



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

## Issued by the Chief Inspector

Name of designated centre:	Greystones Nursing Home
Name of provider:	Greystones Nursing Home Limited
Address of centre:	Church Road, Greystones, Wicklow
Type of inspection:	Unannounced
Date of inspection:	09 June 2020
Centre ID:	OSV-0000045
Fieldwork ID:	MON-0029622

## About the designated centre

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

The centre is based in a town and is close to shops, and local public transport networks. The designated centre provides care and accommodation to male and female residents over the age of 18. It provides a service to residents with a wide range of needs including palliative care, dementia care, acquired brain injury and physical disability. The provider offers long-term and short-term accommodation, respite and convalescence care.

**The following information outlines some additional data on this centre.**

Number of residents on the date of inspection:	50
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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
Tuesday 9 June 2020	15:15hrs to 18:30hrs	Niall Whelton	Lead
Tuesday 9 June 2020	15:15hrs to 18:30hrs	Mary O'Donnell	Support

## What residents told us and what inspectors observed

Inspectors met and spoke with residents in the communal areas during the inspection. Residents told inspectors that they felt safe and staff were kind to them. Residents appeared contented, well dressed and groomed. They were satisfied with the laundry service and said their laundry was always returned to them.

Residents told inspectors that they had adequate wardrobe space for their clothes and space to display their photos and personal objects in their bedrooms. Residents were satisfied with the set mealtimes, the menu choices on offer and the quality of the meals which were served.

Residents said they knew all about Covid-19, because the person in charge and the staff kept them informed and encouraged them to gel their hands and supported them to maintain social distance. They also read about Covid-19 in the papers and one lady lamented that Covid seemed to be always on the television and it was hard to get away from it. Residents were pleased that their wishes were respected during the Covid emergency. The majority of residents preference was to cocoon in the centre but not to self-isolate in their bedrooms. Two residents who wished to cocoon in their rooms were supported to do this. Staff said they visited these residents regularly to ensure that they were not socially isolated. With the easing of restrictions staff were now trying to encourage these two residents to feel safe when they ventured into areas outside of their bedrooms. Inspectors noted that the majority of residents were up and about and there were a variety of seating areas created to support social distancing. The tables in the dining room had been spaced widely apart and place settings were reduced to support social distancing. Residents were glad that they were not forced to remain in their rooms, as they enjoyed meeting socially with other residents and staff. Many residents said the thing they missed most was meeting with visitors and family and while they appreciated staff support to keep in contact by using the tablet or phone, it wasn't the same as meeting someone in person. Inspectors saw that the art and craft room had been decorated to celebrate a resident's 90th birthday. Window visiting has been organised for the family to join in the celebration and later on inspectors saw the birthday girl enjoyed birthday cake with her extended family on Zoom.

## Capacity and capability

This was an unannounced one day inspection of the premises by two Inspectors of Social Services, one of whom is an estates and fire inspector. The purpose of the inspection was to monitor ongoing compliance with the regulations and standards. Inspectors followed up on notifications received by the Chief Inspector of Social

Services since the previous inspection in the centre on 21 October 2019. Actions had been taken since the last inspection to bring the centre into compliance with the regulations. However with respect to Fire Precautions, Regulation 28, further action was required to provide assurance to the Chief Inspector.

The inspection of 21 October 2019 raised concerns about fire precautions in Greystones Nursing Home.

On foot of this inspection, the Chief Inspector referred the centre to the local Fire Authority for review and requested further assurances from the provider in the form of a fire safety risk assessment, to include assessment of the containment measures in the centre, comprising a fire door assessment and review of specific fire containment measures.

The response from the Provider, which included a fire safety engineering assessment advisory report, did provide assurances to the Chief Inspector on a number of matters, however it did not address some of the specific assurances requested, which led to this inspection, including:

- Confirmation that all door sets in the centre provide the required fire performance
- Confirmation of the satisfactory standard and fire integrity of all of the compartment and sub-compartment doors, walls, ceiling and floors
- Assessment of the existing fire separation of high risk areas from escape corridors
- Assurances regarding the means of escape from bedrooms in 'Fire Zone Compartment 10' where escape from those bedrooms is through a lounge/dining space
- Confirmation that the glazed enclosures to the light well at ground and first floor level in the newer part of the building provide the required levels of fire resistance.

Since the previous inspection, records of evacuation drills were submitted to the Chief Inspector which demonstrated staff ability to evacuate the highest risk compartment of eleven residents with night time staff levels in a reasonable time.

During this inspection, the building was inspected in the presence of the Registered Provider Representative. Inspectors noted many good practices in relation to fire precautions and escape routes and exits were noted to be free of obstruction. The registered provider representative highlighted the importance placed on the training of staff and the induction process in place to ensure staff knowledge of the fire precautions in the centre. The findings of this inspection are that the previously requested fire safety risk assessment, fire door assessment and review of fire containment measures are required to provide the necessary assurances to the Chief inspector. Details of the findings of this inspection are in the Quality and Safety Section of this report.

The provider had a clear management structure and an effective system for monitoring the quality and safety of care. The provider and person in charge had

been proactive in relation to the challenges posed by a COVID outbreak.

A comprehensive contingency plan has been put in place to minimise the risk of residents or staff contracting a COVID infection. The plan also set out actions and to ensure the safety, care and welfare of residents in the event of a COVID outbreak. Necessary guidance documents and emergency supplies had been sourced by the provider.

The provider had made contact with support groups, including Public Health and had access to HSE/HPSC guidelines.

Adequate staff had been employed and contingency staffing arrangements were in place to ensure that residents needs would be met in the event of an outbreak.

#### Registration Regulation 4: Application for registration or renewal of registration

The provider submitted a complete application form to renew the registration of the centre in September 2019.

Judgment: Compliant

#### Regulation 14: Persons in charge

The person in charge had worked in the centre since 2012 and was appointed person in charge in 2017. She has the relevant experience and holds a management qualification.

The Deputy Nurse Manager deputises in the absence of the person in charge and a nominated staff nurse would deputise should the person in charge or deputy nurse manager be unavailable for work. The COVID folder held the required information and contact details to ensure the smooth running of the service.

Judgment: Compliant

#### Regulation 15: Staffing

There was a full compliment of staff working in the centre, and inspectors were assured that the staffing levels were appropriate to meet the needs of residents.

There were at least two registered nurses on duty at all times.

The provider and the person in charge had taken appropriate steps to ensure adequate staff were available to meet the current needs of residents and to provide safe care in the event of a COVID-19 outbreak.

Records were available to evidence that staff confirm that they are symptom free and staff temperatures are monitored twice during each shift. Contingency plans are in place in the event that nurses or other staff are unavailable for work.

Other measures were taken to minimise the risk to residents and staff:

- Staff employed in the centre do not work in any other centre.
- Staff are allocated to two teams to work in two separate zones.
- Staff use changing facilities in the two zones to change their uniform/work outfit at the beginning and end of each shift.
- Staff adhere to rules on social distancing and no more than two staff go to break together
- All staff wear face masks. They have been trained to use and dispose of the masks correctly.

Judgment: Compliant

### Regulation 16: Training and staff development

There was a computerised system in place which supported the person in charge to ensure that all staff attended training events, including mandatory training and refresher training. There was documentary evidence that all staff attended mandatory training within the past 24 months. Fire safety training was held in the centre in March, April and May 2020. Relevant on-line training had been made available and staff also attended training in-house on Dementia Care in May 2020.

Staff had access to relevant regulations and standards and the current guidance by the Health Surveillance Centre or HSE in relation to Covid 19.

Judgment: Compliant

### Regulation 21: Records

The inspector reviewed the restraint register and found that it contained information about physical and chemical restraint. There was evidence that the use of restraint was reviewed regularly. The register did not contain details of environmental restraints, such as the key coded doors in the centre. Inspectors followed up on care records such as food and fluid charts and found that staff entered appropriate



information and the records were up to date.

Judgment: Substantially compliant

### Regulation 23: Governance and management

The provider had a clear management structure and an effective system for monitoring the quality and safety of care. The annual schedule of audits had been revised and monthly audits included actions to inform continuous quality improvement. The infection control audit was revised to include an environmental audit, hand hygiene and the appropriate use and disposal of PPE.

The provider and person in charge had been proactive in relation to the challenges posed by a COVID outbreak.

A comprehensive contingency plan has been put in place to minimise the risk of residents or staff contracting a COVID infection. The centre was divided into two zones, with separate staffing in each zone. A second staff changing area was set up in the older section of the centre. The plan also set out actions and to ensure the safety, care and welfare of residents in the event of a COVID outbreak. Necessary guidance documents and emergency supplies had been sourced by the provider.

The provider had made contact with support groups, including Public Health and had access to HSE/HPSC guidelines.

Adequate staff had been employed and contingency staffing arrangements were in place in the event of an outbreak.

Judgment: Compliant

### Regulation 3: Statement of purpose

The Statement of Purpose had been amended and contained all the required information.

Judgment: Compliant

### Regulation 4: Written policies and procedures

Policies and procedures were in place as set out in Schedule 5. The person in charge stated that reviewing of policies was ongoing. The sample of policies examined by

inspectors were current and inspectors noted that relevant policies had been updated to reflect up to date guidance by the Health Surveillance Centre or HSE in relation to Covid 19. The safeguarding and medication policies had been revised and met regulatory requirements.

Judgment: Compliant

## Quality and safety

The health and nursing needs of residents were consistently met to a good standard in the centre. Each resident's care needs were comprehensively assessed. Care plan documentation to guide residents' care was informed by person-centred information that reflected each resident's individual wishes and preferences regarding their care.

Residents were supported in as far as possible to enjoy a decent quality of life while maintaining safety. They had access to medical care as required and medicines were delivered as normal.

Policies and procedures were in place as set out in Schedule 5. The safeguarding and medication policies had been revised and met regulatory requirements.

Risk management had been strengthened and the risk register included environmental clinical and Covid related risks and the control measures to mitigate the risks identified.

The provider demonstrated a proactive approach to managing risk in the centre with measures in place to ensure residents health and safety needs were met.

All staff were facilitated to attend fire safety training and evacuation procedures and staff were knowledgeable regarding fire compartments for evacuation and safe placement of residents in the event of an emergency evacuation. Inspectors noted that an adequate number of escape routes and exits were provided and these were found to be free of obstruction.

In general, inspectors noted the building was subdivided with construction that would resist the passage of fire in most cases, but improvements were required to ensure adequate containment of fire. Deficiencies noted to fire doors and the lack of fire doors to some rooms, combined with the practice of keeping fire doors open, meant that inspectors were not assured that fire safety arrangements in place adequately protected the residents from the risk of fire in the centre.

The provider confirmed to inspectors that a programme of work was underway to replace smoke seals to fire doors, but there was not a time bound plan in place for the completion of this work. The omission of smoke seals to fire doors can allow

uncontrolled spread of smoke in the building, increasing the risk to residents and staff during evacuation, particularly when phased evacuation is the identified evacuation procedure in place.

While residents were not accommodated at the lower ground floor level, the omission of a fire door to the laundry room meant that a fire would not be adequately contained and may spread to other parts of the building. At the time of inspection, this door was found to be open.

Doors to bedrooms and some other rooms were not fitted with automatic closing devices. Instead, the provider relies on staff to carry out this function. Staff spoken with did include the procedure to close doors to bedrooms during an evacuation and the registered provider representative explained their view that door closers are an impediment to the residents quality of life. However current guidance *'Fire Safety in Existing Nursing Homes'* published in 1996 by the Department of Environment, Heritage and local Government, includes that consideration may be given to omitting door closers to bedroom doors; only where the doors are latched and generally closed and there is a procedure to ensure doors are closed when residents are evacuated. The findings on this inspection were that most doors to bedrooms remain in the open position and the omission of door closers extended to rooms other than bedrooms. Where fire doors are routinely left open, this increases the risk of the smoke and fire spreading to escape routes, potentially hindering evacuation of residents and staff. Inspectors were provided with a risk assessment for door closers on bedroom doors and were not assured by the mitigating control measures in place. While they addressed the risk that the impact a door closer may have on a resident, they didn't fully address the fire issues of not providing an automatic door closer nor do they explore alternative options to ensure the safety of residents. This combined with the Providers decision to allow fire doors to remain open created a risk to residents safety.

Inspectors sought assurance from the registered provider representative in relation to the suitability of evacuation aids on escape routes in the centre. The registered provider representative assured inspectors that all evacuation aids were suitable for the escape routes and confirmed there was an evacuation ski sheet in place on all beds in the centre.

## Regulation 11: Visits

The provider had arrangements in place for residents to receive visitors, and suitable communal and private space was available for residents to meet with visitors. In line with National Guidelines visiting was restricted due to the COVID outbreak.

Essential visitors were admitted and compassionate visiting was permitted if a resident was ill. The provider developed a visiting protocol to minimise any risk of

Covid to residents, staff and visitors.

Visitors can come to the centre and communicate through a window.

The provider outlined plans to reopen for visitors on a phased bases in line with the National Guidance.

Judgment: Compliant

### Regulation 12: Personal possessions

Residents were satisfied with arrangements in place for laundering and storage of their clothing and personal possessions. The person in charge told inspectors that relatives had responsibility for marking items of clothing with the resident's name. The laundry service also labeled any clothes that were not marked. Inspectors noted that there were no items in the lost property basket on the day of inspection.

Since the previous inspection the provider had arranged to have a lockable storage facility for all residents in their bedrooms.

Judgment: Compliant

### Regulation 17: Premises

Inspectors found the centre was clean and in a good state of repair. There was an ongoing programme of maintenance in the centre. Inspectors found the standard of decor throughout the centre was good. inspectors observed that some residents had items of furniture from their home in their rooms and their bedrooms were personalised with photographs, pictures and ornaments. The person in charge confirmed that some worn items of furniture had been removed since the previous inspection. The sluice room and a bathroom had been painted since the previous inspection.

Servicing of equipment was prioritised to ensure that essential items were in working working order. For example the emergency fire equipment, hoists, and the lift had all been serviced.

Many of the twin rooms were used as single rooms to support residents to self isolate. The communal areas were reviewed to create a variety of suitable seating areas to support residents to maintain a social distance.

Judgment: Compliant

## Regulation 26: Risk management

The risk management policy was revised and the risk register updated to include environmental risks such as, the access to stairwells, and key coded external doors. Controls were put in place to mitigate risks and inspectors observed that stair gates had been installed since the previous inspection. Clinical risk assessments were carried out to identify any risks for residents who used the stairs and care plans were in place to address the risks identified. There were no incidents or near misses reported in relation to residents use of the stairs. Risks in relation to the storage of oxygen and fire safety are detailed under Regulation 28.

Controls were also put in place to mitigate the risk of COVID 19 infection to residents and staff working in the centre.

- Staff do not move between centres. Staff and their families/households adhered to guidelines and monitored themselves for symptoms at home in addition to staff monitoring in work.
- Staff were aware that they must inform the nurse in charge if they are feeling unwell, exhibiting symptoms or have been in contact with a suspected case of COVID. They have read the relevant policies and the public health guidelines
- The COVID contingency plan was informed by a comprehensive risk assessment. Risks identified include management, procurement, staffing, infection prevention and control, residents' health and well-being, catering, laundry and maintenance. Control measures put in place to manage identified risks were subject to ongoing monitoring to ensure their effectiveness.

Judgment: Compliant

## Regulation 27: Infection control

The infection prevention and control policy was revised to include COVID 19. There were enhanced arrangements regarding infection control set out in the contingency plans developed by the provider. The person in charge and her deputy ensured that staff read and understood the policy, and were appraised of any changes in the national guidance. The management team demonstrated a good awareness of key statutory guidance specific to COVID-19 and demonstrated knowledge of key messages in this guidance. Staff had access to HSE-Land training and they had practical training in hand hygiene and donning and doffing of personal protective equipment (PPE)

Cleaning schedules had been reviewed and there was documentary evidence that regular cleaning and deep cleaning was completed. A programme to decontaminate frequently touched surfaces was carried out twice daily. The household staff had infection control training relevant to their roles - including use of equipment and solutions for cleaning. Inspectors observed that the premises was clean and

equipment such as hoists were clean. Equipment was stored on appropriate storage units in the sluice room and records showed that the bed-pan washer was serviced in Nov 2019.

Hand hygiene facilities were improved to ensure that sanitising stations were accessible in all areas.

The provider had a system in place to ensure that there are adequate supplies of masks, PPE, disinfectant, hand hygiene products, tissues and cleaning products.

Additional pedal bins had been procured.

A contract for waste disposal is in place.

Judgment: Compliant

## Regulation 28: Fire precautions

At the time of inspection, the registered provider had not taken adequate precautions to ensure that residents were protected from the risk of fire. While the provider had submitted a fire safety engineering assessment advisory report, as referred to in the capacity and capability section of this report, on this inspection inspectors found that improvements were required to comply with the requirements of the regulations as follows:

The registered provider was not taking adequate precautions against the risk of fire:

- Fire doors to bedrooms and two other rooms were not generally closed, as outlined above.
- The aforementioned fire safety engineering advisory assessment report, highlighted examples of areas of hazard in a building as being a kitchen, laundry, workshop and boiler room. The findings on this inspection was that the door to the laundry room, was not a fire door and was found in the open position, with a 'sling' hanging over the door. The maintenance room was not fitted with a fire door and the fire door to the kitchen contained a gap at the top.
- Signage was not available in locations where oxygen was stored. Inspectors noted oxygen stored in a medical room opening onto a corridor serving two bedrooms. Neither the medical room or the bedrooms were fitted with fire rated doors. This created an increased risk and as such should be provided with suitable warning signs.

Inspectors were not assured that adequate means of escape was provided throughout the centre:

- Small store rooms, including linen presses, located on bedroom corridors were not adequately protected with fire rated enclosures.

- Inspectors noted the lift in the rear section of the building opened directly to the bedroom corridors. This does not accord with current guidance for existing nursing homes, which indicates that a fire protected lobby should be provided between lift doors and corridors, to afford adequate means of escape.
- Inspectors were not assured that adequate means of escape was provided for the residents in the area previously used as suites. In the ones viewed by the inspector, the bedroom doors and medicine store room were not fire doors, with the door to the 'suite' the only fire door. This means that residents in these bedrooms are not afforded a protected means of escape on the initial portion of the escape route from their room.
- The means of escape provided for the bedrooms opening off the open day space at first floor would benefit from risk assessment to ensure adequate means of escape is provided to the six bedrooms opening onto this space.

Adequate arrangements were not in place for maintaining fire doors along the means of escape:

- While weekly checks of fire doors were taking place, due to the observed deficiencies to fire doors in the centre, improvements were required to ensure the checks of the fire doors were of adequate extent, frequency and detail.

Inspectors were not assured that adequate arrangements were in place for containing fires:

- As previously outlined above, most bedroom doors were in the open position
- A number of doors to rooms other than bedrooms were not fitted with automatic closing devices, two of which were found to be in the open position.
- Some rooms were not provided with fire doors, such as the laundry room, the maintenance room, offices, some bedrooms and small store rooms.
- Inspectors were not assured of the likely fire performance of all door sets (door leaf, frame, brush seals, intumescent strips, hinges, closers and ironmongery) and noted that a fire door assessment was required in this regard. It was observed where fire doors/or door frame had been modified, a door to the residents lounge did not latch to ensure it would stay closed, gaps around doors were observed, screws were missing to hinges, a large percentage were not fitted with smoke seals and some were warped and not able to close fully.
- Inspectors noted a small number of gaps or holes within fire barriers which may require sealing to ensure smoke and fire do not spread through the fire barrier. This requires review.
- Assurance was required that the glazing located in fire compartment boundaries and within enclosures to fire risk rooms provided sufficient fire resistance.

Adequate arrangements had not been made for detecting fires:

- Inspectors noted a store room which was not provided with smoke detection

The person in charge did not ensure that procedures to be followed in the event of a fire were adequately displayed:

- Inspectors noted additional exit signage was required from some areas of the centre to ensure escape routes are readily apparent.
- While the procedures to follow in the event of a fire were displayed, they were not prominently displayed. This is of particular importance where the closing of bedroom doors is reliant on those procedures.

Judgment: Not compliant

### Regulation 29: Medicines and pharmaceutical services

The inspector followed up on issues identified on the previous inspection. The inspector examined the medication policy which had been revised on 10 April 2020. The policy included the procedure for transcribing medications in line with best practice guidelines. Inspectors reviewed medication documentation and found that they held the required information including a photograph of each resident. When PRN (as required) medications were prescribed, the maximum dosage was stated.

Judgment: Compliant

### Regulation 5: Individual assessment and care plan

The centre had a computerised care planning system. Residents had a comprehensive nursing assessment on admission and care plans were developed which were informed by these assessments. Care plans were reviewed at least four monthly.

Inspectors reviewed the care plans of two residents who smoked. They found a smoking risk assessment was completed for each resident and a safety plan put in place to mitigate risks identified. If cigarettes were held by staff the rationale for this was clearly stated, such as, to mitigate the risk of the resident starting a fire or the risk that the resident would smoke all their cigarettes at once and then run out of cigarettes. There was evidence the residents were involved in formulating their care plans or their relatives were consulted where appropriate.

Clinical risks such as malnutrition, falls and pressure sores were assessed and appropriate care plans put in place to mitigate the risks. There were no residents with pressure sores and residents at risk were provided with pressure relieving mattresses and cushions. Inspectors followed up on a resident who had a wound



which was healing and found that the wound assessments and management plan were in line with evidence based practice. Staff had access to specialist tissue viability advice which was reflected in the care plan. The resident was taking prescribed nutritional supplements to aid healing.

The person in charge had taken the necessary steps in relation to assessments and care planning to reflect the impact of infection controls on residents care and well-being and to prepare for an outbreak of COVID.

Staff were aware of atypical symptoms of COVID 19, and residents were monitored for symptoms on an ongoing basis.

Residents wishes were elicited and documented to inform advanced care planning and end of life care

Judgment: Compliant

## Regulation 6: Health care

Residents had access to medical and allied health care services. Residents' general practitioners (GPs) made site visits when required but where possible GPs reviewed and assessed residents using teleconferencing and the e-nursing computer system. Residents had optical and dental assessments in January and February 2020. The physiotherapist, who normally worked across the provider's centres was now worked in the centre four days a week.

There was evidence that nurses engaged in continuous professional development and the nurse management team ensured that nurses were informed of current best practice in relation infection prevention and control as well as the management of residents with suspected or confirmed COVID-19

Residents had access to general psychiatry and old age psychiatry services. A resident with unstable diabetes had access to the diabetic clinic in the acute hospital.

Arrangements were in place to transfer residents to hospital but currently there were no residents admitted to acute services.

Although not actively involved with supporting any residents in the centre at the time of this inspection, links with the community palliative care team were established and their expertise was sought for residents as appropriate.

Judgment: Compliant

## Regulation 7: Managing behaviour that is challenging

There was a policy in place to inform management of responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) and restrictive practices in the centre. Staff identified three residents with responsive behaviours but no residents exhibited responsive behaviours during the inspection. Inspectors observed that staff worked at a pace which created a relaxed atmosphere and interactions between staff and residents were friendly and person centred. Many of the residents were living in the centre for years and the staff and residents knew each other very well. Residents were offered choice in relation to aspects of their daily life and they had a variety of rooms available to them, to facilitate them to move around and sit in a place of their choice with company of their choosing. Residents with responsive behaviours were assessed using the ABC charts and the information was used to inform a behavioural support plan. Staff who spoke with inspectors knew how to identify warning signs and how to support a resident or use techniques such as distraction in order to prevent a behaviour from escalating. In house training in dementia care was organised for staff on 4 June and 11 June. The training included the management of responsive behaviours.

Forty percent of residents were using bed rails. This was a marginal improvement since the previous inspection in October 2019. Only two residents required PRN medication and inspectors were assured that chemical restraint was used only as a last resort. Less restrictive alternatives to bed rails were in use such as bed wedges, monkey poles and grab rails. However there was scope to promote the use of less restrictive alternatives when residents requested bed rails for safety or to enable them to move in bed.

Judgment: Substantially compliant

## Regulation 8: Protection

The policy on safeguarding was reviewed on 25 October 2019. It referenced the Safeguarding Vulnerable Persons at Risk of Abuse National Policy & Procedures 2014 and included the time frames to direct staff when dealing with allegations or suspicions of abuse. Inspectors followed up on a recent allegation and found that the allegation had been appropriately investigated and managed in line with the centre's safeguarding policy.

Safeguarding training was held in October, November and December 2019 and training records showed that all staff had attended this training. Staff who met with

inspectors confirmed that they had attended training and they were familiar with the Safeguarding Policy and procedures.

Judgment: 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
<b>Capacity and capability</b>	
Registration Regulation 4: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 4: Written policies and procedures	Compliant
<b>Quality and safety</b>	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Compliant

# Compliance Plan for Greystones Nursing Home OSV-000045

Inspection ID: MON-0029622

Date of inspection: 09/06/2020

## 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 21: Records	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 21: Records:            The Health &amp; Safety Statement – Risk assessment section now includes the environmental restraint of the key coded front doors to the centre. All individual care plans for those residents to whom the door codes are withheld include reference to the door codes. This has been added to our monthly audits and is now included the quarterly return to HIQA.</p>	
Regulation 28: Fire precautions	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 28: Fire precautions:            28(1)(a): All staff members are fully trained to close doors in the event of a fire outbreak. A list of non compliant fire doors has been drawn up and fire doors will be installed where required. As discussed with the HIQA inspector at the time of the inspection Greystones Nursing Home has a constant program of improvements in place and the minor improvements and replacement of fire protection items is on-going. For example we have been replacing the previously compliant intumescent strips on fire doors with the now available intumescent and smoke seal strips with over 50% of the building completed to date and the remainder to be completed by 31/8/2020.</p> <p>28(1)(b): Greystones Nursing Home is certified by a legislatively defined "competent person" as compliant with Fire Regulations. This includes certified emergency lighting which is fully maintained in line with regulations.</p> <p>28(1)(c)(i): Greystones Nursing Home maintains all of the fire equipment, means of escape, building fabric and building services in line with requirements under the relevant legislation and certification and documentation to this effect has been provided to HIQA.</p>	

28(2)(i): The one missing smoke detector from a small store room will be installed.

28(3): The procedures are displayed in a prominent place and fully trained to all staff. This is reviewed and assess during all mandatory training sessions and evacuation drills.

The inspector has reviewed the provider compliance plan. This action proposed to address the regulatory non-compliance does not adequately assure the chief inspector that the action will result in compliance with the regulations.

Regulation 7: Managing behaviour that is challenging	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:  
This refers to the use of bed rails in the home. We have an on-going constant and consistent approach to trialing of alternatives to bed rails. Every effort is made to encourage residents to feel safe in not using bed rails, however the majority of residents who are admitted from hospital have grown used to the comforting nature of bed rails. Our approach includes understanding and respecting the residents preference in this matter and the safety assessment conducted by us. We have reviewed all residents currently using bed rails and will continue to trial alternatives.

## 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 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.	Substantially Compliant	Yellow	30/06/2020
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Orange	31/10/2020
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	20/07/2020
Regulation	The registered	Substantially	Yellow	20/07/2020



28(1)(c)(i)	provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Compliant		
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	31/08/2020
Regulation 28(3)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place in the designated centre.	Substantially Compliant	Yellow	20/07/2020
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.	Substantially Compliant	Yellow	30/06/2020