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:	Hillview Private Nursing & Retirement Residence
Name of provider:	Hillview Private Nursing & Retirement Residence Partnership
Address of centre:	Rathfeigh, Tara, Meath
Type of inspection:	Unannounced
Date of inspection:	22 April 2024
Centre ID:	OSV-0000141
Fieldwork ID:	MON-0043425

About the designated centre

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

The designated centre provides care for both women and men over the age of 18 from low to maximum dependency needs. It can provide twenty four hour nursing care to meet a range of care needs including for residents with intellectual and physical disability, dementia, acquired brain injury, convalescence, palliative, long term care and short term stay. The centre is located in a rural area. The centre is all located on one floor with an additional activity area located in a basement area accessed by residents via the garden. Accommodation is provided in 25 single bedrooms some of which have en-suite facilities. The aim of the centre is to provide a wide range of nursing and care services to meet the individual needs of residents while actively encouraging residents to fulfil their own potential.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	17

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Monday 22 April 2024	09:00hrs to 16:10hrs	Sinead Lynch	Lead
Monday 22 April 2024	09:00hrs to 16:10hrs	Frank Barrett	Support
Monday 22 April 2024	09:00hrs to 16:10hrs	Manuela Cristea	Support

What residents told us and what inspectors observed

Residents that the inspectors spoke with said they were both happy and comfortable living in the designated centre. Residents appeared well-presented and comfortable in their surroundings. On the day of the inspection many residents were observed partaking in activities while other residents remained in their bedrooms as was their choice. Residents appeared to have a good relationship with staff and staff appeared well aware of residents' likes and dislikes.

Hillview Private Nursing Home and Retirement Residence is a single storey building with 25 single bedrooms. Residents' bedrooms were found to have personal items on display and some residents who spoke with the inspector said they were invited to bring in personal items from home if they wished. Each bedroom had a lockable locker and a wardrobe for their personal belongings.

There were two dining rooms available for residents' use. One dining room led out to an open courtyard that was not secured with any gates. Residents could access a more secure garden from the other side of the centre. Following the previous inspection in February 2024 the provider had given assurances that the communal area for residents activities 'Teach Brid' would return to its intended purpose. On the day of the inspection this communal area had been de-cluttered but was not yet deep cleaned or ready for residents' use. One room in this area designated as a Relaxation room was filled with storage boxes, and the treatment room in the designated centre was contained hair-drying and hairdressing equipment despite commitments given by the provider in the compliance plan from the previous inspection that this room would return to its designated purpose. The person in charge also confirmed that the treatment room was still being used by the hairdresser.

Residents were provided with the opportunity to attend Mass regularly in the centre. There was also a small oratory in the centre should residents wish to avail of this space.

The centre was observed to be largely clean in many areas but the staff showering facilities was found to be unclean and infested with insects; assurances were received following the inspection that this had been promptly addressed. Storage practices continued to be an issue. Inspectors observed hazardous storage practices in the maintenance shed, where oxygen, chemicals, paint and equipment using gasoline and a petrol generator were stored all in one area. This area did not have any fire detection and was not linked with the nursing home. In addition, inspectors observed numerous boxes of continence wear on the floor in this shed.

The next two sections of the report will present the findings of this inspection in relation to the governance and management arrangements in place, and how these arrangements impact on the quality and safety of the service being provided.

Capacity and capability

This unannounced risk 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) Regulation 2013 (as amended)
- follow up on the actions taken by the provider to address significant issues of non-compliance identified during the inspection of the centre in February 2024.
- follow up on solicited and unsolicited information of concern received by the Chief Inspector since the last inspection.

Overall, the findings of this inspection showed a further decline in regulatory compliance and raised concerns about the governance and management arrangements in the centre and the provider's capacity and capability to provide and ensure a safe and high quality service for the residents at all times. While some improvements were identified in respect of the statement of purpose and premises, these were not sufficient to ensure regulatory compliance. Other actions that the provider had committed to implementing following the inspection in February 2024 had not been completed and there were repeated findings of non-compliance in respect of Regulation 17: Premises, Regulation 23: Governance and management and Regulation 31: Notification of incidents. An urgent compliance plan was issued to the provider following this inspection and the response received did not provide the required assurances that regulatory compliance will be achieved.

The registered provider is Hillview Private Nursing & Retirement Residence Partnership. There was a team of nurses and healthcare assistants working in the centre on the day of the inspection that knew their residents well. They were very knowledgeable about their residents' needs and preferences. The organisational structure of the centre has the proposed person in charge and an assistant director of nursing in place to manage and support the centre.

The system in place to manage risk was not effective. The provider's response to identified hazards lacked leadership and foresight. The centre's risk management policy detailed the interventions that should be in place for the oversight of risk in relation to absconsion of a resident. However, this policy was not utilised by management and staff and the interventions were not in place on the day of the inspection. A recent incident where a resident had absconded from the designated centre was not appropriately managed, reported or investigated. While some safeguarding measures had been introduced to prevent a recurrence and to minimise the risk, there was no cohesive approach to risk management informed by a critical incident review and learning from incidents. The person in charge informed the inspectors that there were future plans to fence off the garden for safety reasons, and records of management meetings showed plans to create a safe outside space within one year. An urgent compliance plan was issued in this respect

and the provider's response did not provide assurance that a robust investigation had been carried out.

Records such as the directory of residents was in place in the centre. However, not all records requested on the day were made available to inspectors. Inspectors were informed that a requested staff file was not held in the designated centre and was not made available following the inspection despite a commitment to do so. This is not in line with the requirements of Regulation 21: Records.

The inspectors reviewed nursing care notes and incident reports and found evidence that there had been two recent episodes where a resident had absconded from the designated centre. This information was known to the registered provider as evidenced by minutes of management meetings. Only one incident report had been completed, which did not account fully for the details of absconsion, and the information contained in this report was not in line with information included in the nursing notes. The person in charge stated that there had only ever been one incident and the resident had not left the grounds of the designated centre, however no thorough investigation had been completed to inform such an assessment. The information provided by the person in charge was not in line with information documented in management team meeting records, residents' care notes and unsolicited information received by the Chief Inspector before the inspection. Inspectors requested the provider to complete an investigation and submit it following the inspection, and this was not received.

Policies, procedures and guidelines were in place. They were easy-to-read and understand so that they could be readily adopted and implemented by staff. However inspectors found that not all policies were implemented in practice.

There was a complaints policy and procedure in place in the centre. There were inconsistencies between the complaints procedure displayed in the centre and the local policy, which was shown to the person in charge, who corrected this on the day. The complaints register was viewed by the inspectors. There were no open complaints on the day of inspection. The procedure was displayed in the reception area.

Inspectors reviewed management systems in place to protect residents from the risk of fire. The centre was equipped with a fire detection and alarm system, which was labelled as a "category L1" system which should provide assurance that fire detection was present in all areas used by residents and in all rooms which open onto the escape routes, however, inspectors noted that fire detection was not in all areas as required by the category of alarm. Significant fire risks were identified by inspectors in some areas of the centre, and these risks gave rise to an Urgent Compliance Plan which was partly issued in respect of fire safety. This action plan required assurance that urgent action would be taken on to reduce the level of risk of fire associated with:

- a maintenance shed adjacent to the centre. This shed was full of flammable items including petrol equipment, combustible items such as timber, paper

products etc, and also contained an electrical distribution sub-board which inspectors could not be assured was appropriately fitted to the wall.
- Oxygen cylinders were stored in a non fire rated cupboard on the escape route. The cylinders were not protected from collision within the space and presented a risk to the escape route, and horizontal evacuation
- No fire detection was present in a hot-press which contained a gas boiler, electrical equipment associated with the water supply, and clothing.

The response from the provider to these issues did not provide assurances that the risk had been sufficiently mitigated.

Further fire safety concerns are detailed in Regulation 23: Governance and Management, and Regulation 28: Fire precautions.

Regulation 19: Directory of residents

The directory of residents contained all the information specified in paragraph 3 of Schedule 3 of the regulations.

Judgment: Compliant

Regulation 21: Records

The registered provider did not ensure that the records set out in Schedule 2 are kept in the designated centre and are available for inspection. These records were not kept in an accessible manner. For example, one staff file could not be accessed on the day of inspection and was not provided following the inspection despite a commitment to do so.

The record of a worked roster shown to inspectors was not accurate. The record did not account for the presence of the person in charge in the centre at a time inspectors were told she was there.

Judgment: Substantially compliant

Regulation 23: Governance and management

The inspectors found that management and quality assurance systems that would ensure that the service delivered to residents was safe and effectively monitored were inadequate in a number of areas and were not effective in maintaining compliance with the Health Act 2007 (Care and Welfare of Residents in Designated

Centres for Older People) Regulations 2013. Significant risks and most of the inspectors' findings on this inspection were not identified by the provider through their own oversight and auditing processes. This was evidenced by;

- There was insufficient oversight of the use of premises and inadequate internal communication systems to ensure that the registered premises and facilities were used in line with the statement of purpose as further outlined under Regulation 17. The person in charge was not aware of commitments given by the provider that hairdressing activities will not be carried out in the treatment room, which was designated for clinical purposes. This was a repeated finding.
- Nursing records detailed specific incidents in respect of events involving residents in the designated centre. The inspectors reviewed such records and found that episodes of absconsion had been recorded but had not been recognised as such, not investigated and not notified to the Chief Inspector of Social Services. The failure to notify is a repeated non-compliance.
- Environmental and infection prevention and control audits were carried out at regular intervals, however they did not identify areas for improvement to meaningfully inform oversight and provide a safe environment. For example; the staff showering facilities had an infestation of insects on the day that had not been reported to or identified by the provider.
- The arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents were not adequate and the systems in place for the management and oversight of risk were insufficient to ensure residents were effectively safeguarded at all times. There was no evidence to demonstrate effective oversight, including a comprehensive overview of incidents and robust analysis and review to ensure controls in place were effective. For example a critical incident involving a resident which occurred on 28 February 2024 had not been reported and appropriately investigated by the person in charge, which meant that learning was not identified, it did not inform changes to practices and appropriate safeguards were not put in place at the time. A follow up incident of similar nature occurred on 3 March 2024, which the provider also failed to appropriately investigate. The incident reporting policy and the missing persons policy and procedure was not implemented in practice. For example, the procedure stated that the GP should review the resident following an incident of absconsion and this had not taken place in any of the two incidents identified.The registered provider was requested to submit the investigation of these incidents as part of the urgent compliance request, the provider's response did not provide assurance of regulatory compliance.
- There was a lack of assurance in respect of the management and oversight of care records to inform and support the provision of care. There were unexplained gaps in records of safety checks carried out for residents at risk of absconsion. In addition, the records were ineffective as they did not account for where the resident was last seen and at what time. This meant that in the event of absconsion those records were not effective at supporting the search for a resident or a review of the incident.
- The oversight and management of fire safety required improvement at the centre. A range of fire safety concerns highlighted on inspection resulted in

an Urgent Compliance plan being issued to the provider. The providers response did not provide the assurance required that the risk to residents had been reduced to an acceptable level. While it was acknowledged that some of the items identified required works to be completed which may not be completed quickly, no appropriate mitigating measures were being taken to mitigate the risk in the interim. For example, the storage of petrol equipment continued at the centre after the inspection while the provider sourced a suitable storage space. This meant that the risk of fire associated with these items was still present, without a date for which they would be made safe.

- Information in respect of the organisational structure of the designated centre submitted to the Chief Inspector at previous registrations did not align with the information provided at this time for the proposed person in charge and their previous management experience in the centre.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose in place had been reviewed in the past year, however further action was required to ensure it met the regulatory requirements. For example;

- the complaints procedure did not identify a review officer
- the statement of purpose did not include the services to be provided by the registered provider to meet the needs of the residents
- there were some discrepancies in the measurements and description of facilities and floor plans.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The Chief Inspector of Social Services had not been notified of two episodes of unexplained absence of a resident from the designated centre. This was a repeated failure of the person in charge to ensure all notifiable incidents were reported to the Chief Inspector within three working days.

The inspectors requested that these notifications were submitted retrospectively, and same was received.

Judgment: Not compliant

Regulation 34: Complaints procedure

There was a complaints procedure in place which met the requirements of the regulations. A review of the records found that no complaints had been received in the last 12 months.

Judgment: Compliant

Regulation 4: Written policies and procedures

While, the registered provider had prepared in writing the policies and procedures as set out in Schedule 5 of the regulations, inspectors found that these were not always implemented in practice. For example, the management of incidents and risk as discussed throughout the report and further detailed under Regulation 23: Governance and management.

Judgment: Substantially compliant

Quality and safety

Overall, the inspection found significant concerns in respect of the ability of the registered provider to oversee and provide a safe and quality service for the residents living in the centre. Significant risks in relation to fire safety and the management of risk were identified on this inspection and there were repeated findings in relation to the premises. An urgent compliance plan was issued to the provider following the inspection to mitigate the levels of risk identified in respect of fire safety and the response to incidents. The provider's response did not provide assurance that these identified risks had been appropriately addressed.

Improvement was required in the upkeep of the facilities and premises. Inspectors noted issues relating to the maintenance and upkeep of the premises which ranged from storage concerns, to the maintenance of surfaces and fittings in the centre. Inspectors observed a large amount of insects which were present in the shower tray of a staff shower area. This infestation appeared to be confined to the shower within this room, however, this area of the centre was not far from residents bedrooms, and corridors used by residents. Security concerns were also identified whereby it was possible to push open an exit door that was supposed to be locked and to require a pin code to open. These issues are discussed further under Regulation 17: Premises.

Inspectors reviewed arrangements in place at the centre to protect residents from the risk of fire. All bedroom accommodation is on the ground floor of the centre, with alternative means of escape available to each area. Escape routes were noted to be kept clear, however, a hoist was stored on an evacuation corridor in the Teach Brid section. Fire drills were being conducted at the centre however, on reviewing these records, inspectors noted that there were likely scenarios which were not being trialled, and areas of particular risk, such as the evacuation of the largest compartment area, were not evidenced as being trialled by staff. Containment issues were noted within the centre with service penetrations through compartment ceilings which were not appropriately fire sealed. Containment issues were also noted with fire doors throughout the centre. Inspectors could not be assured of the fire containment ability of any of the doors in the Teach Brid section, and there were inconsistencies with fire doors to bedrooms and compartment lines throughout. These and other fire safety concerns are discussed in more detail under Regulation 28: Fire precautions.

There was a risk management policy in place which had been reviewed and updated as required. While it included the procedure in place for the management of risk of absconsion, the inspectors found that management and staff had not adhered to the procedure.

There was evidence of person-centred care being provided to the residents. Inspectors saw that staff had a good understanding of the residents, their needs, and preferences, and this knowledge was reflected in the residents' care plans. Care plans were comprehensive and they detailed how a staff member could best cater to the resident's unique needs, including communication needs of residents.

Behavioural support care plans were developed for residents, and these detailed the triggers of behaviours and contained de-escalation strategies to guide staff when supporting residents. There was no resident in the centre on the day who was in receipt of end-of-life care. The inspectors reviewed care plans for residents who had recently died, and found that they included residents' expressed wishes. Residents were supported by the staff and the resident's general practitioner (GP) to make informed decisions about the end-of-life process and residents' involvement was evident throughout.

Regulation 10: Communication difficulties

Care plans for residents experiencing communication difficulties described their communication challenges and needs. The care plans outlined in detail the techniques and approaches to be used by staff members to help residents express their emotions and words to enable them to communicate freely.

Judgment: Compliant

Regulation 13: End of life

Where a resident was approaching end of their life, there were appropriate measures in place to ensure the residents religious and cultural needs could be met. Where the resident indicated their preference as to the location this was respected and full-filled.

Judgment: Compliant

Regulation 17: Premises

Improvement was required to ensure that the premises of the designated centre were appropriate to the number and needs of the residents and in accordance with the statement of purpose prepared under Regulation 3:

- The Teach Brid facility which was purposed to be used as communal space for activities had been mostly cleared of the items stored there on the previous inspection. One room, registered as a Relaxation Room, continued to be filled with boxes and used as storage space. Notwithstanding the de-cluttering of this space, the whole Teach Brid facility required a deep clean as residents could not avail of it in its current condition.
- A maintenance and equipment storage space was also used to store clinical materials for use in the centre for example, incontinence wear, toilet tissue etc.
- The treatment room continued to be inappropriately used as a hairdressing facility despite previous commitments given by the provider that this room would revert to its original designated purpose.

The registered provider, having regard to the needs of the residents of the designated centre, had not ensured that the premises conformed to all the matters as set out in Schedule 6. For example:

- The provider had not ensured that there was suitable storage in the centre
    - A building separate but near the centre was used to store a range of items varying from petrol saws and lawnmowers, to paints, to clinical materials and paper products. There was no suitable arrangement of the items, which could impact on stock control and cleaning. There was no available heating in this space to prevent possible mould development.
    - A hot-press was used to store clothing materials and towels. This area also housed a gas boiler, and was not suitable for the storage of these items as discussed under Regulation 28: Fire precautions.
- Inspectors noted some damage to walls and ceilings in the centre, for example, a sluice room ceiling was in poor condition. There were cracks and damage from a previous leak which had not been repaired.

- Garden furniture in place in the large garden to the side and rear of the centre was in poor condition. The seating was not fully intact with parts of the timber rotting. The table surface was also not secured to the frame. This furniture would not have been safe to use by residents or visitors at the centre.
- The security of the centre was noted as being in need of review. There was an exit door was fitted with a "Magnetic lock" and staff claimed that the door could not be opened without the use of a key code or fob. This was not the case, as the door easily opened without the use of the code/fob. This could impact on the safety of the residents, and added an absconsion risk.
- Doors to ancillary rooms such as treatment rooms, sluice rooms meeting rooms etc had no signage to inform visitors and residents.

Judgment: Not compliant

Regulation 27: Infection control

The environment was not managed in a way that minimised the risk of transmitting a healthcare-associated infection in line with *National Standards for infection prevention and control in community services* (2018).This was evidenced by:

Areas within the centre were visibly unclean and required deep cleaning. For example:

- Inspectors noted an infestation of small insects in a staff shower area. It was not clear how these creatures had gotten into the area, however, this issue formed part of an Urgent Compliance plan issued to the provider in the days following inspection. The response from the provider to this item did give assurance that this was being investigated and addressed.
- The communal activities area required a deep clean as surfaces were visibly not clean.

In addition the hand wash sinks in the designated centre were not of the standard specifications, especially in the sluice facility and treatment room.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Fire safety concerns noted during this inspection presented a significant risk to residents. An urgent compliance plan was issued to the provider to address some of the high risk items as mentioned under Regulation 23, however, provider's response

did not provide adequate assurances that the risk was reduced appropriately. Due to the totality of the risks identified on this inspection, the provider committed to obtaining a competent person to carry out a fire safety risk assessment of the centre in order to categorise and identify the risks present.

The registered provider did not take adequate precautions against the risk of fire and did not provide suitable fire fighting equipment, for example:

- Storage within the maintenance and equipment shed presented a significant risk of fire. Petrol equipment, paints, paper products and tools were stored together in an room which also contained an electrical sub-mains board. The electrical board itself did not appear to be securely fitted, and was completely obstructed by maintenance materials. This shed was beside the centre, and was along the dedicated escape route from the lower ground floor level. Fire fighting equipment was seen in this area, however, it was not the correct type of extinguisher for the range of fire types that could have occurred.
- Two large cylinders and two small cylinders of oxygen were stored in a cupboard near the nurses station, located in an escape corridor.
- A hot-press near the main entrance presented a risk of fire, as it was also a boiler room. There were cloths and towels stored on timber shelving in the room. There were also electrical pumps, switches, wiring associated with the water system and boiler within this room. There was a fire extinguisher in this room, however, its location was not clearly identified, and it was partially obstructed by storage of clothing in the room.

The registered provider did not provide adequate means of escape, including emergency lighting, for example:

- There were deficits in the emergency lighting system in place at the centre:
    - There was no emergency lighting in place outside the side and rear fire exit doors from the main dining room.
    - No emergency lighting outside fire exit door towards the smoking area. There was another light in this area which was identified by staff as possibly being an emergency light, however, the bulb had been removed from this light.
    - There was no emergency lighting directional signage in place in the staff area corridor, on the corridor on exiting the chapel, a section of corridor at room 9 and 10, and at room 13-14.
- Gates were placed on external escape routes. While these gates were not locked, they presented an additional constraint on the evacuation route, and were not in areas which were covered by emergency lighting. This could pose difficulty or delays if evacuation was required at times of darkness.

The registered provider did not ensure, by means of fire safety management and fire drills at suitable intervals, that persons working in the centre and, in so far as is reasonably practicable, residents are aware of the procedure to be followed in the case of a fire. For example:

- There was no evidence available that staff had trialled through fire drills, the evacuation of residents by compartment. The evacuation procedure clearly identified in policy, practice and understanding of management and staff at the centre, was progressive horizontal evacuation. There was no evidence that this was being trialled at the centre. Records available indicated that single bedroom evacuation only had been practiced.
- Fire drills were not adequate to assure inspectors that residents would be evacuated safely in a timely manner. No evidence of a practice of evacuation to the external assembly point was available.
- Fire drills did not record the time taken to evacuate the largest compartment under periods of low staffing numbers. This meant the inspectors could not be assured that staff had practised an evacuation of all areas under low staffing numbers, for example, at night.
- There were no layout maps available to assist in the guidance of an evacuation on the walls of the centre. The fire safety policy at the centre referred to layout maps and to floor plans attached to an appendix within the policy. On review, these items were not in place.

The registered provider did not make adequate arrangements for detecting or containing fires. For example:

- While the centre was equipped with a serviced "category L1" fire detection and alarm system, fire detectors were not in place in some areas of the centre as required for this classification of system.
- The fire alarm system at the centre was an addressable zoned system, however, it would not identify the exact location of a fire, as it did not have a display with that functionality. This meant that only the zone in which the fire had occurred would be identified. This could cause delays to the evacuation of residents in the event of a fire, and this issue had not been identified in fire safety practice at the centre.
- Service penetrations were noted in some areas of the centre which were not sealed. This presented a route for smoke fire and fumes to travel through compartment lines for example, through the ceiling in the hot-press.
- Inspectors could not be assured of effective compartmentation within the centre for the following reasons
    - There was no evidence available to indicate that fire protection measures were in place along compartment lines in the attic above bedrooms
    - Service penetrations were noted in some areas of the centre which were not sealed and non fire-rated attic hatches were noted on corridors.
    - Compartment doors in the centre were in place to sub-divide the corridors were ineffective as they were rebated and had no smoke or fire seals along the joining edges, did not have appropriate number or type of hinges to indicate the fire rating, and there was no device present to ensure that they closed in the correct sequence
    - Bedroom doors in many areas of the centre did not have fire rated ironmongery including hinges and handles. Some of these doors were not fitted with the appropriate number of hinges to indicate a level of

fire rating which would provide appropriate protection to the escape route for residents. Some hinges and smoke seals were also painted over which may impair their effectiveness.
- Compartmentation of the hot-press which included a gas boiler was not effective. The door to this room did not appear to be a fire door and there was large gapping around the perimeter
- A storage cupboard which stored medical devices, and oxygen cylinders was not a fire rated cupboard
- A door to the kitchen, which is a high fire risk area, was open using a door stop wedge.

Judgment: Not compliant

Regulation 7: Managing behaviour that is challenging

Residents' care plans relating to responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment) were reflective of residents' needs and triggers and provided clear guidance for staff to assist residents with their care needs.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 13: End of life	Compliant
Regulation 17: Premises	Not compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 7: Managing behaviour that is challenging	Compliant

Compliance Plan for Hillview Private Nursing & Retirement Residence OSV-0000141

Inspection ID: MON-0043425

Date of inspection: 22/04/2024

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 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: We hereby confirm that all electronic files contain the same original information as their hard copy counterparts, moreover the hardcopy counterparts originate from the electronic copies. These electronic records are maintained with the same level of accuracy, integrity and security . We shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector and Records specified shall be kept in such manner as to be safe and accessible.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The Provider accepts responsibility for not communicating this to the PIC who now has complete details. The PIC confirmed on the day of inspection that no hairdressing had taken place in this room in the intervening period of inspections, the hairdresser visits the home on an 8-to-12-week schedule and had not been present between HIQA's two inspection periods. The PIC confirmed that the press in this room was used for storage of hair care products which is brought to the individual residents' rooms for use i.e. hairdryer/curling tongs. The large hair apparatus was stored unused in this room while awaiting a change of use request in accordance with regulation. Our records were correct our notification process was not. These incidents related to one resident and on one occasion this resident had not left the grounds; in this context we have designated one additional staff member to the care of this resident from evening	

till bedtime.

We have introduced a more comprehensive risk assessment protocol to identify residents at higher risk of absconding, this includes regular assessments and updating care plans. We have increased monitoring and have installed additional monitoring systems, including full maintenance of all wander alarms and alarmed exits, to ensure prompt detection of any attempts to leave the facility unsupervised.

Our staff undergo regular and thorough training on recognizing early signs of absconding behaviour and on the specific protocols to follow if a resident is missing. This training is refreshed quarterly and is incorporated into every staff meeting and the Pic keeps abreast of all new formal training available. Training also includes specific characteristics for specific residents . We have ensured additional supervision at established high risk times and environmental modifications.

We have upgraded Reporting Procedures and Immediate Incident Reporting: All absconding incidents are reported immediately to PIC /senior management and recorded in our incident management system. This ensures prompt investigation and action. We have improved our incident report forms to capture comprehensive details about the incident, including time, location, circumstances, and actions taken. This helps in analysing patterns and preventing future occurrences. Clear communication protocols are in place to inform family members immediately after an absconding incident. Regular updates are provided until the situation is resolved.

Our post-Incident review will ensure each incident is followed by a thorough review to identify any procedural gaps or areas for improvement. Lessons learned will be incorporated into staff training and procedural updates. Our reporting procedures are compliant with HIQA regulations and guidelines. We will ensure that all incidents are reported to HIQA as required and that our records are maintained accurately and are available for inspection. We have established a feedback mechanism for staff to provide input on our absconding and reporting procedures. This helps us continuously improve our processes. We are committed to maintaining the highest standards of care and safety for our residents and to ensuring full transparency and accountability in our operations and to this point we completed the requested retrospective reports.

It is important to note that on the day of the inspection the PIC provided the Absconding profile in place for all residents to the Inspector and agreed it met with requisite standards, the inspector requested additional information to be included in the Observation Chart which we have now included in same.
The missing person profile is used in the event of an incident. The PIC and inspector agreed that the fixed description of the resident i.e. physical attributes should not be included on a daily observation chart and agreed upon changes, such as daily attire and last location has now been included on the observation chart

Infestation is defined as the presence of an unusually large number of insects in a place typically so as to cause damage or disease. The issue observed was a seasonal occurrence of small flies confined to the contained staff shower unit. This has been rectified. On 23 April 2024, our pest control contractors examined and advised that the situation was temporary and manageable with standard preventative measures which we

immediately implemented. Pest Control contractors were informed as above and the next day rectified this and installed a new Fly Unit. This was an isolated incident and our contractor perform quarterly audits of all pest control items and we have included this item in our monthly management audits.

We have together with the external Fire Safety Engineer identified and incorporated the following: A certified Electrician will inspect all electrical installations, inspect and secure the electrical distribution box and service all appliances to ensure safe working order, these works are due to commence on 15th July 2024. The electrician will also inspect and secure all associated electrical and mechanical devices to run the boiler and water system within the enclosure.

We have employed the services of a competent Fire Alarm and Detection System contractor to ensure the garage and hot press are compliant with Irish Standard3218:2013+2019 or similar standard if applicable at time of building construction or when any material changes to the building have been made.

All class A combustibles such as incontinence wear in the garage have been taken off the floor and stored appropriately. We have relocated all petrol/ flammable equipment to an outdoor area currently and have ordered a 12ft by 11ft large metal storage container which we expect delivery by June 17th 2024.Oxygen Storage, we have relocated the Oxygen cylinders to a more appropriate area out doors and are awaiting delivery of a large zinc square basket to house these items, we will ensure the area is well ventilated and signage is in place. We will ensure that all corridors and stairways are kept clear of obstructions checked and recorded in the fire safety register.

Hillview confirmed in writing to HIQA in February, March 2024 that our PIC has the requisite experience to act in this role and we refer to the HIQA inspection report of May 24, 2012, page 4 confirming the appointment of a Clinical Nurse Manager. Our current PIC was the then appointed CNM in May 2012 . HIQA are in receipt of all requisite records in this matter.

The compliance plan response from the registered provider does not adequately assure the chief inspector that the action will result in compliance with the regulations.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
The complaints procedure will identify a review officer 28 June 2024.
We are currently reviewing the section of the SOP which refers to the services provided

by the registered provider to meet the needs of the residents and will amend the SOP to reflect same by 28 June 2024.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
For the purposes of Regulation 31 we introduced a more comprehensive risk assessment protocol to identify residents at higher risk of absconding. This includes regular assessments and updating care plans and increased monitoring:

Additional monitoring systems have been installed , including new wander alarms and alarmed exits, to ensure prompt detection of any attempts to leave the facility unsupervised .

Our staff undergo regular and thorough training on recognizing early signs of absconding behaviour and on the specific protocols to follow if a resident is missing. This training is refreshed quarterly and is incorporated into each staff meeting and the PIC keeps abreast of new formal training available.

All absconding incidents are reported immediately to PIC /senior management and recorded in our incident management system This ensures prompt investigation and action. We have augmented our incident report forms to capture comprehensive details about the incident, including time, location, circumstances, and actions taken. This helps in analysing patterns and preventing future occurrences. Clear communication protocols are in place to inform family members immediately after an absconding incident and regular updates are provided until the situation is resolved.

Our Post-Incident Review means each incident is followed by a thorough review to identify any procedural gaps or areas for improvement. Lessons learned are incorporated into staff training and procedural updates. Our reporting procedures are compliant with HIQA regulations and guidelines. We will ensure that all incidents are reported to HIQA as required and that our records are maintained accurately and are available for inspection.

We established a feedback mechanism for staff to provide input on our absconding and reporting procedures. This helps us continuously improve our processes. We are committed to maintaining the highest standards of care and safety for our residents and to ensuring full transparency and accountability in our operations and to this point we completed the requested retrospective reports.

In complying with Regulation 31 , the identification, recording, investigation and learning from serious incidents involving residents have been examined and upgraded

to include additional supervision and environmental modifications. The original incident audit which is undertaken monthly has also been modified and upgraded, it now separated into two sections to reflect an immediate critical incident review and a standard audit .We have introduced a more comprehensive risk assessment protocol to identify residents at higher risk of absconding.

During the inspection the PIC provided the Absconding profile in place for all residents to the Inspector and it was agreed that it met requisite standards and the inspector requested additional information to be included in the Observation Chart which we have now done and the wording as required, has been included in the absconsion profile regarding the contacting of a GP after an incident specifically meaning we will inform G. P. and arrange a medical review if required.

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
We have augmented and reinforced the management of incidents and risk as discussed in the report and detailed under Regulation 23: Governance and management.

We are currently reviewing the points identified by HIQA in our policies and procedures we have addressed the incidents policy and reporting in compliance with Regulation 4 and have addressed the items addressed under Regulation 23 Governance and management in this report and further revisions/updates will be included by 28 June 2024.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
We confirm that the necessary actions have been taken to ensure compliance with Regulation 17, more specifically we have implemented the following measures to meet the standards set forth in Regulation 17 which will be maintained going forward to ensure on-going compliance with Regulation 17.

The Teach Brid facility has been deep cleaned.
Combustible items have been removed from the garage.
The garage is designated for certain storage which does not require additional heating.
We have relocated the items in the hot-press .

The sluice room is currently being repainted and this will be completed by 21 June 2024. We have assessed the condition of the garden furniture and resecured the corner of one table identified by the fire inspector. Other items have been removed and are being replaced accordingly.
The exit door fitted with a Magnetic is an ACTS digital keypad and magnetic lock point has been serviced by our security provider on April 24, 2024, and is in full working order. Doors to ancillary rooms such as treatment rooms, sluice rooms meeting rooms now have requisite signage to inform visitors and residents.

The compliance plan response from the registered provider does not adequately assure the chief inspector that the action will result in compliance with the regulations.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
The issue observed was a seasonal occurrence of small flies confined to the contained staff shower unit. This has been rectified. On 23 April 2024, our pest control contractors examined and advised that the situation was temporary and manageable with standard preventative measures which we immediately implemented. We have also enhanced our monitoring and maintenance protocols to prevent future occurrences. Noting the cleaning staff clean the Staff shower room daily and always after the residents' areas are attended to first as per protocol.

Regarding the hand sinks installed in 2019 as part of a complete re-design of the sluice room, the supplier prior to installation confirmed to us that these sinks complied with correct size criteria, and we have requested written confirmation of same and will forward in due course otherwise we will replace by September 1, 2024.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
We have retained a competent person to carry out a fire safety risk assessment of the centre in order to categorise, identify and remediate the risks present ,July 30, 2024. This was the first inaugural inspection that we underwent
We are currently finalizing a detailed schedule that outlines specific timelines for each required fire safety work. This schedule will ensure that all necessary actions are

completed within a realistic and efficient timeframe. We will share this schedule with you by 30 July 2024.
Together with the Competent Fire expert the adequate precautions against the risk of fire will be implemented in full by 30 September 2024 .

Horizontal Evacuations
We understand the importance of conducting fire drills that incorporate horizontal evacuations. We are revising our fire drill procedures to include these scenarios and will conduct our first updated drill by 6 August 2024. We will document and review the outcomes to ensure continuous improvement.

Containment Issues
We are addressing the containment issues, including service penetrations and the integrity of fire doors. A thorough inspection is scheduled for July 2024 , followed by immediate rectification of any identified deficiencies. This will ensure compliance with fire safety standards and enhance overall building safety.
Fire Risk Assessment
Our fire risk assessment is currently in progress and will be completed by 30th July 2024 and this assessment covers all aspects of fire safety, including evacuation procedures, containment measures, and any additional necessary actions.

We are taking these matters very seriously to ensure the safety and well-being of all residents and staff, the completion of the fire risk assessment is our priority, and we will ensure that all safety measures are thoroughly evaluated and implemented in this process.

Together with the external Fire Safety Engineer we have performed the following to date.

Staff Fire Safety and Evacuation Training was delivered to all staff on May 2, 2024. Fire Alarm maintenance was conducted also, and a copy of each report was issued to HIQA.

The hot-press near the main entrance has been cleared of towels and cloths and storage of clothing does not obstruct the fire extinguisher now.

A certified Electrician will inspect all electrical installations and secure the electrical distribution box in the garage and will service all appliances to ensure safe working order, these works are due to commence on 15th July 2024 .

The electrician will also inspect and secure all associated electrical and mechanical devices and to run the boiler and water system within the Hot-press enclosure, and attic .

We have employed the services of a competent Fire Alarm and Detection System contractor to ensure the garage and hot press comply with Irish Standard3218:2013+2019 or similar standard if applicable at time of building construction or when any material changes to the building have been made.

All class A combustibles in the garage have been relocated. We have relocated all petrol/ flammable equipment to an outdoor area currently and have ordered a 12ft by 11ft large metal storage container which we expect delivery by the end of June 2024 .

Oxygen Storage, we have relocated the Oxygen cylinders to a more appropriate area outdoors and are awaiting delivery of a large zinc square basket to house these items, we will ensure the area is well ventilated and signage is in place.

We ensure that all corridors and stairways are kept clear of obstructions checked and recorded.

We are taking appropriate measures against the risk of fire and the correct firefighting equipment/extinguishers are being researched and purchased, expected time frame is end of July 2024 .

All deficits in the emergency lighting system in place at the centre have been reviewed and upgraded emergency lighting system will be in place by 30 September 2024.

The external safety and security gates are in place to avoid absconsion and all staff are aware of the protocol that these gates are open and remain so in the event of an emergency. We will raise this matter with our Fire expert, and we will follow the advice given on this matter.

There were no layout maps available to assist in the guidance of an evacuation these will be installed by 30th July 2024.

To reiterate a competent Fire Consultant has been arranged to conduct a fire safety risk assessment of the centre in order to categorise, identify and remediate any risks present and identified in accordance with HIQA inspector's findings - noting HIQA's comment that these works may take some time to complete, and we expect them to be complete by 30 September 2024.

The compliance plan response from the registered provider does not adequately assure the chief inspector that the action will result in compliance with the regulations.

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 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.	Not Compliant	Orange	28/06/2024
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.	Not Compliant	Orange	28/06/2024
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a	Substantially Compliant	Yellow	28/06/2024

	designated centre and are available for inspection by the Chief Inspector.			
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Substantially Compliant	Yellow	28/06/2024
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	Red	28/06/2024
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	26/04/2024
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	Not Compliant	Red	30/09/2024

	suitable bedding and furnishings.			
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	30/09/2024
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Orange	02/05/2024
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Red	30/07/2024
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose relating to the designated centre concerned and containing the information set out in Schedule 1.	Substantially Compliant	Yellow	28/06/2024
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs,	Not Compliant	Orange	04/05/2024

	the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.			
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	10/05/2024