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

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| 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: | 10 February 2020 |
| Centre ID: | OSV-0005768 |
| Fieldwork ID: | MON-0025595 |

## 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 purpose-built single storey facility, where bedroom accommodation comprises 54 single and 15 twin rooms, 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 grande piano, fire place, 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.**

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| Number of residents on the date of inspection: | 76 |

## 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 |
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| Monday 10 February 2020 | 12:00hrs to 18:30hrs | Breeda Desmond | Lead |
| Tuesday 11 February 2020 | 08:15hrs to 15:00hrs | Breeda Desmond | Lead |

## What residents told us and what inspectors observed

The inspector spoke with residents and relatives during the two-day inspection. People said that any issue raised with the person in charge was dealt with immediately and followed up to ensure care was appropriate. While feedback was positive regarding the staff, people highlighted that there was a shortage of staff which resulted in long waiting times for assistance throughout the day, evening and night times, and this was 'frustrating' and a source of 'anxiety'.

## Capacity and capability

Due to significant under-resourcing, the registered provider had not provided the necessary supports to enable or ensure adequate systems of oversight to evaluate the service which would improve and hopefully sustain a better service. This was evidenced by poor outcomes for residents due to inadequate staff numbers and skill mix, over-due training, and lack of an effective evaluation of the service. The centre was not staffed in accordance with the aims and objectives espoused in the statement of purpose. While there was a clearly defined management structure with defined lines of accountability and responsibility for the service, the management structure in place was new with the recent appointment of the person in charge and the newly appointed clinical nurse manager. The management team were not adequately supported with their responsibilities to ensure an appropriate service in accordance with their statement of purpose. While the new person in charge had commenced some clinical audits to enable oversight of the service, a programme of audit to enable effective monitoring of the service in accordance with the regulations, was not in place. Collection of data such as weekly key performance indicators to provide oversight of quality of care was not in place. Lack of the fore-mentioned were due to inadequate supports provided by the registered provider. Clinical nurse managers' (CNMs') administration time could not be guaranteed due to an inadequate staff complement, which resulted in the CNMs being required to provide resident care rather than provide the necessary support to enable appropriate monitoring of the service, to ensure effective and safe delivery of care.

Unsolicited information of concern, from a number of sources, submitted to the regulator highlighting shortages of staff with the associated care and welfare issues such as unsatisfactory waiting times for all aspects of care; these were verified on inspection and the registered provider representative was issued an urgent compliance plan to address the staff shortages. This is an unusual step, only taken when the office of the chief inspector has significant concerns.

A schedule of admissions was agreed with the registered provider representative as part of the registration process to ensure that all incoming residents were afforded

the time to be orientated and settle in, and for staff to get to know the new resident and complete their assessment and care plan comprehensively. However, this schedule of admissions was not fully adhered to. For example, occasionally, six people were admitted to the centre, rather than five. On the day of inspection there were two residents admitted, one at 15:30hrs and the second at 18:00hrs. The inspector observed that both nurses on duty were undertaking medication administration at the time of the resident's admission, so the incoming resident could not be afforded the fitting time and attention required to allay fears and have concerns answered.

The person in charge was recently appointed and was full time in post; he was supported in the role by the newly appointed clinical nurse manager (CNM) full time in post, and a second CNM, part-time. Following concerns raised by relatives, he had introduced new control measures to enable better oversight of residents' care needs, for example, the morning hand-over report now included more in-depth clinical information as well as other information to ensure appropriate individualised care was delivered to a high standard. It was reported to the inspector that both CNMs had super-numery hours to the staff roster to enable quality improvements, however, this was not routinely permissible due to staff shortages.

Policies and procedures as required in Schedule 5 were in place, however, they were not up to date as they did not reference current regulations, national standards or national policy, consequently, it could not be assured that care was delivered in accordance with current best practice guidelines. The statement of purpose required updating on inspection to reflect the current conditions of registration; current organisational structure; whole-time equivalents of staff; correct number of residents the service was registered to accommodate and the correct number of bedrooms; accessing medical card services for residents.

The incidents and accidents log was reviewed and notifications to the office of the chief inspector correlated with these. A synopsis of the complaints procedure was displayed in the centre and records demonstrated thorough and timely investigations of issues raised.

A sample of staff documents were reviewed and all staff had vetting disclosures in accordance with National Vetting Bureau (Children and Vulnerable Persons) Act 2012. Nonetheless, there were no written references available for one staff, gaps in employment history and the appropriate documentation to enable a person to work in Ireland, were not in place.

The person in charge had good oversight of the training needs of staff and had organised further training to bring training into compliance. For example, fire safety training with fire drills and evacuations were completed on a weekly basis to ensure competency of staff. There was an in-house physiotherapist that facilitated manual-handling and lifting training, and training was scheduled for staff in February and March. Nonetheless, other outstanding training included protection, hand hygiene and managing behaviours that challenge.

Overall, the number and skill mix of staff was inadequate to the size, layout and

dependency levels of the residents (36 high - maximum dependency residents) and this resulted in poorer outcomes for residents.

## Regulation 14: Persons in charge

The person in charge took up the post in December 2019 and was full time. He had the necessary experience and qualifications as required in the regulations. He demonstrated knowledge regarding the role and responsibility and was articulate regarding governance and management of the service, and proposed quality initiatives to provide oversight of the service to enable learning and quality improvements. He demonstrated good knowledge of residents, their care needs and preferences and the importance of delivering individualised care.

Judgment: Compliant

## Regulation 15: Staffing

The number and skill mix of staff was inadequate having regard to the needs of the residents, assessed in accordance with the regulations, and the size and layout of the centre. Evidence of this is discussed in Quality and Safety and throughout the report. The registered provider representative was issued an urgent compliance plan to address the staff shortages.

Judgment: Not compliant

## Regulation 16: Training and staff development

The inspector observed that due to inadequate staff numbers and skill mix, staff supervision was inadequate to ensure that the care delivered was safe and appropriate, and in line with best practice.

Outstanding training included protection, hand hygiene and managing behaviours that challenge.

Judgment: Not compliant

## Regulation 19: Directory of residents

The directory of residents was maintained in line with the requirements set out in Schedule 3 of the Regulations.

Judgment: Compliant

## Regulation 21: Records

Schedule 2 documentation requirements to be in place for all staff prior to the commencement of employment was not comprehensive.

Medication administration documentation showed gaps in records.

The duty roster did not accurately reflect the staff allocation in accordance with their role and responsibility.

Judgment: Not compliant

## Regulation 23: Governance and management

The centre was not staffed in accordance with the undertaken given by the registered provider when the centre was registered. While there was a clearly defined management structure, the registered provider had not ensured sufficient resources to enable the effective delivery of care in accordance with the statement of purpose, or ensured management systems to support a safe, appropriate, consistent service to be effectively monitored.

Judgment: Not compliant

## Regulation 3: Statement of purpose

The registered provider had not updated the statement of purpose as required, to ensure compliance with the regulations.

Judgment: Not compliant

## Regulation 31: Notification of incidents

Notifications were timely submitted and these correlated with the incident and

accident log reviewed.

Judgment: Compliant

## Regulation 34: Complaints procedure

The complaints log was reviewed and showed that complaints were timely addressed, thoroughly investigated and recorded in line with the regulations.

Judgment: Compliant

## Regulation 4: Written policies and procedures

While Schedule 5 policies were in place, the registered provider had not updated these in accordance with current legislation, national policy or best practice standards.

Judgment: Not compliant

## Quality and safety

While residents gave positive feedback about staff, they reported a poor quality of life, due to waiting times for all aspects of care. There were several issues identified with meal-times that took from the dining experience of residents, not least, the inordinate waiting times to be served. The inspector observed this at breakfast where residents were waiting 25 - 30 minutes to be asked their menu choice. While it was reported that a staff member was rostered to be in attendance in the dining room for mealtimes, that staff member was also responsible for organising breakfast trays and delivering them to some bedrooms. This meant that when residents came to the dining room for their breakfast after 8:00hrs there was no member of staff available for some time. The inspector observed that due to lack of staff supervision, some staff practices were task-oriented and some staff did not actively engaged with residents. Residents reported that they were brought to the dining room for 12:30hrs but usually not served until 13:00hrs at the earliest. On the first day of inspection, residents were not served until 13:10hrs; this meant that people were sitting in the dining room, waiting for 40 minutes. In addition, residents said that staff 'were rushed off their feet all the time'.

A sample of care plan documentation was reviewed. Pre-admission assessments were completed by either the registered provider representative or the person in

charge to ensure the service could provide appropriate care to each resident. While there were assessments and care plans for individual residents with some person-centred information to inform individualised care, other information was generic. Risk assessments completed did not always take into consideration medical histories or recent medical episodes, consequently, risk was under-estimated for the resident and appropriate controls to mitigate unnecessary risk were not consistently applied. Upon return to the centre, resident assessments were not updated to reflect the change in the person's dependency levels. Residents' personal emergency evacuation plans were up to date and accurately described the assistance required should the need arise. The CNM had commenced audits on care planning documentation as part of their quality improvement strategy and had identified areas for improvement, and the inspector concurred with these findings.

The inspector was informed that a new activities person was due to start employment shortly whose expertise and background was social care and would be involved in developing the social aspect of care plans including the 'key to me'. There was a new activities person in post, with activities provided every day of the week. Nonetheless, a comprehensive programme following consultation with residents was to be undertaken to facilitate activities that were meaningful to residents. Feedback given to the inspector by relatives highlighted the inadequacy of activities for maximum dependent residents and the inspector observed this.

Residents notes showed that people had access to medical care such as GP services and psychiatry of old age as well as access to allied health professionals such as occupational therapy, optician, dietician and speech and language therapy, community palliative care and acute care out-patient follow-up services. There was an in-house physiotherapist that provided rehabilitation, assessments including falls assessment, in addition to providing manual handling training to staff.

Residents had good menu choice and gave positive feedback regarding their food. Textured diets were presented in an pleasing manner. Residents had choice in where to dine and were observed coming to the dining room throughout the morning and having their breakfast.

An additional bedside chair was provided in twin rooms during the inspection to afford both residents the comfort of sitting by their bed if they chose. To allay the possibility of confusion, especially for residents with cognitive impairment, orientation signage along lengthy corridors would enhance the new premises. There was a strong odour from the smoking room as the extractor fan appeared to be ineffective. The exit by fire exit 4 required attention as the area outside the door was uneven and unfit to accommodate residents including residents requiring assistance, should the need arise.

Closed circuit television (CCTV) was at entrances and hallways and there was advisory signage regarding use of CCTV.

The inspector spoke with the accountant and who demonstrated robust systems to safeguard residents' finances.

Advisory signage for visitors was displayed in the event of a fire. Floor plans

identifying zones, compartments and location of fire safety equipment were displayed, however, easily accessible points of reference were not consistently available. Fire safety training was up to date for all staff. Training records showed that drills were completed with times of evacuations, discussions following the drills and the learnings to improve evacuation times. Evacuations were undertaken cognisant of night time staff levels and staff spoken with were knowledgeable regarding evacuation procedures. The new person in charge had introduced weekly fire safety sessions to ensure all staff were very familiar with fire safety precautions. The person employed as maintenance was trained in fire safety and facilitated this weekly training along with the person in charge.

## Regulation 11: Visits

Visitors were observed calling throughout the day. They were welcomed by staff and staff knew visitors by name and actively engaged with them.

Judgment: Compliant

## Regulation 12: Personal possessions

The incumbent person in charge reviewed the laundry practices and had introduced some initiatives to mitigate the risk associated with laundry going missing as well as in response to residents and relatives feedback. A new system was introduced for labelling clothes; new laundry bags were purchased for each resident to enable laundry to be washed together and prevent laundry getting mixed up.

One resident's personal alarm mat was removed from the resident's bedroom and was not located.

Judgment: Substantially compliant

## Regulation 13: End of life

At the time of inspection, three residents were receiving the services of the community palliative care nurse who visited the centre several times a week to provide expertise and support.

Judgment: Compliant

## Regulation 17: Premises

Issues identified:

1) the external pathway outside fire exit 4 required attention as it was uneven and the surface was unsuitable for the intended purpose to safely evacuate residents, in particular, those residents requiring assistance
2) there was a lack of advisory signage to orientate residents and allay possible confusion and disorientation and the anxiety caused therein
3) smoking room ventilation was inadequate to appropriately dispel aromas.

Judgment: Not compliant

## Regulation 18: Food and nutrition

Residents had a poor dining experience due to the staff shortages and the inordinate waiting times to be served. There was lack of appropriate supervision during mealtimes to ensure a positive dining experience for residents, every time.

Judgment: Not compliant

## Regulation 25: Temporary absence or discharge of residents

While the inspector was advised that all relevant information about the resident was provided upon transfer or discharge to the receiving designated centre, hospital or service, there was no documentary evidence of this. Upon a resident's return to the designated centre, all reasonable steps to ensure all relevant information about the resident was not in place.

Judgment: Not compliant

## Regulation 27: Infection control

The inspector observed there were adequate cleaning staff during the inspection. Appropriate cleaning practices in line with the national standards were observed.

Judgment: Compliant

## Regulation 28: Fire precautions

Fire safety precautions were in place to enable the safety of residents and staff. Personal emergency evacuation plans (PEEPS) were in place for all residents. Staff spoken with knew the fire evacuation procedures and weekly fire safety training was given to ensure staff were familiar with fire safety and evacuation procedures.

Judgment: Compliant

## Regulation 29: Medicines and pharmaceutical services

Residents had access to pharmacy services and the pharmacist was facilitated to fulfil their obligations under the relevant legislation and guidance issued by the Pharmaceutical Society of Ireland. Controlled drug records were maintained in accordance with professional guidelines. Receipt and return of medications were documented. Medication errors and near miss episodes were recorded and discussed at staff handovers and meetings to provide learning opportunities and mitigate the possibility of recurrence.

Medication administration documentation showed gaps in records, so it could not be assured that residents received their medications. The inspector observed delays in medication administration outside the recommended times in accordance with professional guidelines.

Judgment: Not compliant

## Regulation 5: Individual assessment and care plan

Risk assessments completed did not always take into consideration medical histories or recent medical episodes, consequently, risk was under-estimated for the resident and appropriate controls to mitigate unnecessary risk were not consistently applied. Upon return to the centre, resident assessments were not consistently updated to reflect the change in the person's dependency needs.

Judgment: Not compliant

## Regulation 6: Health care

The inspector examined information relating to a notification submitted to the

regulator and the evidence demonstrated that a high standard of evidence-based nursing care in accordance with professional guidelines was not provided. While information was available on admission of a resident's medical diagnoses, adequate oversight of a resident's known care needs was not provided and this information did not inform care.

Judgment: Not compliant

## Regulation 8: Protection

The service was pension agent for three residents and records examined demonstrated robust safeguards to protect residents.

Judgment: Compliant

## Regulation 9: Residents' rights

A review of the activities programme following consultation with residents was to be undertaken to facilitate activities that were meaningful to residents. Feedback given to the inspector by relatives highlighted the inadequacy of activities for maximum dependent residents and the inspector observed this.

One family member reported that her relative glasses were not routinely donned even though the person needed them to view the television, and the inspector observed this on inspection.

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 19: Directory of residents | Compliant |
| Regulation 21: Records | Not compliant |
| Regulation 23: Governance and management | Not compliant |
| Regulation 3: Statement of purpose | Not compliant |
| Regulation 31: Notification of incidents | Compliant |
| Regulation 34: Complaints procedure | Compliant |
| Regulation 4: Written policies and procedures | Not compliant |
| **Quality and safety** | |
| Regulation 11: Visits | Compliant |
| Regulation 12: Personal possessions | Substantially compliant |
| Regulation 13: End of life | Compliant |
| Regulation 17: Premises | Not compliant |
| Regulation 18: Food and nutrition | Not compliant |
| Regulation 25: Temporary absence or discharge of residents | Not compliant |
| Regulation 27: Infection control | Compliant |
| Regulation 28: Fire precautions | 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-0025595

## Date of inspection: 11/02/2020

**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:<br>Additional staffing across all roles has been added to the duty roster commencing from 12/02/2020 as detailed in the comprehensive response to the Immediate action plan submitted to the Authority on 20/02/2020.<br><br>A baseline audit of staffing levels based on resident's dependencies will be commenced using the Modified Barthel Assessment Tool to ensure existing staffing levels are appropriate. This is to be reviewed weekly.<br><br>Resident satisfaction surveys, resident forum minutes and complaints will be monitored for trends relating to concerns about staffing levels, reviewed at management team meetings and actioned accordingly – monthly. | |
| Regulation 16: Training and staff development | Not Compliant |
| Outline how you are going to come into compliance with Regulation 16: Training and staff development:<br>Staff training highlighted, education day carried out on 25/2/20 (protection, Hand Hygiene, managing challenging behaviors) and every 3 months continuously from now on. Ongoing fire training, ongoing manual handling and infection control to continue and is now fully completed for all staff. All staff are now having updated mandatory safeguarding, challenging behaviors and hand hygiene training at Ennis Road Care Facility. Training matrix is included and discussed at weekly management meetings. Staff are now allocated to specific areas / activities on a weekly basis. Allocation sheet to match roster and to be drawn up by CNMs and signed off by Director of nursing weekly. | |

All shifts to have senior carers, staff nurses assigned to specific areas with CNMs and or DON.

All staff have been reminded of their reporting relationships and organizational structure as highlighted in the Statement of Purpose. Senior carers have now been introduced to all shifts to enable additional peer supervision of care staff in conjunction with the staff nurses on duty. Formal supervision arrangements continue in line with annual appraisals of staff.

| Regulation 21: Records | Not Compliant |
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Outline how you are going to come into compliance with Regulation 21: Records:
Medication Administration documentation showed gaps in records.
Medication administration to be practiced per Ennis Road Care Facility medication policy and procedure and NMBI guidance. A weekly audit by the CNMs or DON has commenced to enable us to identify any patterns and identify gaps identified in terms of certain members of staff or certain medications.
Pharmacy in service and training took place on 3/3/20 all nurses attended to review ordering of medication, out of hours' service, medication administration and signing of medication administration on MARS. Pharmacist presented the medication management in-service training. Nursing staff reported in service very helpful and refocused staff on medication administration and charting. All nurses will have medication competency re demonstration with DON completed before 31/3/20. Nurses will also complete the medication administration competency on hseland.ie

Duty roster not accurately reflecting the staff allocation in accordance with their role and responsibility.
All staff are allocated based on roster shifts and transcribed one week before to allocation sheet. This will be completed by CNMs and signed by DON. Senior, novice and training staff plus staff strength and weaknesses will be taken into account to produce a competent even skill mix to all residents. Any gaps in the roster will be identified and filled to provide high standard person centered care.

Documentation requirements to be in place for all staff prior to the commencement of employment.
All new employees will only be hired once Ennis Road Care Facility Employee check list has been completed and relevant paperwork in their files as per policy. The personnel files of all newly hired staff will be reviewed by the Director of Nursing before and during induction.

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| Regulation 23: Governance and management | Not Compliant |

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Currently weekly staffing ratios and admission numbers, dates and times of admissions are being monitored and emailed to Hiqa as per instructions. Admissions are limited to one per day Monday to Friday. Residents are admitted up to 5 pm Monday to Thursday and up to 3 pm on a Friday. Admissions are classified as either a person who was admitted into hospital while staying at Ennis Road Care Facility and returning to the nursing home or a person who is a totally new admission to the nursing home as per Hiqa instructions on inspection date of 10/2/20.
Resident dependency levels (Bartel) and social care needs are continuously being assessed and reviewed on a weekly basis to ensure that the total staff number and skill mix on each shift meets the care needs of the resident. A comprehensive programme of clinical audits are now continued with the collection of weekly key performance indicators in the areas of restraints-restrictive practice (weekly), wounds/ pressure ulcers (weekly), falls incidents (monthly), The dining experience audit (monthly) care plan audit (monthly), person centered care delivery (monthly), complaints (monthly), medication management audit (monthly) and infection control audit (monthly). Results of these audits and significant trends will be reviewed at the management meetings with the Registered Provider and actioned accordingly to ensure continuous quality improvement and continued learning for all staff of same.

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| Regulation 3: Statement of purpose | Not Compliant |

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
Statement of purpose has been reviewed and updated to reflect the current conditions of registration, the updated organizational structure, the current whole time equivalents of staff, the correct number of residents and bedrooms that the service was registered to accommodate and outside availability of certain services to medical card holders. Updated and complete on 28/2/20. A copy of the updated Statement of Purpose is available on request.

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| Regulation 4: Written policies and procedures | Not Compliant |

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| Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:<br>The Clinical Nurse Manager and Director of Nursing are to update via a literature review the schedule 5 policies in accordance with national policy, current legislation, and best practice standards. This will be completed in phases. Phase one to be completed by 1/5/20 (to include policies on safeguarding, medication management, and recruitment and retention), phase two to be completed by 1/7/20 and phase three to be completed by 1/9/20. |

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| Regulation 12: Personal possessions | Substantially Compliant |

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| Outline how you are going to come into compliance with Regulation 12: Personal possessions:<br>A replacement alarm mat has been ordered and will be provided to the resident in question on 15/2/20.<br><br>On admission staff are taking a detailed inventory and clearly labeling all residents' personal possessions (all residents updated inventory has been reassessed on 10/3/20 and placed in resident's files). |

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| Regulation 17: Premises | Not Compliant |

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| Outline how you are going to come into compliance with Regulation 17: Premises:<br>(1) The external pathway outside fire exit 4 requires attention, it is uneven and the surface is unsuitable for its intended purpose.<br>Plan: smooth concrete pathway to be installed per building regulations in identified small uneven area. This shall facilitate safe evacuation of residents to outside area. To be completed by April 2020. And may be completed earlier depending on weather.<br>(2) Sign on ceiling of corridor C to display nurses station.<br>Meeting with maintenance department on 26/2/20. Nurses station signage ordered on 28/2/20 and completed by 11/3/20.<br>(3) Smoking room ventilation addressed, room now well ventilated with new exacter fan. |

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| Regulation 18: Food and nutrition | Not Compliant |

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| Outline how you are going to come into compliance with Regulation 18: Food and nutrition:<br>A dining room assistant has been assigned solely to the dining room from 7 am to 3 pm daily from 12/2/20. The plan is that all residents once siting in dining room will be attended to by the Dining room assistant within five minutes. They will oversee the dining room and be fully immersed in the dining experience of each resident. A dining room experience audit will be carried out by the CNM and DON monthly. The dining room assistant is an additional new role within our catering team providing a positive dining room experience with in our facility. | |
| Regulation 25: Temporary absence or discharge of residents | Not Compliant |
| Outline how you are going to come into compliance with Regulation 25: Temporary absence or discharge of residents:<br>Currently on admission and transfer of resident to or from our facility the staff nurse completes and files a transfer letter in the residents file. Staff will strive to ensure that residents on admission will have a written discharge letter from the institution in which they came from. The admitting nurse will contact the facility in which the resident was discharged from and have discharge letter scanned to Ennis Road Care Facility. This information will be reviewed and discussed with nurses at hand over meetings daily. Same was discussed at nurse's bi monthly meetings (held on 11/3/20) and will be audited by scheduled chart audits. | |
| Regulation 29: Medicines and pharmaceutical services | Not Compliant |
| Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:<br>Nurses have completed medication administration competencies, and medication administration hseland.ie. All nurses have been instructed and observed administering medications per Ennis Road Care Facility and An Board Altranais agus Cnaimhseachais. recommendations.<br><br>Education training provided by pharmacist on medication administration times, documentation, ordering medications after hours and review of medication administration policies were reviewed on 3/3/20. Attended by all nurses. | |

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| Medication administration times are now closely complied with as nurses are now being allocated specific residents with in a section of the nursing home and is audited monthly. This allocation is available to all nurses one week in advance of their shift. |

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| 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:
Resident assessments and care plans are update every 4 months, March, July, November and also as the resident's status changes. All nurses who have completed their probation, who are familiar with certain residents are allocated these residents. The allocated nurse will Complete all assessments and care plans on admission, when status changes or when residents are readmitted. Audit to be completed CNMs and DON, to be completed monthly.
Clinical Nurse Manager has commenced internal audit by randomly assessing assessments and care plans which will be completed monthly and report to Director of Nursing.
At nurses meeting held on 11/3/20 a case study of an active resident's assessments and care plans were reviewed and discussed by all nurses collectively. As per nurses fed back this exercise proved very beneficial to all nurses when completing their person centered care plans and assessments.

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| Regulation 6: Health care | Not Compliant |

Outline how you are going to come into compliance with Regulation 6: Health care:
Care plans will correspond with medical diagnoses, resident's individual needs and provide detailed person centred care needs of the residents. During the planned nursing meeting a resident was highlighted and all nurses who attended completed the assessments and care plan as a group. Collective learning took place, the nurses reported that this was very beneficial when they complete their care plans ongoing. Care plans are audited by Care plans monthly.

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| Regulation 9: Residents' rights | Not Compliant |

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| Outline how you are going to come into compliance with Regulation 9: Residents' rights: The newly recruited full time social care practitioner is currently assessing all resident's individual preferences and needs in order to form a new and comprehensive programme of activities. This is being undertaken through person centered care planning, discussion with individual residents and relatives, and through feedback within residents' forum meetings, etc. The continued activities programme includes bingo, arts and crafts, live music, mass, phyio therapist led activity groups, hand massages, guided imagery, sensory stimulation, outings and in-house celebration of all occasions. will be operational from 3/3/20. Activities are provided with in the facility for seven hours each day. With a dedicated assistant. | |

## 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 |
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| Regulation 12(a) | The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that a resident uses and retains control over his or her clothes. | Substantially Compliant | Yellow | 25/03/2020 |
| 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 | Orange | 15/02/2020 |
| Regulation 16(1)(a) | The person in charge shall | Not Compliant | Orange | 28/02/2020 |

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| | ensure that staff have access to appropriate training. | | | |
| Regulation 16(1)(b) | The person in charge shall ensure that staff are appropriately supervised. | Not Compliant | Orange | 01/04/2020 |
| Regulation 17(2) | The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6. | Not Compliant | Orange | 30/04/2020 |
| Regulation 18(3) | A person in charge shall ensure that an adequate number of staff are available to assist residents at meals and when other refreshments are served. | Not Compliant | Orange | 01/04/2020 |
| 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 | 01/04/2020 |
| Regulation 23(a) | The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in | Not Compliant | Orange | 20/02/2020 |

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| | accordance with the statement of purpose. | | | |
| Regulation 23(c) | The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored. | Not Compliant | Orange | 20/02/2020 |
| Regulation 25(1) | When a resident is temporarily absent from a designated centre for treatment at another designated centre, hospital or elsewhere, the person in charge of the designated centre from which the resident is temporarily absent shall ensure that all relevant information about the resident is provided to the receiving designated centre, hospital or place. | Not Compliant | Orange | 27/03/2020 |
| Regulation 25(2) | When a resident returns from another designated centre, hospital or place, the person in charge of the designated centre from which the resident was temporarily absent shall take all reasonable steps to ensure that all | Not Compliant | Orange | 27/03/2020 |

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| | relevant information about the resident is obtained from the other designated centre, hospital or place. | | | |
| 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 | 01/04/2020 |
| Regulation 03(2) | The registered provider shall review and revise the statement of purpose at intervals of not less than one year. | Not Compliant | Orange | 28/04/2020 |
| Regulation 04(3) | The registered provider shall review the policies and procedures referred to in 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. | Not Compliant | Orange | 01/09/2020 |
| Regulation 5(4) | The person in | Not Compliant | Orange | 01/05/2020 |

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| | charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where 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 | Orange | 01/05/2020 |
| Regulation 9(1) | The registered provider shall carry on the business of the designated centre concerned so as to have regard for the sex, religious persuasion, racial origin, cultural and linguistic background and | Not Compliant | Orange | 01/04/2020 |

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| | ability of each resident. | | | |
| Regulation 9(2)(a) | The registered provider shall provide for residents facilities for occupation and recreation. | Not Compliant | Orange | 01/04/2020 |
| 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 | Orange | 01/05/2020 |