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 2021 to February 2022

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1.0 EXECUTIVE SUMMARY

This report 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 (20) randomly selected HIQA Inspection Reports. All inspections were completed by HIQA between December 2021 to February 2022.

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 14: Persons in Charge (30% Not Compliant Red and Orange)	The Registered Provider appointed a Person In Charge who did not have three years' experience of nursing older persons within the previous six years and had not completed a post registration management qualification in health or a related field.
Capacity and Capability	Regulation 15: Staffing (37% Not Compliant Red and Orange)	There were insufficient staff resources in place at night to enable residents to be evacuated safely in a timely manner in the event of a fire.
		Over a 1 week period, there was no day where the residential centre operated at full staffing capacity.
		There was insufficient staff allocated to activities on a daily basis. On the day of the inspection, the activities coordinator was allocated to caring due to a deficit in care staff.
Capacity and Capability	Regulation 23: Governance and Management (55% Not Complaint Red and Orange)	Inspectors found that the Management Team resources were redeployed to the provision of direct resident care, and this detracted from implementing the systems to monitor, evaluate and improve the quality of the service provided to residents.
		Analysis of information following regulatory inspections, management meetings or audits were not leading to the development of quality improvement plans or improved resident care.
		Audit tools were not sufficiently robust or effective to identify findings that Inspectors found on the day of inspection.
		Environmental and other audits of key areas of the service were not consistently followed up with clear time-bound action plans and follow-up reviews to ensure that the required improvement actions were completed.

Quality and Safety	Regulation 17: Premises (54% Not Compliant Orange)	Ongoing preventative maintenance required improvement to ensure the premises was maintained to a high standard.
		There were insufficient sanitary facilities. For example, sanitary facilities for 13 residents comprised of two toilets and one shower. When the shower was in use, there was only 1 toilet available for residents.
		There was inadequate storage seen across the residential centre which impacted on resident's rights and infection control.
Quality and Safety	Regulation 27: Infection Control (67% Not Compliant Orange)	The nurse on duty was caring for both residents with confirmed COVID-19 and residents in whom COVID-19 had not been detected.
		Staff practice did not reflect the World Health Organisation's (WHO) five moments of hand hygiene and PPE was used inappropriately.
		Available sinks designated for hand hygiene did not comply with current recommended specifications.
		Resident's used wash-water was emptied down hand wash sinks in resident's rooms.
Quality and Safety	Regulation 28: Fire Precautions (75% Not Compliant Red and Orange)	Fire drill records and night-time staff resources did not provide adequate assurances that the residents could be evacuated in a timely, safe and effective manner in the event of a fire at night.
		While regular evacuation drills were being carried out, the Inspector noted the fire drills lacked detail.
		There was no evidence of fire exit signage or emergency lighting fitted in external escape routes to indicate fire exits and to illuminate this area in the event of an evacuation.

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 Registered Provider must take action within a reasonable time frame to come into compliance.

3.0 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.

Feedback from resident's included:

- **Residents' COVID-19 Experience in the Residential Centre:**
  - Residents who were isolating due to an outbreak in the residential home were finding the restricting difficult and isolating.
  - Residents said that they were kept informed of and understood the reasons for the public health measures and restrictions.

- **Daily Living/Social Activities:**
  - Some residents told the Inspector that they enjoyed the bingo and word game activities best.
  - Residents spoke positively with the Inspector about how they spent their days, and they were seen to be happily occupied throughout the inspection day.

- **Space/Premises in the Residential Centres:**
  - The general feedback from residents was that they were content with their bedrooms. One resident reported that their bedroom was "lovely" and was happy with the space provided for their belongings.

- **Food and Nutrition:**
  - Residents told the Inspectors that the food was very good and they had a choice of hot meals on the menu each day.
  - Residents said that they were offered three choices relating to their meals and were happy with the food provided.

- **Care Provided in the Residential Centres:**
  - Overall, residents were very complimentary about the staff caring for them, stating that they were very kind and patient.
  - All were very complimentary about the professionalism and dedication of staff.
  - In one centre residents confirmed that there was a staff shortage on some days, and that they had to wait for assistance or for bells to be answered.
  - Inspectors were told by two residents that they do not get to shower regularly enough.

- **Safety in the Residential Centres:**
  - Most residents informed the Inspector that they felt safe in the residential centre.
  - In one residential centre three residents told Inspectors that there were times they did not feel safe as the residential centre was understaffed.

- **Identifying a member of staff where issues, concerns or complaints arise:**
  - Residents knew the Person In Charge and told the Inspectors that they would not hesitate to talk to the Person In Charge or any of the staff if they were worried about anything or were not satisfied with any aspect of the service.
  - Residents were confident that they would be listened to and any issues they raised would be addressed to their satisfaction.

- **Visiting in the Residential Centre:**
  - Residents said that they were delighted to be able to meet their visitors in person again after the difficult times when the virus was more rampant.

4.0 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 20 reports. Key areas that were deemed Not Compliant are highlighted within the tables.

Table 2: Capacity and Capability – Registration Regulations (S.I.No. 61 of 2015)

Dimension	Regulation	Regulation Description	No. of Services inspected against this Regulation of the 20 samples	Fully Compliant	Substantially Compliant	% of Services Not Compliant	Not Compliant Red	Not Compliant Orange
Capacity and Capability	4	Application of Registration or Renewal of Registration	4	75%	25%	0%	0%	0%
	7	Application by Registered Providers for the Variation or Renewal of Conditions of Registration	1	0%	100%	0%	0%	0%
	8	Annual fee payable by the Registered Provider of a designated centre for older people	1	100%	0%	0%	0%	0%

4.0 OVERALL REVIEW FINDINGS Continued...

Table 3: Capacity and Capability (S.I.No. 415 of 2013)

Dimension	Regulation	Regulation Description	No. of Services inspected against this Regulation of the 20 samples	Fully Compliant	Substantially Compliant	% of Services Not Compliant	Not Compliant Red	Not Compliant Orange
Capacity and Capability	3	Statement of Purpose	6	83 %	17 %	0 %	0 %	0 %
	4	Written Policies and Procedures	9	56 %	44 %	0 %	0 %	0 %
	14	Persons in Charge	10	70 %	0 %	30 %	10 %	20 %
	15	Staffing	19	42 %	21 %	37 %	5 %	32 %
	16	Training and Staff Development	17	35 %	47 %	18 %	0 %	18 %
	19	Directory of Residents	2	50 %	50 %	0 %	0 %	0 %
	21	Records	9	22 %	45 %	33 %	0 %	33 %
	22	Insurance	2	100 %	0 %	0 %	0 %	0 %
	23	Governance and Management	20	10 %	35 %	55 %	15 %	40 %
	24	Contract for the Provision of Services	3	100 %	0 %	0 %	0 %	0 %
	30	Volunteers	1	100 %	0 %	0 %	0 %	0 %
	31	Notification of Incidents	10	70 %	20 %	10 %	0 %	10 %
	33	Notification of Procedures and Arrangements for periods when Person in Charge is absent from the designated centre	1	100 %	0 %	0 %	0 %	0 %
	34	Complaints Procedure	15	74 %	13 %	13 %	0 %	13 %

4.0 OVERALL REVIEW FINDINGS Continued...

Table 4: Quality and Safety (S.I.No. 415 of 2013)

Dimension	Regulation	Regulation Description	No. of Services inspected against this Regulation of the 20 samples	Fully Compliant	Substantially Compliant	% of Services Not Compliant	Not Compliant Red	Not Compliant Orange
Quality and Safety	5	Individual Assessment and Care Plan	18	34 %	33 %	33 %	0 %	33 %
	6	Healthcare	17	76 %	12 %	12 %	0 %	12 %
	7	Managing Behaviour that is Challenging	9	45 %	33 %	22 %	0 %	22 %
	8	Protection	9	45 %	22 %	33 %	0 %	33 %
	9	Residents' Rights	16	37 %	44 %	19 %	0 %	19 %
	11	Visits	15	100 %	0 %	0 %	0 %	0 %
	12	Personal Possessions	6	16 %	67 %	17 %	0 %	17 %
	13	End of Life	5	80 %	20 %	0 %	0 %	0 %
	17	Premises	13	15 %	31 %	54 %	0 %	54 %
	18	Food and Nutrition	1	100 %	0 %	0 %	0 %	0 %
	20	Information for Residents	1	100 %	0 %	0 %	0 %	0 %
	26	Risk Management	7	57 %	14 %	29 %	0 %	29 %
	27	Infection Control	18	5 %	28 %	67 %	0 %	67 %
	28	Fire Precautions	16	6 %	19 %	75 %	31 %	44 %
	29	Medicines and Pharmaceutical Services	5	40 %	60 %	0 %	0 %	0 %

5.0 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 of Registration or Renewal of Registration

(25% of Services Substantially Compliant of the 4 assessed against this Regulation)

- ***Substantially Compliant:***
  - **Application of Registration or Renewal of Registration:**
    - In the application for renewal of registration of the residential centre, discrepancies were noted between the information provided on the Statement of Purpose and the floor plans.

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

(100% of Services Substantially Compliant of the 1 assessed against this Regulation)

- ***Substantially Compliant:***
  - **Application by Registered Providers for the Variation or Renewal of Conditions of Registration:**
    - An application to vary condition 3 of the registration of one of the residential centre units had been received. This application was to reduce the occupancy of the unit. Action was required to include condition 1 of the registration and correct floor plans and Statement of Purpose.

Regulation 3: Statement of Purpose

(17% of Services Substantially Compliant of the 6 assessed against this Regulation)

- ***Substantially Compliant:***
  - **Statement of Purpose:**
    - The residential centre's Statement of Purpose was recently reviewed and updated but required further review to ensure it accurately reflected the service provided. This was evidenced by the following:
      - The staffing whole time equivalents were not aligned with those previously submitted to the Chief Inspector for the purpose of registration.
      - The design and layout of the building described in the Statement of Purpose did not accurately reflect what was observed by Inspectors on the day of inspection.
      - The clinical governance structure described in the document required review to ensure all personnel involved in the management of the residential centre were identified.

Regulation 4: Written Policies and Procedures

(44% of Services Substantially Compliant of the 9 assessed against this Regulation)

- ***Substantially Compliant:***
  - **Written Policies and Procedures:**
    - The residential centre's policies and procedures, while reviewed within the last three years, did not include relevant supplementary best practice procedures and information that

5.0 DETAILED FINDINGS Continued...

needed to be integrated in the policy document statement to ensure the policy documents described up-to-date procedures and practices.

- Two risk management policies were available to staff and did not ensure ease of access to up-to-date procedures and did not contain the same information or inform consistency in practices.
- Inspectors found that the residential centre's medication policy was not in line with current practice in terms of how medication was dispensed and recorded. The residential centre had implemented a new medication system however the medication policy reviewed on inspection reflected the previous system.
- Not all policies and procedures reviewed during the inspection were being fully implemented. This included policies related to:
    - Risk management,
    - Monitoring and documentation of nutritional intake,
    - Fire safety management,
    - Infection prevention and control,
    - Complaints management.

Regulation 14: Persons In Charge

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

- ***Not Compliant Red:***
    - **Person In Charge:**
        - The Registered Provider appointed a Person In Charge who did not have three years experience of nursing older persons within the previous six years and had not completed a post registration management qualification in health or a related field and therefore did not meet requirements as set out in Regulation 14.

Regulation 15: Staffing

(37% of Services Not Compliant of the 19 assessed against this Regulation)

- ***Not Compliant Red:***
    - **Staffing:**
        - While there were sufficient staff available during the day to meet the assessed needs of residents, there was insufficient staff resources at night to enable residents to be evacuated safely in a timely manner in the event of a fire.
- ***Not Compliant Orange:***
    - **Staffing:**
        - The contingency planning for care staff required action, as short-term absences were not always replaced. A review of recent rosters showed that on some days during the week prior to the inspection, there were only six healthcare assistants, over two floors, providing care for up to 56 residents in the residential centre.
        - A review of the rosters showed that the residential centre was operating with reduced levels of staff (2). Gaps were identified in the following:
            - Over a 1 week period, there was no day where the residential centre operated at full staffing capacity. There was a heavy reliance on agency nurses and healthcare assistants to fill the rosters. When agency staff were not available, this led to low levels of staff. In one 24 hour period, seven 12-hour healthcare assistant shifts went unfilled.
            - Over a two week period there were 10 days where planned healthcare assistant staffing levels were not maintained. A deficit of between six and 18 care hours were noted on some days.
            - The staff roster showed that one nurse was on duty in a residential centre from 9pm until 8am to monitor and care for up to 56 residents. This was not adequate

5.0 DETAILED FINDINGS Continued...

to meet the care needs of residents, particularly during an outbreak of COVID-19.

- The number of nurses available on the roster did not reflect the total nurses' hours committed to in the residential centre's Statement of Purpose.

- The Registered Provider had failed to ensure that the number and skill mix of staff was appropriate to meet the clinical and social care needs of residents and the size and layout of the residential centre. These staffing resources were not adequate due to the following findings:
  - There were insufficient cleaning staff (2).
  - There were 12 vacant positions across multiple disciplines including nursing, healthcare assistants and activities staff.
  - 12 out of 18 residents had high care and support needs and were assessed as needing two staff to meet these needs including their emergency evacuation needs at night. There was only one carer and one nurse on duty at night.
  - There was not enough staff to supervise residents with high care needs at all times in the two sitting rooms and there was no staff with residents in the sitting room for prolonged periods during the morning time.
  - There was insufficient nursing staff to allow for separate nurse led teams for COVID-positive and not-detected residents.
- There was insufficient staff allocated to activities on a daily basis (4). Inspectors found that:
  - There was only one activities coordinator and the position for a second was currently vacant. On the day of the inspection the activities coordinator was allocated to caring due to a deficit in care staff.
  - The activities coordinator was not available until 11.15 each day as they were working as a care assistant prior to this time.
  - Staff with responsibility for facilitating residents' social activities were not rostered at weekends or on bank holidays.
  - Activities for residents were curtailed as a result of insufficient staffing.
  - Activities were not provided for residents each day.
  - A hairdresser position was not replaced. The arrangement in place where the person with responsibility for facilitating residents' social activities provided hairdressing for residents was impacting on their availability to ensure residents' social activity needs were met.
  - The social care practitioner based in the memory care unit was unable to meet the resident's specific social and recreational needs as they had been redeployed to healthcare assistant duties.

Regulation 16: Training and Staff Development

(18% of Services Not Compliant of the 17 assessed against this Regulation)

- ***Not Compliant Orange:***
  - **Training and Staff Development:**
    - Training was being monitored by the Management Team, however all mandatory training was not up to date. Inspectors identified gaps in the following:
      - Responsive behaviour training (2).
      - Manual handling training (2).
      - Safeguarding vulnerable adults training (2).
      - Fire safety training.
    - Inspectors observed that the principles of training were not fully applied by staff in some aspects of their work.

5.0 DETAILED FINDINGS Continued...

- Staff were not being appropriately supervised in their day-to-day practice in personal care delivery and in key areas such as moving and handling, hand hygiene, infection prevention and control and management of laundry.

Regulation 19: Directory of Residents

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

- ***Substantially Compliant:***
  - **Directory of Residents:**
    - The Directory of Residents included most of the required information outlined in part 3 of Schedule 3. The following pieces of information were not included:
      - The address and telephone number for some resident's GP.
      - The address and telephone number for some resident's next-of-kin.

Regulation 21: Records

(33% of Services Not Compliant of the 9 assessed against this Regulation)

- ***Not Compliant Orange:***
  - **Records:**
    - A review of the residents' nursing notes found that the daily progress records reviewed were insufficient (2). This was evidenced by the following:
      - Nursing records did not contain a record of each resident's health, condition and treatment given as required under Schedule 3 (2).
      - Nursing records did not contain a record of medical assessment and referral. For example, a resident who was displaying signs and symptoms of COVID-19 did not have their tests, both antigen and PCR, documented nor was the referral date to the GP documented.
      - The nursing daily progress notes did not give a clear description of the daily status of the resident making it difficult to track each resident's progress and detect changes in their health status in a timely manner.
      - A record of when the residents last received a shower or a bath was not available in the residents' care records.
    - Information and records pertinent to the care provided to residents by healthcare staff was not maintained as the online record system was not accessible to care staff.
    - From a review of staff personnel files, Inspectors found that:
      - While all files contained a valid An Garda Síochána (police) vetting disclosure, records evidenced that two staff had commenced employment in the residential centre in advance of this disclosure being processed.
      - One staff personnel file did not contain two employment references or valid photo identification as required by the regulations.
      - There were gaps in the employment history and no evidence of induction in one staff personnel file reviewed.
    - The staff roster was not kept up to date and did not facilitate effective identification of staffing requirements which resulted in incorrect information being submitted to the HSE Outbreak Crisis Team and impacted on their availability to respond in a timely manner.

Regulation 23: Governance and Management

(55% of Services Not Compliant of the 20 assessed against this Regulation)

5.0 DETAILED FINDINGS Continued...

- ***Not Compliant Red:***
  - **Management:**
    - The Registered Provider had not addressed non-compliances identified on a previous inspection to satisfaction (2).
    - Governance and management arrangements were not effective and did not identify the impact of poor quality care and support being delivered to residents (2). This was evidenced by the following:
      - Risk identification and management systems had not picked up serious issues affecting resident welfare.
      - Safeguarding concerns were not correctly identified and managed leaving residents at risk.
      - Analysis of information following regulatory inspections, management meetings or audits were not leading to the development of quality improvement plans or improved resident care.
      - Further oversight of key clinical information was required as information provided to Inspectors on the first day of inspection in regard to residents receiving end-of-life care, restrictive practices and the number of residents under the age of 65 years living in the residential centre was not accurate.
    - There were inadequate resources in place to ensure the effective delivery of care in accordance with the Statement of Purpose. For example:
      - The staffing resource provided did not assure that the care and assessed supervision needs of residents were met in line with their assessed needs.
      - Inspectors found that the Management Team resources were redeployed to the provision of direct resident care and this detracted from implementing the systems to monitor, evaluate and improve the quality of the service provided to residents.
    - Although a risk register was maintained by the Person In Charge, the system of risk identification required improvement as Inspectors identified a number of risks that had not been entered into the risk register and controls to mitigate the risk were not identified (2). The following risks identified by Inspectors were not included on the risk register:
      - The risk associated with ongoing challenges in maintaining safe staffing in the residential centre.
      - The fire risks identified (2).
    - The systems of risk review, investigation and learning from incidents involving residents required immediate review. Issues included:
      - 25 incidents recorded in the previous 4 months, including thirteen resident falls, had not been reviewed or corrective action implemented.
      - There was no root cause analysis or evidence of learning from the incidents as evidenced by repeated falls involving the same residents.
      - There was no risk analysis or trend analysis of these incidents.
  - **Audits:**
    - Audit tools were not sufficiently robust or effective to identify findings that Inspectors found on the day of inspection (2). This was evidenced by the following:
      - An environmental audit found 98% overall compliance which differed from this inspection and previous inspections where high levels of dirt and poor hygiene were observed.
      - A care plan audit identified a requirement for improvements, however there was no action plan or person responsible identified to oversee and implement the required improvements.
      - An infection prevention and control audit

5.0 DETAILED FINDINGS Continued...

concluded that there were insufficient cleaning hours. While Inspectors were told that cleaning hours had increased and a deep clean was complete, the findings of this inspection were that the Registered Provider had either failed to implement or sustain their own recommendations.

- ***Not Compliant Orange:***
  - **Management:**
    - There were inadequate staffing resources in place to ensure the effective delivery of care in accordance with the residential centre's Statement of Purpose (3).
    - The governance and management systems required strengthening. This was evidenced by the following:
      - Oversight arrangements to ensure that adequate fire safety measures were in place were not effective (3).
      - Following the completion of significant fire safety improvement works in the residential centre, the Registered Provider had not ensured that staff were able to carry out a timely and effective emergency evacuation of residents.
      - Although the Registered Provider had made an application for the renewal of registration and given assurances that the new extension was ready for registration, Inspectors found that the premises, including the new extension, did not meet the requirements of the regulations and further work was required.
      - The roles, remit and decision-making responsibilities of the Operational Management Team were not clearly defined. This resulted in inconsistent monitoring processes and the delegation of some stock control to frontline staff without appropriate oversight.
      - Communications and reporting structures were not clear for all staff, in particular for agency or relief staff and a formal communication system to report changes in a resident's condition or raise issues of concern during the day was not in place.
      - There was insufficient clinical oversight to ensure residents consistently received care in line with their assessed needs and that staff practices were appropriate and in line with training principles.
    - The Nominated Persons identified in the residential centre's COVID-19 contingency plan to manage an outbreak, were no longer employed in the residential centre.
    - The systems in place to manage an outbreak of COVID-19 were not in line with the residential centre's contingency plan. A failure to implement the recommendations of the public health department and an Infection Prevention and Control Specialist in relation to separate staffing teams and cohorting of residents impacted on the health and welfare of both residents and staff and there was significant onward transmission of the virus.
    - Inspectors did not see evidence that the analysis of all information at management meetings was leading to quality improvements. For example, in a management meeting 3 months prior to the inspection there was a discussion relating to inappropriate glove use by staff. This remained a finding on the day of the inspection.
    - All risks were not identified and appropriately mitigated. Inspectors found:
      - Risks to residents in relation to fire safety and infection control identified by Inspectors had not been addressed (4).
      - The risk of insufficient isolation facilities for residents who developed symptoms of, or contracted COVID-19 was not identified and appropriate contingency arrangements were not put in place.
      - Risks were not managed in line with the residential centre's risk management policy.

5.0 DETAILED FINDINGS Continued...

- There was no risk register in place and therefore identified risks had not been assessed and any action taken to mitigate these risks had not been documented.
- A power tool and sharp attachments were left unattended along a corridor. This posed a risk to residents passing by who may have picked the tool up. Staff were observed passing through the area, but they did not identify the risk and did not report it to senior staff or remove the tool to a secure room.

❍ **Audits:**

- Audits completed by staff in the residential centre had not identified a number of non-compliance found on this inspection (2). For example, previous hygiene audits had recorded 100% compliance however Inspectors found examples where adequate cleaning had not taken place.
- Environmental and other audits of key areas of the service were not consistently followed up with clear time-bound action plans and follow-up reviews to ensure that the required improvement actions were completed (2).
- A number of audits seen did not have percentage findings or clear action plans with a person identified to respond to improvements required. For example, eight audits completed over a 5 month period were seen to be incomplete as they did not have a total percentage recorded.

Regulation 31: Notifications of Incidents

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

- ***Not Compliant Orange:***

❍ **Notification of Incidents:**

- Inspectors found evidence where five notifications in relation to an allegation of suspected or confirmed abuse had not been submitted to the Chief Inspector as required.

Regulation 34: Complaints Procedure

(13% of Services Not Compliant of the 15 assessed against this Regulation)

- ***Not Compliant Orange:***

❍ **Complaints:**

- Inspectors found that a number of complaints were not managed or responded to in a timely manner and that the satisfaction of complainants verbalised to Inspectors on the day of inspection did not accord with the complaints record viewed. Issues included:
  - Inspectors heard that written complaints made some months earlier did not receive a response.
  - On review of the complaints record, Inspectors saw that dates entered for receipt of the complaint did not accurately reflect the dates on which the complaints were originally made.
  - The complaint records were not sufficiently detailed to provide an accurate timeline of communications or interventions taken, to determine the adequacy of the response.
  - One complainant had to wait three weeks, following agreement on the manner of resolution, to have the complaint fully resolved.
- Only one complaint had been recorded in the complaints log for 2021. Based on discussions with residents, complaints that had been made to staff prior to the day of the inspection had not been recorded and had not been satisfactorily resolved.

5.0 DETAILED FINDINGS Continued...

Dimension 2: Quality and Safety

Regulation 5: Individual Assessment and Care Plan

(33% of Services Not Compliant of the 18 assessed against this Regulation)

- ***Not Compliant Orange:***
  - **Care Plans:**
    - The Person In Charge and nursing staff confirmed that residents and, where appropriate, their relatives were consulted in regard to their changing needs and consulted when care plan reviewed occurred. However, the records maintained and conversations with residents did not provide assurance in regard to this process (2).
    - Although some daily nursing care records were person-centred and included some details on the resident's mood and well-being, most were focused on basic care needs and did not give sufficient insight into the overall health and wellbeing of residents (2).
    - Clinical risk assessments and associated care plans were not always prepared in line with regulatory requirements which directly led to poor outcomes for residents. Issues identified included:
      - There were no social care plans developed for residents (2).
      - A risk assessment and care plan were not in place for every identified care need (2).
      - Some residents with a high risk of malnutrition did not have an up-to-date nutritional risk assessment completed, there were gaps in their weight records and resident care plans were not updated with the action to be taken to address weight loss (2).
      - A care plan was not completed for a resident admitted to the residential centre 2 months previously.
      - A falls risk assessment was not completed on admission, as required by regulations.
      - A resident sustained five falls in a short time frame. A reassessment of the resident's falls risk was not conducted following each fall. There was no falls care plan or preventative measures in place for this resident.
      - A resident's needs in relation to incontinence had not been recognised on the risk assessment that informed their care plan resulting in insufficient guidance to staff on this resident's care.
      - A resident with a history of pressure wounds and identified as a high risk of developing pressure wounds did not have pressure relieving equipment in the form of an alternating air mattress as described in their care plan.
      - There were no care plans in place for residents receiving antibiotic therapy or pain management care plans for residents receiving analgesia.
      - Two residents reported that their personal hygiene needs were not met. Care plans did not provide evidence of the level of personal hygiene delivered to residents. Records only detailed "wash" and did not provide sufficient detail relating to what this wash entailed. Staff were unable to verify the level of assistance provided to residents.
      - Care plans were not reviewed as resident needs changed, for example when residents return to the residential centre following a period of acute care in hospital, Inspectors found care plans were not updated within 48hours.

5.0 DETAILED FINDINGS Continued...

Regulation 6: Healthcare

(12% of Services Not Compliant of the 17 assessed against this Regulation)

- ***Not Compliant Orange:***
  - **Healthcare:**
    - The organisation of nursing duties did not ensure that residents received a high standard care. Only one nurse was allocated to carry out the medication administration round for 56 residents in the residential centre. Inspectors were informed that this was managed by half of the residents receiving their morning medicines prior to 8am from the night nurse on duty. This meant that these residents received their medications before the prescribed time for administration.
    - The lack of appropriate nursing assessments and reviews meant that a number of referrals for specialist advice and care were delayed. A resident who had been assessed as being at high risk of malnutrition 4 months previously had not been referred to a dietitian and they remained at high risk of malnutrition at the time of this inspection.
    - The Registered Provider did not ensure that a high standard of evidence-based medical and nursing care was provided for all residents. For example:
      - Residents who were COVID-19 positive did not have appropriate as required medication prescribed to manage potential deterioration associated with COVID-19. This was not in line with the residential centre's own COVID-19 preparedness plan which states that an anticipatory care plan will be developed, including supportive palliative management for end of life provision.
      - There was no plan in place for any of the COVID-19 positive residents to be reviewed by their GP.

Regulation 7: Managing Behaviour that is Challenging

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

- ***Not Compliant Orange:***
  - **Managing Behaviour that is Challenging:**
    - Inspectors found that the Person In Charge did not manage and respond to incidents of responsive behaviours that posed a risk to residents. This was evidenced by the following:
      - Staff were not following good practice by completing antecedent behavioural consequence (ABC) charts or reviews on responsive behaviours and therefore did not respond to or manage incidents appropriately.
      - Some incidents of responsive behaviour were not recognised by staff. As a result, these incidents were not managed appropriately and repeat incidents occurred.
    - The Registered Provider failed to ensure that restraint was only used in accordance with national policy (2). Inspectors observed:
      - Some restrictive practices were found to be in place for all residents The door into one unit was locked by key. This was recorded as a restrictive practice in resident care plans with the reason being "doors locked for other residents". Two residents told Inspectors that they would like to leave the unit when they chose to but were unable to.
      - Some residents did not have access back into their bedrooms after they had left them. The doors were only accessible by a fob system, not all residents possessed a fob. Staff stated this system had been installed to prevent residents from entering other resident rooms but in the process had restricted the resident entry into their own bedroom.

5.0 DETAILED FINDINGS Continued...

- The smoking-room door was locked and there was a poster up displaying smoking times. Staff confirmed that the smoking room was locked in between smoking times.

Regulation 8: Protection

(33% of Services Not Compliant of the 9 assessed against this Regulation)

- ***Not Compliant Orange:***
  - **Protection:**
    - The Registered Provider had failed to take all reasonable measures to protect all residents from abuse. Inspectors raised ongoing concerns of abuse as a result of responsive behaviours.
    - Inspectors were not assured that the staffing resources could meet the supervision needs of residents to ensure all residents were safeguarded from the risk of peer-to-peer abuse.
    - The Registered Provider's safeguarding policy was not being followed. Incidents that met the definition of abuse were not managed through the safeguarding procedures. Inspectors found five safeguarding incidents which had not been investigated by the Person In Charge.
    - Although 98% of staff had received safeguarding training, Inspectors found abuse was not recognised and as a result preventative measures were not put in place.
    - While safeguarding risk assessments and safeguarding plans were in place for residents with specific safeguarding needs, further improvement was required to ensure each resident was provided with a Multi-disciplinary Team (MDT) approach and that staff were aware of each resident's safeguarding plans and that the planned actions to mitigate risk were implemented.
    - Inspectors found that the planned actions in resident's safeguarding plans were not being implemented by staff (2). For example, a number of residents were assessed as requiring close supervision by staff when attending communal areas and other residents were assessed as requiring observation checks every 15 minutes. However, Inspectors observed that this was not taking place.

Regulation 9: Residents' Rights

(19% of Services Not Compliant of the 16 assessed against this Regulation)

- ***Not Compliant Orange:***
  - **Resident Rights:**
    - A resident's meeting was held on day one of this Inspection, however the minutes of this meeting did not detail the feedback from residents in a way that improvement actions could be identified and shared with the relevant staff.
    - The layout of multioccupancy rooms did not ensure that residents could undertake personal activities in private (2). Inspectors observed:
      - Residents were sleeping and watching television within their bed spaces without privacy screens. The mobile privacy screens available were not large enough to provide sufficient privacy. Inspectors observed maintenance staff working in these areas.
      - Some privacy screens, when drawn, obstructed the view of the television.
      - The layout of some privacy screens meant that a resident had to enter the bedspace of another resident to access en-suite facilities.
      - In one room there was inadequate space between the foot of the bed and a wardrobe for a resident to pass through with ease.
    - The Registered Provider failed to ensure that residents were able to exercise choice with regards to breakfast time and access to the dining room. The dining room was locked at 09:10 and residents were seen to be queuing

5.0 DETAILED FINDINGS Continued...

outside. Residents commenced their breakfast at 09:45 which was an hour delay according to the agreed breakfast time schedule.

- The ongoing staffing challenges impacted on residents' choice in regards to the provision of showers. Staff reported that only one resident had received a shower on the morning of inspection but all residents had received assistance with personal hygiene needs. Staff reported that they were attempting to complete residents' showers in the afternoon when it was not as busy.
- The Registered Provider was not providing opportunities for all residents to participate in activities in accordance with their assessed needs and preferences. This was evidenced by the following:
    - Residents had restricted access to an activity schedule and social engagement due to the allocation of social care staff.
    - There were no activities for residents who chose to remain in their bedroom. Residents who chose to remain in their bedrooms told Inspectors that they were not provided with meaningful activities or one-to-one engagement unless they used their call bell for assistance.

Regulation 12: Personal Possessions

(17% of Services Not Compliant of the 6 assessed against this Regulation)

- ***Not Compliant Orange:***
    - **Personal Possessions:**
        - Wardrobe space was limited in a number of multi-occupancy bedrooms to small, half width, half-height wardrobes and a chest of drawers for each resident. Inspectors found:
            - In one resident's bedroom numerous items of clothing were seen hanging outside the wardrobe as there was not sufficient room inside to store them all.
            - A number of residents told Inspectors they would like more wardrobe space.
            - One resident said she sent her extra clothes items home due to insufficient space.
            - Not all wardrobes were adjacent to residents' individual bedroom space which made access to their personal clothing difficult.

Regulation 13: End of Life

(20% of Services Substantially Compliant of the 5 assessed against this Regulation)

- ***Substantially Compliant:***
    - **End of Life:**
        - In some records reviewed, resident's end-of-life care wishes had not been obtained and this required further oversight. Inspectors found that records did not evidence if family or friends were kept informed of the resident's condition.

Regulation 17: Premises

(54% of Services Not Compliant of the 13 assessed against this Regulation)

- ***Not Compliant Orange:***
    - **Premises:**
        - Ongoing preventative maintenance required improvement to ensure the premises was maintained to a high standard. This was evidenced by the following:
            - Paintwork on walls, doors, door frames and skirting were badly damaged (5).
            - The floor covering in several circulation areas was damaged or uneven and posed a trip hazard (3).
            - A number of fixtures and fittings were rusted and required maintenance, repair and/or replacement (2).
            - A decommissioned pipe in a shared bathroom created a trip hazard as it was

5.0 **DETAILED FINDINGS** Continued...

protruding from the wall and lying across the floor.

- The external garden had overturned furniture, a traffic cone, bags of rubbish and moss growing on the path.
- The existing staff changing area required review in terms of size, location and facilities.
- One resident's television was awaiting repair for over 5 months.

- Sanitary facilities were limited around the residential centre (3). Inspectors found:
  - Sanitary facilities for 13 residents comprised of two toilets and one shower. When the shower was in use, there was only 1 toilet available for residents.
  - One shower facility was used as a storage area. This meant that 10 residents had access to one shower and one bath. Six residents had to travel to another corridor to access these shower facilities.
  - There was one toilet and one shower for 9 residents.
- There was inadequate storage seen across the residential centre which impacted on resident's rights and infection control. For example:
  - Hoists, commodes and unused beds/ mattresses were stored within resident's rooms (2).
  - Communal rooms were used to store items such as a chair scales, Christmas decorations, a pair of slippers and wheelchairs (2).
  - A room registered for the purpose of storage of equipment was in use as an office.
  - Six commodes were stored in a communal shower/toilet used by residents.
  - Resident's personal hygiene products stored under the sink in the laundry.
  - The cleaning trolley was stored in the dirty utility room.
  - There was no clean utility or treatment room for the storage and preparation of medications, clean and sterile supplies and dressing trolleys.
  - Dedicated safe storage areas for all cleaning chemicals and equipment was not available. Inspectors observed cleaning chemicals inappropriately stored in an unlocked utility room.
- The laundry services were not suitable for their current purpose. The following gaps were identified:
  - There was insufficient space to separate clean and dirty laundry.
  - A stainless-steel sink with double drainer was not available.
  - Inspectors observed laundry containers, walls and ceilings dripping with water caused by condensation due to inadequate ventilation. This presented a risk of water coming into contact with electrical outlets and equipment.
- The 'dirty' utility rooms were small, poorly ventilated and did not facilitate effective infection prevention and control measures. For example:
  - There was one sink designated as a hand wash sink. A separate sink for washing resident equipment was not available. Using sinks for both handwashing and the cleaning of equipment should be discouraged as this will significantly increase the risk of hand and environmental contamination.
  - There was no sluice hopper for disposal of body fluids in the 'dirty' utility room.
- The Registered Provider failed to ensure that the residential centre was designed and laid out to meet the needs of the residents. This was evidenced by the following:
  - Residents in the multi-occupancy bedrooms did not have 7.4m^2 of floor

5.0 DETAILED FINDINGS Continued...

space allocated to them.

- Spacing between resident beds within one multi-occupancy room did not meet the minimum distance of one meter recommended to manage the risk of all droplet transmitted infections including COVID-19.
- Residents were unable to make choices relating to their environment due to the open layout of the multi-occupancy rooms which meant residents could not control light or noise in their bed spaces.
- The resident's bedside locker, wardrobe and chair were outside the privacy curtain.
- Twin bedrooms did not have adequate space for residents to have a comfortable chair at their bedside or an additional chair for visitors, manoeuvre a hoist or to store personal clothes and belongings.
- There was no access to a safe, enclosed outdoor area for residents. The external area in use presented a high risk as it was also used for deliveries and there was a motor bike parked there.
- There was only one communal space, a day/dining room, available for 17 residents which is inadequate.

Regulation 26: Risk Management

(29% of Services Not Compliant of the 7 assessed against this Regulation)

- ***Not Compliant Orange:***
  - **Risk Management:**
    - Risk management processes were not fully established and/or were not embedded in practice. This was evidenced by the following:
      - The arrangement for hazard identification and risk assessment was not sufficient.
      - The risk register did not include all of the risks identified in the residential centre, measures in place to control the risks or an identified person responsible to ensure control measures were not implemented.
      - Inspectors found risks not identified in the risk register. These included risks associated with delegation of stock control, chemicals stored in unlocked storage areas and poor moving and handling practices.
      - A complete cycle of identification, management, trending, learning and ongoing review to ensure improvement to care delivery was not in place.
    - The risk management policy reviewed on inspection did not contain the requirements of Regulation 26 in respect of identifying measures and actions to control risks of:
      - Abuse,
      - The unexplained absence of any resident,
      - Accidental injury to residents, visitors or staff,
      - Aggression and violence,
      - Self-harm.

Regulation 27: Infection Control

(67% of Services Not Compliant of the 18 assessed against this Regulation)

- ***Not Compliant Orange:***
  - **Infection Prevention and Control:**
    - Inspectors identified inconsistencies in infection prevention and control precautions in residential centres experiencing an outbreak at the time of the inspection. This was evidenced by the following:
      - Cohorting arrangements were not in place for residents that had tested positive for COVID-19 infection in line with the residential centre's own COVID-19 Preparedness Plan (2).
      - PPE was not being used appropriately (2).

5.0 **DETAILED FINDINGS** Continued...

Inspectors observed staff not removing PPE in between rooms, staff wearing PPE inappropriately and extensive use of PPE in non-COVID-19 areas.

- There was crossover of cleaning staff between COVID-positive and not detected areas (2). This crossover between areas placed a significant risk on transmission of infection throughout the residential centre.
- PPE stations were haphazard and contained more equipment than was necessary which increased the risk of cross contamination.
- There was no identified Person or Persons with appropriate knowledge and skills to manage key areas of infection prevention and control within the residential centre.
- The nurse on duty was caring for both residents with confirmed COVID-19 and residents in whom COVID-19 had not been detected.
- Separate dining and changing facilities were not available for staff allocated to care for residents with COVID-19 and for those who did not.
- The housekeeping trolleys were not allocated to COVID-19 areas and non-COVID-19 areas, thus, running the risk of cross contamination during cleaning.
- Cleaning equipment was transported between the COVID- positive and not-detected areas. Equipment used in the cleaning and disinfection of an isolation area should be single use where possible and stored separately to equipment used in other areas of the facility.

- There were insufficient local assurance mechanisms in place to ensure that the environment and equipment was decontaminated and maintained as outlined in "*HIQA National Standards for infection prevention and control in community services (2018)*". Inspectors found:
  - Damaged, worn and torn chairs, cushions, mattresses and patient mobility aids were seen which inhibited cleaning for these items (3).
  - Staining and rust were observed on items such as shower chairs, bathroom fittings, grab rails and wheelchairs (3).
  - Toilet bowls and seats were dirty (3).
  - Unacceptable levels of dust were present on the undercarriages of some beds, curtain rails, on top of wardrobes and on lights over resident beds (2).
  - Dirt and debris were seen on the floor in the kitchen (2).
  - Carpets were not clean on inspection and there was no schedule for decontamination of carpets or fabric covered furnishings in place.
  - Inappropriate storage had the potential to lead to cross-contamination (2). For example, Inspectors found cleaning materials stored with food items, staff belongings on shelves in the kitchen and unused incontinence wear removed from its packaging and stored on a shared bathroom shelf.
  - Equipment, cleaning supplies and boxes were seen stored on the floor which is inappropriate and unsafe as cleaning the floor beneath is impossible and the items become contaminated (3).
  - Open-but-unused portions of wound dressings were observed in the treatment room. Re-use of open but unused wound dressings is not recommended due to risk of contamination (2).
  - Reusable nebuliser chambers were not rinsed with sterile water and stored dry after each use. The residual volume should be rinsed out with sterile water after use and reusable nebuliser chambers should be stored clean and dry between uses. Medication is delivered directly to the lungs and could, if

5.0 **DETAILED FINDINGS** Continued...

contaminated, be a source of infection (2).

- Several hoist slings were found hanging off pieces of equipment and no resident identifiers were seen on the slings, indicating they were not resident specific.
- The inspector observed medicine cups and spoons being washed in the hand wash sink in the treatment room.
- The surfaces on a cleaning trolley in use was observed to be unclean (2). This posed a risk of infection transmission as the cleaning trolley was transported to all areas of the residential centre each day.
- Cleaning schedules to ensure all communal equipment was cleaned in between each use were not in place (2).
- Cleaning frequency of frequently touched surfaces was not completed at least twice daily as recommended.
- Cleaning staff were using a hoover without a HEPA filtration system which is not recommended.
- Cleaning products were not being used in accordance with manufacturers guidelines (3). Inspectors observed incorrect dilution rates, bleach being mixed with detergent and a chlorine-based product inappropriately being used for routine environmental cleaning.
- Bottles of cleaning preparations prepared by cleaning staff were not labelled to identify the contents or dated to ensure they were discarded after each 24 hour period.
- The same mop and water were used for up to six bedrooms. Mop buckets were emptied and refilled in resident's ensuite toilets and showers.
- Inspectors were informed that resident's used wash-water was emptied down hand wash sinks in resident's rooms. This practice should cease as this will significantly increase the risk of environmental contamination and cross infection (4).
- The dirty utility room contained a bedpan washer that had a display but did not indicate what temperature was reached during the disinfectant cycle. Records were requested regarding the service history, but none were seen.
- There was no bedpan washer or macerator currently available for use in the residential centre. Manual cleaning and disinfection must be avoided as the risk of contamination is too high (2).
- Spill kits in the dirty utility room contained out of date chlorine disinfectant tablets (3).
- Appropriate signage in the laundry room to clearly support the processes in place were not available.
- Clean laundry was hung directly above a hand wash sink in the laundry which posed a risk of contamination.
- Appropriate resources for the safe transportation and cleaning of soiled clothing and bed linen were not available to staff.

- Barriers to effective hand hygiene practice were identified. Inspectors observed:
  - Available sinks designated for hand hygiene did not comply with current recommended specifications (4).
  - There was a limited number of clinical hand wash sinks in the residential centre and many were dual purpose (4).
  - Staff practice did not reflect the World Health Organisation's (WHO) five moments of hand hygiene (2).
  - More than one staff member was seen to be wearing hand and wrist jewellery (2).
  - The underside and inside of a number of wall mounted soap and alcohol hand gel dispensers were unclean.
  - PPE and alcohol hand rub were not

5.0 DETAILED FINDINGS Continued...

available in key transit areas of the residential centre such as the entrance to dining rooms.

- The following issues important to good infection prevention and control practices required improvement:
    - PPE such as gloves and masks were used inappropriately during the course of the inspection (2). For example, Inspectors observed staff members gelling their gloves, not removing gloves prior to exiting residents' rooms, wearing gloves when there was no indication do to so, wearing the white surgical masks the wrong way around and wearing masks under their chins while outside the building.
    - Inspectors observed that staff members did not adhere to required social distancing measures while on scheduled break times (2).
    - Residents were not social distancing at dinner and were observed to be congregated in a small dining area, which increases the risk of transmission of infection.
    - Care staff were observed entering the kitchen, without following appropriate procedures and wearing appropriate attire, which was an infection control risk and may increase the risk of cross infection.

Regulation 28: Fire Precautions

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

- ***Not Compliant Red:***
    - **Fire Safety:**
        - There were risks identified in relation to fire safety management which resulted in an urgent action plan being issued to the Registered Provider as the Inspector was not assured that residents could be safely and quickly evacuated in the event of a fire (5).
        - The Registered Provider was not taking adequate precautions against the risk of fire (5). Inspectors found:
            - A fire blanket stored in the external smoking shed was undersized for its intended use as a fire blanket for residents.
            - The lint from a dryer in the laundry room had not been emptied and resulted in a build-up of lint.
            - Five oxygen cylinders were stored within the conservatory. While the cylinders were noted to be securely stored in place, there was an excessive number of cylinders stored and they were at risk of being damaged by moving equipment or wheelchairs.
            - An attic area had large volumes of combustible storage and was not adequately fire separated from the rooms below.
            - There were four devices plugged into an extension lead, hoist batteries were plugged into a small area and devices were plugged into an extension lead on top of one resident's wardrobe.
        - The Inspector was not assured that adequate means of escape, including emergency lighting, was provided throughout the residential centre (4). This was evidenced by the following:
            - The compartment boundaries used for phased evacuation were not clearly defined (2).
            - The extent of fire compartments were not fully known by staff which could cause a delay and confusion in the event of a fire evacuation.
            - A fire exit had been decommissioned without an appropriate assessment or consultation with a fire professional. Fire

5.0 **DETAILED FINDINGS** Continued...

signage was still present above the exit.

- The fire exit doors needed a code to release the door locking mechanism and there was no manual override fitted to the door in case a fault occurred. The code for the keypad was not kept beside the door. This could potentially cause a delay in the event of an evacuation.
- An exit door required a key to open it. While the Person In Charge carried a copy of the key, there was no break glass unit to provide a backup key to open the door.
- An external escape route was partially obstructed by rubbish bins.
- There was no evidence of fire exit signage or emergency lighting fitted in external escape routes to indicate fire exits and to illuminate this area in the event of an evacuation (2).
- As access to a number of bedrooms was through the dayroom, the Register Provider needs to be assured that a strategy is in place to ensure the safe evacuation from these bedrooms should a fire occur in the dayroom.

- From a review of the fire drill reports, the Inspector was not assured that adequate arrangements had been made for evacuating all persons from the residential centre in a timely manner with the staff and equipment resources available (5). There were gaps identified in the following:
  - Fire drill records and night time staff resources did not provide adequate assurances that the residents could be evacuated in a timely, safe and effective manner in the event of a fire at night (5).
  - While regular evacuation drills were being carried out, the Inspector noted the fire drills lacked detail (2). The time recorded for each fire drill was unclear if it included the total time from when the fire alarm was activated to when the full evacuation had been completed. It was not clear what location the residents had been evacuated to from the source of the fire to the place of safety.
  - There had been no fire drills completed in the last 6 months, despite monthly fire drills required as per the local policy.
- Adequate arrangements had not been made for detecting fires (4). Inspectors found:
  - Inspectors observed that some rooms had no fire detectors (3).
  - The Inspector observed an old list of room names beside the fire panel. While the new room names were also listed, it could potentially cause confusion.
  - There were two separate fire alarm systems and these were interconnected. While the fire and alarm system for the newer part of the building was addressable and would identify the exact location of a fire, the system in the older part of the building was a zoned system and required a zoned floor plan adjacent to the panel to assist staff to locate a fire.
  - The residential centre's policy stated the fire detection and alarm system was an L1 category, however the current system was L2/L4.
- Inspectors were not assured that adequate arrangements were in place for containing fires (5). This was evidenced by the following:
  - The Inspector was not assured of the likely fire performance of all fire doors (5). For example, Inspectors noticed that some doors were missing the required heat and smoke seals, double fire doors had a gap in excess of the allowable tolerances and fire doors had been re-purposed and modified where a non-fire rated vent had been fitted to a fire door.
  - The inspector noted gaps and holes within fire barriers. For example, there were cable penetrations through fire resistant ceilings that were not adequately sealed up and some attic access hatches were not fire rated (3).

5.0 DETAILED FINDINGS Continued...

- While weekly checks of fire doors were taking place and faults were recorded, not all faults had been identified (2).
- The main fire door into the kitchen, a room of increased fire risk, was in a state of disrepair and was wedged open due to the floor covering.
- Assurances were required relating to the fire rating of timber panelling which is adjacent to a protected corridor.

- The correct procedures to be followed in the event of a fire were not displayed in a prominent place in the residential centre (5). Inspectors observed:
  - Drawings were not up-to-date in some areas of the residential centre (2).
  - Drawings did not show the extent of compartment boundaries to inform the identified evacuation strategy (2).
  - Drawings required a 'mark' for the reader to be able to see his/her location.
  - The procedures displayed did not include the phased evacuation strategy described to Inspectors.

Regulation 29: Medicines and Pharmaceutical Services

(60% of Services Substantially Compliant of the 5 assessed against this Regulation)

- ***Substantially compliant:***
  - **Medication Management:**
    - The medications room was not optimal for the following reasons:
      - There was no worktop space available for nurses to prepare medications safely.
      - The temperature of the pharmacy storeroom read 25.1°C which was above the recommended temperature for the storage of some medications.
      - The two medication fridges and several storage cupboards were not locked in the clinical rooms.
    - Inspectors found that action was required to ensure that medicines were stored in a safe manner. Gaps were identified in the following:
      - Gaps were seen with the recording of daily temperatures of the fridge for storing medication (2).
      - Inspectors saw examples of numerous entries of temperatures which showed that medicines had been stored outside of the recommended temperature range.
      - Staff were not aware of the appropriate temperature range medicines should be stored at.
      - Refresher training with regard to single use items such as wound dressings was required as staff spoken with were unable to identify the single use symbol.
      - Inspectors observed some single use only dressings were opened and not disposed of.
      - Inspectors observed four out of date medicines stored in the medicine fridge on the day of the inspection.

6.0 AREAS OF GOOD PRACTICE

Table 5 below 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 this data as not all of the 20 services reviewed were inspected against each Regulation.

Table 5: Regulations that were deemed fully compliant within the inspections reviewed

Dimension	Regulation	No. of Services Inspected against this Regulation of the 20 sample reports
Capacity and Capability	Registration Regulation 8: Annual fee payable by the Registered Provider of a designated centre for older people	1
	Regulation 22: Insurance	2
	Regulation 24: Contract for the Provision of Services	3
	Regulation 30: Volunteers	1
	Regulation 33: Notification of Procedures and Arrangements for periods when Person in Charge is absent from the designated centre	1
	Quality and Safety	1
Quality and Safety	Regulation 11: Visits	15
	Regulation 18: Food and Nutrition	1
	Regulation 20: Information for Residents	1

7.0 REGULATIONS NOT INSPECTED

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

- Registration Regulation 6 (S.I.No. 61 of 2015) – Changes to Information Supplied for Registration Purposes
- Regulation 32 (S.I.No. 415 of 2013) – Notification of Absences
- Regulation 10 (S.I.No. 415 of 2013) – Communication Difficulties
- Regulation 25 (S.I.No. 415 of 2013) – Temporary Absence or Discharge of Residents

8.0 CONCLUSION

This report illustrates the 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 areas of Staffing, Governance and Management, Premises, Infection Control and Fire Precautions with many residential centres requiring improvements in key areas such as Individual Assessment and Care Planning, Protection and Risk Management.

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