Report of an inspection of a Designated Centre for Older People

Issued by the Chief Inspector

<table>
<thead>
<tr>
<th>Name of designated centre:</th>
<th>St Brendan's Community Nursing Unit</th>
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<tr>
<td>Name of provider:</td>
<td>Health Service Executive</td>
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<tr>
<td>Address of centre:</td>
<td>Lake Road, Loughrea, Galway</td>
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<tr>
<td>Type of inspection:</td>
<td>Unannounced</td>
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<tr>
<td>Date of inspection:</td>
<td>25 September 2019</td>
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<tr>
<td>Centre ID:</td>
<td>OSV-0000633</td>
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<td>Fieldwork ID:</td>
<td>MON-0027766</td>
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About the designated centre

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

St. Brendan’s Community Nursing Unit is a purpose built residential care facility overlooking the lake in the town of Loughrea in County Galway. It provides twenty four hour nursing care for 100 people over the age of 18 years whose care needs range from low to maximum dependency. The building is comprised of four care areas. Sliabh Aughty and Crannogs on the upper floor and Knock Ash and Coorheen on the ground floor. Coorheen provides care for people with dementia. Each care area has 21 single rooms and two double rooms and all bedrooms have accessible en-suite toilet and bathroom facilities. There are two sitting/dining rooms in each care area. An additional quieter sitting room is located on the ground floor which has tea and coffee making facilities and additional visitors rooms are available in the day service area. Four beds are available for residents requiring respite care. There is also a palliative care suite supported by the hospice home care team. Day Care Service is provided for up to 30 clients daily.

The following information outlines some additional data on this centre.

| Number of residents on the date of inspection: | 84 |
This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (hereafter referred to as inspectors) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. **Capacity and capability of the service:**

   This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. **Quality and safety of the service:**

   This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.
This inspection was carried out during the following times:

<table>
<thead>
<tr>
<th>Date</th>
<th>Times of Inspection</th>
<th>Inspector</th>
<th>Role</th>
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<tbody>
<tr>
<td>25 September 2019</td>
<td>09:00hrs to 18:00hrs</td>
<td>Catherine Sweeney</td>
<td>Lead</td>
</tr>
<tr>
<td>25 September 2019</td>
<td>09:00hrs to 18:00hrs</td>
<td>Brid McGoldrick</td>
<td>Support</td>
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What residents told us and what inspectors observed

Residents who communicated with the inspectors did not voice any complaints about their treatment or their care. The centre accommodated a high number of residents who required the maximum level of care. Many residents who could not communicate verbally with the inspectors were observed to be contented and relax in the presence of the staff.

Capacity and capability

This was an unannounced inspection carried out by inspectors of social services from the Office of the Chief inspector. The inspection was triggered following information received from the registered provider that the centre would re-open to admissions following suspension of same due to an action plan developed to manage the contamination of the water supply with Legionella.

On 03 May 2019 the Health Service Executive (HSE), the registered provider, had informed the Chief Inspector that measures to manage legionella contamination of the water supply in the centre included the suspension of admissions to the centre. Since then, the person in charge had submitted weekly updates to the Chief Inspector, up to and including, the 09 August 2019 when the centre re-opened to admissions. Although the contamination of the water supply has not been eradicated, the HSE has reopened the centre on foot of advice and ongoing oversight by the public health department, and a consultant microbiologist. Strict measures to manage the issue remain in place.

The findings from this inspection show that overall governance, infection control, risk management and fire safety precautions were poorly managed. The register provider has failed to ensure that:

- procedures, consistent with the standards for the prevention and control of health care associated infections, were implemented by staff
- there was sufficient staff employed in the designated centre to meet the assessed needs of the residents. The use of high levels of agency staff did not ensure person-centred care and continuity of care
- staff were appropriately supervised
- staff were knowledgeable in relation to the infection control and fire safety policies and procedures on the units, posing a significant safety risk to residents, staff and visitors
- the risk register had identified site-specific risks. Inadequate oversight of the controls and resources in place to manage identified risk was evident in the management of infection control, including the contamination of the water supply.
supply with legionella, and the risks associated with the high level of agency staff

- appropriate management systems were in place to monitor the safe and effective delivery of care
- written policies and procedures were adopted and implemented by staff
- each resident had appropriate personal dining space in the communal areas of the centre.

There was evidence to show that concerns raised on previous inspections had not been addressed by the registered provider.

**Regulation 15: Staffing**

The centre was made up of four units, Sliabh Aughty and Crannogs on the upper floor and Knock Ash and Coorheen, the dementia specific unit, on the ground floor. Each unit was staffed independently with nursing and care staff. Each unit accommodated 25 residents. Inspectors were not assured that the centre had sufficient resources to ensure the effective delivery of care in accordance with their statement of purpose and to meet the needs of the residents.

On the day of the inspection, staff reported a high rate of dependency on agency staff with rosters evidencing 900 hours of agency staff (300 hours for nurses and 600 hours for care staff) per week on a regular basis. A consequence of such a reliance on agency staff was that not all staff knew the residents or were knowledgeable about important issues such as infection control and fire safety.

Oversight of the centre was the responsibility of the person in charge, supported by the assistant director and a team of clinical nurse managers. Each unit was rostered with three nurses and five carers during the day and one nurse and one carer on each unit during the night. There was a clinical nurse manager supervising the centre at night. Inspectors were informed that the centre regularly required up to 300 hours of agency nursing staff support and 600 hours of agency care staff support per week. Sliabh Aughty had the highest requirement for agency staff with one 24 hour period (September 26th) completely staffed by agency nurses.

On the day of this inspection, the centre had three agency staff nurses on day-duty and two on night duty. Rather than ensuring that the agency staff were evenly rostered throughout the centre where they could be supported by core staff, all agency staff were working in two unit; two on day duty and one on night duty in the Coorheen unit and one on day duty and night duty in the Sliabh Aughty Unit. In addition, there were also nine agency care assistants and one agency cleaner on duty in the centre.

The impact of the high level of agency staff on the resident's quality of care was evidenced by

- insufficient staff to supervise cleaning and disinfection procedures
- poor supervision of emergency response procedures
- poor knowledge of policy and procedure in relation to fire safety and infection control

A number of staff files were reviewed and were found to contain all the requirements of Schedule 2 of the regulations. All staff and volunteers in the centre had a Garda Síochána (police) vetting certificate on file and available for review.

Judgment: Not compliant

Regulation 16: Training and staff development

The training matrix reviewed on the day of inspection did not provide assurance that staff had received appropriate training in relation to their role. A revised copy was subsequently forwarded to the Office of the Chief Inspector. A review found that all permanent staff had attended mandatory training including safeguarding older persons from abuse, fire safety, manual handling, infection control. A review of the content of training delivered was required to provide assurance that the training content is effective and improves outcomes for the residents. The training matrix did not include agency staff.

The maintenance supervisor with responsibility for maintaining the fire management system within the centre had not received on-site fire safety training.

Agency staff had not received site-specific training in emergency procedures or cleaning and infection control. The staffing of the centre with high levels of agency staff posed a significant risk to residents.

Judgment: Not compliant

Regulation 23: Governance and management

There was a clearly defined management structure within the centre. The HSE as the registered provider failed to ensure that there was an effective system of governance and management to ensure the quality and safety of residents in the designated centre. Delegated accountability and responsibility for this centre rests with the Chief Officer of CHO 2, the Head of Social Care and General Manager of Older Persons Services and manager of older persons residential services. The provider failed to ensure that actions committed to in the compliance plan following the last inspection were completed, for example actions pertinent to governance and
The person in charge was supported in the operational management of the centre by an assistant director of nursing and an advanced nurse practitioner. Some actions from the previous inspection in September 2018 relating to complaints and contracts of care had been fully addressed.

Inspectors found that the management systems such as auditing, risk assessment, and restrictive practice management were disorganised, disjointed and difficult to review. Audits had been completed in areas including activities, hand hygiene, infection control, medication management, and the sluice rooms with some audits identifying areas for improvement and associated actions plans. However, some reviewed audits did not reflect the findings of this inspection; for example an audit of the sluice room on Sliabh Aughty unit, completed by a member of the management team on the 16 September 2019 found 100% compliance and that no action was required. On the day of the inspection, one week later, incidence’s of poor hygiene and infection control were noted by inspectors in this sluice room including:

- A bedpan, tagged and dated 'clean' on the 04 September 2019 was observed to contain organic matter
- A shower chair within the sluice room was found to have organic matter on it

An action from the previous inspection report in relation to the audit format had not been addressed.

The provider had failed to ensure that policies and procedures for the centre were sufficiently site-specific to address the practice of care in the centre and any associated risks. For example, the infection control policy did not refer to the management of Legionella contamination.

Resident surveys had been completed but the key recommendations and further action required following these surveys had not been clearly identified and communicated to staff.

Judgment: Not compliant

**Regulation 24: Contract for the provision of services**

Inspectors reviewed a sample of residents contracts and found that they contained all the information required under Regulation 24.

Judgment: Compliant
### Regulation 34: Complaints procedure

The centre had a complaints policy in place. The complaints log was reviewed and all information was found to be in compliance with Regulation 34.

**Judgment:** Compliant

### Quality and safety

On the day of inspection, 82 residents were accommodated in the centre, with two residents in hospital. The assessed level of dependencies of the residents were 39 maximum, 21 high, 12 medium and 12 low. Significant failures were observed by the inspectors in the areas of fire safety management, risk management and infection control.

An unplanned triggering of the fire alarm occurred during the inspection. Inspectors observed the staff on the two units on the upper floor responding to the sounding of the fire alarm and the immediate action taken. As a consequence of these observations, inspectors were not assured that staff were familiar with the fire detection equipment or the procedures relating to fire safety.

An immediate review of the fire safety management system was required. The registered provider had failed to:

- take adequate precautions against the risk of fire by failing to make arrangements for the maintenance of all fire equipment, including fire doors
- review fire precautions
- make arrangements for staff to receive suitable training including evacuation procedures
- ensure, by means of fire safety management and drills, that staff were aware of the procedure to be followed in the case of fire.

Due to the risks identified in relation to fire safety, the inspectors issued the registered provider with an immediate action plan.

A risk register was in place and reviewed by inspectors. The register did not contain the risks identified in Regulation 26, Risk Management. The risk management policy in the centre was generic and not site-specific.

The arrangements in place to monitor and oversee infection prevention and control required significant and sustained improvement to provide safe effective care.

- There was a comprehensive infection prevention and control policy in place dated October 2017. The policy included the procedures relating to the
management of Clostridium Difficile infection, Norovirus infection, Hepatitis B and C infection but it did not contain the procedures relating to Legionella contamination of the water supply.

- Inspectors found that neither the infection control policy nor the cleaning policy were adhered to in the centre.
- Supervision of the cleaning was delegated to one of the rostered cleaners

Infection control audits completed in August 2019 did not identify the issues found by the inspectors. The cleaning schedule for rooms and communal areas had been allocated to the cleaning team. The cleaning of all supportive and assistive equipment such as wheelchairs, commodes, and shower chairs had been allocated to the health care assistants. No cleaning training had been received by any staff. A full audit of all cleaning and disinfection practices is required.

Inspectors noted an improvement in the development of assessment and care plans. However, improvement was required to ensure that assessments and care plans are person-centred and up-to-date. Residents had access to activities and social events.

Inspectors found that the the provision of dining space for residents and the organisation of some of the residents notice boards required review.

Regulation 26: Risk management

The risk management policy and the risk register in the centre did not include the requirements of Regulation 26, Risk Management. Risks that had been identified were not included in the risk policy or the risk register. Control measures for risks identified did not identify the resources required to facilitate the controls.

Inspectors observed, and were informed by staff of, a number of other risks on the day of inspection, such as,

- the high level of agency staff used in the centre
- the floor cleaning equipment had been broken for two weeks and had not been replaced
- equipment was not made available to the cleaners to enable them to clean in accordance with the cleaning and infection control policy
- staff were not immediately identifiable by name or their role, or if they were permanent staff or agency staff, as they did not wear identification badges
- a register of all nurses' signatures, including agency nurses, was not in place. On review of medication charts one signature could not be identified.
- inappropriate storage of medical supplies such as gloves and wipes on the corridor and in the assisted bathroom
- a control measure in relation to the management of the contamination of the water supply with Legionella was for all taps and showers to be flushed daily for four minutes each. The action plan did not specify the resources required to achieve this action without impacting on other areas of the
These risks were not identified in the risk register.

Judgment: Not compliant

**Regulation 27: Infection control**

Infection control management required urgent review. The management of overall infection control in the centre was poor. Inspectors were concerned that the poor supervision of infection control practices, in light of the fact that the centre is currently managing an action plan to address the contamination of the water supply with legionella, has a negative impact on the residents, staff and visitors to the centre. Practice observed by the inspectors was not in line with the centres' infection control and cleaning policy.

Evidence of poor practice was observed by

- the cleaning procedures for bedrooms in the unit were not in line with the centres cleaning or infection control policy. Floor dust was removed with a dustpan and brush and a colour-coded cloth system was not in place.
- the cleaning team had not received up-to date cleaning training
- Inspectors found gaps in signatures on the cleaning scheduled within the sluice room
- commode bowls which had been tagged as clean were visibly unclear with organic matter.
- commodes, shower-chairs and weighing chairs were found to be contaminated with organic matter.
- stagnant water was found in the assisted bath and the water dispensers throughout the centre.
- a high number of cobwebs and insects were observed to cover the outside of the bedroom windows and were also found in some bedrooms.
- the management and supervision of the control actions in relation to the contamination of the water supply with Legionella was poor. Cleaning, care and nursing staff were responsible for the flushing of all taps and showers within the centre. This system was not adequately monitored.
- access to the hand-washing sink in the sluice room was blocked with yellow plastic 'wet floor' signs
- the toilet brush used to clean the bedpans in the sluice room was visibly unclean with organic matter.

Inspectors were informed that the centre did not have access to an infection control nurse specialist.

Judgment: Not compliant
The governance and oversight of fire safety management system required immediate attention. Inspectors identified multiple risks relating to fire safety management.

- A number of compartment and sub-compartment doors did not close properly, one door’s intumescent strip was observed hanging loosely. An assessment of all fire doors is required to ensure that they will perform in the event of a fire.
- Records of fire testing equipment was inconsistent and ineffective. For example, the fire alarm was due to be tested weekly. On review of the documentation inspectors found that there were gaps of two to three weeks between tests. Only one zone (five) was repeatedly tested. This did not provide assurance that all zones monitored by the fire alarm were in working order.
- The fire procedure notices displayed in the centre were not prominent. Inspectors noted a procedure notice was obscured by a calendar on a notice board.
- No way-finding maps were available to residents or visitors to the centre
- The personal emergency evacuation plans (PEEP’s) for residents were not organised in a way that information could be easily accessed in the case of an emergency.
- Fire evacuation drill records reviewed did not provide assurances that residents could be evacuated safely in a timely manner in the event of a fire. Records showed that the fire drills carried out had simulated the evacuation of only one resident. There was no recorded evidence of full compartment evacuations with regards to evacuation resources (staffing and equipment) and residents dependency levels. Simulated evacuation drills using night time staffing levels was required for the bedroom with the highest evacuation dependencies, the compartment with the highest evacuation dependencies.
- On activation of the fire alarm, staff were not aware of the procedure to be followed. Inspectors observed staff leaving both units on the upper floor of the centre. There was no direction given to staff. Staff spoken with stated that they did not know where they should be. A resident was left unattended and was observed holding her fingers in her ears. One staff member attempted to press the button to use lift.
- On activation of the fire alarm, the location detail of the triggered sensor on the fire alarm panel was complex and confusing and led to a delay in identifying the area of the triggered sensor. Repeated alarms were sounded as there was a delay in closing a damper which was a requirement. The procedure for closing the damper was not outlined in the fire procedure viewed.
- Staff were not aware of the procedure required to reset the fire alarm in a timely manner.
- The content of fire safety training required review, and training was required
for staff (including agency staff) for all evacuation measures and on the alarm system in place.

- Inspectors were advised that four staff are required in the dementia specific unit when the alarm is activated. The specific requirements were not risk assessed and no drill had tested that this number of staff would be sufficient in the event of a fire in this area.

These issues posed an immediate and significant risk to the residents, visits and staff in the centre. The provider was issued with an urgent action plan to address these risks.

Judgment: Not compliant

### Regulation 5: Individual assessment and care plan

Individual assessments and care plans were in place for each resident. Most of the residents' care plans were informed by the assessment process and clearly guided staff. Care plans for residents with dementia or cognitive symptoms were evidence based and person-centred. Improvements were noted in the care plans, in particular, those supporting residents with responsive behaviours were seen to evidence consultation with resident and their representatives. However, some gaps were noted in the assessment process. For example, some assessments in relation to nutritional risk had not been reviewed in line with a resident's needs. Some of the care plans reviewed were generic in nature and did not contain person-centred information.

Further improvements were required to ensure that assessments and care plans were person-centred and up-to date.

Judgment: Substantially compliant

### Regulation 6: Health care

Residents had good access to general practitioners and other allied health care professionals. The advanced nurse practitioner confirmed to inspectors that residents were referred to allied health professionals based on the clinical assessment. A review of the residents files found this to be the case.

The centre did not have access to an infection control nurse. The issue of water contamination by legionella was overseen by the Public Health department.

Judgment: Substantially compliant
Regulation 9: Residents' rights

The provision of activities for the residents was based on a comprehensive assessment of their social care needs using two validated assessment tools. A community choir was in place and rehearsed weekly before Mass. There was a music night scheduled once a month. Residents had access to local newspapers, television and radio in the communal and personal areas of the centre.

A notice board was in place in every unit. The notice board in the dementia unit was used as an effective orientation board detailed the time and date, and contained clear and uncluttered information for residents. The notices on the other three units were overloaded with information including important safety notices in relation to the contamination of the water supply.

Each resident had a poster beside their beds, displayed in an attractive and respectful way, that identified the things that were important to each resident. The initiative called 'What matters to me' described what was personal to the resident and enabled staff to communicate to the residents using information that was person-centred and meaningful to the residents.

An inspector observed the dining experience in one of the units. The space was limited and could not accommodate comfortably the residents who were present having their meal. This aspect has been identified by management and staff. While there are future plans to increase the space provided no interim measure such as provision of an additional sitting has been implemented to meet current resident needs.

Judgment: Substantially compliant
Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

<table>
<thead>
<tr>
<th>Regulation Title</th>
<th>Judgment</th>
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<tbody>
<tr>
<td><strong>Capacity and capability</strong></td>
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<tr>
<td>Regulation 15: Staffing</td>
<td>Not compliant</td>
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<tr>
<td>Regulation 16: Training and staff development</td>
<td>Not compliant</td>
</tr>
<tr>
<td>Regulation 23: Governance and management</td>
<td>Not compliant</td>
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<tr>
<td>Regulation 24: Contract for the provision of services</td>
<td>Compliant</td>
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<tr>
<td>Regulation 34: Complaints procedure</td>
<td>Compliant</td>
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<tr>
<td><strong>Quality and safety</strong></td>
<td></td>
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<tr>
<td>Regulation 26: Risk management</td>
<td>Not compliant</td>
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<tr>
<td>Regulation 27: Infection control</td>
<td>Not compliant</td>
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<tr>
<td>Regulation 28: Fire precautions</td>
<td>Not compliant</td>
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<tr>
<td>Regulation 5: Individual assessment and care plan</td>
<td>Substantially compliant</td>
</tr>
<tr>
<td>Regulation 6: Health care</td>
<td>Substantially compliant</td>
</tr>
<tr>
<td>Regulation 9: Residents' rights</td>
<td>Substantially compliant</td>
</tr>
</tbody>
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Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant** - A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant** - A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action within a reasonable timeframe to come into compliance.
Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be SMART in nature. Specific to that regulation, Measurable so that they can monitor progress, Achievable and Realistic, and Time bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider’s responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider’s response:

<table>
<thead>
<tr>
<th>Regulation Heading</th>
<th>Judgment</th>
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<tr>
<td>Regulation 15: Staffing</td>
<td>Not Compliant</td>
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Outline how you are going to come into compliance with Regulation 15: Staffing:

- A staffing, whole time equivalents (WTE) analysis has been re-done, based on an agreed staffing level and skill mix, for each care area. This exercise identified where the staffing gaps were in terms of both frontline and governance posts
- National approval has been sought to fill all identified vacant posts
- In the interim agency staff are being engaged to supplement staff to ensure appropriate staffing levels are in place for safe levels of care.
- Agency staff are to be allocated per care area to optimise knowledge of the Care Area and the residents to ensure continuity of care
- Under the Health Service Executive (HSE) Service Arrangement for Agency staff, all clinical staff must have completed specific training including fire safety.
- Site specific fire training is being provided to Agency staff
- Prior to the Inspection a General Manager (GM) led process was underway to reduce the level of Agency for Healthcare Assistants (HCA) staff. A meeting is taking place with union officials on 6th November 2019 to progress this
- Hygiene team, with additional dedicated trained resources is in place, based on flushing time requirement to achieve daily flushing for legionella
- Hygiene staff have received training in cleaning process from external Infection Control Consultant, with a further session planned
- A structured room cleaning template has been provided by the Infection Control and Prevention (IPC) Consultant and work has commenced on implementing this
- The Hygiene Team Supervisor role is being reviewed to ensure that the education and training required for the role are in place
- Emergency response procedures have been reviewed, fire training has been delivered to the majority of staff and simulated evacuation drills have been completed on three occasions for a compartment. Four more training & evacuation sessions planned. All site specific training is made available to agency staff

The inspector has reviewed the provider compliance plan. This action proposed to address the regulatory non-compliance does not adequately assure the Chief Inspector that the action will result in compliance with the regulation
• The centre is currently closed to all short stay admissions and no long stay admissions have been admitted whilst the areas of noncompliance are addressed. On 6th November 2019 there are 83 residents.

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<th>Regulation 16: Training and staff development</th>
<th>Not Compliant</th>
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Outline how you are going to come into compliance with Regulation 16: Training and staff development:

• A training matrix is in place for all HSE staff

• The Service Level Agreement between the agency and the HSE requires that all agency staff have received mandatory training prior to commencing work in St Brendan’s CNU with training updates completed as required by the stipulated mandatory time frames.

• Agency staff are now receiving site specific fire training including simulated evacuation drills. Infection Prevention and Control (IPC) training is delivered by the agency. Site specific legionella information is given at report every morning by the Nurse in Charge/CNM/Person in Charge to all staff

• A training matrix incorporating agency staff training to capture all training availed of by agency staff delivered in or by St Brendan’s CNU will also be maintained. Email sent to agencies with dates of site specific fire training and evacuation and IPC staff training.

• Maintenance supervisor had received site specific fire training on the St Brendan’s campus and is trained on the fire alarm.

A new HSE Fire Safety Trainer is commencing in January 2020 following a procurement process. The fire safety training modules for Designated Centres are to be agreed by senior management and will include the required level of simulated evacuation

• Prior to the HIQA Inspection, a GM led process was underway to reduce the level of Agency HCA staff and a meeting is taking place with union officials on 6th November 2019 to progress this

• A review of what level of services can be safely delivered in St Brendans is being undertaken framed by the constraints of the built environment of 4 wards; one of which is dementia specific, the fact that there are currently 83 residents and the need to retain free rooms on each care area to maintain accessible communal showers while the legionella levels are brought back within standard
Outline how you are going to come into compliance with Regulation 23: Governance and management:

- All vacant posts to meet the accepted staffing levels, including the two vacant Clinical Nurse Management (CNM) posts, have been submitted and in some cases re-submitted as priority in accordance with the HSE recruitment processes which currently require National Director approval – the CNM 2 posts were re-submitted to National Director for approval on 31.10.2019

- Risk management system has been reviewed in conjunction with the Social Care Risk Manager to ensure that all identified risks have a completed risk assessment form and are included in the Risk Register. Risks assessments have been reviewed to ensure controls and resources are identified to manage the identified risks. Risks will be escalated to the Social Care Risk Register and an organisational Risk Register as per agreed process, where appropriate.

- Audits have been reviewed & organized to aid the retrieval of data & the clear identification of risks. Quality Improvement Plans are developed to address the non-compliance in a structured manner

- Infection Prevention and Control (IPC) training has been delivered by an external IPC Consultant.

- A review of infection control processes is being undertaken in each care area with an Infection control audit scheduled for December by an external IPC Consultant.

- Site specific management of legionella information has been added to the Infection Control policy

- Audit training to be provided to all senior staff.

- The General Manager has competed an audit of the Legionella Flushing process and the recommendations identified are being implemented

- Resident’s survey has been reviewed by the Multi-disciplinary team and the recommendations and future actions required following the survey are under review.

<table>
<thead>
<tr>
<th>Regulation 23: Governance and management</th>
<th>Not Compliant</th>
</tr>
</thead>
</table>

| Regulation 26: Risk management | Not Compliant |
Outline how you are going to come into compliance with Regulation 26: Risk management:
The risk register has been updated to include all completed risk assessments.
• Risk assessment of agency staff has now been completed.
• Cleaning equipment risk assessment completed following which an alternative machine is to be used in future. If there is a breakdown of the corridor cleaning machine the corridor may be hoovered & washed in sections. In addition a review of cleaning equipment has been completed and additional cleaning equipment purchased
• Risk assessment completed on staff utilization of identification badges, agreed that staff name and grade would be included. Agency staff has been requested to ensure compliance- this will be monitored by Clinical Nurse Manager (CNM) /Nurse in Charge. Uniform policy updated & reissued to all staff. This will be monitored by the CNM 2 and also audited to ensure compliance.
• A record of all nurses signatures is now in place and maintained in Nursing administration, with a standard operating procedure for agency staff induction.
• CNM to review storage in each area of gloves, wipes and equipment.
• Staff has been reminded about general tidiness and appropriate storage. Compliance will be addressed through the IPC (Infection Prevention and Control) Audit
• Hygiene team, with additional dedicated resources is in place, based on the standard 3 minute flushing time for both cold and hot taps, to achieve daily flushing for legionella
• Risk assessment completed in relation to Legionella and resource identified for flushing.
• The Risk Management Policy has been developed to include all site specific identified Risks
• The registered provider has ensured that the risk management policy set out in Schedule 5 includes the measures and actions in place to control abuse. A Section on the management of abuse within St Brendans has been incorporated into the Risk Management Policy.
• A Section on the management of unexplained absence of any resident within St Brendan’s CNU has been incorporated into the Risk Management Policy.
• A Section on the management of measures and actions in place to control accidental injury to residents, visitors or staff within St Brendan’s CNU has been incorporated into the updated Risk Management Policy.
• Section on the management of measures and actions in place to control aggression and violence within St Brendan’s CNU has been incorporated into the Risk Management Policy.

| Regulation 27: Infection control | Not Compliant |

Outline how you are going to come into compliance with Regulation 27: Infection control:
• Training has now been delivered to cleaning staff regarding cleaning process with all reminded of the rational for and requirement to adhere to the set out procedures. An audit of hygiene is currently being scheduled by the external auditor
• Equipment used by cleaning team has been reviewed by the external auditor and
equipment ordered as indicated.
- The revised structured cleaning schedule provided by the Infection Prevention and Control (IPC) Consultant is designed to ensure all areas including internal and external window cleaning in embraced.
- A schedule of window cleaning is in place, all windows to be next cleaned in November 2019
- A new cleaning schedule for sluice rooms to include commodes and shower chairs has been implemented and is monitored weekly by the Clinical Nurse Manager (CNM) to ensure compliance.
- CNM is responsible for ensuring cleaning signatures are recorded in respect of sluice rooms, and this is monitored weekly.
- Commodes, shower chairs and weight chairs are part of the structured cleaning programme and will also be part of the above audit by CNM
- Training on cleaning of equipment has been delivered to some Health Care Assistants (HCA) with further training scheduled.
- Stagnant water in a bath is thought to have occurred from the legionella flushing process. The flushing procedure has now been amended to include checking of the area by staff for stagnant water before leaving the area. Water dispensers trays are cleaned daily by HCA staff
- The General manager has completed an audit of flushing process, night staff (All HSE-Agency only engaged for night shift in an emergency situation) are now trained in advance of going on night duty on the week prior to commencement of night duty. CNM/Nurse in Charge on Night duty is responsible for governance.
- Sluice areas audited by CNM and storage is currently being reviewed
- Toilet brush replaced
- Signs have been erected beside the wash hand basin in the Sluice Rooms stating “keep free of stored items to ensure available for hand-washing”
- An IPC Nurse for Community healthcare region is approved and being recruited

<table>
<thead>
<tr>
<th>Regulation 28: Fire precautions</th>
<th>Not Compliant</th>
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</thead>
<tbody>
<tr>
<td>Outline how you are going to come into compliance with Regulation 28: Fire precautions:</td>
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<tr>
<td>Notices in place at fire panel in each care area on procedure to follow on activation of fire alarm. Staff go to the fire alarm panel in their own care area &amp; take direction from Clinical Nurse Manager (CNM) /Nurse in charge who will delegate staff to go to the active zone &amp; staff to remain and care for residents. Fire procedure outlined to all staff at each handover.</td>
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<tr>
<td>A Step and magnifying glass has been put in place at alarm panel so display information can be seen regardless of height.</td>
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<tr>
<td>Fire Alarm instructions in place outlining location of key to open fire panel door &amp; procedure to follow to silence alarm.</td>
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</tr>
<tr>
<td>Designated fire safety lead identified on all shifts &amp; notice board in reception to communicate this information to all staff. This lead is aware of management of Fire Alarm System &amp; procedure to follow in event of fire.</td>
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</tbody>
</table>
• Signs identifying the location of the stairs have been erected.
• Protocol agreed that in the event of Zone 11 (basement area) being activated during night duty with the fire brigade to be called immediately.
• The fire panel & damper panel has been separated & resetting alarm following activation in Zone 11 damper compartment does not now involve resetting damper panel. This was approved by the independent fire safety engineer.
• Kitchen protocols clearly state cleaning store door to be kept closed. Sign erected to this effect. Fire detector head in this cleaning store replaced on 23.10.19
• A site specific Fire safety policy for St Brendan’s CNU is currently being developed and will be completed by 25th November 2019 and will include
  □ location of Fire Panels
  □ Who takes charge in the event of a fire alarm and/or damper activation
  □ The protocol to be followed in each care area including day care and the basement kitchen & laundry area in the event of a fire alarm activation
  □ Where individual Patient Evacuation Plans are located
  □ Routine Fire Safety Checks
  □ Fire safety training
  □ How maintenance are contacted
  □ How potential absconsion is handled when door closers are overridden in a fire alarm activation
  □ A basic individual exit plan for each room
  □ Fire Alarm Monitoring protocols
  □ Location of stairs.
  □ Visitor evacuation plan

• Provider has engaged an independent third party fire specialist company to inspect the Fire Detection and Alarm System (FDAS) in St Brendan’s Community Nursing Unit. This inspection took place on 23.10.19 by fire specialist engineer on FDAS. The report noted that several checks carried out by the fire specialist confirmed that the device text to be correct.
• An assessment of 155 single doors and 58 double doors in the centre has been requested by the provider, from door specialists, due on 18.11.2019.
• Maintenance has completed remedial actions on the doors identified as a concern during the inspection.
• On-site fire training & evacuation training has been in place since 25th September 2019 and all site safety training scheduled includes training and instruction on FDAS in St. Brendans CNU.
• Three night staff simulated evacuations have taken place which records the timelines for the drills, the number of residents evacuated & the dependency level.
• Four further training sessions & night time staffing simulation evacuations are planned for 7/11/19, 20/11/19, 27/11/19 & 10/12/19. Agency staff will be scheduled to attend the fire training sessions and participate in the evacuation simulations.
• Fire specialists conduct three monthly fire safety checks as per service contract, with the most recent visit on 30th October 2019.
• Users of the FDAS are involved in the weekly tests carried out by maintenance in a different area each week.
• Audit of fire safety has been approved & commissioned.
• Senior management have formally notified the fire officer in Galway County Council of fire safety concerns raised during recent inspection.
<table>
<thead>
<tr>
<th>Regulation 5: Individual assessment and care plan</th>
<th>Substantially Compliant</th>
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</thead>
<tbody>
<tr>
<td>Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:</td>
<td></td>
</tr>
<tr>
<td>• Each resident has an assigned Nurse responsible for developing their person centered care plan</td>
<td></td>
</tr>
<tr>
<td>• Advanced Nurse Practitioner (ANP) is currently undertaking 1 year programme on person centered care planning and has commenced a working group with representatives from Coorheen Dementia Care Area</td>
<td></td>
</tr>
<tr>
<td>• CNMs are responsible to audit care plans for their area of responsibility to ensure compliance, including that the plans are person centred and that nutritional risks are reviewed</td>
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<tr>
<td>• Electronic care plan system is enhanced to set up schedule of required care plans which alerts staff when an assessment is due</td>
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</tbody>
</table>

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<thead>
<tr>
<th>Regulation 6: Health care</th>
<th>Substantially Compliant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outline how you are going to come into compliance with Regulation 6: Health care:</td>
<td></td>
</tr>
<tr>
<td>• An Infection Control Nurse has been engaged from a private provider</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Regulation 9: Residents' rights</th>
<th>Substantially Compliant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outline how you are going to come into compliance with Regulation 9: Residents' rights:</td>
<td></td>
</tr>
<tr>
<td>• Notice boards have been reviewed by CNM and information segregated</td>
<td></td>
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<tr>
<td>• The dining room area is been reviewed by an architect, a plan has been submitted, which will increase dining room space.</td>
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<tr>
<td>• Dining room experience is been reviewed by CNM, Nursing Management, ANP and Catering Manager to enhance the dining room experience, maximize space at mealtimes, resident choice and social dining. Identified improvements will be actioned</td>
<td></td>
</tr>
</tbody>
</table>
Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

<table>
<thead>
<tr>
<th>Regulation</th>
<th>Regulatory requirement</th>
<th>Judgment</th>
<th>Risk rating</th>
<th>Date to be complied with</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 15(1)</td>
<td>The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>01/03/2020</td>
</tr>
<tr>
<td>Regulation 16(1)(a)</td>
<td>The person in charge shall ensure that staff have access to appropriate training.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>07/11/2019</td>
</tr>
<tr>
<td>Regulation 16(1)(b)</td>
<td>The person in charge shall ensure that staff are appropriately supervised.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>01/03/2020</td>
</tr>
<tr>
<td>Regulation 23(a)</td>
<td>The registered provider shall ensure that the designated centre has sufficient resources to ensure the</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>01/03/2020</td>
</tr>
<tr>
<td>Regulation 23(c)</td>
<td>The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>01/03/2020</td>
</tr>
<tr>
<td>Regulation 26(1)(a)</td>
<td>The registered provider shall ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>07/11/2019</td>
</tr>
<tr>
<td>Regulation 26(1)(c)(i)</td>
<td>The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control abuse.</td>
<td>Not Compliant</td>
<td>Yellow</td>
<td>07/11/2019</td>
</tr>
<tr>
<td>Regulation 26(1)(c)(ii)</td>
<td>The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the</td>
<td>Not Compliant</td>
<td>Yellow</td>
<td>07/11/2019</td>
</tr>
<tr>
<td>Regulation</td>
<td>Description</td>
<td>Not Compliant</td>
<td>Colour</td>
<td>Date</td>
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<tr>
<td>26(1)(c)(iii)</td>
<td>The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control accidental injury to residents, visitors or staff.</td>
<td>Not Compliant</td>
<td>Yellow</td>
<td>07/11/2019</td>
</tr>
<tr>
<td>26(1)(c)(iv)</td>
<td>The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control aggression and violence.</td>
<td>Not Compliant</td>
<td>Yellow</td>
<td>07/11/2019</td>
</tr>
<tr>
<td>27</td>
<td>The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.</td>
<td>Not Compliant</td>
<td>Red</td>
<td>01/01/2020</td>
</tr>
<tr>
<td>28(1)(c)(i)</td>
<td>The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and</td>
<td>Not Compliant</td>
<td>Red</td>
<td>04/10/2019</td>
</tr>
<tr>
<td>Regulation</td>
<td>Description</td>
<td>Compliance</td>
<td>Result</td>
<td>Date</td>
</tr>
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<tr>
<td>28(1)(d)</td>
<td>The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.</td>
<td>Not Compliant</td>
<td>Red</td>
<td>10/12/2019</td>
</tr>
<tr>
<td>28(1)(e)</td>
<td>The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>10/12/2019</td>
</tr>
<tr>
<td>28(2)(iv)</td>
<td>The registered provider shall make adequate</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>10/12/2019</td>
</tr>
<tr>
<td>Regulation 28(3)</td>
<td>The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place in the designated centre.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>07/11/2019</td>
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<tr>
<td>Regulation 5(2)</td>
<td>The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person’s admission to a designated centre.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>07/11/2019</td>
</tr>
<tr>
<td>Regulation 5(3)</td>
<td>The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident’s admission to the designated centre</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>07/11/2019</td>
</tr>
<tr>
<td>Regulation 6(2)(c)</td>
<td>The person in charge shall, in so far as is reasonably practical, make available to a resident where the care referred to in paragraph (1) or other health care service requires additional professional expertise, access to such treatment.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>07/11/2019</td>
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<tr>
<td>Regulation 9(2)(a)</td>
<td>The registered provider shall provide for residents facilities for occupation and recreation.</td>
<td>Not Compliant</td>
<td></td>
<td>01/12/2019</td>
</tr>
</tbody>
</table>