HCI

Quality and Safety of Care, Improved

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

Inspections completed during December 2020 to March 2021

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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 twenty-four (24) randomly selected HIQA Inspection Reports. All inspections were completed by HIQA between December 2020 to March 2021.

Table 1 below highlights some of the key findings under the related dimensions and regulations.

Table 1: Summary of Key Not Compliant Findings (S.I.No. 415 of 2013)

Dimension	Regulation	Not Compliant Findings
Capacity and Capability	Regulation 15: Staffing (33% Not Compliant Red and Orange)	Insufficient number of nurses available to allow for unprecedented demands of COVID-19.
Capacity and Capability	Regulation 16: Training and Staff Development (33% Not Compliant Red and Orange)	Training records illustrated gaps in mandatory training requirements.
		Staff were not adhering to the designated centre's policies and procedures such as Infection Prevention and Control.
		Staff with responsibility for completing audits had not received any audit training.
Capacity and Capability	Regulation 23: Governance and Management (50% Not Compliant Red and Orange)	The Registered Provider abdicated its responsibility and was failing in accountability, as required by the Health Act 2007.
		A lack of clearly defined management structure that identified the lines of authority and accountability, specifies roles and details the responsibilities.
		Supernumerary hours were not in place for senior staff.
Capacity and Capability	Regulation 34: Complaints Procedure (19% Not Compliant Orange)	Policies and procedures did not comply with legislative requirements for complaints.
		No evidence of follow up or evidence that the Complainant was satisfied with outcome.
Quality and Safety	Regulation 17: Premises (59% Not Compliant Orange)	The Registered Provider was not providing a premises which conformed to the matters set out in Schedule 6 of the Regulations. The major impact was on daily experience for residents living in the designated centre, for example, the lack of privacy to perform basic care, noise, risk of infection and fire evacuation risks.

Quality and Safety	Regulation 27: Infection Control (46% Not Compliant Red and Orange)	Infection prevention and control practices and protocols in the designated centre were not in line with the HPSC guidance for the Infection Prevention Control Guidelines on the Prevention and Management of COVID-19 Cases and Outbreaks in Residential Care Facilities.
		Insufficient oversight of staff's infection control practices.
		Not all staff had attended up to date training and refresher courses in IPC and a lack of knowledge was evident in practices observed.
Quality and Safety	Regulation 28: Fire Precautions (75% Not Compliant Red and Orange)	The Inspector found staff were insufficiently trained or experienced to manage their roles and responsibilities in relation to fire safety.
		Inspector not assured that the largest compartment could be evacuated in a timely manner.
		Simulated fire drills with nighttime staffing conditions evidenced poor evacuation times.
Quality and Safety	Regulation 29: Medicines and Pharmaceutical Services (28% Not Compliant Red and Orange)	Staff administered medication without a prescription.
		A number of medicines were found to have been transcribed without authorisation, were not transcribed correctly, were not signed by the transcriber or did not detail what route the medicine was to be administered.

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

- Registration Regulation 8 (S.I.No. 61 of 2015) – Annual fee payable by the Registered Provider of a designated centre for older people
- Regulation 19 (S.I.No. 415 of 2013) – Directory of Residents
- Regulation 30 (S.I.No. 415 of 2013) – Volunteers
- Regulation 32 (S.I.No. 415 of 2013) – Notification of Absence
- Regulation 33 (S.I.No. 415 of 2013) – Notification of Procedures and Arrangements for Periods when Person In Charge is Absent from the Designated Centre
- Regulation 25 (S.I.No. 415 of 2013) – 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 Inspector's 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).

The findings of all monitoring inspections are set out under the 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.

3.0 AREAS OF GOOD PRACTICE

Table 2 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 3 below, as not all of the 24 services reviewed were inspected against each Regulation.

Table 2: Regulations where Good Practice was identified

Dimension	Regulation	No. of Services Inspected against this Regulation of the 24 sample reports
Quality and Safety	Regulation 10: Communication Difficulties	3
	Regulation 13: End of Life	3

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 centre. 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 twenty-four (24) reports reviewed was positive. Feedback included:

- **Residents' COVID-19 Experience in the Residential Centre:**
  - Residents were aware of the COVID-19 risks and the precautions they had to take to protect themselves and others.
  - Residents were not moving much as there was no place to go except for a walk to the bathroom. A normally mobile resident informed the Inspector that they have become very stiff and wanted to get back walking again.
  - Some residents were unanimous in their praise for staff in the residential centre.
  - Some residents missed day trips out of the residential centre.

- **Daily Living/Social Activities:**
  - Some residents found the days long and there was little to occupy them.
  - Some residents said that the activity and physiotherapy sessions provided a good diversion during the day when they are available.
  - A resident commented on the poor Wi-Fi and the need for the resident to provide their own internet access as it was not possible to access the residential centre's Wi-Fi from their bedroom.

- **Space/Premises in the Residential Centres:**
  - Some residents said bedrooms were comfortable, clean and well furnished.

- **Food and Nutrition:**
  - Some residents praised the variety and selection of food that was made available to them.
  - Some residents said food was well presented and the dining experience was positive.
  - Some residents said the food in the designated centres was not great and they would like more choice.

- **Care Provided in the Residential Centres:**
  - Some residents were happy with the care provided to them.
  - Staff were observed by Inspectors to be very caring and gentle towards residents.
  - Staff interactions with residents were respectful, appropriate, and meaningful.
  - Some residents were complementary of staff saying that they were excellent, friendly, courteous, and understanding.
  - Some residents said there were occasions where they had to wait for their call bells to be answered.
  - Some residents stated that nighttime staff were very busy and they could be waiting for up to 25 minutes if they needed help.

- **Safety in the Residential Centres:**
  - Residents said they felt safe and well looked after in the residential centre.

- **Identifying a member of staff where issues, concerns or complaints arise:**
  - Residents communicated that they were aware of who to contact if they were unhappy with anything or wanted to make a complaint in the residential centre.
  - Residents were aware of who was in charge in the residential centre.

- **Visiting in the Residential Centre:**
  - Some residents said that visiting restrictions in place due to COVID-19 were difficult for residents, however, they understood the risks associated with visiting.

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 3 and 4 below) with Dimension 2 focusing on Quality and Safety (detailed in Table 5 below). The tables show the percentage of the Services in compliance, or in breach of, the requirements per Regulation for the 24 reports. Key areas that were deemed Not Compliant are highlighted within the tables.

Table 3: Capacity and Capability – Registration Regulations (S.I.No. 61 of 2015)

Dimension	Regulation	Regulation Description	No. of Services inspected against this regulation of the 24 samples	Fully Compliant	Substantially Compliant Yellow	% of Services Not Compliant	Not Compliant Red	Not Compliant Orange
Capacity and Capability	4	Application of Registration or Renewal of Registration	4	75 %	0 %	25 %	0 %	25 %
	6	Changes to Information Supplied for Registration Purposes	1	0 %	0 %	100 %	0 %	100 %
	7	Application by Registered Providers for the Variation or Renewal of Conditions of Registration	2	50 %	0 %	50 %	0 %	50 %

5.0 OVERALL REVIEW FINDINGS Continued...

Table 4: Capacity and Capability (S.I.No. 415 of 2013)

Dimension	Regulation	Regulation Description	No. of Services inspected against this regulation of the 24 samples	Fully Compliant	Substantially Compliant Yellow	% of Services Not Compliant	Not Compliant Red	Not Compliant Orange
Capacity and Capability	3	Statement of Purpose	10	60 %	30 %	10 %	0 %	10 %
	4	Written Policies and Procedures	3	67 %	33 %	0 %	0 %	0 %
	14	Persons In Charge	10	80 %	10 %	10 %	0 %	10 %
	15	Staffing	24	46 %	21 %	33 %	4 %	29 %
	16	Training and Staff Development	24	38 %	29 %	33 %	8 %	25 %
	21	Records	2	50 %	50 %	0 %	0 %	0 %
	22	Insurance	2	50 %	0 %	50 %	0 %	50 %
	23	Governance and Management	24	17 %	33 %	50 %	17 %	33 %
	24	Contract for the Provision of Services	5	60 %	20 %	20 %	0 %	20 %
	31	Notification of Incidents	16	75 %	19 %	6 %	0 %	6 %
	34	Complaints Procedure	21	67 %	14 %	19 %	0 %	19 %

5.0 OVERALL REVIEW FINDINGS Continued...

Table 5: Quality and Safety (S.I.No. 415 of 2013)

Dimension	Regulation	Regulation Description	No. of Services inspected against this regulation of the 24 samples	Fully Compliant	Substantially Compliant Yellow	% of Services Not Compliant	Not Compliant Red	Not Compliant Orange
Quality and Safety	5	Individual Assessment and Care Plan	23	48 %	39 %	13 %	0 %	13 %
	6	Healthcare	23	87 %	9 %	4 %	0 %	4 %
	7	Managing Behaviour that is Challenging	12	67 %	25 %	8 %	0 %	8 %
	8	Protection	10	80 %	10 %	10 %	0 %	10 %
	9	Residents' Rights	20	45 %	30 %	25 %	0 %	25 %
	11	Visits	14	93 %	7 %	0 %	0 %	0 %
	12	Personal Possessions	4	50 %	25 %	25 %	0 %	25 %
	17	Premises	17	6 %	35 %	59 %	0 %	59 %
	18	Food and Nutrition	3	67 %	33 %	0 %	0 %	0 %
	20	Information for Residents	1	0 %	0 %	100 %	0 %	100 %
	26	Risk Management	16	44 %	44 %	12 %	0 %	12 %
	27	Infection Control	24	33 %	21 %	46 %	8 %	38 %
	28	Fire Precautions	16	6 %	19 %	75 %	19 %	56 %
	29	Medicines and Pharmaceutical Services	7	43 %	29 %	28 %	14 %	14 %

6.0 DETAILED FINDINGS

The following provides examples of the 'Not Compliant' findings (including 'Not Compliant Orange and Red') and 'Substantially Compliant' (Yellow) 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

Registration Regulation 4: Application for Registration or Renewal of Registration

(25% of Services Not Compliant of the 4 assessed against this Regulation)

- ***Not Compliant Orange:***
  - Application of Registration or Renewal of Registration:
    - The Registered Provider failed to submit a completed application to renew the registration of the designated centre within the necessary timeline by the Chief Inspector in contravention of section 48(3) of the Health Act 2007 (as amended).

Registration Regulation 6: Changes to Information Supplied for Registration Purposes

(100% of Services Not Compliant of the 1 assessed against this Regulation)

- ***Not Compliant Orange:***
  - Changes to Information Supplied for Registration Purposes:
    - The notification made to the Office of the Chief Inspector regarding the departure of the Person In Charge did not:
      - indicate the name of the new Person In Charge.
      - was not signed by an authorised signatory.
      - the required Schedule 2 information was not supplied in full until a later date.

Registration Regulation 7: Applications by Registered Providers for the Variation or Renewal of Conditions of Registration

(50% of Services Not Compliant of the 2 assessed against this Regulation)

- ***Not Compliant Orange:***
  - Applications by Registered Providers for the Variation or Renewal of Conditions of Registration:
    - The designated centre made an application to vary Condition 1 of its current registration. Inspectors examined the designated centre and found that the area was not fit for the proposed purpose and function, e.g., appropriate privacy and screening for all resident bedrooms were not in place.

Regulation 3: Statement of Purpose

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

- ***Not Compliant Orange:***
  - Statement of Purpose:
    - Management systems in place were not in line with the Statement of Purpose and did not consistently and effectively ensure that the service being provided was safe and appropriate.

6.0 DETAILED FINDINGS Continued...

Regulation 4: Written Policies and Procedures

(33% of Services Substantially Compliant of the 3 assessed against this Regulation)

- ***Substantially Compliant Yellow:***
  - Written Policies and Procedures:
    - Policies were not reviewed and updated in the last three years in line with the Regulations.
    - Polices not reflective of requirements or best practice included:
      - Communication.
      - The creation of, access to, retention of, maintenance of and destruction of records.
      - The handling and investigation of complaints from any person about any aspect of the service, care, support and treatment provided in, or on behalf of a designated centre.

Regulation 14: Persons In Charge

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

- ***Not Compliant Orange:***
  - Persons In Charge:
    - The Person In Charge did not have a post registration management qualification in health or a related field as required by the Regulations.

Regulation 15: Staffing

(33% of Services Not Compliant of the 24 assessed against this Regulation)

- ***Not Compliant Red:***
  - Staffing:
    - The Inspector observed from the roster that there were insufficient nurses to allow for the unprecedented demands of any pandemic related isolation or sickness absence. The Inspector required assurance that:
      - There were sufficient staff on the roster to support day and night duty for seven days of the week.
      - The Registered Provider had to update the contingency plan with staffing arrangements.
      - The current staffing levels at night in the designated centre required review due to the diverse layout of the designated centre and due to additional time required for donning and doffing of PPE at each care interaction for isolated residents.
- ***Not Compliant Orange:***
  - Staffing:
    - The Inspector found that staffing levels and the current skill-mix were not sufficient to meet the assessed needs of residents (2).
    - The Inspectors identified that the skill mix at night time required review as there was only one nurse available after 20:00 hours to administer night time medication and provide nursing care
    - Staffing levels on the roster and as detailed in the designated centre's Statement of Purpose did not ensure that adequate staff resources or an adequate skill-mix was available to ensure that staff in the designated centre could quickly recognise, contain and manage a second outbreak of COVID-19.

6.0 DETAILED FINDINGS Continued...

- The allocation of staff to cleaning duties required review.
- There were insufficient resources to ensure the safe delivery of care in accordance with the aims and objectives of the designated centre's Statement of Purpose. Issues identified included:
    - The allocation of one nurse from 17:00 hours to 08:00 hours to address the nursing needs of the 28 residents accommodated was not adequate to ensure safe good quality care and it did not ensure that, in an outbreak situation, that dedicated staff could be allocated to the area identified for isolation residents suspected or confirmed to have COVID-19 in accordance with the Interim Public Health Infection Prevention and Control on the Prevention and Management of COVID-19 Cases and outbreaks in Residential Care Facilities.
    - A newly recruited nurse was scheduled to work on their own and take charge of the designated centre when the Person In Charge completed their working day.
    - Staffing levels were not sufficient to safely evacuate residents from large compartments when staffing levels were lowest.
    - Staffing allocation for activities required review as the current arrangement was not meeting the occupational and recreational needs of residents in the designated centre.
    - There was an insufficient number of staff on duty to meet the needs of residents. For example:
        - Residents requiring supervision were left unsupervised for long periods of time.
        - Call bells were left ringing for greater than three minutes.
        - No meaningful activities available for the residents as outlined in the designated centre's Statement of Purpose.
        - Residents' assessments and care plans were not completed in line with the designated centre's policies and procedures.
    - Call bell audits did not look at the length of time residents waited when calling for assistance.
    - No records to demonstrate that decontamination cleaning of frequently touched areas was completed after household duty ended.

Regulation 16: Training and Staff Development

(33% of Services Not Compliant of the 24 assessed against this Regulation)

- ***Not Compliant Red:***
    - Training and Staff Development:
        - Observations were made by the Inspector that staff were not implementing the designated centre's policies and procedures and were not consistently adhering to the correct infection prevention and control guidance.
        - Nominated supervisory roles such as the Clinical Nurse Manager (CNM) and their deputy were in place in the designated centre, however, they were working as staff nurses.
        - Staff supervision and comprehensive audit was required in the management of medicines as the relevant policies and professional guidelines were not followed in a sample of records viewed by the Inspector.
- ***Not Compliant Orange:***
    - Training and Staff Development:
        - Training records reviewed found gaps in mandatory training including (3):

6.0 DETAILED FINDINGS Continued...

- Fire Safety
- Manual handling
- Safeguarding
- CPR
- Infection prevention and control

- Training matrix reviewed by the Inspector identified significant gaps in the mandatory training. Areas included:
  - Infection prevention and control
  - Safeguarding vulnerable adults
  - Responding to behaviours that challenge
  - Manual handling
- Training records did not provide evidence that all staff had access to mandatory training.
- Training to support residents who had responsive behaviours were not in place for staff.
- New staff members did not receive training in relation to the emergency procedures in the designated centre.
- The system to monitor and record training was not sufficiently robust and did not allow management to have full oversight of training requirements.
- The Inspector found that there were two days allocated for the formal induction of a new nurse who was assigned to be in charge. This required review to ensure the new nurse had time to complete the range of training required to equip them to safely undertake this responsibility. The two day induction documented on the rota did not ensure they were appropriately prepared to be in charge on their own and respond to a fire situation.
- Training records requested by the Inspector were not readily available.
- Members of the Management Team, who were responsible for completing audits, had not received any audit training.
- Lack of oversight and supervision of staff led to poor practices. For example, cleaning staff were not clear about what were the required procedures for environmental cleaning and decontamination practices.

Regulation 21: Records

(50% of Services Substantially Compliant of the 2 assessed against this Regulation)

- ***Substantially Compliant Yellow:***
  - Schedule 2, 3 & 4 Documents:
    - Improvements were required to ensure staff files were in line with Schedule 2 of the Regulations. The Inspector found some staff files did not include:
      - Written references
      - Full employment history
      - Documentary evidence of relevant qualifications
    - Fire records were not maintained effectively.

Regulation 22: Insurance

(50% of Services Not Compliant of the 2 assessed against this Regulation)

- ***Not Compliant Orange:***
  - Insurance:
    - Insurance polices for the building that accommodated the designated centre and protection against other risks, including injury to residents and loss or damage to resident's property were held by a third party that was not the Registered Provider.

6.0 DETAILED FINDINGS Continued...

Regulation 23: Governance and Management

(50% of Services Not Compliant of the 24 assessed against this Regulation)

- ***Not Compliant Red:***
  - Management:
    - The operational management structure and oversight processes in place in the designated centre were not robust to ensure that safe and appropriate care and services were consistently provided to residents in line with their needs.
    - Clinical oversight required improvement to ensure effective and safe delivery of care.
    - Staff were not appropriately supervised in the management of residents in isolation nor were they made aware of their responsibilities in adhering to the guidelines in the designated centre.
    - There were no measures in place to ensure that staff understood the training, were retrained where applicable and were supervised in applying the training in their daily practice.
    - Staff files were not maintained as required under Schedule 2 of the Regulations by ensuring a reference was available from the previous employer and each curriculum vitae included precise dates of previous employment.
    - Interim arrangements in place to provide safe care and services until the full implementation of the long term refurbishment plan were not fully considered to ensure the designated centre was appropriately resourced to support staff and residents.
    - Management systems required improvement to ensure they were effective and that the service was consistent and appropriately monitored. These included assurances that the policies and procedures were implemented by staff.
  - Audits:
    - The Inspector was not assured that the auditing system was sufficiently robust to identify areas for improvement and was followed up with SMART (specific, measurable, achievable, realistic and time bound) action plans in respect of all relevant areas.
    - Management systems did not cover all areas and did not identify the root cause in that the infrastructural limitations impacted on staff's ability to adhere to correct infection prevention and control procedures. For example, an audit identified that staff were leaving their personal belongings inappropriately, but it did not establish that there were no appropriate facilities for staff to change and safely store personal items or that the arrangement sin place had not been effectively communicated to all staff. The audit did not identify the overall level of risk it posed, and the urgency required to mitigate the risk.
- ***Not Compliant Orange:***
  - Management:
    - There was a lack of clearly defined management structure that identified the lines of authority and accountability, specifies roles and details the responsibilities for all areas of care provision.
    - There was inadequate oversight of the day-to-day operation by the management team. A review of a management meeting showed that neither the Director of Nursing nor the Assistant Director of Nursing were solely responsible for the designated centre both having responsibilities outlined for other parts of the services.
    - As the designated centre was new, some of the management systems were only being commenced and had not been fully implemented. This was evidenced by a lack of effective systems to monitor staff training, fire safety, care planning and residents rights.
    - The 2020 Annual review did not include any

6.0 DETAILED FINDINGS Continued...

residents feedback or a quality improvement plan for 2021.

- Increased oversight was required by the management team in relation to:
    - Fire precautions
    - Ensuring an adequate social programme for residents.
    - Infection control practices.
    - Ensuring staff records were maintained effectively to include all the requirements as per Schedule 2 of the Regulations.
    - Effective monitoring of the service.
- There is a failure on behalf of the Registered Provider to maintain oversight of the quality and safety of care in the designated centre. The Registered Provider abdicated its responsibility and was failing in accountability, as required by the Health Act 2007, for the overall quality and safety of services delivered to residents.
    - The Registered Provider could not evidence consistent participation in management ream meetings and staff meetings.
    - The Registered Provider was not taking any responsibility for staff management issues.
    - The Person In Charge did not report to the Registered Provider.
    - The Registered Provider was no longer providing required resources for the operation of the designated centre. For example:
        - It had not financed the purchase of new equipment such as ski sheets, wheelchairs and fire equipment.
        - Inspector was advised that the Registered Provider did not intend purchasing equipment required to reduce bed rail usage such as low low beds and crash mats.
- Improvements were required in the governance and management to ensure the safe delivery of the service. Improvements required included:
    - The decision to move residents back to a unit when construction works were not complete. This decision did not provide for person centred care.
    - Record management required review as staff training records were not easily retrievable.
    - Senior management were not aware of the gaps in training records reported to the Inspector.
    - Inspectors found that failure to adequately implement and monitor adherence to the cleaning policy meant that practice was inconsistent and posed a risk to the cleanliness of the premises.
    - The management of risk and the system in place to identify, assess, and ensure appropriate follow up required updating.
- The communication between members of the management team was informal and did not ensure that the service was managed and delivered in line with the designated centre's Statement of Purpose, policies and procedure. For example, minutes of meetings reviewed did not reflect a set agenda and the minutes were vague and did not identify who was responsible for implementing any agreed changes.
- The Inspector found gaps in the oversight of key areas such as infection prevention and control and fire safety. The designated centre had not been adequately progressed in line with the designated centre's current conditions of registration. The updated safety statement in place made reference to a minimum of two fire evacuation drills to be carried out per year, however, these drills were not carried out. This was not identified through the current monitoring processes and as a result, the Inspector found staff were not clear about what to do to keep all residents safe in the event of a fire emergency.
- The Inspector found that the Person In Charge was the only senior person on the roster to

6.0 DETAILED FINDINGS Continued...

work in a supernumerary capacity, available to support staff and responsible for carrying out all routine oversight activities such as audit and monitoring key performance indicators. The Clinical Nurse Manager did not have any designated administrative time to provide support to the Person In Charge.

- The Inspector was not assured there was adequate resources available to ensure there were sufficient staff to deliver care to residents in line with the Statement of Purpose. Additional resources were required to upgrade and maintain many areas in the designated centre such as:
    - Bedroom flooring.
    - Carpets.
    - Bathrooms.
    - Ensuring that furniture and fittings were in a good state of repair and easy to clean.

❍ Audits:

- There was no evidence that the audits completed had been analysed, action plans developed or implemented by whom or within what time frame. For example, a falls audit completed had no analysis of the findings and no action plan.
- Audit reports viewed did not identify where the shortfalls had been or what remedial actions had been taken to improve the service. For example, the audit of care plans described improvement since the previous audit but did not describe what deficits had been noted or the changes that had led to the improvements.
- The audit tools used followed a basic format and did not adequately monitor key areas of the service.
- No formalised system of disseminating and communicating findings of audits to staff was evident.
- There was no audit schedule in place for 2021.

Regulation 24: Contract for the Provision of Services

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

- ***Not Compliant Orange:***

❍ Contract of Care:

- Payments were made to a third party that was not the Registered Provider.

Regulation 31: Notifications of Incidents

(6% of Services Not Compliant of the 16 assessed against this Regulation)

- ***Not Compliant Orange:***

❍ Notification of Incidents:

- Information in relation to allegations of misconduct were not notified to the Chief Inspector.

Regulation 34: Complaints Procedure

(19% of Services Not Compliant of the 21 assessed against this Regulation)

- ***Not Compliant Orange:***

❍ Complaints:

- Policies and procedures did not comply with legislative requirements for complaints as an independent appeals process was not in place for the management of complaints.
- The complaints log showed some complaints had not been managed in accordance with the complaints process.

6.0 **DETAILED FINDINGS** Continued...

- The policy and procedure for the management of complaints did not reference the Registered Provider.
- The complaints register reviewed by the Inspector lacked the detail required under Regulation 34.
- No evidence of follow up investigation or evidence that the complainant was satisfied with the outcome of the investigation.
- Complaints were not documented in line with the designated centre's complaints policy.
- No evidence that the person responsible for overseeing complaints reviewed the complaints on a consistent basis.
- A complaint from 2020 in relation to call bells was not responded to in a timely manner.

6.0 DETAILED FINDINGS Continued...

Dimension 2: Quality and Safety

Regulation 5: Individual Assessment and Care Plan

(13% of Services Not Compliant of the 23 assessed against this Regulation)

- ***Not Compliant Orange:***
  - Care Plans:
    - Issues identified included:
      - Assessments were not updated on a regular basis to reflect a resident's changing needs as required by the Regulations (2). This includes following a diagnosis of COVID-19.
      - Care plans were not person-centred, with many referring to "the patient" and "the client" as opposed to the resident's individual name.
      - Care plans were not personalised with enough detail to fully direct staff to provide appropriate care.
      - Some care plans were not reviewed during 2020. The Regulations require that the care plan is based on the assessment and that care plans are formally reviewed at intervals not exceeding four months or sooner where the residents condition changes.
      - Inspectors noted in a number of care plans that there was no daily record of the care provided by staff.
      - Comprehensive assessments were not completed within 48 hours of the resident being admitted to the designated centre.
      - Comprehensive assessments were not reviewed within a four monthly time period.
      - There were inconsistencies in the risk assessments completed for each resident. For example, some residents had no skin integrity assessment completed.
      - No evidence available that Do Not Resuscitate orders (DNRs) were discussed with the resident and/or their next of kin.
      - Care plans were not in place to reflect resident's assessed needs. For example, a resident who was diabetic did not have a care plan in place for diabetes.
      - Residents' care plans were not updated following review by health care professionals. For example, a resident had been reviewed by a physiotherapist who made four recommendations regarding changes to the care. This resident had no mobility related care plan in place.
      - Daily nurse evaluations were not linked to the resident's care plan. Some entries had no time of entry.

Regulation 6: Healthcare

(4% of Services Not Compliant of the 23 assessed against this Regulation)

- ***Not Compliant Orange:***
  - Healthcare:
    - Wound management documentation was not in line with best practice. Notes for a resident suggested that a daily review of the wound was required, however, this was not completed. It was completed on alternate days.
    - The wound measurements recorded did not correlate with the wound photography seen.
    - Review of consent documentation was required to ensure they were completed in line with the resident's ability and the information detailed in their assessment correlated with the consent form.

6.0 DETAILED FINDINGS Continued...

- Routine signing upon receipt of medication to indicate medications were checked and correct, did not routinely happen.

Regulation 7: Managing Behaviour that is Challenging

(8% of Services Not Compliant of the 12 assessed against this Regulation)

- ***Not Compliant Orange:***
  - Resident Assessments:
    - Assessments and care plans for residents displaying responsive behaviours did not clearly identify the known behaviours of the residents.
    - Care plans did not reflect the potential triggers and deescalating techniques that the resident responds to and they did not provide enough detail to guide staff interventions.
    - A resident's care plan was not updated to reflect changes made to their plan of care after the GP's review.

Regulation 8: Protection

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

- ***Not Compliant Orange:***
  - Protection:
    - The Registered Provider failed to demonstrate that they had taken all reasonable measures to protect residents from abuse.
    - Residents' finances, petty cash etc., were being managed by a third party.

Regulation 9: Residents' Rights

(25% of Services Not Compliant of the 20 assessed against this Regulation)

- ***Not Compliant Orange:***
  - Resident Choice:
    - Communal space was limited and impacted on resident's choice of areas for dining, activation and visiting. For example, not all residents could be accommodated in the communal areas at the same time.
    - Residents on the first floor of the designated centre were unable to use the stair lift and their rights to freedom of movement were restricted.
    - Inspectors found that decisions made on the movement of residents between areas had not been appropriately assessed for the impact the decisions were having on the residents. For example, a resident told Inspectors that they were not permitted to leave the area. The decision had not been reassessed throughout the entire period of isolation.
    - Failure to respond to residents needs in respect of provision of regular showers did not allow residents to exercise choice.
  - Activities:
    - Rights of residents to participate in activities in accordance with their interests and capabilities were very limited.
    - No scheduled activities were provided to residents at the time of inspection.
    - The Inspector was informed that residents only wanted activities between 14:00 to 16:00 hours, however, there was no evidence of consultation with the residents regarding this.
    - Improvements were required regarding the provision of activities for residents with advanced needs.

6.0 DETAILED FINDINGS Continued...

- Improvements were required in the ongoing assessment of activity needs for all residents to ensure activities provided and planned would meet their needs.
- There was poor oversight of activity provision as care plans were not updated as resident's needs or preferences changed, and staff were not clearly guided to provide appropriate activities or meaningful occupation.

❍ Privacy and Dignity:

- Privacy and dignity of residents were impacted on by the premises layout:
  - Beds were located in close proximity to each other, and the bays also doubled as corridors or thoroughfares to access the toilets and shower area.
  - Space was limited and residents could not hang up pictures and some residents could not see out the window.
  - Impossible to block or prevent noise and smells from pervading throughout.
  - Majority of residents did not have access to their own TV.
- In a multi-occupancy room, the Inspector observed a resident with responsive behaviour that was calling out at frequent intervals. This calling out was distressing to another resident sharing the room.
- Residents' rights and privacy were not always promoted. In the dementia unit, a decision was made to close the communal bathroom and use it temporarily as storage. Residents who did not have ensuite facilities were being showered in the ensuite bathrooms of other resident bedrooms.

Regulation 11: Visits

(7% of Services Substantially Compliant of the 14 assessed against this Regulation)

- ***Substantially Compliant Yellow:***

❍ Visits:

- Some parts of the designated centre could not facilitate private visits due to the lack of available or appropriate space.

Regulation 12: Personal Possessions

(25% of Services Not Compliant of the 4 assessed against this Regulation)

- ***Not Compliant Orange:***

❍ Resident Choice:

- Single wardrobe storage in the designated centre was found to be inadequate to provide for residents' personal storage needs.

Regulation 17: Premises

(59% of Services Not Compliant of the 17 assessed against this Regulation)

- ***Not Compliant Orange:***

❍ Premises:

- The Registered Provider was not providing a premises which conformed to the matters set out in Schedule 6 of the Regulations. The major impact was on daily experience for residents living in the designated centre, for example, the lack of privacy to perform basic care, noise, risk of infection and fire evacuation risks (2).
- A number of issues were identified with the premises that required action including:
  - There were not sufficient bathrooms/ shower rooms to meet the requirements of residents that did not have ensuite

6.0 **DETAILED FINDINGS** Continued...

facilities.

- The sluice room did not contain sufficient racking and facilities to enable the correct storage of urinals and bedpans.
- The layout of the laundry required review to ensure correct segregation of clean and dirty laundry.

- A high standard of refurbishment was not consistent throughout the designated centre.
- The following areas required review to ensure regulatory compliance:
  - Insufficient number of shower facilities available to ensure a maximum ration of one shower to eight residents.
  - A lack of storage facilities in the designated centre. For example, wheelchairs were stored in an unoccupied designated bedroom, hoists were stored on a corridor which, although did not block a fire escape route, could pose a tripping hazard.
  - Absence of designated staff changing facilities.
  - Insufficient handwashing facilities to mitigate associated infection control risks.
  - Reduced access to appropriate sluice facilities. For example, one sluice was located in the isolation area while the second sluice was in the area that had been closed off for refurbishment purposes and was not clean on inspection.
  - Signs of wear and tear in some areas of the designated centre that required attention. For example, damaged walls and damaged flooring both in the communal areas and residents' bedrooms.
- Communal space was below the recommended 4 square metres per person as detailed in the HIQA National Standards for Residential Care Settings for Older People in Ireland 2016.
- Two multi-occupancy rooms did not comply with the minimum floor space requirements of 7m^2 per person as set out in the amended Regulations S.I. No 293 of 2016.
- Design and layout of a four bedded room did not allow for privacy and dignity of residents at all times. This was evidenced by:
  - The beds were too close in proximity. Insufficient room for all residents to have a chair at their bedside.
  - Only one resident had a shelf to place personal items.
  - The residents in the middle two beds did not have any place except their locker to put personal possessions.
  - When screening is in use, it impacts negatively on other residents.
- Residents were relocated in the designated centre due to building works that were in progress. The Inspector found that this had a negative impact on residents.
- Building works were in progress and presented risk of injury to residents due to:
  - The corridor along which the old part of the building meets the new extension was not signposted to alert residents that works were taking place.
  - Resident bathrooms and shower for communal use were at the end of this corridor and so 24 hours safe access was required. Residents had to travel past the partition to their facilities.
  - The partition was not sufficiently braced.
  - The present of the partition, the width of th corridor did not allow for staff to walk alongside residents to provide assistance. In addition, the corridor was noted to be dark which posed a falls risk.
  - The area in front of bathrooms and shower had an accumulation of clay and dust.
  - Noise from drills were heard on the days of inspection.

6.0 DETAILED FINDINGS Continued...

- The Inspector identified a number of areas that required significant review and attention:
    - Flooring and carpets in a number of bedrooms and communal areas had significant tears and rips and some floor surfaces in a number of bedrooms appeared uneven.
    - Toilet and bathing facilities required upgrading to ensure that these facilities supported residents' rights to independence and mobility needs. For example, a number of domestic baths, step-in showers and domestic toilets were identified which residents found difficult to use and posed risk to those with impaired mobility.
    - There was insufficient storage for larger items of equipment such as hoists and commodes.
    - Surface areas of some items of furniture and equipment had cracks and tears.
    - Some fixtures, such a sluice sink and a toilet, showed signs of rust.
    - The designated centre's laundry located beside the catering kitchen, was a small confined cluttered space which did not support unidirectional flow of laundry.
    - A double bedroom with a surface area of 13 meters squared did not meet the requirements of the Regulations.
    - Privacy curtains, that had shrunk due to laundering, were no longer sufficient to ensure resident's right to privacy and dignity.
    - The main road to the designated centre was very uneven and posed a potential risk of falls to residents and others with impaired mobility.

Regulation 18: Food and Nutrition

(33% of Services Substantially Compliant of the 3 assessed against this Regulation)

- ***Substantially Compliant Yellow:***
    - Food and Nutrition:
        - The Inspector noted there was repetition of chips at lunch and at evening meals. A review was required to ensure the diet is appropriately nutritious

Regulation 20: Information for Residents

(100% of Services Not Compliant of the 1 assessed against this Regulation)

- ***Not Compliant Orange:***
    - Information for Residents:
        - The residents guide did not accurately reflect the terms and conditions relating to residence in the designated centre. It did not reflect the withdrawal of the Registered Provider from active management of the designated centre.

Regulation 26: Risk Management

(12% of Services Not Compliant of the 16 assessed against this Regulation)

- ***Not Compliant Orange:***
    - Risk Management:
        - A robust system for hazard identification and assessment of risk was required to ensure compliance with the Regulation and to ensure safety of residents and staff.
        - Significant improvements were required in relation to managing environmental risks such as fire safety and infection prevention and control.

6.0 DETAILED FINDINGS Continued...

Regulation 27: Infection Control

(46% of Services Not Compliant of the 24 assessed against this Regulation)

- ***Not Compliant Red:***
  - Infection Prevention and Control:
    - An urgent action plan was issued by Inspectors. Issues identified included:
      - A yellow clinical waste bin, which was seen to be blocking any access to hand washing facilities all day, had not been moved by the end of the inspection day.
      - No access to the soap dispenser in the hand washing facilities.
      - The area of the designated centre identified by the IPC team as most suitable for isolation purposes had not been prepared.
      - Not all dani-centres (wall-mounted containers for personal protective equipment (PPE)) were fully stocked with PPE.
      - A shower room was shared by 8 residents. It was also used by the hairdresser.
      - The shower outlet cover was missing and there was no seat on the toilet.
      - The flooring required replacement as it had been patched.
      - There was an amount of material that was required to be cleared and removed both from outside around the designated centre and inside in the stores and sluice rooms.
      - Storage was an issue in the designated centre, as items of furniture was stored in an empty room.
      - Evidence of legionella testing of the water was required.
      - Infection prevention and control practices and protocols in the designated centre were not in line with the HPSC guidance for the Infection Prevention Control Guidelines on the Prevention and Management of COVID-19 Cases and Outbreaks in Residential Care Facilities.
      - Oversight of staff's infection control practices is required. For example, staff were coming on and going off duty in their uniforms as there were no designated staff changing facilities provided; staff were seen wearing nail polish and stone rings; on a number of occasions staff were seen wearing the facemask incorrectly; staff's temperature was not consistently monitored and recorded on a twice daily basis.
      - Not all staff had attended up-to-date training and refresher courses in infection prevention and control; a lack of knowledge was evident in some of the practices observed on the day.
      - Enhanced signage was required throughout the designated centre to effectively alert and remind staff, residents and visitors of appropriate infection prevention and control procedures.
      - Inadequate storage and segregation processes and practices was observed throughout all ancillary facilities posing a cross contamination risk. For example, staff member's personal belongings being stored in the treatment room, the housekeeping room or laundry; boxes and items of linen inappropriately stored on the floor; residents' equipment inappropriately stored in assisted bathrooms or the dirty sluice facility.
      - Inappropriate linen storage, transport and segregation practices being implemented.
      - The system in place to identify clean and dirty equipment and the processes for decontaminating equipment between each use required full review, for example, the process of decontamination the blood pressure cuffs between use.
      - A full review of clinical waste bins was required to ensure they were fit for purpose, appropriately labelled and colour coded to support correct segregation at the point of source.

6.0 DETAILED FINDINGS Continued...

- ***Not Compliant Orange:***
  - Infection Prevention and Control:
    - Improvements were required regarding infection control practices within the centre due to:
      - A poor cleaning regime of the designated centre. A single use using cleaning system was not in place for each bedroom, therefore increasing the risk of transmission of infection from one room to another.
      - Poor monitoring of deep cleaning of bedrooms.
    - The following areas were noted to require attention:
      - The sluice was cluttered, and staff could not reach the sink to wash their hands.
      - Some items of equipment used by residents, such as hoists, were dusty and surfaces were not adequately clean.
      - The uniform policy was not adhered to by all staff. Some staff were working in their normal clothes and this requires oversight to reduce the risk of infection transfer.
      - A hoist sling in use was not labelled, worn and required disposal.
    - Other findings identified that the following areas required review:
      - A bathroom did not appear to be part of the cleaning protocol and was visibly unclean with debris noted in the bathtub.
      - There was an empty urine bottle stored on top of a bathtub.
      - Residents' jumpers were drying on hangers in the bathroom.
      - A large waste bin in the bathroom was mis-labelled as infectious waste.
      - Large clinical waste bin stored in the yard was not locked and was not in an area secured from public access.
      - Clinical waste bags were stored on the ground beside the bin as it was full.
      - Staff facilities were in a temporary structure to the rear of the designated centre.
      - Staff changing rooms were not clean and were used to store a variety of items such as activity equipment, incontinence wear, a mattress, and walking aids.
      - The staff dining room was not suitable for staff to spend time as it was not clean and was cold.

Regulation 28: Fire Precautions

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

- ***Not Compliant Red:***
  - Fire Safety:
    - The Inspector found staff were insufficiently trained or experienced to manage their roles and responsibilities in relation to fire safety, for example a newly recruited nurse, who was due to be left in charge of the designated centre during the evening, had not completed fire safety training.
    - Serious and significant risks concerning the safe evacuation of residents in large compartments were found. Risks remain around the evacuation of residents, compartment sizes, vertical evacuation training and practice, and updated building fire safety reviews were required.
    - Simulated fire drills with night time staffing conditions evidenced poor evacuation time lines. For example, it took nine minutes for three staff to evacuate ten residents.
    - The Inspector released multiple fire compartment doors and observed that the doors did not seal. The Inspector was able to see through the gap between the fire doors.

6.0 DETAILED FINDINGS Continued...

- ***Not Compliant Orange:***
  - Fire Safety:
    - A number of fire safety issues were identified:
      - Residents were permitted to smoke on their room balconies. Inspectors observed one balcony did not have a fire blanket and one did not have smoking aprons.
      - The outside garden area was littered with cigarette butts on the ground. There was no fire blanket or appropriate ashtrays in this area.
    - The Registered Provider did not take adequate precautions against the risk of fire including:
      - The gas shut off point in the kitchen was not easily accessible or readily apparent.
      - The fire doors to the kitchen serving hatch were held open with shooting bolts. The hinge was also damaged which meant the door could not close.
      - There were hoist batteries on charge on the bedroom corridor, which were not risk assessed.
      - A door adjacent to the reception that opened out across the path of escape in the stairs enclosure was not risk assessed.
    - Inspectors were not assured that adequate means of escape was provided throughout the designated centre:
      - Inspectors were not assured that the stairs enclosure at first floor, adjacent to the office of the person in charge, was a suitable means of escape.
      - There were a number of unprotected openings along the height of the stairs. This requires review by the competent fire safety professional to determine its suitability as a means of escape.
      - External ramps and steps to the front from the lower ground floor require review to ensure they are safe.
      - Additional emergency lighting was required to the rear external escape routes.
      - Combustible items were stored in nonfire rated enclosures on escape routes, or stored directly in the escape route.
    - Adequate arrangements were not in place for maintaining all fire equipment.
    - Adequate arrangements had not been made for detecting fires. The stairs enclosure adjacent to the office of the Person In Charge was not fitted with a smoke detector.
    - Inspectors were not assured that adequate arrangements were in place for containing fires:
      - The Inspector was not assured of the likely fire performance of all door sets and glazed screens (door leaf, frame, brush seals, intumescent strips, hinges, closers and ironmongery).
      - Assurances were required that fire compartment boundaries provided appropriate fire resistance.
      - Potential breaches were noted in relation to the fire resistance of the ceilings due to observed recessed light fittings and non-fire rated attic access hatches.
    - The Person In Charge did not ensure that procedures to be followed in the event of a fire were adequately displayed in the designated centre:
      - Additional exit signage was required for some areas of the designated centre to ensure escape routes were readily apparent.
      - Drawings displayed did not show the extent of compartment boundaries to inform the identified evacuation strategy of horizontal evacuation.
      - Appropriate zoning floor plans were not displayed next to the fire alarm panel.
    - The emergency lighting was not being serviced three monthly as per the Regulations.

6.0 DETAILED FINDINGS Continued...

- Fire training for all staff had expired. Staff had not attended a practice fire drill in the previous year.
- Full compartment evacuations were not undertaken with night time staffing levels simulation.
- The electrical system required certification.
- Installation of additional emergency lighting required completion.
- Fire performance of glass double doors in some bedrooms required review to ensure they were up to the relevant fire standard.

Regulation 29: Medicines and Pharmaceutical Services

(28% of Services Not Compliant of the 7 assessed against this Regulation)

- ***Not Compliant Red:***
  - Medication Management:
    - Inspectors found that there were a number of serious issues of concern in relation to medicine management. For example,
      - Staff had administered medicines without a prescription.
      - Staff had transcribed a number of medicines which was not allowed under the relevant policy in the designated centre which contained a notice to staff that staff were not to transcribe medicines.
      - A number of medicines which had been transcribed without authorisation were not transcribed correctly, not signed by the transcribers and did not state the route by which the medicine was to be administered.
- ***Not Compliant Orange:***
  - Medication Management:
    - Non-compliance observed by the Inspector included:
      - Poor practice in administration of medication.
      - Incomplete detail on medicine administration charts including resident photo and prescriber's signature.
      - The Registered Provider had a plan in place to update medication administration systems and had engaged with local pharmacy services. This plan had not yet been implemented.

7.0 CONCLUSION

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 Staffing, Training and Staff Development, Governance and Management, Infection Control, Fire Precautions and Medicines and Pharmaceutical Services with many residential centres requiring improvements in key areas such as, Records, Complaints, Personal Possessions and Premises.

Good practice was identified in relation to Communication Difficulties and End of Life.

Further Information
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