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:	Áras Deirbhle Community Nursing Unit
Name of provider:	Health Service Executive
Address of centre:	Aras Deirbhle, Belmullet Community Hospital, Belmullet, Mayo
Type of inspection:	Unannounced
Date of inspection:	03 November 2021
Centre ID:	OSV-0000644
Fieldwork ID:	MON-0033809

About the designated centre

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

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	23

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 3 November 2021	08:50hrs to 16:50hrs	Fiona Cawley	Lead

What residents told us and what inspectors observed

On the day of the inspection the inspector observed that residents were supported to enjoy a good quality of life by staff who were kind and caring. Many of the residents who spoke with the inspector said they were happy with their life in the centre which was homely and welcoming.The overall feedback from the residents was that they were very well cared for by the staff. The centre was well managed and assured regulatory compliance across most regulations.

This unannounced inspection was carried out over one day. The inspector was welcomed to the centre on arrival and guided through the infection prevention and control measures in place. These included temperature check, hand hygiene and face covering before entering the centre. The clinical nurse manager (CNM) on duty facilitated the inspection. There were 23 residents accommodated in the centre on the day of the inspection and seven vacancies. The CNM informed the inspector that due to ongoing staffing shortages and high levels of absenteeism, the occupancy of the centre was maintained at 26 residents as opposed to full occupancy of 30 residents. The CNM informed the inspector that there were a number of staff on long term sick leave and that maintaining adequate staffing levels was an ongoing challenge. This will be discussed further under Regulation 15 Staffing.

Aras Deirbhle is a community nursing unit operated by the Health Service Executive and located on the campus of Belmullet Hospital. The facility was situated on the outskirts of Belmullet, County Mayo overlooking the Atlantic ocean where the location provided lovely views of the surrounding countryside and coastline. It is a single storey purpose built building and the accommodation comprised of four twin ensuite rooms and 22 single rooms. The layout also included a large day room which looked onto the sea, a welcoming visitors room, an oratory, a hairdressing room, reception area, a smoking room and number of seating areas along the corridors. There was also access to an outdoor sensory garden for the residents.

The inspector spoke with a six residents during the inspection who said that they were happy in the centre and that the staff were always kind and helpful to them. A number of residents were living with dementia and therefore conversations with some of these residents were limited. Those residents who were unable to communicate verbally were observed by the inspector to be very content. One resident who recently moved into the centre told the inspector that they liked their new home and that they got everything they needed from the staff. Another resident said they never had any complaints as things were always good in the centre. The residents who spoke with the inspector were aware of the COVID-19 pandemic and the need for the current restrictions.

The inspector spoke with one visitor who was very satisfied with the care and support their loved one received. They could not praise the staff enough and described the care and attention as 'wonderful' and 'out of this world'. They added that the rapport between the residents and staff was fantastic and there was always

a friendly atmosphere and a 'bit of craic'.

The inspector completed a walk about of the centre on the morning of the inspection together with the clinical nurse manager. There was a friendly, relaxed and calm atmosphere throughout. Overall, the inspectors found the premises was laid out to meet the needs of the residents and to encourage and aid the resident's independence. The centre was pleasant throughout and it was clear that the management and staff made efforts to create and maintain a homely atmosphere. The entrance area was bright, airy and welcoming. The communal area was a large bright space with panoramic views of the ocean. It was nicely decorated with comfortable furnishings, a fire place, book shelves and included a domestic style kitchen area.

The corridors were wide and well lit. The walls were decorated with colourful pictures. Grab rails were available along the corridors to assist residents to mobilise safely. The building was warm and well ventilated throughout. All non-resident areas were accessible via keypad to ensure the safety of the residents.

Overall, the centre was clean and tidy. Housekeeping staff who spoke with the inspector were knowledgeable about the cleaning process required in the centre. However, the inspector noted a small number of areas that required attention. This will be discussed under Regulation 27. The building was generally well maintained but a number of areas were identified that required attention and will be discussed further under Regulation 17 Premises.

The residents' bedrooms were generally clean and tidy and many were furnished with personal items such as photographs and ornaments to create a comfortable, homely environment. The residents who spoke with the inspector were happy with their rooms. Overall, there was sufficient space for residents to live comfortably in most of the bedrooms including adequate space to store personal belongings. However, on the day of the inspection the inspector noted that in three of the single bedrooms the layout of the rooms did not allow access to the wardrobe spaces without moving the beds.

On the day of the inspection the arrangements for dining had been reconfigured to facilitate replacement of the dining room flooring. This was an action from the previous inspection. Dining was available in the day room and other communal areas. The lunch time period was observed by the inspector on the day of the inspection and the temporary arrangements were managed well by the staff on duty. The inspector observed that residents who required help were provided with assistance in a sensitive and discreet manner. Staff members supported other residents to eat independently and residents were not rushed. The atmosphere in the dining room was social whilst the communal seating areas provided a quieter environment. Staff and residents were observed to chat happily together and all interactions were respectful. During mealtimes, residents were provided with a choice of meals from the daily menus which were on display. The inspectors saw that the meals served were well presented and there was a good choice of nutritious food available.

There was unrestricted access to a pleasant outdoor area for the residents. This sensory garden had a variety of suitable seating areas, various plants and foliage including raised beds . This space also included a well being hut which was used by residents and staff. However, on the day of the inspection the garden area was in need of attention as it was overgrown in parts with visible moss growing on the walkways and several items of waste observed on the ground all of which created a risk of trips or slips and compromised the safety of the space. The CNM informed the inspector that a member of staff had been rostered to tend to the sensory garden on the day of the inspection but due to an unexpected absence they had been deployed to work elsewhere.

Call bells were available throughout the centre and the inspectors observed that these were responded to in a timely manner.

There was adequate signage in place at key points throughout the centre in relation to infection prevention and control. The signage alerted residents, staff and visitors of the risk of COVID-19 and control measures in place such as social distancing and visiting restrictions. There were a small number of appropriate pictorial signs in place to identify rooms in the centre, however they were not sufficient in number to guide residents living with dementia to the different areas of the building. This issue had been raised during the last inspection.

Throughout the day residents were observed mobilising and using the various areas of the centre and were seen to be happy and content as they went about their daily lives. There was a happy atmosphere present throughout the centre. The staff knew the residents well and provided support and assistance with respect and kindness. Staff were observed helping residents with hand hygiene throughout the inspection. Many residents were observed socialising with each other and with staff members.

Residents who exhibited responsive behaviours (how residents who are living with dementia or other conditions may express their physical discomfort or discomfort with their social or physical environment) were observed to be assisted and supported competently and sensitively by the staff. The staff were observed to be very knowledgeable about the residents' individual behaviour patterns and residents had timely access to psychiatry of later life. Care plans were in place to guide staff and ensure interventions were effective.

The provision of care was observed to be person-centred and unhurried. However, on the day of the inspection there was not sufficient staff on duty to ensure the residents' needs could be adequately met as there was no allocated member of staff to provide activities for the residents. Care staff were observed providing various activities whilst supervising the residents in the day room. There was no planned schedule of activities for the residents and care staff organised the activities on a day to day basis.

Overall, the inspector observed staff engage with the residents in a very positive manner and friendly interactions were heard throughout the day. Staff who spoke with inspectors were knowledgeable about the residents and their needs. Residents moved around the centre freely and the inspector observed a number of residents

walking around the centre independently or with the help of staff. The majority of the residents were up and about on the day of the inspection and the staff provided regular safety checks on the few residents who wished to remain in their own bedrooms.

Residents had access to television, radio, newspapers and books. Internet and telephones for private usage were also readily available. Visiting was facilitated in line with current guidance (Health Protection and Surveillance Centre COVID-19 Guidance on visits to Long Term Residential Care Facilities).

In summary, this was a good centre with a responsive team of staff delivering good standards of care and support to residents.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impacted on the quality and safety of the service being delivered. The levels of compliance are detailed under the individual regulations.

Capacity and capability

The inspectors found that overall the centre was managed to ensure that the residents were supported and facilitated to have a good quality of life. The majority of the required improvements from the previous inspection had been implemented by the provider. However, the inspector was not assured that the person in charge was sufficiently involved in the day to day operational management of the designated centre which was reflected in the non-compliances found on this inspection.

There was a defined management structure in place with identified lines of authority and accountability. The person in charge (PIC) worked full time but also had responsibility for the Belmullet Community Hospital which was on the same site. The PIC was not included on the roster and therefore it was difficult to determine how much of their time was allocated to the centre. There were deputising arrangements in place for when the person in charge was absent and the CNM deputised for the PIC to facilitate this inspection. As a result the inspector was not assured that the PIC was sufficiently involved in the day to day running of the designated centre.

The person in charge was supported in the role by two clinical nurse managers and a full complement of staff including nursing and care staff, housekeeping staff and catering staff. There was a minimum of one registered nurse on duty at all times. All care staff were employed as multi task attendants. The multi task attendants' role also included housekeeping duties but it was difficult to determine from the roster which MTA was allocated to direct care and which MTA was allocated to house keeping roles on a daily basis. There were shared arrangements in place with

Belmullet Community Hospital for administration support, portering and laundry services. As a result staff were working in more than one care facility which is not in line with Health Protection and Surveillance Centre guidance.

On the day of the inspection the inspector observed that good standards of care were delivered on the day by staff who had the required skills, competencies and experience to fulfil their roles. However numerous staff members informed the inspector that staff shortages were an ongoing concern. The staff communicated to the inspector that it was very challenging combining the two roles of activity provision and supervision of residents in the day room. They also reported that supervision often prevented them from providing activities especially when some residents displayed responsive behaviours that required close monitoring.

Unsolicited information had been received in July 2021 regarding concerns about staffing levels. A provider assurance report was received in response to this concern which required the provider to review their compliance with Regulation 15. The provider's response gave assurance that staffing had been reviewed and that the staffing levels in the designated centre were satisfactory. However on the day of the inspection the centre's own risk register reported numerous risks identified as a result of staff shortages. The CNM informed the inspector that recruitment of new staff was ongoing in order to address staff shortages. However, the inspector found that there was not sufficient staff to meet residents' individual social care needs due to the lack of dedicated activity staff on duty.

The clinical nurse managers provided clinical supervision and support to all the staff. However, rosters showed that they were also often required to work as part of the nursing team due to staff shortages and were not available to provide supervision of staff delivering care and services. Consequently, this impacted on the effectiveness of the oversight of the service. This will be discussed further under Regulation 23.

Policies and procedures were available which provided staff with guidance about how to deliver safe care to the residents. The Inspector reviewed the policies required by the regulations and found that all policies had been reviewed and were up-to-date.

A sample of four staff personnel files were reviewed by the inspector and found to have all the information required under Schedule 2 of the regulations.

Staff with whom the inspectors spoke with were knowledgeable regarding fire safety, manual handling, safeguarding, hand hygiene and complaints management.

Minutes of various meetings were made available to the inspector including a safety meeting held in May 2021, staff meetings held in 2020, regional director of nurses meetings for 2019/2020. However, the inspector found no evidence that regular management meetings had taken place. The CNM informed the inspector that such meetings had taken place but minutes were not available on the day.

A range of audits were carried out in 2021 which reviewed practices such as resident weight management, environmental hygiene and the call bell system. Areas for improvement were identified and action plans were put in place. However, the

inspector also observed that a number of areas had not been reviewed in recent years including care plans, continence management and prescription charts

The person in charge had completed an annual review of the quality and safety of care in the centre for 2020 which included a detailed quality improvement plan.

A complaints log was maintained with a record of complaints received, the outcome and the satisfaction level of the complainant. The complaints procedure was displayed in the centre and contained the information required by the regulation.

Regulation 15: Staffing

There were not sufficient numbers of support staff on duty to meet the social needs of the residents. The multi task attendant (MTA) who was responsible for providing meaningful activities for the residents in the day room was part of the direct care hours and was also required to supervise this area. This supervision included residents with responsive behaviours who could potentially require increased levels of support.

The role of porter was shared with the community hospital and included supporting nursing and care staff in the provision of direct care in the designated centre as well as general portering duties across both the designated centre and community hospital.

Two multi task attendants on the roster also worked in the community hospital.

Staff nurses reported that due to staff shortages they often had to provide direct care with the MTAs and therefore assessment and care planning was not always up to date.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff had access to mandatory training appropriate to their role. This included Infection Prevention and Control, COVID-19, Manual Handling, Safeguarding, Basic Life Support and Fire Safety Training. However, the training record reviewed by the inspector showed that there were some significant gaps in training relevant to the client group for whom staff were providing care. For example, a number of staff had not completed training in responsive behaviours and dementia whilst others had not

received any up dates to their skills and knowledge in these areas for a number of years.

Judgment: Substantially compliant

Regulation 21: Records

The inspector reviewed a sample of staff files and they were found to contain the information as required by the regulations. However, the inspector observed that residents' records that were not securely maintained in accordance with the regulatory requirements.

Judgment: Substantially compliant

Regulation 23: Governance and management

Although there were systems in place to monitor and evaluate the quality and safety of the service, there had been a limited number of audits carried out during the previous year. The audits that were carried out in 2021 included action plans with identified time frames and persons responsible for actions.

The management structure in the centre was not in line with the centre's statement of purpose. The role of the person in charge (PIC) was not clear as they were also the Director of Nursing for the community hospital based on the same site. It was not clear how much of their time was dedicated to the management of the designated centre. The PIC was not included on the staff roster.

There were two clinical nurse managers who provided support and supervision to staff. However, they were often on duty as the nurse delivering care to the residents. The lack of consistent supernumerary hours to carry out their management role had an impact on the oversight of a number of key areas. As a result the centre's own quality assurance systems had not identified a number of areas of non-compliance found by the inspector during this inspection.

The provider had not ensured that there were sufficient resources to meet the needs of the residents. For example:

- a number of areas were not well maintained and had not been redecorated.
- there was no planned schedule of activities and recreation available for the residents.

Judgment: Not compliant

Regulation 34: Complaints procedure

There was a complaints policy in place and this was updated in line with regulatory requirements. Records of complaints were maintained in the centre and the inspector observed that these were acknowledged and investigated promptly and documented whether or not the complainant was satisfied. There was a low level of complaints and there were no open complaints on the day of the inspection.

Judgment: Compliant

Regulation 4: Written policies and procedures

A policy for the health and safety of residents, staff and visitors (including food safety) was not available on the day of the inspection.

Judgment: Substantially compliant

Quality and safety

The inspectors found the care and support provided to the residents of this centre to be of a good standard. On the day of the inspection the residents were well-groomed, nicely dressed and observed to be content and happy. There was a person-centred approach to care and staff were respectful and courteous with the residents.

Residents were well cared for and their health care needs were assessed using validated tools which were used to inform care planning. The inspector reviewed a sample of resident records and found evidence that residents had an assessment of their needs prior to admission to ensure the service could meet the assessed needs of the residents. Care plans were generally initiated within 48 hours of admission to the centre. Individual care plans were comprehensive with person-centred detail and were generally updated regularly to provide very clear guidance to staff. The staff nurses on duty informed the inspector that due to staff shortages, care plans and

assessments did not always get updated as per the regulatory requirements.

Residents had very good access to medical care with the residents' general practitioners providing on-site reviews. Residents were also provided with access to other healthcare professionals in line with their assessed need.

The inspector found that there were limited opportunities for residents to participate in meaningful social engagement, appropriate to their interests and abilities. On the day of the inspection there was no planned schedule of activities. no dedicated activities staff available and care staff were allocated to provide those activities that were organised as part of their care duties.

Residents who exhibited responsive behaviours (how residents who are living with dementia or other conditions may express their physical discomfort or discomfort with their social or physical environment) were observed to be assisted and supported competently and sensitively by the staff. The staff were observed to be very knowledgeable about the residents' individual behaviour patterns and residents had timely access to psychiatry of later life. Care plans aware in place to guide staff and ensure interventions were effective. Staff members informed the inspector that there were occasions when residents' responsive behaviours were challenging and difficult to manage but the inspector did not observe any such issues on the day of the inspection.

The centre had a residents council which provided the residents opportunities to consult with management and staff on how the centre was run. Residents had access to an independent advocacy service.

Although store rooms were available, there were inadequate storage facilities available on the day of the inspection. This will be discussed further under regulation 17 Premises.

There was a risk register in place which identified risks including risks associated with COVID-19 in the centre and the controls required to mitigate those risks. Arrangements for the identification and recording of incidents was in place.

Infection Prevention and Control measures were in place. Staff had access to appropriate infection prevention and control training and all staff had completed this. Staff who spoke with the inspector were knowledgeable in signs and symptoms of COVID-19 and the necessary precautions required. Good practices were observed with hand hygiene procedures and appropriate use of personal protective equipment. However, some improvements were required to ensure the premises and lived environment supported appropriate infection prevention and control practices. This will be discussed under Regulation 27.

Staff were knowledgeable and clear about what to do in the event of a fire and the fire evacuation procedure to use in the event of afire emergency. Evacuation equipment was available and accessible in the event of a fire. Firefighting equipment was in place throughout the centre. Fire exits were clearly visible and free from obstruction. Personal evacuation plans were in place for each resident. Fire safety

training and evacuation drills were carried out regularly.

The centre had a comprehensive COVID-19 contingency plan in place which included guidance from Health Protection and Surveillance Centre (Health Protection and Surveillance Centre Interim Public Health, Infection Prevention and Control Guidelines for the Prevention and Management of COVID-19 Cases and Outbreaks in Long Term Residential Care Facilities).

Although the premises was generally clean and tidy, there were areas identified by the inspector that required improvement. These will be discussed further under Regulation 17 Premises.

Regulation 11: Visits

Visits were facilitated in line with the current guidance, (Health Protection and Surveillance Centre COVID-19 Guidance on visits to Long Term Residential Care Facilities). Residents who spoke with the inspectors confirmed that they were visited by their families and friends.

Judgment: Compliant

Regulation 17: Premises

Overall, the design and layout of the centre was suitable for the number and needs of the residents accommodated there. However, a number of areas required review to ensure regulatory compliance.

- Although there was storage facilities available in the centre, on the day of the inspection better organisation of equipment was required. For example;
    - Storage rooms were cluttered and disorganised.
    - There was inappropriate storage of items of equipment on one corridor blocking access to fire fighting equipment.
    - There was inappropriate storage of clinical equipment in the linen cupboard where a number of electrical items were also left on charge.
    - A number of items of equipment were stored in the day room resulting in restricted access to the water fountain.
    - There was inappropriate storage in the sluice facilities including clinical equipment stored on open shelving.
    - There was inappropriate storage of residents' chairs in bathrooms.

A number of these findings had also been identified in an internal audit but no action had been taken to address the issues.

In addition the inspector found;

- A number of maintenance issues were identified including items of furniture visibly scuffed, chipped paintwork and wall tiles in need of repair.
- The layout and configuration of three bedrooms prevented easy access to residents' wardrobe spaces as the beds were placed directly in front of the wardrobe doors.
- The garden area was overgrown in parts with visible moss growing on the walkways and several items of waste on the ground which posed a falls hazard.
- A number of doors to non resident areas which had keypads for staff access had the codes visible on the doors.
- The nurses office was very cluttered and served as both an administrative office and clinical room. Resident files were stored on open shelving and were not secure.
- Resident nutritional supplements were observed to be stored on the floor.
- There was a lack of appropriate dementia friendly signage to guide the residents around the various parts of the centre.
- The hoist charger was left on charge in the smoking room.

Judgment: Substantially compliant

Regulation 26: Risk management

The centre had an up to date comprehensive risk management policy in place which included the all of required elements as set out in Regulation 26.

Judgment: Compliant

Regulation 27: Infection control

A small number of areas for improvement to ensure the centre was in compliance with infection prevention and control standards were identified by the inspector on the day of the inspection including:

- There was visible dust on a number of surfaces including skirting boards, behind fire doors, and other items of furniture.
- The housekeeping room was not cleaned to an acceptable standard and

included heavily stained sinks.

- The underside and inside of numerous wall mounted hand gel dispensers were visibly unclean.
- The house keeping trolley was stored in the sluice room when housekeeping staff were on break which posed a risk of cross contamination.
- One vacant bedroom was not cleaned to an acceptable standard and had a visibly unclean mattress.
- Personal protective equipment (PPE) was not disposed of in accordance with best practice. For example, a used gown was observed on the ground in the garden area.
- The inspector observed gaps in the records documenting twice daily temperature checks for staff.
- The same trolley was used to transport clean linen to the centre and soiled linen to the laundry department - this issue had been identified in an internal audit and there was a plan in place to review this system.
- There were no cleaning schedules in place to monitor frequency and standard of cleaning in the centre. This deficit was also identified in an internal audit and a cleaning schedule had been developed but not yet introduced.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The fire procedures and evacuation plans were prominently displayed throughout the centre. All staff were trained in the fire safety procedures including the safe evacuation of residents in the event of a fire. Regular fire evacuation drills were undertaken including night time drills. Personal evacuation plans were in place for each resident. Evacuation sheets were available on every bed. There were adequate means of escape and all escape routes were unobstructed and emergency lighting was in place. Firefighting equipment was available and serviced as required. Fire safety management checking procedures were in place.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

The inspector was assured that the care delivered to the residents was of a good standard. The care plans which provided guidance to staff were very detailed with holistic and person-centred information to guide care delivery. Whilst there was evidence that assessments and care plans were reviewed in the last year, a number of records reviewed showed that reviews were not carried out in line with the

regulatory requirements.

Daily progress notes demonstrated good monitoring of care needs and effectiveness of care provided.

Judgment: Substantially compliant

Regulation 6: Health care

The inspectors found that the residents had access to medical assessments and treatment by their General Practitioners (GP) and the person in charge confirmed that GPs were visiting the centre as required.

Residents also had access to a range of allied healthcare professionals such as physiotherapist, speech and language therapy, psychiatry of old age and palliative care. However, the centre did not have access to occupational therapy or dietetic services for long stay residents.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

Staff informed the inspector that staffing levels often impacted on their ability to manage residents with responsive behaviours (how residents who are living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). Some residents required constant monitoring due to such behaviours to ensure the safety of all residents. A review of resident's care plans in relation to responsive behaviours and observation of residents found that behaviour which is challenging was appropriately managed within the centre on the day of the inspection. There were timely referrals to psychiatry of later life (POLL). Care plans contained guidance for staff on resident's preferences, triggers for certain behaviours and de-escalation techniques to manage responsive behaviours. These care plans were updated regularly in response to ongoing input from POLL. Although training records reviewed by the inspector showed that not all staff had training in managing responsive behaviours or dementia, on the day of the inspection residents were observed to be assisted and supported competently and sensitively by the staff.

There were a number of residents who requested the use of bed rails. Resident records contained evidence of appropriate risk assessments being carried out prior

to use. Alternative options that were considered were documented. A record of all bed rails in use was maintained and risk assessments were reviewed on a regular basis to ensure usage remained appropriate.

Judgment: Compliant

Regulation 9: Residents' rights

There was limited opportunities for residents to participate in meaningful activities in line with their abilities and preferences. The inspector observed that a number of residents did not have access to activities or entertainment on the day of the inspection.

There had only been one resident council meeting in 2021. Satisfaction surveys had been carried out with resident and relatives with very positive results, however there had not been a survey carried out since early 2020.

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 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Áras Deirbhle Community Nursing Unit OSV-0000644

Inspection ID: MON-0033809

Date of inspection: 03/11/2021

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:
There are more than adequate staff in Belmullet for the total number of beds however the number available to fill the roster to standard norms presents challenges due to the high level of absenteeism. Admissions are kept in line with current resident numbers, dependency and staffing level.

Recruitment of Nursing (including CNM2) and HCA /MTA to replace long term sick leave and maternity leave. Interviews taking place in January 2022.

Access to agency.

Available Staff across the Belmullet Campus are allocated based on current residents in the Designated Centre.

Allocated staffing includes a dedicated resource, who leads on activities in the Day Room from 09:00-17:00 time in addition to support from other care staff.

Historically the skill mix is Belmullet had a significantly higher percentage of nurses than care staff. The HSE had been working for a decade to balance skill mix. Pending this occurring in Belmullet through natural attrition nursing staff participate in care duties as well as nursing duties. Care planning and documentation is part of nurses role on day to day management of the resident and there is sufficient nurse staffing to ensure they undertake this core duty during their rostered shift. This will be monitored through audit.

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

Regulation 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
Training is provided and available from Centre nurse midwife education centre as well as online training from HSEland. Staff that have not participated in training in dementia and responsive behaviours or any other training deemed necessary based on resident needs will be supported to attend training. Non attendance and non compliances will be monitored, supervised and dealt with under disciplinary procedure if deemed appropriate

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
Resident records to be stored securely in designated area by involving maintenance to reconfigure nurses station layout to facilitate lockable storage.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
3 (a) Approval given for painting of areas on phased basis awaiting start date for painters to commence. Replacement of flooring also requested awaiting quotes which will be approved.

Activity Programme has been developed and published for 7 days per week.

23 (b) The Director of Nursing in Belmullet is PIC for Aras Deirbhle and is involved in the day to day management of all OPS residential services in Belmullet. This situation pertains elsewhere

23 (c) As outlined there is a DON for a maximum of 42 residents as well as a CNM2 Plus a CNM1 for 30 residents, which is a satisfactory level of governance. All CNM2 have half their time (19.5 hrs per week) allocated to "supernumary hours" to assist the DON in

ensuring compliance with the Regulations and identifying areas for improvement through regular audits etc. This is challenging at present due to the long term absence of the current CNM2. Temporary replacement has been unsuccessfully pursued and a recruitment process is now underway

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

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
Health and safety policy in place.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Areas decluttered and reorganized to ensure clinical and resident equipment in correct designated areas and not impeding access to fire equipment, water fountain etc.

There is ongoing replacement of damaged furniture and maintenance programme in place to repair broken tiles and address chipped paintwork.

Maintenance are looking at options to address to the reconfigurations of 3 single rooms that beds are impeding easy access to wardrobes due to layout and size.

Quote received for more appropriate dementia friendly signage

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:

Cleaning schedules in place.
Areas cleaned and records kept.
Separate trolleys in place for clean and dirty line.
Above monitored by audit.

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
Ensure each resident care plans and assessment is reviewed at interval of 4 monthly or sooner if residents condition changes. This will be monitored through audit.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
Approval given to use agency AHP dietician and OT and request submitted to agency.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Residents to have opportunity to take part in 3 monthly resident council meetings and participate in satisfaction surveys.

Residents to have opportunity to take part in meaningful activities by ensuring allocated staff are available to support residents to participate in the structured activities programme.

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	Orange	31/03/2022
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/04/2022
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.	Substantially Compliant	Yellow	30/06/2022
Regulation 21(6)	Records specified in paragraph (1)	Not Compliant	Yellow	31/03/2022

	shall be kept in such manner as to be safe and accessible.			
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	Orange	30/06/2022
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	31/03/2022
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.	Substantially Compliant	Yellow	31/03/2022
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and	Substantially Compliant	Yellow	13/12/2021

	control of healthcare associated infections published by the Authority are implemented by staff.			
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.	Substantially Compliant	Yellow	07/11/2021
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Substantially Compliant	Yellow	28/02/2022
Regulation 6(2)(c)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the care referred to in paragraph (1) or other health care service requires additional professional expertise, access to such treatment.	Substantially Compliant	Yellow	31/01/2022
Regulation 9(2)(b)	The registered provider shall	Not Compliant	Orange	31/03/2022

	provide for residents opportunities to participate in activities in accordance with their interests and capacities.			
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned.	Substantially Compliant	Yellow	31/01/2022