Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Ennis Road Care Facility
Name of provider:	Beech Lodge Care Facility Limited
Address of centre:	Ennis Road via Limerick, Clare
Type of inspection:	Unannounced
Date of inspection:	27 July 2020
Centre ID:	OSV-0005768
Fieldwork ID:	MON-0029727

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. 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 hairdresser's salon and an area to be developed into a coffee dock. There are additional comfortable seating areas off the activities room. Residents have access to two enclosed gardens with walkways, seating and raised flower beds. Ennis Road Care Facility provides 24-hour nursing care to both male and female residents whose dependency range from low to maximum care needs. Long-term care, convalescence care, respite and palliative care is provided.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	44

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
Monday 27 July 2020	09:20hrs to 17:00hrs	Breeda Desmond	Lead
Monday 27 July 2020	09:20hrs to 17:00hrs	Mary Dunnion	Lead
Monday 27 July 2020	09:30hrs to 17:00hrs	Susan Cliffe	Lead

What residents told us and what inspectors observed

On the day of the inspection inspectors found that there was a relaxed atmosphere in the centre with residents comfortable in the presence of staff.
Staff were knowledgeable about each residents' preferences for personal care, daily routines and activities.

Visiting to the centre had resumed and residents were happy with the easing of restrictions. Visiting was well managed, with all visitors asked to complete a COVID-19 questionnaire which enabled contact tracing if necessary. Visitors temperatures were checked and hand sanitisation requested. Since the last inspection, a full-time administrator was employed to address the concerns that relatives were unable to contact the centre and speak with staff or their family members as they wished.

One resident also reported that since the last inspection there had been an improvement in the mealtimes, the resident reporting 'no delays or hanging around like before'. One resident was observed taking their meal in the foyer later in the day, in accordance with their choice.

Other residents spoken with said they loved sitting in the main foyer looking out at the hills and watching all the activity and traffic passing by. One resident said that while it was lovely in the summer time, it was even better later in the year when the leaves have fallen from the trees and their was so much more to see. Residents reported they were happy with the laundry services.

A physiotherapist worked full time in the centre and inspectors observed that he provided individualised care to residents in their bedrooms.

Capacity and capability

Ennis Road Care Facility is a nursing home owned and operated by Beech Lodge Care Facility Ltd, a limited company with two directors. Beech Lodge Care Facility Ltd is the registered provider of two nursing homes located 40 km apart. On this inspection, inspectors were told that neither director had entered the Ennis Road Care Facility since the onset of COVID-19 but one director regularly visited the centre meeting staff in a shed on the grounds of the centre. This decision, described as a precautionary measure to prevent the possibility of spreading COVID-19 between both centres, effectively meant that the registered provider had not had direct oversight of the care of residents and operation of the centre since April 2020. Separately, Beech Lodge Care Facility Ltd was engaged with the Chief Inspector with regard to their wish to appoint this director as the person in charge in their second nursing home, a full time post, which would further reduce the

provider's oversight of the Ennis Road Care Facility.

Senior staff in the centre advised that one of the directors (the director nominated to the Chief Inspector as the registered provider representative) was in daily contact with the centre and available by phone at any time.

At the time of this inspection there was a COVID-19 outbreak in the centre which was ongoing since the end of April. Although there were no COVID-19 positive residents in the centre, a small number of residents who had returned to the centre from hospital were still isolated from the rest of the residents in line with the Interim Public Health, Infection Prevention and Control Guidelines on the Prevention and Management of COVID-19 Cases and Outbreaks in Residential Care Facilities and Similar Units issued by the Health Protection and Surveillance Centre(HPSC). Public Health had not yet declared the COVID-19 outbreak in the centre over as the centre had not experienced 28 days without a new case of COVID-19 among staff and residents.

This was an unannounced risk-based inspection undertaken to follow up on the findings of two previous inspections, in February and May of this year, both of which identified poor governance and management arrangements in the Ennis Road Care Facility.

In line with the findings of the May inspection, this inspection also found that:

1. the provider as the responsible legal entity had limited oversight of the service and insufficient assurance arrangements in place to monitor how the service was running
2. the provider had not provided the necessary 'on the ground' supports and resources to enable the effective delivery of a good quality service
3. the service was under resourced in the context of available nursing and care staff and as a consequence was reliant on support provided by the Health Service Executive to consistently meet the care needs of residents.

On this inspection on 27 July 2020, the Person in Charge in the centre had been there since 08 June 2020, having transferred to the centre on a temporary basis following the departure of the previous post holder. The person in charge, who had committed to staying in the centre until a replacement was recruited, had prioritised overseeing resident care and ensuring Ennis Road Care Facility was zoned in line with guidance from the HPSC. She had introduced a daily morning visit to each resident, ensuring the 44 residents were comfortable and cared for. During the course of this inspection the person in charge clearly articulated that there was considerable work to be done to create a sustainable good service. the person in charge identified key concerns which included:

- staffing shortages
- a continuing reliance on agency and HSE staff, the requirement for an effective system of local management
- the centres ability to detect, manage and control any further COVID-19 outbreaks.

In line with the May inspection, on 27 July inspectors found a continued reliance by the provider on the Health Services Executive (HSE) for nursing staff to make up the shortfall of nurses directly employed by the centre, albeit this reliance was reducing. The person in charge reporting that she liaised with the HSE on a weekly basis discussing the number of nurses and carers they required to ensure the continuous care of the 44 residents living in the centre.

At the time of this inspection, there were some indications that the staffing deficits were being addressed. Two new clinical nurse managers were appointed, one of whom was being orientated during the inspection. Four additional staff nurses were employed since the previous inspection, and had completed their induction. Two further nurses were recruited and due to commence employment shortly. However, a number of staff had also resigned their positions, so it was unclear what the net increase in staffing levels actually was.

Despite the recruitment of additional staff, the number of staff available were not sufficient to ensure the person in charge could address the regulatory non compliance and issues that still required addressing in the Ennis Road Care facility. On the day of inspection, there was an over reliance on the person in charge with no deputising or contingency arrangements in place to manage any untoward event.

In addition the registered provider was unable to -

- confirm when a new person in charge would be recruited to take up the role in the Ennis Road Care Facility on a permanent basis
- detail the actual workforce and skill mix requirements of the centre at full occupancy
- describe their recruitment plans to have sufficient competent staff to incrementally increase their residents numbers.

Inspectors were informed that the provider had plans to engage an external human resource agency to assist with this process. The provider was requested to submit a copy of any report of staffing when it was available.

On the day of this inspection, inspectors found that the person in charge had worked with the staff in the centre to effect the following improvements:

- there were improved arrangements to isolate and cohort suspected and/or confirmed COVID-19 residents and those returning from hospital. For example, there was a wing allocated for cohorting and isolation purposes to accommodate suspected or self-isolating residents in line with the HPSC guidance.
- there was daily communication with the public health team and weekly contact with infection prevention and control personnel in the HSE
- the person in charge conducted a daily walk-about to observe staff adherence to infection control guidance
- the refurbishment of the sluicing and storage facilities were in progress and three nurse stations were being constructed

- at staff hand-over meetings, the person in charge provided information to staff on HPSC guidance updates and used the meeting to remind staff of hand hygiene and other infection control practices.

Nonetheless, in line with the previous inspection, issues were again identified relating to infection control, cleaning practices and environmental hygiene.

The system in place for recording medical assessments of residents also required review. The provider had not provided GPs who visited the centre with an individual password to enable them to use the electronic system in the centre to record medical assessments and their recommendations. In addition records of medical review were difficult to access.

The systems in place for filing and storing records also required review. The person in charge had identified a suitable storage room for records but plans to for records to be stored in this room had yet to be realised. The person in charge had also begun to establish a formal audit process. However, this was in the early stages of development and required significant work to support the registered provider to monitor the quality and safety of the service.

Overall, the findings of this inspection were that the provider needed to take immediate action to strengthen the governance and management of the centre, to support the person in charge in the changes that were required, and to resource the centre to be able to independently care for the current population of 44 residents.

Regulation 14: Persons in charge

The person in charge was full time in post. She was a registered nurse with the required management qualification and care of the older person nursing experience.

Judgment: Compliant

Regulation 15: Staffing

Since the last inspection the provider had some success in recruiting additional staff with the appointment of four additional nurses who had completed their induction and a further two nurses who were due to commence work in the coming weeks. Two clinical nurse managers (CNMs) were also recruited to replace two CNMs who had or were about to leave, with one of the new managers beginning induction on the day of inspection. Additional healthcare assistants (HCAs) were appointed with the centre approaching the required number of carers deemed necessary for a complement of 44 residents.

On the day of the inspection, while there were sufficient numbers of nursing and

care staff on duty to meet the needs of residents (44) in the centre on that day, the provider continued to be reliant on the Health Services Executive (HSE) for nursing staff to make up the shortfall of nurses directly employed by the centre. A review of current, previous and prospective rosters showed that the provider continued to rely on the support of the Health Service Executive (HSE) Mid West COVID Response Support Team to staff the centre and meet the needs of 44 residents.

On a weekly basis the person in charge liaised with the HSE regarding the number of shifts for nurses and carers that could not be filled by staff employed by the provider. The HSE Mid West COVID Response Support Team then provided a combination of agency and HSE staff to provide additional nurses and health care assistants.

Judgment: Not compliant

Regulation 16: Training and staff development

All staff had completed online COVID-19 training that incorporated hand hygiene, and the use of personal protective equipment.

However, better staff supervision was necessary to be assured that all staff implemented learning in practice and adhered to infection control best practice. For example,

- some staff wore jewellery impacting their ability to undertake proper hand hygiene
- another member of staff did not put on the required PPE when they were about to enter a resident's bedroom in the isolation wing.

In addition, the findings of this inspection indicated a need for greater supervision of staff, including cleaning staff to ensure that the centre was cleaned to the required standard.

Judgment: Not compliant

Regulation 19: Directory of residents

A directory of residents was maintained. While the date of a resident's transfer out of the centre was recorded, the date the resident returned to the centre was not documented in the directory. The inclusion this information in the directory would ensure accurate records of the number of residents accommodated in the centre at any given time.

Judgment: Substantially compliant

Regulation 21: Records

Records set out in Schedule 2 (Documents to be held in respect of the person in charge and for each staff member) were reviewed. Staff had vetting disclosures in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012. However, some references viewed were letters of employment rather than a reflection of the employee's performance. In addition, some information in one reference did not correlate with work experience detailed in the individual's employment history.

Medical records were not easily accessible. As reported on the last inspection, GPs did not have their own unique log-in details for the centres electronic recording system, which would facilitate them to record their medical review in the medical record of the resident. As a consequence some GPs input their notes using nursing passwords so the notes were then electronically recorded in the nurse's name rather than that of the GPs, or a record of a GPs visit might be created by a nurse in the daily narrative section of the record.

Information was difficult to retrieve in some of the records reviewed and it was not always possible to definitively say who had created the record.

At different times during the inspection (10:20hrs, 10:33hrs and 14:00hrs), inspectors found computers at nursing stations on main corridors were open and residents' personal information was visible to people passing. Consequently, confidentiality of information was not assured.

Judgment: Not compliant

Regulation 23: Governance and management

Similar to the two previous inspections (February and May 2020) this inspection found that the provider had failed to ensure that effective governance and management arrangements were in place to ensure the safety, care and welfare of residents.

The registered provider maintained oversight of the centre from a distance and that oversight was reduced further in recent weeks by the decision of the registered provider representative to take up a full time position as a person in charge in the provider's other nursing home.

Inspectors found that there was an undue reliance on one person (the person in charge) to effect the totality of the changes required to ensure the safety of

residents in the centre, and to move towards compliance with the regulations. In the context of the diminished governance and management structure in the centre and the increased demands presented by COVID-19, it was difficult to see how one person would effect the necessary changes in the short term. This was evidenced by the number of initiatives that the person in charge had identified which required attention but which had yet to be addressed, as follows:

- development of a robust system of staff supervision with allocated roles and responsibilities
- supervision of staff
- commencement of a meaningful program of clinical audit
- overhaul of systems of creating, storing and accessing records
- review of policies and procedures.

While some improvement was noted in the number and skill mix of available staff resources since the May inspection, the centre still did not have sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose for the centre:

- the provider could not independently staff the centre with the numbers required to care for the current occupancy of 44 residents
- the provider did not have a strategy to determine the numbers of staff required if the centre was to admit the total number (84) of residents that it was currently registered to accommodate.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

Contracts of care reviewed showed they were in line with the requirements of the regulations with fees to be charged and room accommodation identified.

Judgment: Compliant

Regulation 3: Statement of purpose

As found on the last inspection the Statement of Purpose for the service had not been updated in the last 12 months and the version available in the centre did not accurately reflect the current management team or the resources available in the centre.

Inspectors had on several occasions requested the provider to update the Statement of Purpose and to submit a copy to the Chief Inspector, but this was not

forthcoming.

Judgment: Not compliant

Regulation 31: Notification of incidents

The person in charge on the day of inspection was aware of the regulatory requirement to submit notifications and these were submitted in a timely manner and in accordance with the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

The complaints procedure was discussed with the person in charge who demonstrated good oversight of complaints as well as detailing investigations, follow up and liaising with families and complainants. She articulated that she regarded these as a system of quality improvement which highlighted areas for improvement.

Residents who spoke to inspectors confirmed that they could raise issues of concern and be assured that they would be addressed. This was an improvement since the last inspection.

Judgment: Compliant

Quality and safety

Residents gave positive feedback about staff and reported improvements in their quality of life, specifically mentioning improvements in their dining experience. The inspectors observed that while there was adequate staff available to assist residents with their meals, some staff practices were task-oriented and some staff did not actively engage with residents. For example, staff stood around rather than chatting with residents while they were waiting for their meals to be served. Senior staff present in the dining room during lunch did not recognise or correct these practices.

The person in charge on the day of inspection had introduced new infection prevention and control measures, whereby all staff members had their temperatures checked twice daily. Each morning following hand-over, staff were reminded of the signs and symptoms of COVID-19 and the requirement of staff to report any

symptoms. The person in charge reported that this time was also used as an opportunity to provide ongoing education to staff regarding infection control practices such as hand hygiene and proper use of personal protective equipment (PPE). Additional cleaning staff were in place to enable deep cleaning and other COVID-19 related cleaning of hard surfaces and frequently used surfaces. Nonetheless, some practices observed and rooms examined showed that effective cleaning was not assured.

A sample of care plan documentation was reviewed. Pre-admission assessments were completed to ensure the service could provide appropriate care to each resident. Improvement was noted in care planning with personal information available to inform individualised care. The person in charge had commenced audits on care planning documentation as part of their quality improvement strategy and had identified areas for improvement, and the inspectors concurred with these findings. For example, occasionally, risk assessments were not initiated for known clinical risks.

Group activities for residents had re-commenced in the main day room, however, inspectors observed that the activities available were inappropriate for maximum dependant residents. The person in charge outlined that she had attended residents' meetings and had administered a survey to each resident the previous week, to determine their preferences regarding meaningful activities. The feedback from this survey would inform the activities programme and provide meaningful activities in accordance with their interests, ability and capacity.

There was an in-house physiotherapist who provided rehabilitation, assessments including falls assessment, in addition to providing manual handling training to staff.

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. The external grounds to emergency exit 4 was not appropriately maintained. These were a repeat finding.

Better oversight of the delivery of care was required to promote an organisational culture that focused on a rights' based approach for residents.

Regulation 11: Visits

In line with the Public Health guidance in place at the time of inspection, visits were scheduled and timed in line with HPSC guidance. There was adherence to infection control protocols upon entry in to the centre regarding temperature checks, contact tracing and other COVID-19 related information recorded.

Judgment: Compliant

Regulation 13: End of life

The sample of care plan documentation reviewed showed improvement in information available in that end-of-life care wishes were discussed with residents and their next-of-kin, when appropriate, to ensure that care delivered was in accordance with their preferences and stated wishes.

Judgment: Compliant

Regulation 20: Information for residents

The residents' Guide was available to residents in their bedrooms. This was updated to reflect the person in charge and the new CNM.

Judgment: Compliant

Regulation 27: Infection control

In an urgent compliance plan submitted following the May inspection the provider had committed to using an independent external company to perform monthly infection control audits and generate an action plan for the centre. This had not happened and the only audit available for review on this inspection was an audit of the cleaning of one bedroom in June. Staff in the centre were not aware of any plan to instigate an independent system of infection control audits.

The person in charge, in consultation with the HSE Mid West COVID Response Support Team, had reviewed the lay out of the centre and designated an appropriate corridor for accommodating residents who required isolation. Appropriate clinical waste bins were placed outside doors in the this wing and personal protective equipment was readily available. Additional hand gel dispensers were displayed throughout the centre. Staff caring for residents in the cohort/isolation wing were segregated from other staff to minimise the risk of cross infection. Separate changing and dining facilities were also provided for these staff.

Protocols were in place on entry to the centre, and visitors were required to complete a COVID-19 questionnaire and provide details for contact tracing as well as having their temperature checked, in line with HPSC guidance.

Cleaning staff spoken with were knowledgeable regarding cleaning solutions and protocols. However, while additional cleaning was put in place, with additional deep-cleaning scheduled per area once a week, some cleaning regimes were not in

keeping with the recommendations of best practice which outlines that infected or suspected rooms would be cleaned last rather than first, to mitigate the possibility of cross infection. In addition observation throughout the inspection demonstrated that the centre was not cleaned to the required standard, for example:

- some en suite facilities were not clean
- deep cleaning and high dusting was required in many rooms that were checked
- equipment and furniture in empty rooms labelled as having been deep cleaned were not cleaned to the required standard
- there was food dried into a bed trolley
- breakfast ware with dried porridge and tea remained on another bed table at 14:30hrs
- rooms previously used as bedrooms but which had been re designated as staff dining rooms were not clean. There was food debris on the floors and dirty utensils left on bed tables. The sink in the associated en suite contained dirty cutlery and a fridge in one of these rooms was not plugged in.

There was a system of documentation in place which required a cleaning staff signatures to indicate that they had cleaned each room twice a day. Records were available for the previous two weeks to say that every room reviewed by the inspectors had been cleaned twice a day. There was no system in place to quality check the cleaning of the centre. Increased supervision and audit of cleaning practices including cleaning documentation was needed.

The cleaners' room was cluttered and additional floor-mop holders were required as several mops were seen on the floor. It was reported that the bedpan washer for the sluice room on the back corridor was ordered and due to be installed, but this was put on hold due to COVID-19 visiting restrictions. Consequently, staff had to go some distance to access sluicing facilities and in the current COVID-19 climate, this was not in keeping with best practice guidance.

Judgment: Not compliant

Regulation 28: Fire precautions

The following concerns pertinent to fire safety in the designated centre required attention:

1. the emergency floor plans on display in the centre to guide evacuation required review. Some did not clearly identity a point of reference or indicate the position; some floor plans were not orientated appropriately; this was a repeat finding
2. the external pathway outside fire door exit 4 was not maintained to enable adequate means of escape; this was a repeat finding
3. there was a bolt lock on one compartment fire door which inspectors

requested be removed immediately
4. one fire-door magnet was broken
5. another fire-door magnet was detached from the wall and placed on a nearby radiator.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Gaps in administration records were seen, so it could not be assured that residents received medication in accordance with their prescription.

It was observed that medications prescribed for 08:00hrs were being administered at 10:40hrs and this was outside the recommended parameters stipulated by An Bord Altranais agus Cnaimhseachais professional guidelines. This was a repeat finding.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Improvements were noted in the care plan documentation. The person in charge had commenced an audit of care plan documentation and had identified areas for improvement, such as assessments to support care planning. Care planning was set out under the headings of nursing diagnosis, actual needs and quality of life or life maintenance. This facilitated staff to reflect on the resident holistically, and establish the inputs necessary to improve a person's quality of life where possible and maintain their current level of independence. Risk assessments were conducted for various clinical risks including the risk of developing pressure sores, malnutrition, falling and dependency levels. Ongoing evaluation and responses to changes in prescribed medications and non-pharmaceutical interventions was evidenced, to enable better outcomes for residents. Person-centre information was available in plans of care including detailed food preferences and preferred dining experiences for breakfast, lunch and tea. Personal emergency evacuation plans were available and information here correlated with other risk assessments; this was an improvement on the previous inspection findings.

Families were consulted with on a regular basis to ensure they had current information about their next-of-kin status. This was an improvement from the last two inspections.

Judgment: Compliant

Regulation 6: Health care

Documentation reviewed showed that residents had timely access to speech and language and dietician services. The chiropody services had resumed on 21 July 2020.

Improvement was noted in healthcare with the appointment of a locum GP, who attended the centre twice a week. He reviewed any residents who required a medical assessment and liaised with other GPs when on site. Fourteen GPs provided services for residents in the centre and most had resumed attending the service post the COVID-19 outbreak.

One resident was administered oxygen as an emergency measure, however, this was not followed up with the GP to ensure an appropriate prescription was in place in accordance with professional guidelines.

Some residents with enduring medical conditions did not have a clinical risk assessment completed in line with evidence based nursing care.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The previous two inspection reports highlighted the necessity for an activities programme that was meaningful and worthwhile for all residents. While the person in charge had undertaken a resident survey to determine residents' interests and preferences, this had yet to inform the activities programme.

Medications were administered during meal-times and this was not in keeping with a rights' based approach to residents and facilitating their enjoyment ot their mealtimes.

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	Substantially compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 13: End of life	Compliant
Regulation 20: Information for residents	Compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Substantially compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Ennis Road Care Facility OSV-0005768

Inspection ID: MON-0029727

Date of inspection: 27/07/2020

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:
Our Centre experienced a COVID-19 public health challenge which impacted on our residents and staff and the Provider, as appropriate, engaged constructively with the HSE, the competent public health authority for the provision of requisite resources to assist the Provider to address the challenge, as is appropriate and advised by the State's authority.

Now that the challenge has been successfully addressed and the Provider has made arrangements for the deployment of HSE human resources back to the HSE, the Provider is currently engaged in an active recruitment programme to ensure that all staffing positions are filled with suitability qualified and experienced staff, and same has been advised to the Chief Inspector in detailed correspondence following the Inspection.

In anticipation of our Centre returning to full staffing levels, instead of our Centre's maximum number of 84 residents will be operated at a capacity of 45 residents until the Provider has full staffing complements and we have provided detailed information and undertakings in this regard to the Chief Inspector prior to returning this Compliance Plan.

We are aware that the Chief Inspector, from a Notice issued to the Provider, is satisfied for the Centre to be operated with a maximum of 45 residents until the staff numbers, after the COVID-19 episode within the Centre, are recovered to its full complement. In the meantime, the following has occurred:

(1) Full Time Person-in Charge engaged since 24/08/2020 (supported by interim PIC x 1 month) with notice to the Chief Inspector;
(2) Full Time Clinical Nurse Manager 2 commenced 27/07/2020
(3) Full time Clinical Nurse Manager 1 with plan to have this position filled by the 25/09/2020
(4) Staff nurses employed (total 17) with reliance on HSE human resource support no longer required to assist in addressing the public health challenge
(5) In-house "bank staff register" is developed and the Provider is currently advertising

for additional position on an ongoing basis.

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
Noting that the Minister for Health has addressed compliance with Regulation 16 to the Person in Charge of our Centre, while the assessment of non-compliance appears to be addressed during the Inspection to the Provider, the Provider to assuage the concerns of the Inspectors has taken the following actions:

(1) Training matrix updated of staff competencies

(2) Weekly dedicated time for whole team topical training sessions

(3) Competency Framework CPD folder for ongoing professional development and reflection

(4) Whole team Microsoft meeting/training and staff reflections for CPD folder

(5) Support framework for all staff

(6) Appraisal discussions for review & CPD

(7) Staff monthly newsletter for updates & information

(8) Individualized staff email addresses for confidential assurance of electronic information

(9) Extended supervision by Senior HCA and Senior Nurses

(10) HSE IP&C course lounged for all staff to re-educate and update on current guidelines

(11) Leadership development for all Staff

(12) Scrubs introduced as part of the uniform for all staff. Uniform policy read and signed by all staff.

Regulation 19: Directory of residents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 19: Directory of residents: (1) The Directory of Residents has been reviewed and updated :30/07/2020	
Regulation 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: (1) All GPs registered for resident's visits now have their own system access logins for electronic medical records. 30/08/2020 (2) Content of staff/personal files presently been reviewed and audited. Will be completed by 31/09/2020. (3) A standardised Employees Reference form implemented to ensure compliance with Regulation 2. 1/09/2020 (4) Questionnaire to be added to employer reference request to encourage reflective information of employee performance (5) HR dedicated for employee record compliance (6) For telephone references, questionnaire to be completed by interviewer to standardise responses (7) Cross referencing checklist to be added to employee compliance checklist to ensure provided information correlates (8) Re-enforcement of staff training on GDPR & detailed in employee handbook (9) All electronic data entry to completed by individual only for information security	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The Provider ensures that there is a properly defined management structure in place for the Centre.	

The Provider is registered by the Chief Inspector as a fit person to operate the Centre under the Act.

The Provider, itself, as the registered provider of the Centre, comprises directors who sit on its Board of Directors, and who notified to the Chief Inspector and registered in those positions in accordance with Company law requirements.

One of the Directors of the Provider is appointed by the Chief Inspector to be the Registered Provider Representative for the Centre.

The Chief Inspector has registered and approved persons as fit person to be the Persons Participating in Management (PPIM) who are responsible for the management of the Centre.

Our Centre's has employed a Person-in-Charge and we refer to the registration decisions by the Chief Inspector.

(1) In addition, the Provider has attended to recruiting an new Director of Nursing and a Clinical Nurse Manager both of whom have commenced employment and developed an enhanced organizational structure which will be incorporated into our Centre's Statement of Purpose on approval from the Chief Inspector in compliance with Condition 1 of our Centre's Certificate of Registation. Leadership roles are also being introduced to supervise staff performance and to ensure ongoing high quality of care delivered.

(2) Policies including Schedule 5, IP&C and medication have been updated and were distributed to staff to read and have signed and implemented in practice enabling the Centre's management to maintain satisfactory standards within our care facility. 31/08/2020.

(3) The Centre's contingency plan has been updated to include staffing resources and a "nurse bank" as we work back up for occupancy to 85 residents, when it appropriate to do so after all requisite engagement with the Chief Inspector.

(4) Working direction of employed roles created for contingency planning.

(5) Clinical audits ongoing, results are actioned by the Centre's management, debriefing sessions re audit performance and learning outcomes discussed with staff to ensure continuous quality improvement within our care facility. Report at weekly management group meeting to PIC, CNM and supervisor.

(6) Residents past manual records storage updated & identification process created with a view to full implementation on 11/09/2020.

(7) Staff recruited and recruitment ongoing, with all staff required to have an induction period as supernumerary until the Provider is satisfied that they are fully competent to discharge duties.

For any other relevant actions please refer to written representations made in response to the Chief Inspector's recent Notice.

Regulation 3: Statement of purpose	Not Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
(1) The Provider has attended to the updating of the Centre's Statement of Purposes and where further updating is required a draft Statement of Purpose will be submitted to the Chief Inspector for agreement in due course to ensure full compliance with Condition 1 of the Centre's Statement of Purpose.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
Noting that the Inspectors have made this assessment under Regulation 27 are not by reference to HIQA Standards but rather by reference to public health measures, the Provider has done the following to ensure full compliance with infection control measures:

(1) When the COVID-19 outbreak occurred in our Centre, the Provider as appropriate engaged the competent public health authority, the HSE, which deployed resources to the Centre to support the infection control;

External audit to conduct IPC audit arranged.

(2) Cleaners daily schedule updated, audited, checked and signed off by Management.

(3) IPC audits to be conducted randomly pre and post cleaning for CPD of cleaners awareness & quality auditing

(4) Sluice facilities on maintenance schedule for redesign

(5) All equipment is being acid labeled for cleaning purposes and cleaning schedule developed.

(6) Room within the Centre is identified and identified for cleaning equipment.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
(1) Either end of zoned areas to have full building map with insitu zone colour highlighted- 18/09/2020

(2) Individual rooms to have zoned map on door with exact standing position and highlighted exit pathway drawn and all other exits available in zone highlighted 18/09/2020

(3) Pathway outside exit 4 on maintenance schedule for full disability access design- 12/09/2020

(4) All fire doors to be checked daily for emergency access

(5) Maintenance schedule for checking fire doors and exits

(6) Fire –door Magnet replaced and audited - 28/07/2020

The Provider notes that the Minister for Health has addressed compliance with Regulation 28(3) to the Person in Charge of our Centre, while the assessment of non-compliance appears to be addressed during the Inspection to the Provider, the Provider to assuage the concerns of the Inspectors has taken the necessary action to ensure ongoing compliance.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
Noting that the Minister for Health has addressed compliance with Regulation 29 to the Person in Charge of our Centre, while the assessment of non-compliance appears to be addressed during the Inspection to the Provider, the Provider to assuage the concerns of the Inspectors has arranged for the following actions to be taken:

Medication administration times have been reviewed and changed by pharmacy to allow compliance with recommended parameters for administering medications- 28/08/2020

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
(1) The Provider has ensured the employment of a new Director of Nursing who is a Prescribing Nurse Practitioner having applied to NMBI for prescribing registration. The new Director of Nursing will develop shared protocol with residents' GP(s) for shared care to allow timely compliance and coalition of medication changes and clinical risk assessments are in place for each resident's diagnosed conditions.

(2) An audit of all clinical risk assessments has been completed to evaluate same and to ensure the highest quality of care for all residents.

For any other relevant actions please refer to written representations made in response to the Chief Inspector's recent Notice.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
(1) Residents surveys has been completed & ideas box for suggested activity changes or concern

(2) Newsletter will be developed to allow residents to fully acknowledge and interact with ERCF

(3) Resident & friends' group to be developed to allow volunteers/relatives after vetting to entertain and aid with residents' activities

(4) Activities coordinators employed to create meaningful and provoke happy memories

(5) As outlined under regulation 29, medication time has been changed in consultation with GP and pharmacy, to accommodate residents' protective times

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 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Red	31/08/2020
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	30/09/2020
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	07/09/2020
Regulation 19(3)	The directory shall include the information specified in paragraph (3) of	Substantially Compliant	Yellow	30/07/2020

	Schedule 3.			
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	30/09/2020
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Not Compliant	Orange	30/08/2020
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Red	31/08/2020
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Not Compliant	Orange	25/09/2020
Regulation 23(c)	The registered provider shall ensure that management systems are in	Not Compliant	Red	20/09/2020

	place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.			
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Not Compliant	Orange	31/10/2020
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	12/09/2020
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.	Not Compliant	Orange	18/09/2020
Regulation 29(5)	The person in charge shall ensure that all medicinal products are administered in accordance with the directions of the prescriber of	Not Compliant	Orange	28/09/2020

	the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.			
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	25/08/2020
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.	Substantially Compliant	Yellow	28/08/2020
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	Not Compliant	Orange	30/09/2020

	background and ability of each resident.			
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Not Compliant	Orange	07/09/2020
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	30/08/2020