Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	Ennis Road Care Facility
Name of provider:	Beech Lodge Care Facility Limited
Address of centre:	Ennis Road via Limerick, Clare
Type of inspection:	Unannounced
Date of inspection:	27 May 2020
Centre ID:	OSV-0005768
Fieldwork ID:	MON-0028780

About the designated centre

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

Ennis Road Care Facility is a designated centre located on the outskirts of Limerick city on the old Ennis Road. It is registered to accommodate a maximum of 84 residents. It is a single storey facility, where bedroom accommodation comprises 54 single and 15 twin bedrooms, all with en-suite facilities of shower, toilet and hand-wash basin. Additional toilet facilities are available throughout the centre. There is a spa room with assisted bath. Communal areas comprise a spacious dining room, a large garden room (day room), activities room, smoking room, and oratory. Main reception is an expansive space with a grand piano, a fireplace, and lots of seating hubs. Off the main reception is the hairdressers salon and an area to be developed into a coffee dock. There are additional comfortable seating areas off the activities room. Residents have access to two enclosed gardens with walkways, seating and raised flower beds. Ennis Road Care Facility provides 24-hour nursing care to both male and female residents whose dependency range from low to maximum care needs. Long-term care, convalescence care, respite and palliative care is provided.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	43

How we inspect

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:

Date	Times of Inspection	Inspector	Role
Wednesday 27 May 2020	10:00hrs to 16:30hrs	John Greaney	Lead
Thursday 28 May 2020	10:00hrs to 17:00hrs	John Greaney	Lead
Wednesday 27 May 2020	10:00hrs to 16:30hrs	Mary O'Mahony	Support
Thursday 28 May 2020	10:00hrs to 17:00hrs	Mary O'Mahony	Support

What residents told us and what inspectors observed

Inspectors observed staff interacting with residents and noted that they treated residents in a warm and caring manner. It was evident that staff knew residents well and residents were comfortable and relaxed in the presence of staff.

Discussions with staff indicated that they knew individual residents well and were able to relate to inspectors the specific care needs on an individual basis. Staff were knowledgeable about each residents preferences for personal care and for their daily routines and activities.

Over the two days of the inspection most residents were seen to spend a significant amount of time in their bedrooms. Residents had only recently commenced exiting their bedrooms in the days prior to this inspection as guidelines from the Health Protection and Surveillance Centre (HPSC) are that residents should remain in their bedrooms to minimise the risk of spreading the virus. The activity coordinator was absent for the two days of the inspection and the staffing roster was amended so that activities could be facilitated by another member of staff. However, a significant number of residents spent long periods in their rooms with limited social contact throughout the day.

A small number of residents spoke with inspectors when outside enjoying the gardens and also within the centre. Concern was voiced at how isolating the pandemic has been for residents and the negative impact it is having on their daily lives. Residents spoken to wished for family visits to resume. Some measures had been put into place such as window visiting and inspectors observed relatives visiting residents and communicating with them by phone. Inspectors noted that relatives were facilitated to visit residents at end of life and relatives spoken with expressed satisfaction with this arrangement and also commended staff on supporting them through the end of life process.

Inspectors noted that better engagement with relatives was required when they phoned enquiring about the status of residents. On occasion, the information shared with relatives when they phoned was very brief and would not have provided a comprehensive picture of the resident's well being.

Capacity and capability

This was an unannounced risk-based inspection conducted over two days. The registered provider is Beech Lodge Care Facility Limited and the provider is involved

in the operation of one other designated centre.

A recent inspection, conducted in February 2020, found that the centre was under resourced. It was found that there was inadequate support for the person in charge, inadequate staffing levels and inadequate systems of oversight to evaluate the service, which would improve and sustain a better service. Following that inspection, a regulation escalation process was initiated, with the first step being a planned meeting with the provider to outline the concerns of the Chief Inspector and to ascertain how the provider intended to attain regulatory compliance.

Subsequent to that inspection, the centre was significantly impacted by the COVID-19 pandemic and a large number of residents and staff were found to be positive for the virus following whole-centre testing.

Inspectors acknowledged that residents and staff living and working in centre have been through a challenging time. They acknowledged that staff and management always had the best interest of residents at the forefront of everything they did at the height of the outbreak and at the present time. However, significant improvement and focus is now required on implementation of adequate and effective management systems to ensure that the quality and safety of care delivered to residents achieves regulatory compliance.

On this inspection it was found that many of the issues found on the February 2020 inspection remained unaddressed. In line with the findings of the last inspection, management systems in place required significant review and enhancement to ensure the service provided was safe, appropriate, consistent and effectively monitored. Clinical oversight and supervision on the consistent delivery of resident care required improvement.

As a result of the concerns of the inspectors in relation to the findings of this inspection, an urgent compliance plan was issued to the Provider under:

- Regulation 23: Governance and Management
- Regulation 15: Staffing
- Regulation 16: Training and staff development
- Regulation 5: Assessment and care planning
- Regulation 6: Health care

The person in charge had submitted their resignation approximately 10 days prior to the date of this inspection. The Chief Inspector was not notified of the intended change in the identity of the person in charge. Furthermore, two clinical nurse managers (CNMs) had also resigned and ceased employment in the centre. The person in charge was now supported by one CNM that worked part time.

Due to the significant number of staff and management impacted by the virus, the resultant increase in care needs of residents due to the virus, and staff shortages, there were insufficient numbers and skill-mix of staff to safely care for residents. In response, the Health Service Executive (HSE) had provided nursing staff, care staff, and administrative staff to support staff in the centre care for residents. On the days of the inspection there was continued reliance by the Provider on these HSE staff to

make up the shortfall of staff directly employed by the centre.

Advice was obtained from public health and infection prevention and control personnel through emails and telephone conversations on a regular basis. A local committee had been formed, prior to the outbreak, to plan for a potential outbreak, but did not meet during the outbreak. This team comprised nursing staff, care staff and ancillary staff.

There was inadequate oversight of the outbreak by the registered provider at a local level, to ensure that it was managed in accordance with infection prevention and control standards. On the days of this inspection the outbreak had abated, but it was not over. There were two residents in the centre that had tested positive for the virus. One of these residents tested positive on the first day of the inspection and the second had tested positive in the days prior to the inspection. Inspectors found that guidance in relation to infection prevention and control, relating to the segregation of staff and residents, based on test results and symptoms was not being followed. There was also a need to enhance oversight of infection prevention and control practices to ensure that staff were adhering to recommended guidance. Inspectors observed that staff were not adhering to hand hygiene guidance in relation to the wearing of jewellery and also in relation to wearing Personal Protective Equipment (PPE) when discarding clinical waste.

Significant improvements were required in relation to medical, nursing and care records. By way of example, intake and output fluid records, critical to monitoring the well-being of residents, particularly when they were seriously ill, were not maintained. Records of the repositioning of residents to prevent the development of pressure sores were not always completed.

The system used for recording assessments by General Practitioners (GPs) required review to ensure they were readily accessible. Assessments of residents conducted by GPs were not always recorded in the medical review section and were therefore difficult to access, as they were frequently recorded under nursing daily notes.

Regulation 14: Persons in charge

The person in charge (PIC) meets the requirements of the regulations in the context of being a registered nurse, having a management qualification, having the required management experience and having experience in care of the older person.

Judgment: Compliant

Regulation 15: Staffing

The centre had been significantly impacted by a COVID-19 outbreak and a large

number of staff had tested positive for the virus. While many of the staff had recovered and returned to duty, a number of staff had not yet returned to work. The inspector acknowledged that residents and staff, living and working in the centre, were still emotionally effected by the impact of the COVID-19 outbreak and the isolation brought about due to the visitor restrictions. Staff expressed sadness about those residents who had died during the outbreak but also of satisfaction of seeing other residents on the road to recovery.

The provider was heavily reliant on support from the Health Service Executive (HSE) to maintain staffing at the required levels since early May due to the number of centre staff that had tested positive for the virus. On the week of the inspection, HSE staff continued to make up a significant portion of staff working in the centre. For example, seven HSE staff nurses were on the roster to cover eighteen shifts and thirteen HSE healthcare assistants (HCAs) were on the roster to cover thirty seven shifts. The planned roster for the week following this inspection indicated that the provider had adequate numbers of HCAs but would remain reliant on nurses not directly employed by the provider, either agency or HSE staff.

Discussions with staff indicated that some staff had their working hours cut and these hours were allocated to staff not directly employed by the centre. The provider stated that this was to allow staff that tested positive for the virus an opportunity to recover. This was not done in consultation with individual staff members who were unaware why their hours were cut.

On the afternoon of the first day of the inspection the staffing roster was found to be incomplete for night duty; this meant that there would be an inadequate number of HCAs on duty that night. Management, when asked, were unable to confirm to inspectors that an adequate number of HCAs would be available on that night. Inspectors were informed that additional HCAs were being made available by the HSE and the provider would only be made aware of exact staffing levels late each evening.

In the wider context, the provider was requested as a priority to review and ensure that going forward, that there is an adequate the number and skill mix of staff available to care adequately for the residents living in the centre. The provider was also requested to develop a contingency plan, should staff become ill so that delivery of the service could be sustained.

Staff members spoken with were knowledgeable of residents' needs. In respect of COVID 19, the staff met were knowledgeable of typical and non-typical presentation of CoViD-19 and what symptoms and signs to look out for in residents, should they become unwell.

There were two residents in isolation on the days of the inspection. One of these residents had tested positive for the virus prior to the inspection and the second resident tested positive on the evening of the first day of the inspection. Inspectors were informed by the person in charge that staff caring for the COVID-19 positive residents also assisted in caring for other residents. This is not in compliance with recommended guidance.

Throughout the two days of inspection inspectors observed that segregation of duties, in accordance with recommended infection and prevention and control practices were not always practiced. This was particularly relevant and of concern in light of the isolation procedures in place. Staff that were delegated to only work in areas accommodating suspected and confirmed cases of COVID-19 were also seen to work in other areas of the centre in contradiction of recommended practice.

Judgment: Not compliant

Regulation 16: Training and staff development

Training records indicated that all except one member of staff had completed a combined module of hand hygiene and infection prevention and control training in either 2018, 2019, or 2020.

With particular reference to the National Public Health Emergency (NPHE), all staff had completed online training on CoViD-19 that incorporated hand hygiene and the application and removal of PPE. The HPSC had issued and updated national guidelines throughout the NPHE. The person in charge informed inspectors that he provided opportunistic updates on latest developments and guidance in relation to CoViD-19, however, records of staff attendance at these briefings were not always maintained.

There was a lack of assurance arrangements in relation to staff' adherence to infection prevention and control arrangements and practices in the centre. By way of example, staff supervision and opportunistic audits to ensure that staff were abiding by recommended infection prevention and control guidance were inadequate. Inspectors observed that staff did not always adhere to guidance in relation to hand hygiene, maintaining social distance and in wearing PPE.

Judgment: Not compliant

Regulation 21: Records

Records set out in Schedule 3 were reviewed by inspectors and were found to be incomplete and difficult to access.

While there were no residents receiving subcutaneous fluids on the days of the inspection, a review of records indicated that during the CoViD 19 outbreak, a number of residents had received subcutaneous fluids. Inspectors found that accurate fluid intake and output charts were not maintained. It was therefore not possible to ascertain exactly when the fluids commenced, the period of time the infusion was in place, the amount of fluids infused or residents' urine output during

the infusion.

Medical records were not readily accessible and sometimes not available. Nursing and care records were predominantly in electronic format. When a resident's general practitioner (GP) visited a resident they either recorded their assessment electronically or on the resident's paper file. GPs did not have their own unique login to the electronic record and usually recorded their assessment under one of the nurses login details. Occasionally this note was recorded under the medical review section but more frequently was recorded in the nurses 'daily notes' section. Therefore, the information contained in the medical review was difficult to distinguish from the daily nurses' notes and involved scrolling through weeks and sometimes months of nurses' notes.

It is very important that the Providers maintains accurate, contemporaneous and accessible residents' records. On the days of inspection , inspectors found significant concerns in this regard. By way of example, on the day of the inspection inspectors requested the prescription chart of a recently deceased resident in order to review the prescribed medicines. Nursing staff were unable to locate the kardex prescription despite an extensive search. In addition, there were a number of gaps in residents repositioning records and it was therefore not possible for inspectors to ascertain and be assured the frequency at which each resident was repositioned, particularly at night time.

The absence of complete and accurate records did not assure inspectors that residents' well-being was accurately monitored.

Judgment: Not compliant

Regulation 23: Governance and management

The most recent inspection of this centre, conducted in February 2020, found that the registered provider had not ensured that effective governance arrangements and sufficient resources were in place to enable the effective delivery of care, in accordance with the nursing home's statement of purpose.

Subsequent to that inspection the centre had been significantly impacted by the COVID-19 pandemic and a large number of residents and staff had tested positive for the virus, following whole-centre testing. This had resulted in a significant reduction in available staff to care for residents who now had significantly higher levels of care needs. At the time of this inspection the impact of the outbreak was still being felt by staff and residents in the centre and was further exacerbated by the departure of the two clinical nurse managers and the resignation of the person in charge.

The governance arrangements in place to manage this centre remained inadequate and unchanged since the February 2020 inspection and is further impacted by new vacancies in the management structure. In addition to these, the findings of this

inspection included:

- inadequate managerial oversight of infection prevention and control practices to ensure that staff were adhering to recommended practice and residents were been cared for in line with the HPSC guidelines
- lack of clarity and staff understanding in relation to the correct re-designation of areas within the centre for the segregation of residents suspected or confirmed COVID-19 positive and from residents that had recovered from COVID-19 or had tested negative
- lack of clarity around the designation of staff specifically to care for residents who were suspected or confirmed COVID-19 positive
- the absence of sufficient managerial support for the person in charge
- conflicting information as to why the hours of staff employed directly by the centre were reduced and lack of communication with staff about their reduced hours
- failure to submit a mandatory notification to the Chief Inspector of the intended change to the identity of the person in charge
- prior to the inspection information had been submitted to the Chief Inspector in relation to inadequate communication arrangements, particularly where relatives were seeking information from the provider of the well-being of residents. Incidences of poor or inadequate information exchanges over the phone with relatives were heard by inspectors during the inspection.

Judgment: Not compliant

Regulation 3: Statement of purpose

An updated Statement of Purpose had not been submitted to the Chief Inspector following the most recent inspection outlining the governance and management arrangements in place at that time.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Notifications required to be submitted to the Chief Inspector were submitted in accordance with the requirements of the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

Inspectors reviewed the complaints log, and in particular the complaints recorded since the last inspection. Records indicated that some, but not all, of the complaints were investigated satisfactorily. There was a need for further detail of the investigation process and what, if any, improvements were implemented as a result of the complaint. There was also a need to ensure that the outcome of the complaint was communicated to the complainant.

Judgment: Not compliant

Regulation 4: Written policies and procedures

The inspectors reviewed a sample of policies and procedures and found that a number of these were revised to reflect the emergence of CoViD-19. The policy on subcutaneous fluids, however, was developed in the weeks prior to this inspection and was not in place when the fluids were being administered.

Judgment: Not compliant

Quality and safety

Inadequate governance and management arrangements negatively impacted on the quality and safety of care delivered to residents. This is supported by findings in relation to inconsistent infection control practices, non-compliant medication management practices, and poor nursing documentation used to support care delivery. To achieve optimal outcomes for residents, the governance systems in place to review and monitor the quality and safety of care required review to ensure that staff confidence is enhanced, lessons are learned and improvements made are sustained and consistently reflected in work practices.

As previously stated, the centre had a significant outbreak of COVID-19, and while the outbreak had abated, it was still ongoing and at the time of this inspection there continued to be newly diagnosed COVID-19 residents.

Inspectors were informed by the person in charge that the centre was divided into isolation zones. The purpose of zones is to target outbreak control measures to specific areas of the centre in the event of an outbreak. Inspectors found, however, that some staff moved between zones, which compromised the purpose of the zones. While the layout of the centre supported the cohorting of residents based on their infection status, this was not being done on the days of the inspection. Additionally, there was inadequate segregation of staff caring for the various category of resident. Improvements were also required in relation to hand hygiene

practices and the appropriate use of PPE.

During the inspection a number of important areas were identified as requiring improvement to comply with legislation, professional guidelines and safe resident care. This included the need for staff to comply with relevant professional guidance when administering medications, including oxygen and subcutaneous fluids, and to ensure that there was a valid prescription available to guide administration.

In addition, resident assessment and care planning practice required review to ensure that residents' care plans were updated to reflect issues identified on assessment and also to reflect the changing condition of residents. Specifically, there was a need to ensure that end of life care preferences were reflected in care plans and accurately reflected each residents and families current wishes and incorporated multi-disciplinary input. There was also a need to ensure that contemporaneous records were maintained of the care provided to each resident that included fluid intake and output records and the repositioning of residents at risk of developing pressure sores.

Regulation 11: Visits

In line with the Public Health guidance in place at the time of inspection, visiting restrictions were in place and no visitors were allowed except in exceptional circumstances. Relatives were observed coming to windows outside the sitting room and communicating with residents via telephone. The next of kin was observed to be facilitated to visit a resident at end-of-life while observing appropriate infection prevention and control measures. Relatives spoken with were happy with that end of life arrangement.

Judgment: Compliant

Regulation 13: End of life

Inspectors were informed staff had end of life discussions with residents that have capacity to make decisions. However these arrangements for determining up-to-date end of life and 'ceiling of care' preferences of residents, taking into account the on-going pandemic were significantly inadequate. The process was not multi-disciplinary and discussions had not yet taken place with each resident's medical practitioner.

Judgment: Not compliant

Regulation 25: Temporary absence or discharge of residents

It was found on the previous inspection that inadequate information was shared with the receiving facility about the medical and nursing care needs of the resident. On this inspection, a review of a sample of records of residents that had been transferred to hospital indicated that adequate information was shared with the receiving facility. In particular, the transfer letter for a resident, which had been the subject of a complaint that a transfer letter had not been sent to the hospital, was available and was reviewed. A contemporaneous note had been recorded in the resident's nurses' record stating that a transfer letter accompanied the resident and a copy of the letter was maintained in the resident's file. The provider and person in charge were advised to consult with their information system provider in relation to ascertaining if a copy of the transfer letter could be retained electronically.

Judgment: Compliant

Regulation 27: Infection control

It is acknowledged that the normal Infection Prevention and Control (IPC) precautions in a nursing homes are not commensurate with what is required for managing a COVID-19 outbreak. During and post a COVID-19 outbreak, the provider must be assured that all IPC arrangements are in line with public health advice and the national HPSC guidelines.

During this inspection it was identified that significant improvements were required to ensure their infection prevention and control practices, and staff and visitors adherence to these, are in line with the national guidance.

There were procedures in place for monitoring residents and staff for signs and symptoms of COVID-19, such as monitoring temperatures and ascertaining if they were symptomatic, to prevent a further outbreak in the centre. There were hand gel dispensers located at suitable intervals throughout the premises. There were, however, limited clinical hand wash basins in the premises.

Required improvements in relation to infection prevention and control included:

- the centre was anecdotally divided into a Zone A and a Zone B. The purpose of zones is to cohort both staff and residents and to allow outbreak control measures to be targeted to a zone rather than facility wide in the event of a confirmed case of COVID-19. On the days of the inspection, there was no clear distinction between these zones as staff caring for positive residents moved between zones.
- there was no designated area for residents that were confirmed or suspected COVID-19 positive. COVID-19 positive residents were accommodated in both Zone A and Zone B. As there was considerable distance between the

bedrooms, staff had to travel between zones and the corridor adjacent to isolation rooms was used as a thoroughfare to get to non-isolation bedrooms
- staff caring for a newly diagnosed symptomatic positive resident were not wearing the appropriate PPE as per national HPSC guidelines
- inspectors were given conflicting information by management with regard to whether or not staff caring for residents with suspected or confirmed COVID-19 also provided care to other residents
- inspectors observed staff disposing of clinical waste without using appropriate PPE
- inspectors observed staff carrying out duties in communal areas following the carrying out of duties in the bedroom of a resident that was COVID-19 positive
- PPE for use in a COVID-19 positive room was stored in an untidy manner with excess amounts stored on the table. This PPE was also being used by staff for other areas of the centre
- doors to COVID-19 positive bedrooms were at times left open
- inspectors observed staff wearing rings and wrist watches, which is not in compliance with recommended hand hygiene practices
- inspectors found two used face masks in the staff room that were not disposed of in accordance with relevant guidance. One was left on the window ledge of the staff room and the other was discarded in an open waste bin
- the staff room was untidy and required cleaning

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Medication management practices were not in line with relevant guidance. As stated previously under Regulation 21, Records, the prescription sheet for one resident was unavailable and inspectors were unable to verify that medicines administered for end of life symptom management were prescribed. Due to the COVID-19 outbreak in the centre GPs were not visiting the centre and provided advice and guidance to nursing staff over the telephone. Inspectors found that a significant number of residents were administered subcutaneous fluids and oxygen in the absence of a medical practitioner prescription and in the absence of a contemporaneous record that the need for subcutaneous fluid was discussed with each resident's GP. In fact, it was noted that one GP specifically stated that this was initiated without their knowledge but observed that it was well intended and based on the professional judgment of the nursing staff.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Comprehensive residents' assessments were completed on admission and care plans were developed based on the outcome of these initial assessments. Risk assessments were conducted for various clinical risks including the risk of developing pressure sores, the risk of malnutrition, the risk of falling and dependency levels.

However, some care plans were not always updated as each resident's condition changed. Care plans were not in place for all issues identified, such as a nutritional care plan for residents with specific dietary requirements and a care plan for Parkinson's Disease and pain. Up to date resident care plans are essential to ensure a continuity of care across staff rosters. By way of example, one residents 'falls risk' assessment stated they walked with the aid of a walking frame and with the assistance of one staff member, while the resident's personal evacuation plan (PEEP) stated they were independently mobile.

Almost two weeks prior to this inspection the centre was visited by a team of senior clinical and non-clinical staff from the University of Limerick Hospitals Group to provide support to the centre and to make recommendations to the provider to action and review in the context of the CoViD-19 outbreak. The Inspectors used this report to inform the lines of enquiry of this inspection. One of the recommendations was the use of an assessment tool that would assist staff in recognising the deteriorating health status of residents and also to communicate that information to a medical officer. On the days of the inspection, inspectors were informed that informal training was provided to staff on the use of this tool but was not yet being utilised. When requested by inspectors, an example of when it was used for a resident was not available.

Judgment: Not compliant

Regulation 6: Health care

The centre is located on the outskirts of Limerick city and as a result, a large number of GPs are involved in the care of residents living in the centre. Inspectors were informed that residents were under the care of approximately 18 different GPs.

During the height of the outbreak in the centre, GPs were providing a service remotely and advised staff over the phone. This included remote prescribing. Residents that became acutely unwell were generally transferred to acute care services, both in Limerick and Ennis. As GPs did not visit the centre during the outbreak, the person in charge took responsibility for pronouncing the death of residents during the outbreak. Discussions with the person in charge indicated that there was not full compliance with recommendations issued by the Nursing and Midwifery Board of Ireland (NMBI) in relation to the completion of a self-assessment

of competency prior to the pronouncement of death.

Following a recent visit by a team of senior clinical and non-clinical staff from the University of Limerick Hospitals Group, the provider was requested to have each resident assessed by their GP immediately and to review the residents prescribed medications . On the days on the inspection this had only been completed for approximately 16 of the 41 residents in the centre despite evidence that a number of phone calls to the relevant GP's requesting they review their residents had been made by staff.

Judgment: Not compliant

Regulation 8: Protection

All residents spoken with with stated that they felt safe and received care to a good standard. All interactions by staff with residents were noted to be respectful and caring.

Judgment: Compliant

Regulation 9: Residents' rights

Findings on the previous inspection in February 2020 found that significant improvements were required in relation to the provision of activities for residents. Due to the outbreak of COVID-19, group activities had been curtailed and residents had only commenced exiting their bedrooms in the two days prior to this inspection.

Records of activities conducted during the outbreak were scant and it was not possible to ascertain, on an individual basis, the level of activities provided to each resident. An activities coordinator is employed full-time in the centre. At the commencement of the first day of the inspection the activities coordinator was observed to be engaging with residents in the reception area. Feedback from residents and staff were very positive in relation to the activity coordinator. However, the activity coordinator was not on duty for the remaining of the first day of the inspection or for the entirety of the second day of inspection.

Even though the activity coordinator was replaced with another member of staff, the level of activity available to residents was minimal and required review, particularly in light of the HPSC guidance and the aligned reality that now residents continued to spend significant time in their bedrooms. On the days of inspection the sun was shining, and event though staffing levels were enhanced above usual levels, only a handful of residents were seen to be facilitated to use the lovely enclosed garden area.

Judgment: Not 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:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Not compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 13: End of life	Not compliant
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 27: Infection control	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Ennis Road Care Facility OSV-0005768

Inspection ID: MON-0028780

Date of inspection: 28/05/2020

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. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime 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:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
Regulation 15: Staffing - Outline how you are going to come into compliance with

1. Following the inspection the management team arranged for an immediate review of staffing, direct care hours, taking residents' dependency levels int account and balancing with roster & skill levels available.

2. To ensure ongoing safe staffing compliance, a daily Care Hours Breakdown template was developed incorporating resident's dependency levels & same is forwarded to HIQA for the review and feedback this is supported by staff rosters.

3. By the very nature of care resident's dependency levels and needs are ever changing. Social, care needs, staffing levels and skill mix of staff are blended to ensure all these needs are reached. Staff levels and mix are evaluated through auditing, observation, supervision on the floor and out of hour's management's visits which are discussed at the regular clinical governance and staff meetings.

4. Following the easement of COVID-19 challenges the care facility was in a position on 11 June 2020 to review the care facility layout, and size. From this rereview residents' quarters were divided into three separate zones incorporating two additional nursing stations, sluice rooms and Storage rooms. A second clinical room within these allocated zones was implemented.

The objective of this zoning is to ensure nurses and care staff have their own dedicated zone areas ensuring appropriate monitoring as well as accountability and responsibility for their allocated residents during both day and night shifts. This will also reduce unnecessary movement of staff outside of their zones within the care facility.

5. We are continuously recruiting for staff across all disciplines within our care facility. The acting Person- in-Charge is currently in the process of completing and reviewing staffing contingency plans in preparation if staffing level were depleted due to a further

outbreak. (see attachment).

6. The organizational management team of the Centre is undergoing restructuring to reflect:
□ Full time Person In Charge Commencing 29/07/2020
□ Full time Clinical Nurse Manager 2 commencing 27/7/2020
□ ACNM 1 took up full time post 15/6/2020

These roles will be supported by the current team in the Ennis Road facility, external assistance secured and other resources with the Beech Lodge Care Facility Limited group.

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
The following actions have been taken in relation to staff adherence to infection prevention and control arrangements and practices in the centre.

1. Additional onsite infection control training was completed by staff 08/06/2020 & 15/07/2020 by certified health and safety company on hand hygiene practices, correct use of PPE within different contexts, donning & doffing PPE, segregation and removal of clinical waste, physical distancing.

2. To increase the standards on hygiene, and infection prevention and control practices within the care facility, a 3 day Cleanpass training course was facilitated onsite commencing on 29 May 2020 to support staff improved adherence to HIQA quality and national standards. hand washing, donning/doffing PPE, segregation of linen/waste, cleaning and disinfection environmental surfaces/terminal cleaning

3. Refresher on line HSE educational modules (Hseland) for hand hygiene, infection control, transmission based precautions, and breaking the chain of infection are completed monthly and records are maintained on staff files.

4. In house daily updates and guidance during hand over includes, hand hygiene, PPE including face mask guidelines and signs and symptoms of covid-19 and social distancing. This also accommodates the opportunity to update all staff on latest public health guidelines. All handovers are led by the PIC or the CNM on duty.

5. Review and updating of policies incorporating Covid-19 national guidelines were redistributed to members of the Ennis Road team following easement of the emergency caused by the COVID-19 outbreak. All members of the team now sign as proof of their implementation in practice enabling management to maintain satisfactory standards

within the care facility. E.g. Covid 19 outbreak management for suspects/confirmed, Uniform Policy

The training and staff development will be ongoing within the Centre; staff training has become a weekly agenda item in management meetings. A training matrix is reviewed and updated weekly to maintain ongoing compliance.

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
In line with the updated Subcutaneous policy, nursing staff supported by CNM ensures that all residents records of fluid intake over 24 hours and repositioning charts are recorded for all residents and completed in a timely manner in order to ensure that the appropriate care needs of the residents are achieved.

Fluid records and repositioning charts are reviewed and monitored on each changeover shift and discussed at the daily safety pause debriefing sessions.

GP's medical information can now be accessed seamlessly and viewed in a timely way in the medical review section on the inhouse resident care software.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
1. Clearly defined governance arrangements and management structures continue to be followed within the Centre which details staff member's responsibilities and roles.

□ The registered provider's role is clearly defined in relation to overseeing & evaluating the services provided by the care facility.
□ The Person-in-Charge oversees all clinical plus care aspects for residents and reports to the provider on a weekly basis. Subsequent updates are offered to the management team at monthly meetings. This would also incorporate all weekly updates from the management of the Ennis Road Care Facility

2. An updated Statement of Purpose with the present management organizational structure completed 21/07/2020.

3. As outlined in regulation 15 (staffing), daily staffing care hour ratios to resident's dependency level breakdown analysis is completed and forwarded to HIQA as required but at regular intervals.

4. The appropriate staffing levels, skill mix and supervision are reviewed and monitored weekly to ensure both day and night shifts meets the dependency care needs of residents and submitted to HIQA as required but at regular intervals.

5. In discussion with the Inspectors it was agreed that the transfer of the Person-in-Charge from within the group would be accommodated so to manage the Centre on an interim basis for the period of recovery following C-19 outbreak, offer professional support and assurance to staff and until the management structure was restored.

6. Again, post easement of COVID-19 outbreak a detailed Infection Prevention & Control audit was undertaken by the PIC which included Environmental cleaning, Hand Hygiene, PPE, Waste, Linen among other factors. This work was concluded with the production of a Quality Improvement Plan (QIP) that sets priorities and goals so to ensure continued quality and resident/staff safety within care facility.

7. A Quality & Safety visual communication board has been implemented with the aim of providing audit performance metrics, goals and targets which has heightened staff awareness.

8. As outlined in our Compliance Plan under Regulation 15 (staffing), the implementation of the dedicated zone areas facilitates the appropriate staffing structure for the care centre enabling management to supervision, lead and support nursing and care staff on a daily basis.

9. To enhance and improve the delegation, supervision and leadership of all staff the Person-in-Charge supervises staff care practices and standards Mon – Friday via daily management walk around, debriefing educational sessions, auditing and out of hours visits.

10. To ensure our Centre is safe and effectively managed, an Audit schedule process has commenced again following the easement of the COVID-19 outbreak Non-compliance audit results have been actioned.

11. Again, following easement of COVID-19 outbreak arrangements for communication with families within the Centre have been enacted:

□ Information in relation to resident's care is communicated to residents(and or next of kin) by nursing staff assigned to their care. Records are maintained in the Relative/resident Communication section on the inhouse resident care software.

□ The Person-in-Charge / clinical nurse manager continues to be available for family members to review the care of their relatives.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
The Statement of Purpose is updated to reflect all updated and changes in relation to the present key management organisation structure.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The complaints policy has been reviewed and updated to reflect changes to the present governance structure. All complaints are reviewed, monitored and managed by the PIC in accordance with the policy.

The satisfaction level of the complainant with the outcomes of any investigation will be communicated and documented as per policy.

The Person in Charge will provide feedback and learning outcomes to assist with care standards and will be discussed at staff meetings and reiterated prior to handover

Regulation 4: Written policies and procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
Again following the easement of COVID-19 outbreak best practice and standards of care in the relation to the administration, procedures and guidelines on all matters (including subcutaneous fluids), all medication related policies have been read, signed off and understood by all nursing staff and others engaged in any aspect of medication management within the Centre.

Regulation 13: End of life	Not Compliant

Outline how you are going to come into compliance with Regulation 13: End of life:
1. As part of the contingency plan for any reoccurrence of COVID-19 senior staff nurses have agreed to participate in training associated pronouncement of death.

2. Advance care planning incorporating ceiling of care has been completed for residents, in consultation and discussion with residents, GP's, Residents representative or Next of Kin.

3. Monitoring of this process is now part of the wider resident care plan and is now part of the monthly audit schedule to assist with ongoing compliance.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
Post easement of the COVID-19 outbreak a review was undertaken of the Centre's layout, and size.

Residents' quarters were divided into three separate zones 1,2 and 3 (Zone 3 identified isolation/cohort designated area) incorporating two additional nursing stations, sluice rooms and Storage rooms.

A second clinical room within these allocated zones was actioned and implemented. The objective of this zoning is to ensure nurses and care staff have their own dedicated zone areas ensuring appropriate monitoring as well as accountability and responsibility for their allocated residents during both day and night shifts. This will also reduce unnecessary movement of staff outside of their zones within the care facility.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
1. A synchronized filing system has been implemented and is enacted within the care facility where all resident's records are accurately recorded and all files contains a full suite of documents as required under regulation 21 – this filing system is available for

review.

2. To ensure medication practices compliance, all staff have completed online medication management modules through Hseland which is also updated on the training matrix. Training on medication management competency, assessment and drug rounds is completed for all staff nurses including any starters which is included as part of their induction.

3. Each week a separate Medication Policy is chosen for special study by all staff nurses as part of the Continuing Professional Development. (including administration of subcutaneous fluids).

4. To support and complement the culture of safety and risk management and maintain resident care a locum registered Medical Practionner has been engaged, weekly, for in-house resident consultations.

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
Following the easement of C-19 outbreak an Audit schedule process is maintained which has also being communicated to HIQA for their consideration. This process incorporates

1. Completion of a comprehensive care plan audit incorporating risk assessments. Non-compliance audit results are actioned by management through debriefing sessions with staff, re audit performance and learnings from the outcomes.

2. Continuing Professional Development of staff nurses incorporating care planning, refresher training on assessments advising on the case plan. This shall remain an ongoing process.

3. Staff nurses commenced online HSE training (Hseland) on how to recognise the deteriorating patient, to assist with the monitoring of daily vital signs using the HSE modified observation chart, which is an assessment tool to support nurses in this area.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:

Following easement of the COVID-19 outbreak the Ennis Road Care Facility have ensured residents have received consultations from either the Medical Practionner (engaged directly by Ennis Road Care Facility) or from the residents own GP's. As part of the contingency plan for any reoccurrence of COVID-19 senior staff nurses have agreed to participate in training associated pronouncement of death.

Regulation 9: Residents' rights	Not Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: Activities are provided seven days per week by a social care practitioner and activity coordinator (10 am to 5 pm daily each day of week). The activity programme is reviewed each week to ensure individual social and care needs of residents are prioritised as part of their individual and wider activities planed for forthcoming week.	

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).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 13(1)(a)	Where a resident is approaching the end of his or her life, the person in charge shall ensure that appropriate care and comfort, which addresses the physical, emotional, social, psychological and spiritual needs of the resident concerned are provided.	Not Compliant	Orange	21/08/2020
Regulation 15(1)	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.	Not Compliant	Red	15/06/2020
Regulation 15(2)	The person in charge shall	Not Compliant	Orange	24/07/2020

	ensure that the staff of a designated centre includes, at all times, at least one registered nurse.			
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Red	04/06/2020
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Red	11/06/2020
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Not Compliant	Orange	11/06/2020
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Not Compliant	Orange	10/08/2020
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Red	23/07/2020
Regulation 23(c)	The registered provider shall ensure that	Not Compliant	Red	04/06/2020

	management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.			
Regulation 27	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.	Not Compliant	Orange	15/06/2020
Regulation 29(5)	The person in charge shall ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.	Not Compliant	Orange	12/06/2020
Regulation 03(2)	The registered provider shall review and revise the statement of purpose at intervals of not less than one year.	Substantially Compliant	Yellow	23/07/2020

Regulation 34(1)(d)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall investigate all complaints promptly.	Not Compliant	Orange	26/06/2020
Regulation 34(1)(g)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall inform the complainant promptly of the outcome of their complaint and details of the appeals process.	Not Compliant	Orange	26/06/2020
Regulation 34(1)(h)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall put in place any measures required for improvement in response to a complaint.	Not Compliant	Orange	26/06/2020
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in	Not Compliant	Orange	31/08/2020

	paragraph (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.			
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Not Compliant	Red	29/06/2020
Regulation 5(2)	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.	Not Compliant	Red	29/06/2020
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where	Not Compliant	Orange	29/06/2020

	necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.			
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.	Not Compliant	Red	12/06/2020
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Not Compliant	Yellow	29/06/2020
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Not Compliant	Yellow	29/06/2020