Health Information and Quality Authority
Regulation Directorate

Compliance Monitoring Inspection report
Designated Centres under Health Act 2007, as amended

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	Hazel Hall Nursing Home
Centre ID:	OSV-0000049
Centre address:	Prosperous Road, Clane, Kildare.
Telephone number:	045 868 662
Email address:	info@hazelhallnursinghome.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Esker Property Holdings Limited
Provider Nominee:	Samantha Boylan
Lead inspector:	Nuala Rafferty
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	43
Number of vacancies on the date of inspection:	2

About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

▪ Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
▪ Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

▪ to monitor compliance with regulations and standards
▪ to carry out thematic inspections in respect of specific outcomes
▪ following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
▪ arising from a number of events including information affecting the safety or wellbeing of residents.

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.

Please note the definition of the following term used in reports:
responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was following receipt of unsolicited information. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
19 June 2017 06:30	19 June 2017 20:30

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

Outcome	Our Judgment
Outcome 02: Governance and Management	Non Compliant - Major
Outcome 03: Information for residents	Substantially Compliant
Outcome 05: Documentation to be kept at a designated centre	Non Compliant - Moderate
Outcome 07: Safeguarding and Safety	Non Compliant - Moderate
Outcome 08: Health and Safety and Risk Management	Non Compliant - Major
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 15: Food and Nutrition	Compliant
Outcome 18: Suitable Staffing	Non Compliant - Major

Summary of findings from this inspection

This was an unannounced inspection, further to information received, by the Health Information and Quality Authority (HIQA). The purpose of the inspection was to monitor ongoing compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and the National Standards for Residential Care Settings for Older People in Ireland.

The findings of the last inspection, a registration inspection in January 2016, and progress on some of the actions arising from that inspection, were also considered. Three breaches of the regulations were identified on the inspection in January 2016. Actions arising from these were reviewed, and found that two of the actions were not addressed and one was in progress on this inspection The inspector met and spoke with some residents who were satisfied with the care they received and said they felt safe in the centre.

Residents had good access to nursing, medical and allied health care and the administration of medicines was satisfactory. However, improvements in several areas were required including improvements to governance, risk management, staff training and skill mix, and the assessment, planning and recording of care.

The Action Plan at the end of this report identifies areas where prioritised and sustained improvements are required to comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

The action plan response, submitted by the provider to some of the required actions, did not satisfactorily address all of the failings identified in the report. As some of the responses were not acceptable, HIQA have taken the decision not to include these responses in the published report.

Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

Outcome 02: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.

Theme:
Governance, Leadership and Management

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

Findings:
A clearly defined management structure as outlined in the statement of purpose was not in place. The inspector found that the roles, responsibilities and the lines of authority and accountability of each member of the management team were not clear. The job descriptions of some senior managers employed by the provider were recently amended and the inspector found that the management team were not clear on their areas of responsibilities or level of accountability. This impacted negatively on the overall governance of the centre, particularly in relation to oversight of staff, in terms of recruitment, induction, orientation, training and assessment of competence.

There was a lack of clarity within the management team on their roles and responsibilities. The inspector found that job descriptions (an official written description of the responsibilities and requirements of a specific job), were not in place for all members of the management team. Where they were in place, the descriptions were confusing in that, the responsibilities of some managers overlapped, while other key management responsibilities were not identified, and none were linked to existing policies.
Examples included:
•A senior manager, was not identified to hold responsibility and accountability for all:
1. recruitment and retention processes.
2. staff appraisals, performance management and competence assessments.
3. supervision direction and management of each staff group.

•The roles and responsibilities of staff as outlined in the current job descriptions for each grade contradicted policies currently in place in the centre including: the policies for recruitment and retention, delegation and supervision and induction. For example, the recruitment and retention policy identified the person in charge, as the responsible person for ensuring staff have access to appropriate training, but the responsibility was

included in the job description for the deputy director of operations.
•The roles of the registered nurse and care practice facilitator overlapped where both grades were assigned the same responsibilities to supervise healthcare assistants and provide and complete inductions for new healthcare assistants. Differentiation in the level or type of responsibilities was not clear and the inspector found that the registered nursing team had little input into the supervision of healthcare assistants during the inspection.
•Responsibilities to ensure the completion and sign off of induction and orientation training processes for new staff were not assigned to any manager, nurse or other staff grade.
The inspector found that the governance systems, in place, were not effective. Examples included:
•Evidence that orientation programmes for all new staff were fully completed was not found.
•The orientation booklet for new staff employed within the previous nine months had not been completed or signed off by a senior manager, nurse or assigned carer.
•The qualifications of staff who had already completed their probation periods had not been verified nor had a competence assessment been conducted.
•Verification of training or identification of any additional training needs had not been made. As referenced under outcomes 8 and 18 all new staff had not been provided with required and mandatory training prior to or subsequent to their commencement in post.
•Responsibility for the completion and return of the orientation booklet was left solely with the new employee.
The impact of the lack of effective governance on residents is referenced under other outcomes of this report such as: poor moving and handling practices, care plans not fully implemented, staff knowledge of current policies and the care needs of all residents required improvement, the recording of care delivery did not evidence delivery of suitable care in a timely manner.

Some systems were in place to monitor quality and safety of care. Data was being collated on a monthly basis on key performance indicators (KPIs) of clinical care such as: pressure ulcers, restraint, infections nutrition, responsive behaviours and falls. These KPIs are used as a way to assess the standard of care being delivered in the centre. Regular, monthly meetings of the senior management team took place and a sample number of minutes of these meetings held were viewed. The inspector was told that the management team considered the data collated on the KPIs and used this information to identify actions to improve the standard of care delivered to residents. However, there was limited documented evidence of data analysis, or that the results of all audits were used to promote improvements in care standards. Improvements to these care monitoring systems were required to establish a complete cycle of audit.

An annual review of safety and quality of care was conducted and a copy of the draft report was viewed. The aim of the report was to acknowledge quality of care delivery in 2016 and identify areas of improvement for 2017. The report included information on areas such as: occupancy, complaints, staff training, analysis and results of resident satisfaction surveys. It also referenced quality care indicators such as the results of audits conducted on falls, care plans, use of restraints and medications. The results of resident and relatives satisfaction audits for 2016 were also included.
However, the inspector noted that the information used to inform the report did not

always relate to the year the report referenced. For example, all audits referenced were from 2013 and 2015. The details of staff training delivered were from 2015 and not 2016.

Judgment:
Non Compliant - Major

Outcome 03: Information for residents
A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

Theme:
Governance, Leadership and Management

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

Findings:
A resident's guide to the centre was available. This described the centre services, management and complaints procedure. Communal areas such as the lobby also had information on display regarding the complaints procedure, evacuation instructions and contact details for advocacy services.

Each resident had an agreed written contract which deals with the resident's care and welfare. The contract included all details of the services to be provided for that resident and the fees to be charged.
This included a list of facilities and services provided including laundry, meals, and housekeeping. Services offered in the centre which incurred additional fees were listed. However, the contract did not outline the terms of residency, in that, it did not identify whether the room to be occupied was a single or shared room. The inspector was told that the contract was revised to reflect the terms of residency, prior to the end of the inspection.

Judgment:
Substantially Compliant

Outcome 05: Documentation to be kept at a designated centre
The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:
Governance, Leadership and Management

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

Findings:
All lines of enquiry were not reviewed for this outcome.
Records set out in Part 6 of the Regulations were available and kept in a secure place. General records, as required under Schedule 4, such, such as visitors log, food records and notifications were also in place.

The centre maintained a suite of policies including those required under Schedule 5 of the regulations. Some polices were reviewed on a regular basis and within the three year timeframe required by the regulations, although not all. Examples of policies not reviewed included the fire strategy policy and the delegation and supervision policy. The inspector also found that some staff were not familiar with the policies in place and had not had an opportunity to read them.

A process was in place whereby staff were to sign off on an acknowledgement, 'sign-off', page to indicate they had read and understood each policy. The inspector looked at these 'sign-off' pages and noted that only two staff had signed as having read the policies to date in 2017 despite a considerable number of new staff starting in 2017. It was also noted that few staff (between three and five people only) had signed to indicate they had read the policies during 2016, this included the senior management team, where only the person in charge, the assistant director of nursing and a member of the administration team had signed.

Judgment:
Non Compliant - Moderate

Outcome 07: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe care and support

Outstanding requirement(s) from previous inspection(s):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
Staff had received training on the prevention of elder abuse and all staff spoken with were clear on their role and responsibilities in relation to reporting abuse. Some staff spoken with could tell the inspector how they would recognise the possible signs and

symptoms of abuse, and outlined the appropriate ways in which allegations should be responded too and managed. The inspector spoke with a small number of residents who said they felt safe in the centre. Where residents were unable to, or did not wish to speak with the inspector, behaviours associated with fear were not observed.

Assessment of risks, associated with the use of restraints such as bed rails and lap belts, were in place and regularly reviewed. The use of bed rail restraint had reduced since the last inspection, and the use of alternative measures such as low-low beds, mat and bed alarms had increased. Falls management systems included appropriate supervision of residents by staff.

Improvements to the systems in place to assist residents' to manage their finances were being progressed. An external consultant on financial processes was assisting the management team to review financial procedures to ensure they were compliant with all relevant legislation. This process was not fully completed and a full determination could not be made at the time of the inspection.
However, safeguards such as good recruitment processes, were not in place, were not fully implemented or monitored by the senior management team and created potential risks for residents' safety. This is fully referenced under outcome 18.

Judgment:
Non Compliant - Moderate

Outcome 08: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Safe care and support

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

Findings:
The inspector reviewed aspects of the fire safety management practices in place in the centre. Records for maintenance, fire safety training of staff and policies and procedures relating to fire safety were also viewed. The internal and external premises and grounds of the centre appeared safe and secure, with locks installed on all exterior doors. There were fire and smoke detection and containment measures in place throughout the building and all exits were free from obstruction. A health and safety statement and related policies and procedures were in place.

Certification and servicing documents were available on fire-fighting equipment, emergency lighting and fire alarms. These showed that a contract to service the fire alarm on a quarterly basis was in place and had occurred throughout 2016. The fire alarm was also serviced in February 2017. However, the service due to take place in May 2017 was outstanding.

The inspector found that some aspects of the precautions against the risk of fire required improvement. Issues found on the inspection included:
-A detailed emergency plan was stored beside the fire alarm at the nurses' station in the reception area. The plan included details of alternative accommodation arrangements for residents in the event of an emergency evacuation of the premises. It also included emergency contact details for: emergency services, the senior management team, residents' next of kin and the contact details of most staff.
A composite list of the current residents' personal evacuation plan was also stored at the fire alarm panel. This list included each resident's level of dependency, and identified the number of staff required to assist each individual resident, and the most suitable evacuation aid to be used, both day and night. The inspector was told that this list was updated daily by one of the administration team. The inspector was told that an administration staff member would check with the nursing team each morning to identify any changes to residents' dependency, level of assistance required or mode of evacuation. Where any changes occurred later in the day or where there were any admissions or discharges, it was the responsibility of the nursing team to inform the administration staff so that the list would be updated. At weekends or outside normal office hours, nurses were to document these changes onto the list in writing.
The inspector was shown the most up to date list which was dated 19th June 2017. However, it was noted that the details on the list for several residents had not been changed to reflect their current status, despite the changes occurring some days earlier. Examples included; some residents who were previously mobile and were now immobile and others who could no longer be evacuated using a wheelchair. In addition, there were some residents who were identified to the inspector, who could possibly be transferred from their bedroom in their beds, but this had not been risk assessed.
-A fire safety protocol was in use in the centre. This protocol guided staff on the procedure they should follow when responding to a fire event. The protocol directed that all staff should respond to a fire alarm by closing all doors on their way to the fire alarm panel. Most staff spoken with, although not all, were familiar with the protocol, and the inspector found that there were different interpretations across the staff team. The inspector spoke to a number of staff and members of the management team and found that they differed in their interpretation of the protocol. Some said that staff who were rostered to provide 1:1 supervision of some residents should not go to the fire panel, but should remain with the resident, and others said all staff, including those rostered to provide 1:1 supervision, should go to the fire panel. In addition, the management team said that a staff member should also remain to supervise residents in the Abbey unit, as the key pads on the exit doors from this unit would be de-activated during a fire scenario. However, this is not stated in the fire safety protocol.
-There were a number of recently appointed staff on duty on the day of inspection and the inspector found that not all of these new staff had received orientation training from the identified in-house fire safety training officer. It was also found that some were not aware of the protocol to be followed in the event of a fire. This was brought to the attention of the in-house fire safety officer who delivered the orientation to these staff prior to the end of the inspection. Nonetheless, another new staff person was rostered for duty, on the night shift previous to the inspection, and the coming night shift who had not received this orientation in fire safety.
- The inspector was told that the response by staff to fire alarm activation was regularly spot checked and practiced. Records of drill practices were available and showed that

two drills were held up to the date of the inspection for 2017. One took place during the night shift when staffing would be at the lowest level.
However, the records of fire drills viewed, were not sufficiently detailed, and staff knowledge was not adequate enough, to demonstrate that the procedures in place, for evacuating all persons, where necessary, in the event of a fire, were fit for purpose. For example the records did not state whether the drill reflected the simulated evacuation of one 'resident' only or whether all residents in a specific compartmented area could be safely evacuated within a reasonable time-frame. The record did not include details on the duration of the drill or any learning identified to improve the evacuation process.

Moving and handling practices in the centre also required improvement. The inspector observed two instances of unsafe moving and handling practice during the inspection. Staff were assisting residents' to transfer from a wheelchair to a straight chair. Assistive devices such as a standing hoist or transfer belt were not used. Staff assisted the resident by placing their arms under both shoulders and pulling upwards. This form of lifting is considered unsafe for both staff and residents. The inspector also found that assistive devices such as slide sheets were not being used for some residents who required to be regularly re-positioned in bed. Some staff spoken with confirmed that they re-positioned some residents, by pulling on the bed sheet underneath from side-to-side. This practice is considered unsafe as it can cause friction and may result in the formation of pressure ulcers. The inspector learned that one resident, whom staff were turning in this manner was currently being treated for a friction related pressure ulcer.

Judgment:
Non Compliant - Major

Outcome 11: Health and Social Care Needs
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

Theme:
Effective care and support

Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
The findings of the last inspection required actions to improve care planning and assessment processes to make them more specific and ensure they meet residents' needs. On the last inspection it was found that the care plan system was not sufficiently detailed to guide staff and assessments were inadequate. These findings were recurrent on this inspection.

Evidence of referral and review by a range of medical and allied health professionals was found with documented visits, assessments and recommendations by dietician, speech and language therapists and physiotherapy reviews.
Systems were in place for the assessment, planning, implementation and review of healthcare needs. This included nursing assessments, care plans and clinical risk assessments. Samples of these clinical records were viewed. Considerable improvements to the standard of clinical documentation and assessment of care needs were required to ensure the full needs of all residents were met in a holistic manner. The inspector found that some identified risks, associated with the activities of living were not fully assessed. These included activities such as: mobility, personal care and skin integrity.

Care plans were not in place for every identified need. Examples included pain management, bruising and nutritional monitoring.
Where care plans were in place, they were found to contain the minimum information required to manage the health problem. The information was general and not person centred. Examples included:
- Some care plans that guide staff on personal care preferences were not updated to reflect deterioration in resident's' condition and current inability to participate in meeting their personal care needs such as brushing their hair or teeth.
-Samples of care plans in place to manage the problems associated with deteriorating mobility were viewed. Some did not guide staff practice on all appropriate forms of assistance to be provided to residents. In particular they did not reference the need for assistive equipment such as: slide sheets, hoists or transfer belts. Risks associated with poor moving and handling practices were found and are referenced under Outcome 8 of this report.
- Some care plans in place to manage pressure area care for residents spending long periods of time in bed or chairs were viewed. These did not reference the frequency of re positioning required to manage the need or the requirement to provide opportunity for movement with passive or active exercise to maintain or promote blood flow and muscle tone.
-Where care plans were in place they were not specific enough to guide staff and manage the needs identified examples included; Positive behaviour support plans were not in place to manage behaviours associated with restlessness and agitation. The care plan in place to manage these needs did not fully guide staff on the signs to look for as potential triggers to responsive behaviour. The plans also did not guide staff on the type of distraction techniques which could be employed to reduce escalation or of all measures which were known to manage the behaviour and prevent recurrence.
Although it was found that long term regular staff were familiar with their residents needs and could recognise changes to their demeanour, for new staff, care assessment and planning documentation was not sufficiently explicit to direct care.
Additionally it was noted that the reviews of care plans did not consider the effectiveness of the interventions to manage and or treat the need.

Judgment:
Non Compliant - Moderate

Outcome 15: Food and Nutrition
Each resident is provided with food and drink at times and in quantities

adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.

Theme:
Person-centred care and support

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

Findings:
All lines of enquiry for this outcome were not reviewed on this inspection.
Residents were provided with food and drink at times and in quantities adequate for their needs. Residents spoken with said that the food provided was hot and appetising. The main kitchen was located beside the dining room. Food was served directly from there by a team of staff. Residents on modified consistency diets also received the same choice of menu options as others. Drinks such as water, milk, tea and coffee and fresh drinking water at all times were available. Evidence of referral to relevant allied health professional including dietician or speech and language therapists was found and there was a system in place to monitor the intake of residents identified as at risk of malnutrition.

Judgment:
Compliant

Outcome 18: Suitable Staffing
There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

Theme:
Workforce

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

Findings:
The inspector found that there was a lack of direction and supervision of staff by the professional nursing team. Also, no evidence was found that full orientation, induction, and required training was provided to all new staff to ensure the delivery of a safe and suitable standard of care to residents. Information was received in the form of concerns, in recent months by HIQA, from relatives of current residents. Aspects of these concerns, such as high turnover of staff and changes to skill-mix with higher numbers of

inexperienced staff, resulting in poor standards of care delivery, were upheld on this inspection.

The inspector found that the current profile of residents in the centre were frail elderly with a high level of complex needs. 77% of all residents were assessed as being at high or maximum dependency, meaning that they required the assistance of two staff with most or all of the activities of daily living. In addition 79% had a diagnosis of cognitive impairment or mental health disorder.
Of the ten care assistants on duty, 40% were newly recruited staff, the majority having worked in the centre for less than one week and the remainder, less than one month. 75% of these new staff were placed on the Abbey unit and all were allocated to supervise specific residents on a one-to-one basis.

Direct care staffing levels on the day shift at the time of this inspection included: Two registered nurses and ten care assistants. The staff were divided into two teams to cover two identified areas in the centre called the Abbey unit and corridors B and C. The Abbey unit is a secure unit accessible through a key coded access door and is where most of the residents who have a diagnosis of dementia live.

The staff teams consisted of: a registered nurse and four carers on corridors B and C, and a registered nurse and three carers on the Abbey unit. In addition three carers were rostered to provide one-to one supervision to three specific residents on the Abbey unit. Each team also included (within these numbers) a senior carer or care practice facilitator. Part of the senior carer role was to supervise and direct the other carers on the team. The inspector observed a senior care assistant give direction to some other carers within the team, including those who were providing personal care and or supervision to the general resident population within the unit. The senior carer was also observed to assist the new staff to re-position some residents. However, there were limited opportunities for the senior carer to supervise the new staff members as she was also involved in direct care provision and supervision in the communal areas when the new staff remained in the bedrooms with the residents for the most part of the day.
The inspector found that there were negative impacts to residents as a consequence such as:
-Poor moving and handling practices as previously referenced under Outcome 8.
-Care plans were not being implemented in full. The inspector spoke with a number of staff and learned that some had not yet had opportunities to read the care plans in place. Others acknowledged that the care plans did not give them enough guidance. For example, the inspector observed several residents, seated at a table who required the assistance of two staff to mobilise. All were observed to remain at the table throughout the morning but the inspector did not observe any opportunity being provided to the residents to stand or move, despite two residents with care plans specifically identifying the need to stand or mobilise on a two hourly basis.
- All interactions observed by the inspector, between staff and the residents, were pleasant, helpful, respectful, and patient. However, it was also noted that care was delivered in a task orientated manner. A culture of promoting and maintaining independence was not found. For example, the inspector observed residents having breakfast and being offered mid-morning tea and snacks. Despite several residents having the capacity to add milk and sugar to their tea, or spread jam on their bread, all of this was done by staff.

-The inspector was told that the nurses also supervised direct care delivery. There is one main nursing station located at the reception lobby where all clinical documentation and the main computer system is located and where the nurses normally work from. Nurses were observed to spend most of their time administering medication, liaising with the medical and healthcare allied health professionals on reviews and follow ups or delivering direct care such as wound care, diabetic, pain or percutaneous endoscopic gastrostomy (PEG) feed management. The direct care nurse to resident ratio is 1:23 over a 24 hour period. This is not reflective of current guidance on safe staffing levels such as the recommendations of the 2016 nurse staffing taskforce interim report. The inspector spent most of the day between 9am and 2pm on the Abbey unit. The inspector only observed the nurse being in the unit on three occasions. Twice when administering medication to the residents and briefly during the lunch period. The inspector did not observe the nurse liaise with the senior carer on the unit regarding the status of resident's, or give direction to any member of the care team, although it is acknowledged this could have taken place elsewhere.
- Approximately 25%of all residents on each unit were assessed as at high risk of falls. Two recent falls had resulted in significant injuries to residents requiring hospitalisation and intervention.
- Two residents in the Abbey unit had pressure ulcers and two other residents were noted to have sacral redness. All required a high level of monitoring and intervention by staff to prevent further deterioration of skin integrity. At 2pm the inspector noted that no entries had been made to the computerised recording system for any resident since 08:30 in respect of the two hourly re-positioning of residents in bed, or the food diary for residents whose intake was being monitored due to weight loss. It was further noted that where food diaries were in place on the previous day for one resident, there were only two entries to indicate the resident had eaten throughout the day. No other entries were recorded to indicate whether food had been offered and or refused.
-Due to the lack of adequate training, induction, direction and opportunities to become familiar with the centres' policies and procedures and residents care plans, staff, in particular new staff did not have the required skills or experience to adequately meet residents' needs.

Recruitment processes were reviewed on this inspection and sample of staff files were viewed. These did not fully meet the requirements of Schedule 2 of the Regulations. A Garda vetting process was in place and all staff files viewed showed that the Garda Síochána (police) vetting process was completed prior to commencing employment. However, evidence of staff qualifications and two written references were not available in all files viewed. In the case of one file viewed, it only contained evidence of the completed garda vetting process. No other documentation was in the file.

Training records were reviewed and showed that all staff had not been provided with required mandatory training such as fire safety and moving and handling. Other findings in respect of staff induction, training and competency assessment are also referenced under Outcome 2 of this report.

Judgment:
Non Compliant - Major

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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Regulation Directorate

Action Plan

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Provider's response to inspection report[1]

Centre name:	Hazel Hall Nursing Home
Centre ID:	OSV-0000049
Date of inspection:	19/06/2017
Date of response:	21/08/2017

Requirements

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

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

Outcome 02: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A clearly defined management structure as outlined in the statement of purpose was not in place. The roles, responsibilities and the lines of authority and accountability of each member of the management team were not clear.

1. Action Required:
Under Regulation 23(b) you are required to: Put in place a clearly defined management

[1] The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.

structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

Please state the actions you have taken or are planning to take:
The action plan submitted by the provider, for this action was not acceptable to HIQA, as it did not satisfactorily address all of the failings identified in this outcome of the report.

Proposed Timescale:

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Effective governance was not in place particularly in relation to oversight of staff, in terms of recruitment, induction, orientation, training and assessment of competence.

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

Please state the actions you have taken or are planning to take:
The action plan submitted by the provider, for this action was not acceptable to HIQA, as it did not satisfactorily address all of the failings identified in this outcome of the report.

Proposed Timescale:

Outcome 03: Information for residents

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The contract did not outline the terms of residency, in that, it did not identify whether the room to be occupied was a single or shared room.

3. Action Required:
Under Regulation 24(1) you are required to: Agree in writing with each resident, on the admission of that resident to the designated centre, the terms on which that resident shall reside in the centre.

Please state the actions you have taken or are planning to take:
The Contract for Care was amended on the day of inspection to outline whether the

room to be occupied was a single or shared room .

Proposed Timescale: Completed

Proposed Timescale: 21/08/2017

Outcome 05: Documentation to be kept at a designated centre

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some staff spoken with were not familiar with the policies in place and some had not been provided with an opportunity to read them.

4. Action Required:
Under Regulation 04(2) you are required to: Make the written policies and procedures referred to in regulation 4(1) available to staff.

Please state the actions you have taken or are planning to take:
The action plan submitted by the provider, for this action was not acceptable to HIQA, as it did not satisfactorily address all of the failings identified in this outcome of the report.

Proposed Timescale:

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Key policies such as the induction and recruitment and moving and handling policies were not being fully implemented.

5. Action Required:
Under Regulation 04(1) you are required to: Prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.

Please state the actions you have taken or are planning to take:
The action plan submitted by the provider, for this action was not acceptable to HIQA, as it did not satisfactorily address all of the failings identified in this outcome of the report.

Proposed Timescale:

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all policies were reviewed within the three year timeframe.

6. Action Required:
Under Regulation 04(3) you are required to: Review the policies and procedures referred to in regulation 4(1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.

Please state the actions you have taken or are planning to take:
The policies identified for review were revised and re-issued.

Proposed Timescale: 21/08/2017

Outcome 07: Safeguarding and Safety

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
All reasonable measures were not taken to ensure residents safety, including fully implementing appropriate and thorough recruitment procedures.

7. Action Required:
Under Regulation 08(1) you are required to: Take all reasonable measures to protect residents from abuse.

Please state the actions you have taken or are planning to take:
The action plan submitted by the provider, for this action was not acceptable to HIQA, as it did not satisfactorily address all of the failings identified in this outcome of the report.

Proposed Timescale:

Outcome 08: Health and Safety and Risk Management

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some new staff had not received orientation training from the identified in-house fire safety training officer. It was also found that some were not aware of the protocol to be followed in the event of a fire.

8. Action Required:
Under Regulation 28(1)(d) you are required to: 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.

Please state the actions you have taken or are planning to take:
The action plan submitted by the provider, for this action was not acceptable to HIQA, as it did not satisfactorily address all of the failings identified in this outcome of the report.

Proposed Timescale:

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some staff were not familiar with the procedure to be followed in the event of a fire and staff, and the senior management team differed in their understanding of the procedures in place.

9. Action Required:
Under Regulation 28(1)(e) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and residents are aware of the procedure to be followed in the case of fire.

Please state the actions you have taken or are planning to take:
The action plan submitted by the provider, for this action was not acceptable to HIQA, as it did not satisfactorily address all of the failings identified in this outcome of the report.

Proposed Timescale:

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Records of fire drills viewed were not sufficiently detailed, and staff knowledge was not adequate enough, to demonstrate that the procedures in place, for evacuating all persons, where necessary in the event of a fire, were fit for purpose.

10. Action Required:
Under Regulation 28(2)(iv) you are required to: Make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and safe placement of residents.

Please state the actions you have taken or are planning to take:
The action plan submitted by the provider, for this action was not acceptable to HIQA, as it did not satisfactorily address all of the failings identified in this outcome of the report.

Proposed Timescale: 21/08/2017

Outcome 11: Health and Social Care Needs
Theme: Effective care and support **The Registered Provider is failing to comply with a regulatory requirement in the following respect:** Assessment and care planning were not specific enough to direct the care to be delivered or guide staff on the appropriate use of interventions to consistently meet the identified need. This is a recurrent action from the last inspection. **11. Action Required:** Under Regulation 05(1) you are required to: Arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2). **Please state the actions you have taken or are planning to take:** The action plan submitted by the provider, for this action was not acceptable to HIQA, as it did not satisfactorily address all of the failings identified in this outcome of the report.
Proposed Timescale:
Theme: Effective care and support **The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:** Complete comprehensive clinical risk assessments were not carried out for each resident in respect of every identified need. **12. Action Required:** Under Regulation 05(2) you are required to: 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 the designated centre. **Please state the actions you have taken or are planning to take:** The action plan submitted by the provider, for this action was not acceptable to HIQA, as it did not satisfactorily address all of the failings identified in this outcome of the report.
Proposed Timescale:
Theme: Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Reviews of care plans did not include a determination of the effectiveness of the plans to meet the needs identified.
This is a recurrent action from the last inspection.

13. Action Required:
Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.

Please state the actions you have taken or are planning to take:
The action plan submitted by the provider, for this action was not acceptable to HIQA, as it did not satisfactorily address all of the failings identified in this outcome of the report.

Proposed Timescale:

Outcome 18: Suitable Staffing

Theme:
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A review of staffing is required to ensure that the number and skill-mix of staff is appropriate to meet the assessed needs of residents in a timely manner.

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

Please state the actions you have taken or are planning to take:
The action plan submitted by the provider, for this action was not acceptable to HIQA, as it did not satisfactorily address all of the failings identified in this outcome of the report.

Proposed Timescale:

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff were not appropriately supervised to ensure that a good standard of care was

delivered which met residents needs in accordance with their care plan.

15. Action Required:
Under Regulation 16(1)(b) you are required to: Ensure that staff are appropriately supervised.

Please state the actions you have taken or are planning to take:
The action plan submitted by the provider, for this action was not acceptable to HIQA, as it did not satisfactorily address all of the failings identified in this outcome of the report.

Proposed Timescale:

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some staff had not been provided with required mandatory training in some areas including fire safety or moving and handling.

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

Please state the actions you have taken or are planning to take:
The action plan submitted by the provider, for this action was not acceptable to HIQA, as it did not satisfactorily address all of the failings identified in this outcome of the report.

Proposed Timescale: