside their living space where their clothes were stored.

Regulation 13: End of Life

(71% of Services Not Compliant of the 7 assessed against this Regulation)

- **Not Compliant Orange:**

- End of Life Care:

- Residents' with advance care directives did not have an end of life care plan, and a care plan for all had not been developed within three months of a resident's admission in accordance with the residential home's policy.
 - The location preferences for all residents had not been explored or assessed and reflected in a relevant care plan. For example, a resident's preference for a single

bedroom when approaching end of life was not assessed or determined.

- There were not enough single rooms in the residential home to facilitate residents to have privacy at end stage of life.
- There were no suitable facilities available for families to spend time alone with residents as they approached end of life. Residents told inspectors how difficult it was when another resident was at end stage of life in their room.
- Residents who were receiving end of life care in the multi-occupancy bedrooms and their families were not offered a choice or the option of a single bedroom for the provision of their end of life care.

Regulation 17: Premises

(87% of Services Not Compliant of the 15 assessed against this Regulation)

- **Not Compliant Orange:**

- Premises:

- The layout of some bedrooms and hairdressers room required attention.
 - There was inadequate protection in the smokers' shelter, insufficient storage in some kitchenettes, flooring and paintwork all required consideration to ensure the premises was in compliance with Schedule 6 of the Regulations.
 - The provision of a secure outdoor garden/courtyard area was in progress. Presently, however, residents did not have free access to a safe outdoor area.
 - Some areas of the residential home fabric were in need of repair and painting.
 - The Inspector observed a passenger lift to be very busy especially during mealtimes and queues were formed on occasions outside the lift. Some residents were observed to encounter prolonged delays in gaining access to the lift.

6.0 DETAILED FINDINGS Continued...

- The ramps on the corridor on the ground floor of the residential home had handrails fitted on one side only. This presented a potential risk to the safety of residents.
- Sufficient grab rails were not fitted in all showers and unstable frames were placed over toilet bowls in the absence of appropriate grab rails.
- There were insufficient storage facilities for hoists and some residents' assistive equipment and used laundry skips. This equipment was stored in a toilet/shower that was used by residents on the day of inspection.
- While the premises were homely and comfortable, there were several issues identified that required attention:
 - Shower walls and flooring were in a poor state.
 - Some shelving was not varnished so effective cleaning could not be assured.
 - Some twin and multi-occupancy bedrooms had inadequate space to accommodate a comfortable chair alongside residents' bed; others had poor storage for personal possessions.
 - Paint work and grab rails were in a poor state.
 - The carpet was lifting on the corridor which posed a falls risk.
- The following areas were identified as needing improvement:
 - Sluicing facilities were not adequate as there was insufficient space for staff to work. Space for drying or storing cleaned equipment was limited and confined to safely segregate dirty and clean equipment. The sluice area was not secured and therefore unauthorised access to this potentially hazardous area was not controlled.
 - Some showers and toilets did not have suitable grab rails fitted to promote residents' safety and independence.
 - Storage for residents' assistive equipment was not adequate.
 - The communal room on the ground floor, where the more dependent residents

spent their day, lacked sufficient natural light.

- Residents in assisted wheelchairs and with impaired mobility could not access the sitting room and dining room on the ground floor due to the presence of two steps.
- There was no signage available to assist residents with cognitive issues to recognise their own bedrooms or the main facilities.
- There was no designated cleaner's room, laundry room, or sluice in the residential home.
- Mattresses used by residents were observed to be worn and may not provide appropriate pressure relief or comfort for residents.

Regulation 18: Food and Nutrition

(22% of Services Not Compliant of the 9 assessed against this Regulation)

• Not Compliant Orange:

○ Food and Nutrition:

- The Inspector observed the lunchtime experience in dining rooms and within the residential home, the approach and arrangements varied between units. One dining room demonstrated a reasonably positive experience while the other primarily represented institutional and neutral care and support. The Inspector observed the set-up, serving, support and assistance to be primarily task orientated with little quality interaction, meaningful conversation or social engagement. The presence of the hot trolley within the dining room was not appropriate as an accessible adjoining kitchenette for this was available that was accessed from outside of the dining room. The meals being provided from the dining room to other residents that dined in other parts of the unit resulted in staff entering and leaving the main dining room numerous

6.0 DETAILED FINDINGS Continued...

times.

- Some residents in the residential home dined in areas other than in the dining rooms, and the Inspector was not assured that all of these arrangements were person-centred or appropriate. For example, a small number of residents dined in their bedroom by choice, but other residents observed dined along open planned corridors and in day rooms using bed tables required review. A complete review of the dining experience throughout the residential home was required.
- Residents were not aware of the lunch menu options in advance. The options were written on a white board within each dining room for those attending and was difficult to read and understand. For example, the writing was unclear it did not specify the type of 'mince' that was available. The Inspector concluded that the dining experience for all residents required much improvement as a social occasion with adequate systems, planning and means of communication to offer residents opportunities to interact, socialise and engage.

Regulation 26: Risk Management

(70% of Services Not Compliant of the 10 assessed against this Regulation)

• Not Compliant Orange:

○ Risk Management:

- A ramp along the main corridor where there was a change in floor level required clear markings to help identify the change in floor level and to minimise the risk of falls were not in place. This did not form part of the hazard identification and assessment of risks schedule.
- A risk assessment was not carried out to determine if there was suitable equipment

available to alert staff in the event a resident sustained a fall. No risk assessment had been carried out to determine if the seating provided for example for dining met the current assessed needs of residents. There was insufficient equipment available to transport residents if required.

- The risk management policy required review as it did not address all of the requirements of the regulations, such as the unexplained absence of a resident.
- The risk register required review as it was not reviewed and updated regularly. The risk register did not adequately identify control measures that were in place for the risks identified and the impact of control measures on the risk rating.
- The risk register was not dated, and it was not evident that the register was reviewed on an on-going basis. This is supported by findings on this inspection that identified a number of risks, including:
 - The door to the staff changing room was not locked and residents could gain access to personal items in clothing and handbags that could pose a risk to residents with a cognitive impairment.
 - The door to the sluice room was frequently unlocked and there were cleaning chemicals and other items that were a potential risk for residents.
 - The door to a storage room that contained cylinders of oxygen was unlocked.

Regulation 27: Infection Control

(73% of Services Not Compliant of the 11 assessed against this Regulation)

• Not Compliant Orange:

○ Infection Prevention and Control:

- There was an absence of audit of practice which could not provide assurances that

6.0 DETAILED FINDINGS Continued...

infection prevention and control practices were in compliance with best practice and National Standards.

- The Registered Provider failed to ensure that procedures, consistent with the standards for infection prevention and control published by the Authority were implemented by staff. For example:
 - Cleaning staff were routinely used to replace sick leave among care staff resulting in 24 to 48 hour periods without cleaning in the residential home.
 - Residents had unrestricted access to clinical waste bins which contained wound dressings.
 - Lack of advisory signage to demonstrate best practice.
 - The hand-wash sink in the clinical room was inaccessible due to the volume of items stored there.
 - There was inappropriate storage of commodes, hoists and linen trolleys in toilets, shower rooms and bathrooms.
 - One sluice room remained out of order since before July 2018.
 - Cleaning cloths were observed hanging from or lying on hand-wash sinks for an extended period of time.
- Inspectors did not observe good standards of hand hygiene practices by two staff.
- Recent hygiene audits had not captured the areas of concern highlighted by the inspectors.
- The cleaning and sign off sheets had multiple gaps.
- On a walk of the premises with the Person In Charge, Inspectors highlighted multiple surfaces that were in poor state of repair and not conducive to effective cleaning. For example, rusted shelving and commode chairs that could not be properly cleaned. In addition, communal toiletries were found in bathrooms.
- The residential home did not ensure that the procedures and practices for infection control were consistent with good practice standards. For example:
 - There were no systems in place to ensure

equipment used by residents was in a clean and hygienic condition.

- There was no dedicated time allocated to cleaning of the residential home and cleaning schedules were not completed.
- Practices in place to underpin the management of laundry and linen required review including a system for the
 - Segregation of clean and used linen.
 - The washing, drying and storage in line with best practice was required.
 - The waste management system also required attention.

• **Not Compliant Yellow:**

○ Infection Prevention and Control:

- The hygiene auditing process did not consistently improve practice and the standard of hygiene in some areas of the residential home did not reflect best practice standards in infection prevention and control. For example,
 - Some sanitary ware in communal toilets were unclean, the worktop and sink in the sluice room were heavily soiled.
 - Damaged wall tiles and shower seals in a communal/toilet and damaged surfaces on some skirting boards and door frames caused by passing equipment hindered effective cleaning.

Regulation 28: Fire Precautions

(75% of Services Not Compliant of the 16 assessed against this Regulation)

• **Not Compliant Red:**

○ Fire Safety:

- Service records were examined. There was a strong smell gas from the cooker/ oven in the kitchen. The service records for this appliance was dated 21 November 2016 and was due for next review by

6.0 DETAILED FINDINGS Continued...

20 November 2017, but this was not evidenced. This was highlighted as an urgent action during the inspection.

- **Not Compliant Orange:**

- Fire Safety:

- A record demonstrating that the fire safety works were complete to the satisfaction of the fire Authority was not available following a recent review.
- Fire drills were not completed at suitable intervals to provide assurances regarding fire safety management.
- The following non-compliances were present:
 - Deficiencies to some fire doors, examples include doors not closing fully, heat and smoke seals partially missing and gaps around the door.
 - The in-house fire safety checks required review to ensure they were of adequate extent, frequency and detail.
 - The extent, size and location of fire compartments necessary for phased evacuation were not clearly defined on the drawings displayed around the residential home.
 - The Registered Provider had arranged for externally facing door handles to be fitted to exits where staff may be required to assist with evacuation from the outside. On this inspection, the door handles were not capable of opening the exit doors. The panic bolt on the inside of one exit was not functioning correctly and the exit was difficult to open.
- The extent and size of compartments for evacuation was not clear. The Registered Provider had commissioned a fire safety engineer to carry out a review of fire compartments in the residential home. The report referred to guidance which indicated that where four staff were on duty, there should be a maximum of nine residents in a subcompartment. However, the evacuation procedure explained to Inspectors and

detailed in the proposed evacuation strategy did not correlate with the above.

- Timely emergency evacuation for residents was also not assured due to the storage of waste bins and equipment for disposal on the external emergency evacuation route.
- Inspectors found that all gates located on the external emergency escape routes were locked. A key for the gate to a lane at the back of the residential home was located nearby. The keys for the locks on the other gates were held by the nurses on duty.
- A used linen skip and a weighing chair partially obstructed an internal evacuation route.
- Personal emergency evacuation plans (PEEPs) lacked sufficient detail regarding residents' supervision needs post their emergency evacuation.
- The doors to the sluice room and the doors on a storage cupboard opened out into a corridor/evacuation route. These doors did not fully close and were not fire doors. They did not have smoke seals fitted.
- The residential home did not meet the requirements of the Regulations in the following areas:
 - Adequate arrangements had not been made for maintaining all means of escape, building fabric and building services.
 - A designated escape route was impeded by office furniture.
 - Inspection certificates were not available for electrical installation.
 - There were no records in the fire and safety register regarding the maintenance or inspection of fire doors. The Inspector observed that closers had been removed from some doors that were intended to be fire doors.
 - Adequate arrangements had not been made for reviewing fire precautions.
 - There was no documented process in place for identifying and mitigating fire hazards and risks throughout the premises.

6.0 DETAILED FINDINGS Continued...

- The Inspector observed that all necessary evacuation equipment was not provided, and fire zoning notices did not reflect the recently installed fire detection and alarm system.
 - Adequate arrangements had not been made for testing fire equipment.
 - Weekly checks on the operation of the fire detection and alarm system were not being carried out, the alarm log book was incomplete.
 - Inspectors were not assured that people working in the residential home were adequately prepared for the procedure to be followed in the case of fire.
 - The scenarios documented in fire drill reports did not provide assurance that all staff were adequately prepared or resourced for the most demanding evacuation procedures that are likely to be required.
 - It was confirmed to Inspectors that a simulated full evacuation of the residential home has not been carried out using only night time staffing levels (two staff) and procedures.
 - Adequate arrangements had not been made for detecting and containing fires.
 - The certification for the fire detection and alarm system contained a discrepancy regarding the classification of the installed fire detection and alarm system. On some documents it is referred to as an L1 system, and on other documents it is referred to as an L2 system where an L1 system is required.
 - The Inspectors were not assured of the likely fire performance of all door sets (door leaf, frame, brush seals, intumescent strips, hinges, closers and ironmongery), including the recently fitted door leaves and door frames that have been retro fitted with brush seals. The doors intended to perform as fire doors were not fitted with plates or tags confirming their fire performance.
 - The Inspector was not assured that the doors to the sluice room and the hot press or store located along bedroom escape corridors or the door to the staff changing room would achieve their required fire performance.
 - The bedroom accommodation was not compartmented and did not facilitate the phased horizontal evacuation of the residential home. In the event of a fire, the residential home must be completely evacuated.
 - Due to the considerable number of ceiling mounted extractor fans, attic access hatches and numerous unsealed service penetrations, the inspector was concerned about the effectiveness of the ceiling in restricting fire spread through the roof space of the premises.
 - It was observed that some high risk-areas have not been adequately protected from the risk of fire that is to say, ELCB and electrical distribution boards in the office, the linen press in the escape corridor, the kitchen, and the hot press area.
 - Four non fire-rated tall storage presses containing bed linen, towels, and supplies were located along the bedroom escape corridor, presenting an increased fire risk to the only escape route in the bedroom part of the building.
 - The Inspector could not find evidence that the emergency lighting had been serviced as required.
- Training:
- Gaps were identified in relation to fire safety training in the staff training matrix record.
 - A high number of staff were uncertain about the process for the operation and interpretation of the recently installed fire alarm panel.

6.0 DETAILED FINDINGS Continued...

Regulation 29: Medicines and Pharmaceutical Services

(50% of Services Not Compliant of the 8 assessed against this Regulation)

- **Not Compliant Orange:**

- Medication Management:

- There were several gaps in the drug administration records, and it could not be assured that all medicines were administered in accordance with professional guidelines.

- **Not Compliant Yellow:**

- Medication Management:

- Inconsistencies were noted in the records maintained for controlled drugs. Not all medicine which was no longer in use had been returned to pharmacy. Some medicine for “stock” use was labelled with residents’ names. Drug cupboards within the clinic room were not locked.

- **Substantially Compliant:**

- Medication Management:

- The Inspector noted there was a significant amount of stock medications, such as antibiotics, available for out-of-hours use when there was no access to a pharmacy. An adequate record was not maintained of this medication and the Inspector found that at least two containers of antibiotics were past their expiry date.
 - The Inspector noted the maximum dose of medicines to be administered as and when required (PRN) were not consistently recorded.

- The Inspector saw that planned improvements were scheduled including changing the documentation, and systems for returning medications to pharmacy.

7.0 CONCLUSION

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This report illustrates the new layout of the HIQA inspection reports and details the continuing trends in HIQA findings in relation to residential care settings for older people in meeting the relevant requirements.

The trends show that high risk findings are still evident in the area of Records and Fire Precautions, with many residential homes requiring improvements in key areas such as Training and Staff Development, Governance and Management, Individual Assessment and Care Plan, Residents' Rights, Personal Possessions, End of Life, Premises, Risk Management and Infection Control.

Good practice was identified in relation to Information for Persons In Charge.

Further Information

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