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:	Farranlea Road Community Nursing Unit
Name of provider:	Health Service Executive
Address of centre:	Farranlea Road, Cork
Type of inspection:	Unannounced
Date of inspection:	18 April 2024
Centre ID:	OSV-0000713
Fieldwork ID:	MON-0042079

About the designated centre

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

Farranlea Road Community Nursing Unit is a designated centre located near the suburban setting of Wilton, Cork. It is registered to accommodate a maximum of 89 residents. It is a two-storey facility with stairs and lift access to the first floor. Farranlea Road is set on a large site with enclosed courtyards and gardens for residents to enjoy. Residents' bedroom accommodation is set out in four units, Oak, Sycamore and Willow each are 25-bedded units accommodating older adults; and Cedar is a 14 bedded unit accommodating younger residents. Each unit is self-contained with a dining room, kitchenette, day rooms, a quiet sitting room and comfortable resting areas along corridors.Bedroom accommodation comprised single, twin and multi-occupancy wards, all with wash-hand basins, and en suite shower, toilet and wash-hand basin facilities. There were additional shower and toilets and a bath room in each unit. Farranlea Road Community Nursing Unit provides 24-hour nursing care to both male and female residents whose dependency range from low to maximum care needs. Long-term care, rehabilitation and palliative care is provided.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	79

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
Friday 19 April 2024	08:30hrs to 16:30hrs	Ella Ferriter	Lead
Friday 19 April 2024	08:30hrs to 16:30hrs	Robert Hennessy	Lead
Thursday 18 April 2024	18:00hrs to 21:00hrs	Ella Ferriter	Lead

What residents told us and what inspectors observed

This was an unannounced inspection carried out over one evening and one day. One inspector attended the centre on the first evening and two inspectors were present for day two. The inspectors met with the majority of 79 residents living in the centre over the two days and spoke in detail with 15 residents. The inspectors also spent time observing residents' daily lives and care practices in the centre in order to gain insight into the experience of those living there. Residents told the inspectors that staff were very kind and helpful to them and always treated them with respect and kindness.

Farranlea Community Nursing Unit is a two story designated centre situated in Wilton, Cork City, which is registered to provide care to 89 residents. The facility has one main entrance and the inspectors saw that there was a full time person available at the reception desk to meet with visitors and ensure people signed in on arrival. Residents accommodation in the centre is situated over four units, two on each floor. Units are named after types of trees, Willow and Cedar on the ground floor and Oak and Sycamore are situated on the first floor. The inspector spent time walking around each unit on the first evening and noted that the majority of residents were in their bedrooms and the living and dining rooms were empty, with the exception of approximately eight residents. Discussions with residents, visitors and staff indicated that it was common practice in the centre for residents to return to their room at 4:30 pm, have their supper in their rooms and stay there for the night. This did not offer residents choice and was an institutionalised practice, which is actioned under regulation 9, residents rights.

The inspector saw that there was ample staff available in the evening up until 8pm, however, after this time on each unit there was one nurse and two care staff. This staff compliment was found to be inadequate on all units with the exception of Cedar, considering the high care requirements of some of the residents. The inspector observed residents waiting for care delivery and residents calling for assistance and staff not being available to them. The inspector also noted that the nurse was interrupted from medication administration numerous times. Discussions with staff indicated that they were responsible for assisting a large proportion of residents with their nutrition, hydration, continence and mobility and it was exceptionally busy and difficult to attend to residents care and assist residents at this time of night. This finding is actioned under regulation 15, staffing. The inspector also observed over the course of the evening that a number of residents did not have call bells available in close proximity to them and residents were calling out for assistance. Two residents told the inspector that they would call out if they needed help and they were not routinely given their call bells. This finding is actioned under regulation 23.

The inspector had the opportunity to attend the shift handover between day and night staff on one of the units. Although information was conveyed between the two registered nurses, the inspector found that pertinent information pertaining to

residents care requirements was not effectively communicated or relayed to the two health care attendants that would be caring for them. This finding is actioned under regulation 23.

Bedroom accommodation in the centre comprises of 65 single rooms, six twin rooms and three four bedded rooms, all with en suite bathroom facilities. The inspectors observed that single bedrooms were observed to be very personalised with items of significance to each residents such as family photographs, ornaments, football memorabilia and soft furnishings. Residents spoken with stated that they loved their bedrooms and staff had assisted them in decorating them and assisting them to purchase items that they would like.

Each unit, with the exception of Cedar unit comprises of 25 residents. Cedar provides accommodation for up to 14 young adults and all bedroom accommodation is single occupancy. Inspectors were informed that currently occupancy was maintained at 10 residents and four of the beds were closed to admissions. Residents were observed over the two days of this inspection having a good quality of life in the Cedar Unit. There were adequate staffing levels, some residents were observed to be going to day centres or out with family and there were activities and social stimulation provided. The inspectors saw one resident was busy planning to move from the unit to independent living and had been assisted by the team of staff in putting all necessary arrangements in place. Additional resources such a sensory room, activity room and occupational therapy room with a therapeutic kitchen were available in this unit and residents were assisted and encouraged to use and enjoy these facilities.

The inspectors saw that there was communal space available on each of the four units which comprised of dining rooms, kitchenettes, day rooms and a library. These areas were seen to be decorated in a domestic homely style. Residents were observed to be enjoying these areas during the day watching television, reading books and chatting with each other. There is a large communal room called the atrium on the first floor, situated between the two units. This was observed to be a busy area on day two of the inspection where many residents met for activities.

Residents were observed to be engaged in numerous meaningful activities throughout the second day of this inspection, and all residents spoken with reported that they were happy with the daily activities programme. Activities staff regularly consulted with residents on what activities and events they would like to celebrate, and this was also discussed at monthly residents meetings. The activities schedule was displayed around the centre and included a variety of activities. Mass was available for residents here in the morning as well as arts and crafts. In the afternoon a 15 piece singing group entertained residents and over 45 residents were seen to enjoy this concert. Staff were seen to encourage participation and stimulate conversation with residents during activities. Residents told the inspectors the days were great in the centre and there was always something to do and look forward to. Some residents were unable to articulate their experience of living in the centre and the inspectors observed that those residents appeared comfortable, relaxed and content in their environment and in the company of staff and other residents.

Residents had access to a number of outside courtyards and balconies on each floor which were well developed and enclosed. The doors to these areas were observed to be open and were easily accessible. The garden areas were attractive with flower bedding and outdoor furniture provided for residents use. However, inspectors noted that smoking areas required to be reviewed to ensure that there was appropriate equipment available, in the event of an emergency. This finding is actioned under regulation 28 fire precautions.

It was evident that residents were offered their preferred choice of food, with some residents requesting and receiving an alternative meal to what was offered on the menu. Residents expressed a high level of satisfaction with the quality and quantity of food. The inspectors spent time observing the dining experience for residents on day two of the inspection. Staff were observed to engage positively with residents during meal times, ensuring appropriate encouragement. Staff providing assistance sat at eye level with residents and used the time to chat about topics of interest to the resident. The majority of residents attended the dining room in the centre, for their main meal.

Over the two days the majority of feedback from residents was very positive in relation to the staff working in the centre. They described staff as very approachable and helpful, two residents stating they "couldn't ask to be cared for by nicer people". Some residents told the inspectors that there were a lot of new staff and they sometimes did not know their names and they found this difficult. The management team told inspectors that this had been brought to their attention in the past and they would ensure that staffs name badges were visible to residents on their uniforms going forward.

Visitors were observed coming and going throughout the two days of this inspection. The inspectors spoke with six visitors who expressed their satisfaction with the quality of care provided to their relatives living in the centre. Visitors stated that they could visit at any time and there was not a booking system for visiting.

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

This two day unannounced inspection was carried out by inspectors of social services to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centre for Older People) Regulations 2013 (as amended). The inspectors also followed up on the actions taken by the provider following findings of the previous inspection of June 2023. Findings of this inspection were that the management systems in place in the centre were not fully effective and did not provide assurance there was appropriate oversight of the services provided to

residents. Significant action was required to comply with the regulations and these will be detailed under the relevant regulations of this report.

Farranlea Road Community Nursing Unit is a designated centre for older people operated by the Health Services Executive (HSE), who is the registered provider. Within the centre the organisational structure and the lines of authority and accountability are clearly outlined. The management team comprises a suitably qualified person in charge, who works in a management and supervisory capacity. They are supported by a management team comprising of an assistant director of nursing, eight clinical nurse managers and a night superintendent. There is also a team of registered nurses, health care assistants, domestic, activities, catering and administrative staff. The person in charge reports to a general manager for older person's services in the HSE, who the inspectors were informed, are available for consultation and support on a daily basis. The centre is also supported by centralised departments such as human resources, finance, fire and estates and clinical practice development. An annual review of the quality and safety of the service was completed that linked resident and relative feedback to the identified quality improvements to be implemented in 2024.

This inspection found that although there were adequate resources provided during the day in the centre action was required to ensure that there was an appropriate amount of staff working from 8pm to meet the care requirements of residents. There was also insufficient systems in place to monitor residents dependency levels in the centre and inadequate oversight of this by management. Therefore, staffing resources could not be effectively planned and monitored. These findings are actioned under regulation 15 and 23.

Significant action was required pertaining to staff training. On review of training records it was evident that for a large proportion of staff mandatory training, as per the centres policy, was expired and there was poor oversight of training. There was also not evidence of an induction programme for newly recruited staff, to support them in their roles. This is further detailed under regulation 16.

While there were systems in place to record and investigate incidents and accidents involving residents, the inspectors found that the incident reporting system was not sufficiently robust. This resulted in delayed identification of factors which may have contributed to medications incidents occurring or to identify learning so that similar incidents could be prevented. This is further detailed under regulation 23. Incidents, as detailed under Schedule 4 of the regulations, were notified to the Chief Inspector, within the required time frame.

The provider had management systems in place to monitor the service via an electronic audit system which was the responsibility of mangers on each unit. However, inspectors found that these were not effective in identifying areas for improvement as identified on this inspection. Information communication systems required strengthening to ensure there was effective oversight of the service and services provided were safe. These findings and others pertaining to governance and management are further detailed under regulation 23. The management team acknowledged this finding on the day of the inspection and informed the inspectors

that they were in the process of developing a quality improvement plan in this area. Inspectors acknowledge there had been and extensive project completed on falls prevention in the centre which had a positive impact on residents and had resulted in a decrease in falls.

A summary of the complaints procedure was displayed in the centre and a record of complaints raised by residents and relatives was maintained. It was evident that complaints were responded to in a timely manner by the complaints officer. However, the complaints process did not always adhere to the requirements of the regulations, which is actioned under regulation 34. All residents residing in the centre were provided with a contract of care, which contained all information as required by the regulations.

Policies and procedures were available which provided staff with guidance about how to deliver safe care to the residents. The inspectors reviewed the policies required by the regulations and found that some policies were outdated, as actioned under regulation 4.

Regulation 15: Staffing

There was insufficient staffing levels to meet the needs of residents on the first evening of the inspection. Specifically, there was not adequate staff allocated to supervise, monitor, and respond to residents needs during periods when two staff were providing care to residents and the registered nurse was administering medication. On review of residents dependency levels some residents required assistance of three staff for transfer. These findings were supported by observations on this inspection of residents waiting on care delivery, delays in the administration of medications and inadequate supervision of residents in their bedrooms.

This was also a finding on the previous inspection and had not been adequately addressed by the registered provider.

Judgment: Not compliant

Regulation 16: Training and staff development

Significant action was required with regards to training and staff development evidenced by the followings findings:

- records demonstrated significant gaps in training in safeguarding vulnerable adults, managing responsive behavior, cardiopulmonary resuscitation and manual handling, all of which were listed as mandatory training in the centres policy.
- further training was required in relation to assessment and care planning, as

evidenced by the findings detailed under regulation 5.

- there was not evidence that staff had a comprehensive induction programme to ensure that they were informed regarding the centres policies and practices.
- although there was ten nurse managers working during the day, there was not any of these managers rostered between 6-8pm to supervise care delivery.

This was a repeat finding and also an area identified that required action following the previous inspection.

Judgment: Not compliant

Regulation 23: Governance and management

The management systems in place to monitor and improve the quality of the service required action to ensure the service provided to residents was safe, appropriate, consistent and effectively monitored, evidenced by the following findings:

- there was evidence of a lack of effective systems in place to monitor staffing, training and care planning, which are all outlined further under the specific regulations.
- there was inadequate oversight to ensure call bells were available within easy reach of residents at all times.
- incidents pertaining medication errors in the centre had not been acted on in a timely manner and used to learn from to improve the service.
- there was not effective communication systems in place in the centre to ensure that management had effective oversight of the centre and that information pertaining to residents care was communicated effectively at shift changes. This posed a risk to the delivery of a safe service.
- there were not effective audit systems in place for the senior management team to assess information on each unit to evaluate and improve the quality and safety of the service provided to residents.

The registered provider had not to ensured that resources in the centre were planned and managed to ensure person-centred, effective and safe services, specifically the allocation of health care staffing levels after 8pm as evidenced in the first section of this report.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

All residents were issued with a contract for the provision of services. The contracts outlined the services to be provided and the fees, if any, to be charged for such services.

Judgment: Compliant

Regulation 31: Notification of incidents

A record of incidents occurring in the centre was maintained. All incidents had been reported in writing to the Chief Inspector as required under the regulations, within the required time period.

Judgment: Compliant

Regulation 34: Complaints procedure

A review of the complaints log in the centre found that complaints were not consistently managed in line with the requirements under regulation 34. Specifically, there was not always evidence that the registered provider had provided a written response informing the complainant whether or not their complaint has been upheld, the reasons for that decision, improvements recommended and details of the review process.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

The policies and procedures outlined in Schedule 5 of the regulations were available to staff, however, some required updating as they had not been reviewed in over three years. This is a requirement of the regulation.

Judgment: Substantially compliant

Quality and safety

This inspection found that residents reported they felt safe and content in the centre and interactions between residents and staff were kind and respectful throughout

the inspection. Nonetheless, the inspectors found that the quality and safety of care provided to residents was compromised as a result of ineffective systems of governance and management described in the first section of this report. Action was required in relation to residents' assessments and care plans, health care, the use of restraint and resident's rights.

Residents had good access to general practitioner (GP) services, allied health professionals and out-patient services. There was a full time physiotherapist available in the centre. Services such as tissue viability nurse specialists, speech and language therapy, occupational therapy and dietetics were available when required. The inspectors found that advice given was acted upon which resulted in good outcomes for residents.

Residents' records showed that a pre-admission assessment was carried out for each resident. A sample of care plans were reviewed by inspectors and it was evident that significant action was required. For example, two residents did not have care plans in place to direct care and others were not updated as their needs changed. Details of these findings are set out under regulation 5. Residents had access to pharmacy services and the pharmacist was facilitated to fulfil their obligations under the relevant legislation and guidance issued by the Pharmaceutical Society of Ireland.

Inspectors identified some examples of good practice in the prevention and control of infection. Infection prevention and control information and reminders were displayed on designated notice boards around the centre and there were adequate hand washing sinks available for staff. There was cleaning staff allocated to each unit within the centre. However, some practices were also identified which had the potential to impact on the effectiveness of infection prevention and control within the centre. Findings in this regard are presented under regulation 27.

The management of fire safety was kept under review. The centre was provided with emergency lighting, fire fighting equipment and fire detection and alarm system. Fire records were well maintained and evidenced that equipment was being serviced at appropriate intervals. Records documented the drill scenarios created and how staff responded, which was an improvement since the previous inspection. However, some further action was required to achieve full compliance, which are further detailed under regulation 28.

Inspectors were satisfied with the measures in place to safeguard residents and protect them from abuse and improvements were noted following the findings of the previous inspection. Any safeguarding issues identified were reported, investigated and appropriate action taken to protect the resident. The provider had allocated additional social work support to the centre following the findings of the previous inspection which had a positive impact on the oversight of safeguarding plans for residents.

The inspectors observed staff engaging with residents who exhibited behavioral and psychological symptoms of dementia. Engagement was respectful and non restrictive. However, as found on the previous two inspections of the centre there

was a high use of bedrails with over half of residents assigned bedrails. Further actions are required to ensure that restraints are not used as a result of family wishes and requests and there is appropriate assessment and consent obtained. These findings are actioned under regulation 7.

Residents had access to information and news, a selection of newspapers and Wi-Fi was available. Residents had access to advocacy services and were regularly consulted in relation to the running of the centre. Residents had opportunities to participate in meaningful coordinated social activities throughout the day that supported their interests and capabilities, however, there was limited opportunity for social engagement in the evenings. Residents were facilitated to exercise their religious rights and priest was available in the centre weekly.

Regulation 10: Communication difficulties

Residents who had communication difficulties and special communication requirements were observed to be supported to communicate freely. Residents were also supported to access additional supports such such as assistive technology to assist with their communication.

Judgment: Compliant

Regulation 11: Visits

The registered provider had arrangements in place for residents to receive visitors. Those arrangements were found not to be restrictive and there was adequate private space for residents to meet their visitors.

Judgment: Compliant

Regulation 12: Personal possessions

Residents had adequate space in their bedrooms to store their clothes and display their possessions. Clothes were marked to ensure that they were safely returned from the laundry and residents expressed satisfaction with this service.

Judgment: Compliant

Regulation 17: Premises

There was not sufficient suitable storage space in the designated centre. This was evidenced by the inappropriate storage of equipment such as mattresses, trolleys and wheelchairs in a residents communal bathroom. This bathroom facility was observed to be unavailable to residents as the bath was full of old unused equipment and the toilet was inaccessible due to the storage of unused wheelchairs.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Residents were provided with wholesome and nutritious food choices for their meals and snacks and refreshments were made available at the residents request. Menus were developed in consideration of residents individual likes, preferences and where necessary, their specific dietary or therapeutic diet requirements as detailed in the resident's care plan.

Judgment: Compliant

Regulation 27: Infection control

Standard infection control precautions was generally implemented in a way that minimised the risk of transmitting a healthcare-associated infection, however, further action is required to be fully compliant. This was evidenced by;

- housekeeping rooms were observed to be full of equipment and inappropriate storage, therefore, these room could not be effectively cleaned and hand washing sinks were not accessible to staff.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Action was required by the provider to ensure they took adequate precautions to protect residents from the risk of fire and to bring the centre into compliance with Regulation 28: Fire Precautions, as follows:

- the inspectors observed poor practices with regards to chairs being used to

hold three fire doors opened. Therefore, in the event of a fire these would be ineffective.
- there were a number of residents requiring oxygen in the centre, however, they did not have signage in place to alert people in the centre and the fire service, if required to the presence of oxygen.
- although residents had personal evacuation plans in place some were found not to reflect the residents dependency and requirements to evacuate safely. Increased oversight was required to ensure that these were reviewed and updated as needs of residents changed.
- appropriate fire safety equipment such as fire aprons and fire blankets were not available to residents and staff in the centre's designated smoking areas.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

There were adequate systems in place for the administration and storage of medicines. Controlled drug records and drug administration records reviewed by inspectors were found to be maintained in line with professional guidelines. Residents had access to pharmacy services and the pharmacist was facilitated to fulfil their obligations under the relevant legislation and guidance issued by the Pharmaceutical Society of Ireland. Action was required to ensure effective action was taken following medication errors in the centre, as actioned under regulation 23.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

A review of a sample of resident's assessment and care plans found that they were not in line with the requirements of the regulations. For example;

- it was evident that not all residents had comprehensive assessments completed on admission to identify their care needs using validated assessment tools. This included assessment of dependency needs, falls risk, nutritional risk and risk of impaired skin integrity.
- two residents who had been admitted in the last ten days did not have care plans in place to direct care. It is a regulatory requirement that resident have a care plan formulated no later than 48 hours after admission.
- although validated assessment tools were being used for residents to assess the risk of malnutrition, pressure ulcers and falls these were not informing care plans. For example; a residents assessment that indicated weekly weights and reassessment for malnutrition monthly, did not have this care

implemented or evidenced in their care plan.

- care plans for residents who presented with responsive behaviours did not outline de-escalation techniques, and ways to effectively respond to behaviours.
- a resident requiring oxygen did not have any reference to this in their breathing care plan.
- residents dependency levels were not assessed to inform care delivery and in one of the units were found to be last updated seven months prior to this inspection.

Judgment: Not compliant

Regulation 6: Health care

The following required action pertaining to healthcare to ensure that evidence based nursing care was consistently provided:

- one resident who required to be on a fluid restriction did not have evidence that this was being recorded and monitored. Therefore, the inspector was not assured that care was provided as per the resident's assessed needs.
- one resident who had a history of recent surgery did not have evidence that their pain was being assessed regularly to determine if analgesia was required.
- although wound care practices were found to be carried out to a good standard, there was not always documentation completed to indicated that a wound had healed and treatment was not longer required.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

A review of restrictive practices, staff knowledge and practice was required to ensure that where restraint is used it is only used in accordance with national policy. As per the findings of the previous two inspections there was a very high use of bedrails in use in the centre with over 52% of residents allocated bedrails. Inspectors found that where bed rails were in use there was not always evidence of a comprehensive assessments and consent and alternative interventions had been trailed. A large number of staff had not attended training in the management of responsive behaviours to ensure they had the skills and knowledge they needed to provide support and care for residents with known responsive behaviours, which is actioned under regulation 16.

Judgment: Not compliant

Regulation 8: Protection

Inspectors were satisfied with the measures in place to safeguard residents and protect them from abuse. Any safeguarding issues identified were reported, investigated and appropriate action taken to protect the resident. Improvements were noted from the previous inspection in the oversight and management of safeguarding plans. The provider had ensured there was expertise available by social care workers, to provider guidance and expertise on safeguarding concerns.

Judgment: Compliant

Regulation 9: Residents' rights

Significant action was required to ensure that residents were offered choices with regards to a dining experience in the evening and the availability of social stimulation at this time. The routine practice throughout the centre that residents to return to their room at 4:30pm was an institutionalised practice and did not respect residents rights.

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	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Farranlea Road Community Nursing Unit OSV-0000713

Inspection ID: MON-0042079

Date of inspection: 19/04/2024

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: • All vacant positions have been identified and escalated for derogation. Currently all staff are being offered overtime and agency staff are also being utilised to address these staffing deficits. • All staffing deficits have been recorded as risks and escalated to the office of the General Manager, under the HSE Enterprise Risk Management Policies and Procedures. • Since 18.04.2024 a review of RGN & HCA rosters has been undertaken, and are reviewed daily. Staff allocations are based on current resident's dependency levels and risks identified across all 4 x Wards. • Since 20.04.2024 additional, agency HCA staff has been introduced for twilight cover. • Since 25.04.2024, Senior Enhanced RGN's, with experience in gerontology, have been identified to provide Senior Nurse Management between 18.00hrs – 20.00hrs as an interim measure. • A more sustainable long-term measure is to appoint a CNM1 to work to 20.00hrs daily, in a supervisory capacity, from June 2024, pending staffing levels.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • A system has been introduced since 27.04.2024 for training records to be maintained by clerical staff and monitored through a monthly audit by the ADON • Staff who require mandatory training will be clearly identified and contacted by the ADON with a date of completion agreed. • Farranlea CNU will have all mandatory trainings completed by 30.08.2024.	

2 x CPR instructors have completed training and have commenced in service CPR training since 16th and 17th May, 2024.
2 x Responsive Behaviour Trainers have completed a train the trainer course and in service training is commencing on 12.06.2024
To support all staff in completing their Manual Handling training, additional training has been outsourced and is due to take place on 11th, 12th and 25th June 2024.
• Care planning training to focus on assessment, nursing interventions, and person centered approach to care. 2 X training sessions have been completed in May, with two planned sessions scheduled for June 2024.
• By the end of June 2024, the CNMs on all 4 x units will review the staff induction documentation to ensure completion of same and submit to the DON for recording purposes.
• As an interim measure, since 25.04.2024, Senior Enhanced RGN's, with experience in gerontology, are identified to provide Senior Nurse Management between 18.00hrs – 20.00hrs.
• A more sustainable long-term measure is to appoint a CNM1 to work to 20.00hrs daily, in a supervisory capacity, from June 2024, pending staffing levels.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• Monitor Staffing: All vacant positions have been identified and escalated for derogation. Currently all staff are being offered overtime and agency staff are also being utilised to address these staffing deficits.
All staffing deficits have been recorded as risks and escalated to the office of the General Manager, under the HSE Enterprise Risk Management Policies and Procedures.
• Monitor Training: Staff training matrix and records will be monitored through a monthly audit by the ADON and training dates arranged for staff with outstanding training.
• Monitor Care planning: There is a monthly Care Plan Documentation Audit schedule in place in each unit. The audit is conducted by the CNM and the results are validated by the ADON.
• Since inspection on 18.05.2024, Call Bells are now included on the daily safety pause document on all 4 units to ensure staff are checking that all call bells are in place, in working order and in reach of all residents. A weekly call bell audit has now been introduced to each unit from 06/05/24
Recommendations from previous medication errors, have been implemented include, (i) the continued use of red tabards to reduce risk distraction is to continue on all 4 wards,(ii) RGN's to complete medication management module on www.hseland.ie annually, and as required, records maintained. Changes have been made to Medication Administration Chart (MARS) includes, (i) increasing the FONT size and bold colour Red: Allergic to penicillin to all pages of the MARS chart. (ii) Allergy status has been added to safety pause on all 4 Wards(iii) additional training for RGN's on BIODOSE Medication

system scheduled 18thJune '24.. Monthly Viclarity Medication Audits in Medication Administration will be completed and validation of same will be carried out by the ADON on a monthly basis. Pharmacy Provider to introduce an electronic 'on admission form' to allow all relevant personal information be entered and saved. Where the allergy status is requested, this will be a mandatory field – the user cannot move on without entering allergy status information. Time frame for introduction of electronic admission form – provisional 30.12.2024.• Medication Management: All staff involved in medication administration errors have now retrained in Medication Management on www.hseland.ie.
• Communication Systems Improvements: A nursing handover document using the ISBAR format since 27.05.2024. This ISBAR communicates all essential information to deliver safe resident care including dependency levels and needs. An agreed set of KPIs from all 4 units is submitted by the CNM to the DON office every Monday morning, commenced on 20.05.2024.
• An updated Safety Pause Document to improve the communication of risks at ward level is currently on trial on Sycamore and Willow Wards. This document is due to be evaluated at the end of June 2024. Feedback will be reviewed by all CNMs and introduced to all units by end of July.
• Viclarity Training has been arranged for all senior nurse managers for mid-June and all Viclarity Audit results will be reviewed on a monthly basis with the ward CNMs and senior management. Action Plans, timelines and monitoring of implementation will be addressed at this meeting.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
• A review of complaints log has been undertaken in May 2024. Complaints that had not been responded to, in a timely manner, have now been addressed. Records are available of meetings convened, letters and emails, exchanged with residents, and family members who have made a complaint.
• Complaints Policy is currently being updated by the Clinical Development Coordinator in line with Statutory Instrument 628 and will be available by the end of June 2024. All Senior Nurse Managers will submit certificates of course completion in Complaints Management on www.hse.ie by end of June 2024.

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies

and procedures:
• Schedule 5 Policies are currently under active review by 4 CNMs as members of the Clinical Development Committee and in consultation with the Clinical Development Coordinator.
• Outstanding Policies will be updated as follows: Admissions & Discharge Policy due end June 2024, Responsive Behaviors Policy due end of July 2024, End of Life Policy due end June 2024, Medication Management Policy is due end June 2024.
• All Schedule 5 Policies will be kept under review every 3 years in line with current legislation or earlier if changes in legislation or evidence based practice.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• Designated appropriate storage areas have been identified for unused wheelchairs.
• All CNMs at ward level have identified all unused equipment for removal, repair or replacement and all equipment has been removed. A system has been introduced to clearly identify equipment (stickers) which is then moved off the ward area weekly.
• CNM's are reminded of the decluttering practice at fortnightly CNM meetings.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
• Measures were immediately taken to remove the large piece of cleaning equipment from the cleaner's room.
• The domestic supervisor was met with both DON and ADON following this inspection report, to ensure the cleaners room is maintained, kept clean and tidy, and access to the handwashing sink is available to staff at all times.
• The cleaner's room on each unit, will be checked on a daily basis, by DON, ADON CNM's day and night, when on walkabouts. A documentary comment record will be maintained by DON, ADON and CNM.
• This issue will be kept under review with additional environmental IPC audits introduced in May 2024, for completion by the IPC Link Nurse.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• The importance of ensuring fire doors are not wedged open has been brought to the attention of Fire Safety Trainer, who has confirmed that this will now be included in all fire training sessions going forward. This was addressed daily at Safety Pause since the date of inspection. Daily fire checks at ward level now includes checking all fire doors.
• Oxygen in use signage now in place on all bedrooms, where Oxygen is stored or in use. (18.04.24)
• CNM's have been reminded of their responsibility in relation to updating PEEPS and that all PEEPS are reviewed and updated with Care Plans.
• Since 18.04.2024, all CNMS have confirmed to the DON that all PEEPS are updated and they will be reviewed quarterly with the Care Plans to include the resident's dependency levels and evacuation requirements.
• Fire equipment including fire extinguishers and fire retardant aprons have been ordered and are will be installed on 04.06.2024.

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
• Monthly Viclarity Care Plan Audits are being reviewed at ward level and all areas of non-compliance will be addressed. Additional Viclarity Training has been requested to support Nurse Managers in using Viclarity System to support improvement in practice. Viclarity to provide training at CNM meeting on June 18th, 2024.
• Care planning training to focus on assessment, nursing interventions and person centered approach to care is currently being rolled out. This will also include nursing management and interventions of residents displaying responsive behaviour. 2 x training sessions were completed on 24.05.2024 and a further 2 sessions are due to be delivered on 14.06.2024.
• Care plans and assessments are on the agenda for discussion with the individual CNM at the quarterly Performance Achievement Meetings.
• CNM's will monitor all new admissions care plans to ensure Care Plan is completed and in place within 48 hours.
• CNM3 on night duty is to check care plans nightly, to ensure new admission care plans are opened in the required time period and the appropriate care assessments are completed. Any non-compliance with regulation will be reported to and actioned by the ADON and DON with specific unit.
• Since 20.05.24 residents dependency levels are now being monitored on the recently implemented KPI collection tool.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
• Monthly Viclarity Care Plan Audits are being reviewed at ward level and all areas of non-compliance will be addressed.
• Care plan training that is currently being rolled out by the CDC focusses on wound care documentation, pain assessment tools and comprehensive resident care interventions.
• Care plans identified on inspection with omissions have been reviewed and updated.

Regulation 7: Managing behaviour that is challenging	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
• Care Plan training focusses on restrictive practices documentation including bed rail assessments, consent and trialing of alternative interventions. All staff are to sign to confirm having read the National Restraint Policy
• All staff will have completed care plan training with a focus on restrictive practice, documentation to include bedrail assessments, consent and trial of alternative interventions by 30th September 2024.
• Responsive Behaviour Policy is currently being updated and will be available by the end June 2024.
• Two staff members have completed Train the Trainer in responsive behaviour, this training also focuses on dementia and restrictive practice. This will be rolled out from 12.06.2024. Two RGNS (Trainers) are now available on site, to facilitate presentations and in service education on Responsive Behaviors.
• The CNM3 on night duty is to monitor the use of restrictive practice and to implement a QIP: to Reduce the use of restrictive practice over a 6 month period, June 24-December 24. The monthly, local restrictive practice data, will measure this practice, identify areas of concern, and a PDSA approach to quality improvement, will be undertaken, to make improvements in this area of restrictive practice.
• The MDT monthly meetings per unit will include identifying all residents with a restraint in place. This meeting will discuss individual restraint practices in relation to, a) continuation, b) removal and c) replacement with an alternative less restrictive practice.
• In addition Headway Service does provide responsive behavior training to staff in Cedar Ward.
• St Luke's Centre of Nurse Education will support achieving 100% compliance with responsive behaviour training by 30.08.2024.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• A Dining Experience, observational survey, was completed in April 2024, the feedback and proposed improvements that will be implemented will discussed at the next CNM meeting (June 5th)
• Recommendations from this audit will be considered and implemented where practicable.
• A WCCAT Audit has been recommended by the CDC to be introduced as an observational tool to capture workplace culture and support practice development initiatives. It will be introduced by 31/07/2024.
• Residents meeting with DON scheduled for 11th June 2024 where resident's preferences will be discussed regarding social activities for afternoons.
• Satisfaction surveys will be distributed to each resident in June 2024 and the results of same will be discussed at the residents meeting mid July 2024.

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	30/06/2024
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	30/08/2024
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	30/06/2024
Regulation 23(a)	The registered	Not Compliant	Orange	30/09/2024

	provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.			
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	30/09/2024
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.	Substantially Compliant	Yellow	31/05/2024
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and	Substantially Compliant	Yellow	14/06/2024

	suitable bedding and furnishings.			
Regulation 34(2)(c)	The registered provider shall ensure that the complaints procedure provides for the provision of a written response informing the complainant whether or not their complaint has been upheld, the reasons for that decision, any improvements recommended and details of the review process.	Substantially Compliant	Yellow	30/09/2024
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Substantially Compliant	Yellow	30/06/2024
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Not Compliant	Orange	30/06/2024

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.	Not Compliant	Orange	30/06/2024
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	30/06/2024
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of	Not Compliant	Orange	31/12/2024

	Health from time to time.			
Regulation 9(1)	The registered provider shall carry on the business of the designated centre concerned so as to have regard for the sex, religious persuasion, racial origin, cultural and linguistic background and ability of each resident.	Not Compliant	Orange	30/06/2024