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:	Hazel Hall Nursing Home
Name of provider:	Esker Property Holdings Limited
Address of centre:	Prosperous Road, Clane, Kildare
Type of inspection:	Unannounced
Date of inspection:	07 May 2024
Centre ID:	OSV-0000049
Fieldwork ID:	MON-0042236

About the designated centre

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

Hazel Hall Nursing Home can accommodate up to 46 female and male dependent adults, aged over 18. The majority of residents are aged 65 and over, and can provide for the following care needs: General (Care of the Older Person), Dementia, Physical Disability, Intellectual Disability, Acquired Brain Injury and Young Chronic Care. Hazel Hall Nursing Home is purpose built and set in its own secure grounds with car parking facilities and is monitored by CCTV. It contains 44 bedrooms (42 single and two twin rooms). Each room is equipped with Cable TV (Flat Screen) and call bell system.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	42

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
Tuesday 7 May 2024	19:50hrs to 22:05hrs	Aislinn Kenny	Lead
Wednesday 8 May 2024	09:00hrs to 17:40hrs	Aislinn Kenny	Lead
Wednesday 8 May 2024	09:00hrs to 17:40hrs	Helena Budzicz	Support

What residents told us and what inspectors observed

This inspection was conducted over two separate days. The inspectors spent time in the centre to see what life was like for residents living at Hazel Hall Nursing Home. The inspectors observed different experiences in different units between daytime and night. While on the second day of inspection the atmosphere in the centre was calm and relaxed, the evening inspection found that there were insufficient staff available to meet the needs of all the residents. Residents spoken with said 'staff will do anything you ask of them' and another resident told inspectors 'staff are great and the food is lovely'. Inspectors found that staff were working very hard and although the residents were well cared for by staff, significant improvements were required to ensure the safety of the residents and compliance with the regulations which will be discussed further in the report.

The first day of the inspection commenced in the evening at 19:50hrs. The inspector was welcomed to the centre by the staff nurse on duty. The inspector walked around the centre and observed the nightly routine, speaking with staff and residents. The registered provider representative arrived shortly after and provided the inspector with documents for review.

There were 40 residents in the centre on the day of inspection residing in Hazel Hall Nursing Home at the time of inspection, two residents were away. The centre is a single storey building and is divided into three suites Liffey, Moate and Abbey. There is a lounge area, day room, dining rooms, an oratory and internal courtyards available for residents' use. The rear garden at the Liffey suite is decorated with a small cottage, model animals and a vintage car. There was also an internal courtyard with flower beds, trees, bushes and plants, a memory garden for those who have died, ornamental bicycles, seating benches, a fountain, rabbit and guinea pig hutches, a greenhouse for residents to garden and tables and chairs.

On the evening of the inspection the inspector walked around the centre and observed the three suites. The majority of residents in Liffey and Moate were in bed at 8pm. Day staff informed the inspector part of their routine was to assist residents to bed, some residents were in their rooms watching television. Some residents in Abbey suite, which is the dementia unit, were in bed, others were in the communal day room and some residents were walking with purpose around the corridor. Throughout the evening the inspector observed a staff in this unit providing close supervision to a resident walking along the corridor. There were no other staff available in this unit to supervise the remaining 16 residents. The inspector observed instances when this staff member was unable to respond to other residents in a manner that was meaningful, as they were busy attending to the one resident who required increased supervision. The inspector observed how the staff member served the tea in this unit. The resident reached to touch the hot teapot, the staff member left the tea round in order to redirect the resident temporarily while they attended to other residents. As a result the tea was delayed for some residents and the resident was unsupervised for a period of time. The staff nurse

was present in this area at the time, however they were dispensing medications. In the meantime, there was only one other healthcare assistant supervising the remaining two units Moate and Liffey. The inspector also observed periods of time in the Abbey suite where residents were not supervised in the day room due to the lack of available staff. The registered provider was issued with an urgent compliance plan to address staffing arrangements following the inspection and the provider's response did provide adequate assurance this would be addressed. The inspector observed that on the second day of inspection there was a staff member dedicated to providing one-to-one care to a resident in the Abbey unit. These findings are further described under Regulation 15: Staffing.

The inspector walked around all suites and observed that not all residents had appropriate access to call bells, some were placed in their dedicated wall holders away from the residents reach and not accessible, others had no call bell chord attached. This did not ensure that residents could summon assistance if required and that they could exercise choice at all time. The inspector raised this issue with the registered provider and all call bells were reviewed by the registered provider by the second day of inspection.

On the second day of inspection, residents were observed relaxing in the day rooms and in their bedrooms. A breakfast buffet was nicely laid out in the dining area of Liffey and Moate and activities were provided in the lounge and day rooms where residents had gathered to enjoy crafts. A residents' meeting also took place on the second day of inspection. Inspectors walked around the centre with the clinical nurse manager and observed inappropriate storage arrangements in the centre and areas requiring maintenance. Immediate actions were issued on the second day of inspection as inspectors observed electrical items being stored in a high voltage area that was unlocked and a large container of chemicals was stored beside the boiler in the boiler house. These were removed on the day of inspection. Residents' rooms were generally well-maintained and residents spoken with were happy with their rooms. There were areas of the building observed in need of maintenance, in particular areas of the roof and the flooring in some areas. Fire safety risks were also identified and these are discussed further in the report under the relevant regulations.

The following two sections, capacity and capability and quality and safety will outline the quality of the care and services provided for the residents. The areas identified as requiring improvement are discussed in the report under the relevant regulations.

Capacity and capability

The oversight arrangements in the centre were not sufficient to proactively identify, respond to and manage significant issues found in respect of appropriate staffing arrangements, fire safety, notifications of incidents and premises.

This was an unannounced risk inspection carried out over two days. The purpose of the inspection was to assess the provider's level of compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centre for Older People) Regulations 2013 (as amended). In preparing for this inspection, the inspectors reviewed actions from the last inspection, the information provided by the provider and the person in charge and unsolicited information received by the Chief Inspector of Social Services. The inspection found areas of repeated non-compliance with the regulations. In addition, assurances given to the Chief Inspector from the registered provider relating to the compliance plan from the previous inspection on 9 January 2024 had not all been completed. Significant action and enhanced governance and management oversight was now required to provide assurance that a high quality and safe service was provided at all times.

Esker Property Holdings Limited is the registered provider of Hazel Hall Nursing Home. The centre had a full-time person in charge who was supported in their role by a clinical nurse manager, a team of nursing staff, care staff, housekeeping, catering, administrative and maintenance staff. The management team including a company director, facilities and finance manager and floor manager provided support to the person in charge with the day-to-day operations of the centre. The person in charge was not in the centre on the days of inspection however, the clinical nurse manager deputised for them and the registered provider representative was present for both inspection days.

Although this inspection found that there were governance and management structures in place, there was insufficient oversight of service to ensure the effective and safe delivery of care in accordance with the centre's statement of purpose. In addition, there was inadequate supervision of staff practices which resulted in the failure to recognise and report risks associated with premises, fire safety and care planning as evidenced further in this report.

There were management systems in place such as monitoring of staff training and audits in areas such as nutrition, falls analysis and infection prevention and control. However, the audit system was not sufficiently robust or comprehensive, for example; a recent infection prevention and control audit failed to identify any of the findings under Regulation 27: Infection control. There was evidence that a review of care plans had taken place and was ongoing based on the findings of a previous inspection. A finding of the audit was that new staff needed time to get used to the systems used and it required a further review. However, this inspection found assessment and care planning non compliant again as per previous inspection report dated 9 January 2024. This was due to the fact that the person in charge and clinical nurse manager were working as staff nurses instead of providing the appropriate time to audit, which was similar to the findings of the inspection of 13 July 2023. Management meetings took place in the centre, and minutes reviewed showed that staff had raised concerns over the impact of staffing on residents and in particular the availability of nursing staff to residents at night. There was one

registered nurse available at night for the 40 residents living in the centre and this was not sufficient to ensure effective clinical oversight. The registered provider told the inspectors there was a recruitment plan in place and new staff were due to start in the coming weeks. Inspectors were not assured that the provider had the required numbers of staff available with the required skill mix having regard to the size and layout of the centre and the assessed needs of the residents. An urgent action was issued to the provider to address staffing arrangements in the centre. A review of worked rosters over the past three months found that the person in charge had been rostered as a staff nurse for a short period of time to provide direct resident care. The person in charge had worked various night and day shifts over the period of a week in the absence of alternative nursing cover available. This meant the oversight of staff and service could not be maintained during this time. This was a repeat finding from a previous inspection and also impacted on the governance and management arrangements in the centre. In addition, the clinical nurse manager had not been working in a supernumerary capacity as they were covering nursing vacancies also. This is further addressed under Regulation 15: Staffing and Regulation 23: Governance and management.

An annual review of the service had taken place with input from residents and their nominated representatives.

A review of the incident and accident log and complaint log found seven safeguarding incidents that had not been notified to the Chief Inspector of Social Services. This was a repeat finding.

The centre-specific complaints policy was in line with regulatory requirements. Inspectors reviewed a sample of documented complaints which demonstrated that complaints and concerns were promptly investigated. Written responses were completed in line with regulatory requirements.

Regulation 15: Staffing

The registered provider did not 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. This is evidenced by;

- While there were 42 residents admitted to the centre, there were 40 residents present on the day of inspection. After 8pm, the staffing levels decreased to three staff members responsible for the care of the residents spread across three units, one of which was dementia-specific. One of these staff was a registered nurse, and the inspector observed that the evening medication round lasted up to two hours. This level of clinical oversight for such a large number of residents is insufficient. Inspectors observed that staff

located in one unit could not appropriately supervise residents in day rooms and their bedrooms, provide tea to residents and answer call bells.
- A resident, assessed as needing one-to-one supervision was not receiving this as the staff member supervising the unit was also supervising and attending to up to 16 other residents in that unit on that night.
- Notwithstanding the provider's efforts to recruit, there were a number of vacancies that impacted the service and consequently the quality of care provided. For example, the registered provider was required to have 26 whole time equivalent (WTE) healthcare assistants as per their statement of purpose upon which the registration of the designated centre was granted. On the day of inspection there were 18 healthcare assistants employed in the centre. There were also vacancies in the area of activities coordinator which meant that healthcare staff were tasked to provide activities in addition to their role.

Judgment: Not compliant

Regulation 23: Governance and management

The registered provider did not ensure the designated centre had sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.The full-time staffing levels in the statement of purpose did not reflect the staffing levels available in the centre due to staff vacancies, especially in the areas of nursing staff and healthcare assistants. These staff shortages critically impacted the quality and oversight of service and the ability of the registered provider to deliver a service in line with its statement of purpose and condition of registration.

- The person in charge was not engaged in a full-time leadership role to ensure effective governance and management of the service. According to the roster, on the last week in February 2024, the person in charge had worked a variety of day and night shifts over a seven day period to provide nursing cover in the centre and compensate for staff shortages. This is similar to the findings of the inspection of 13 July 2024.
- Staffing resources at night were not appropriate for residents' assessed needs, specifically there was insufficient nursing staff to provide safe effective care for over 40 residents.
- Adequate resources were not put in place when required; For example a resident assessed as needing one-to-one care did not receive this on the evening of inspection

The management systems in place to monitor the quality of the service to ensure the service provided to residents were not fully consistent and appropriately

monitored. For example, some of the systems used to evaluate and improve aspects of the service were not effective. For example:

- A new cooking stove was stored uncovered in the sitting room, which was a space registered for residents' use. This posed a risk of injury to residents, and this risk was not included in the centre's Risk register.
- The day-to-day management of fire risk in the centre did not ensure that risks were identified and managed effectively. These findings are set out under Regulation 28.
- Two pieces of cleaning electrical equipment were observed to be stored in the store room with the high voltage box. This room was also left unlocked. An immediate action was issued on the day of the inspection, and this was rectified immediately.
- Audits of infection prevention and control and the quality of environmental hygiene were not effective in identifying areas of the service that required quality improvement.
- Risks were not effectively recognised and managed in the centre. For example:
- Further oversight was required for the process of reviewing and managing residents' individual care needs, assessments, and care plans. Inspectors were not assured that the management of responsive behaviours was in line with the guidance provided in the centre's policy. This is detailed under Regulation 7: Managing behaviour that is challenging.
- There were recurrent findings from two previous inspections in respect of the failure of the person in charge to appropriately notify the Chief Inspector of significant incidents as required by the regulation, and as further described under Regulation 31: Notification of Incidents.
- The oversight of the medication practices in the centre was not adequate, as discussed under Regulation 29: Medicines and pharmaceutical services.
- Seven safeguarding incidents had occurred in the centre that had not been recognised and appropriately responded to by following the centre's safeguarding policy. This did not provide assurance that the registered provider ensured a safe high quality service was provided at all times for the benefit of the residents.

Judgment: Not compliant

Regulation 31: Notification of incidents

Two complaints related to care and five incidents that met the criteria for notification to the office of the Chief Inspector were not notified within the required timelines. This is a repeat finding from previous inspections. These were submitted retrospectively following inspection, at the request of the inspectors.

Judgment: Not compliant

Regulation 34: Complaints procedure

There was an accessible policy and procedure available in the centre, which incorporated the amendments to Regulation 34 as directed by SI 628 from 2022. The inspectors reviewed the complaints log, and found that all complaints were processed in accordance with the designated centre's policy and procedure.

Judgment: Compliant

Quality and safety

While there were some positive aspects of the service being delivered, arrangements in relation to infection control, fire safety and premises were not adequate. There were repeated non-compliance observed on this inspection also. Gaps in the oversight of clinical practices and weakened governance and management arrangements impacted on residents' quality of care and quality of life.

Residents had access to medical and health care services. Residents were reviewed by their general practitioner (GP) as required or requested. Residents had access to a consultant geriatrician and a psychiatric team, nurse specialists and palliative home care services.

Residents' needs were assessed on admission to the centre through validated assessment tools in conjunction with information gathered from the residents and, where appropriate, their relatives. However, it was noted that not all data was collected on the pre-admission assessments, which is crucial for informing staff about resident's needs and ensure appropriate arrangements are put in place prior to admission Furthermore, the assessments and care plans were not always completed or reviewed within the prescribed time line of the regulation. Further findings are discussed under Regulation 5: Individual assessment and care plan.

The inspector reviewed the care plans for residents who displayed responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). These care plans did not outline personalised strategies and interventions, which are important for guiding staff in appropriate care delivery.There was a safeguarding policy in place. However, the inspectors observed

that not all potential safeguarding incidents were recognised, and actions were not completed according to the centre's policy, which could potentially lead to repeated incidents as outlined under Regulation 8: Protection.

The inspectors reviewed processes and practices around the administration of medicines and medication storage and found that not all practices were in line with professional guidelines, and further improvements were required in this area.

The inspectors observed that there were sufficient resources in place to ensure daily and deep cleaning of residents' rooms and premises could occur. The provider had a number of assurance processes in place in relation to the standard of environmental hygiene. These included cleaning checklists, flat mops and colour-coded cloths to reduce the chance of cross infection. However, inspectors noted that the storage practices were not effective, and some equipment in use was not being cleaned effectively. Further action was required to ensure compliance with the regulation as outlined under Regulation 27: Infection control.

The design and layout of the centre was appropriate for the number and needs of the residents. However, some parts of the centre were in need of repair and action was required to ensure the designated centre conformed to all matters, as set out in Schedule 6 of the regulations.

Inspectors identified concerns regarding the precautions and arrangements in place to ensure against the risk of fire, including containment and detection issues. Some of these issues were repeat findings previously issued in an urgent compliance plan to the provider.

Regulation 17: Premises

Some areas of the premises did not conform to the requirements set out in Schedule 6 of the regulations as follows For example:

There were inappropriate storage arrangements in the centre as evidenced by;

- There was excessive storage of broken and discarded items in an external area to the side of the building which was unsightly as this area was visible to residents when looking out their bedroom window. Inspectors were informed a skip was ordered to collect these items.
- Hoists were observed being stored and charged in registered bedrooms that were not in use at the time of inspection. This practice posed a fire safety risk and required prompt review.

Some areas of the centre required maintenance to be kept in a good state of repair internally and externally, for example;

- Areas of the external roof were patched with wood and paint was seen peeling away

- Floor coverings outside the kitchen and on corridors were damaged and unclean.
- The hand wash sink in the medication room was damaged and coming away from the wall.
- There was damage to the wall in the Personal Protective Equipment (PPE) room with damp observed behind the water pump. This could compromise the PPE stored in that area.

Emergency call bells were not accessible from each residents bed during the evening of inspection.

- Not all residents had appropriate access to emergency call bells as some were placed in their dedicated wall holders away from the resident's reach and not accessible.
- In four residents bedrooms there were no call bell chords available and although staff could reach to use the button on the wall this was not accessible to residents.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

All residents had access to fresh drinking water. A choice was offered at all mealtimes, and inspectors observed that adequate quantities of food and drink were provided. The meals were well-presented and appeared appetising. There were sufficient staffing levels available if residents required any support during meal time.

Judgment: Compliant

Regulation 26: Risk management

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

Judgment: Compliant

Regulation 27: Infection control

The provider did not ensure that infection prevention and control procedures were consistent with the *National Standards for Infection Prevention and Control in Community Services (2018)* published by HIQA. The care environment and equipment were not managed in a way that minimised the risk of transmitting a health care-associated infection. This was evidenced by;

- There were no hand washing sinks available for the staff to wash their hands. Staff informed inspectors that they washed their hands in the sinks available within residents' rooms and communal bathrooms. This practice was not appropriate and increased the risk of cross-contamination.
- The area around the sink in the nurses' treatment room was damaged and coming off the wall, and the trolley used for dressings was very unclean. This increased the risk of cross-infection.
- Three clean basins used for residents' personal hygiene were observed inappropriately stored on the ground in a sluice room, posing a risk of cross-contamination.
- The external store room and the area behind the washing machines and dryer were not cleaned to an appropriate standard. Some of the doors were observed to be stained, and the back splash in the laundry was peeling off. Floor surfaces, such as carpets and marmoleum in some corridors, the hairdressing room, and several residents' bedrooms were very stained.
- There was no specimen fridge allocated for specimens only. The staff informed the inspectors that they were using the medication fridge for this, which posed a health and safety risk.
- Inspectors observed that nasal prong masks and oxygen masks used for oxygen concentrators and nebulisers were unclean and not stored properly. In addition, no glucometers were allocated to the individual residents, which was not in line with best practice. This increases the risk of infection cross contamination.

Judgment: Not compliant

Regulation 28: Fire precautions

The inspectors were not assured that the registered provider had taken all reasonable actions to ensure that residents were appropriately protected from the risk of fire.

- A large oxygen tank was stored in a resident's room despite not being required or in use by the resident
- Oxygen concentrators had no signage to indicate use and alert staff to the fire hazard
- Oxygen was observed to be inappropriately stored in an unsecured manner in a dedicated external storage area. While there was a storage cage in place, only one large oxygen tank was observed to be stored within. There were

eight other small oxygen cylinders and one large oxygen tank observed to be unsecured, piled on top of each other in a haphazard manner.
- The residents' smoking shed was a wooden structure that was damaged, there was no fire extinguisher or call bell in the area and the wooden bench was not flame resistant.

The provider was issued with two immediate actions on the day of inspection:

- A carpet cleaner and vacuum cleaner were being stored in a high voltage area next to electrical panelling which was unlocked. This was removed on the day of inspection and a lock was installed.
- A large container of flammable liquid was being stored in the boiler house. This was removed on the day of inspection.

There was inadequate containment and detection of fire, for example;

- A previous inspection had identified fire compartment doors that required repair or replacement due to not closing properly. This inspection found maintenance to these doors had not been actioned and inspectors again identified fire doors that required repair or replacement due to large gaps, that would not prevent the spread of smoke or fire.
- There were penetrations through ceilings and flooring in the boiler house, generator rooms and storage room. Assurance is required that the penetrations are appropriately sealed.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Medication management practices were not in line with best practices or local policy, which led to unsafe practices. For example:

- Some medications were administered in the covert and crushed format in the absence of a clear direction from the prescriber recorded on the prescription on the electronic medication system used in the centre.
- There was extensive storage of medications in the cupboards, some of which were expired and not returned to the pharmacy. This posed a risk that residents could receive out-of-date medication. The stock of medications for emergency use was not monitored in the Stock register.
- Inspectors observed inappropriate storage of the oral nutritional supplements in one of the dining rooms.
- Inspectors observed that the temperature was not monitored in all rooms where medications were stored.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Based on the sample of care plans viewed, action was required in individual assessment and care plans to ensure the needs of each resident are assessed and an appropriate care plan is prepared to meet these needs. For example:

- A sample of pre-admission assessments reviewed did not all have documented information to support the resident's admission. For example, information sharing consent, medication management needs details, special treatment needs, information for residents requiring special medical reviews, and the details for resident representatives were missing from residents' pre-admission assessments.
- Comprehensive assessments and care plans were not always completed within 48 hours of the resident's admission. For example, when the resident was admitted in February 2024, the dependency assessment, skin integrity assessment, fall risks, and MUST assessment were not completed until April 2024.
- Care plans reviewed for residents with a history of Multi-Drug Resistant Organisms (MDRO) were generic and did not provide specific information about the actual infection or guidance to staff on how to care for residents living with the infection and how to prevent further spread.
- Medication management care plans were not updated for residents with covert medication and crushed medication administration process as advised by the prescriber.
- Safeguarding care plans were not in place or implemented for all residents who were involved in safeguarding incidents.
- As per the centre's policy, the safeguarding care plans were also not implemented at the residents' admission following the pre-admission and post-admission assessments or responsive behavioural incidents for each resident based on their cognitive abilities and challenging behavioural patterns. These residents may be at risk of abuse because of another resident's response to their displayed behaviour.

Judgment: Not compliant

Regulation 6: Health care

Residents had timely access to medical assessments and treatment by their general practitioners (GP). Residents also had access to a range of health and social care professionals, such as dietitians, speech and language therapists, chiropodists, tissue viability services and physiotherapists, as required.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

The centre had a number of incidents of responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment). While there were assessment and analysis tools available to use for managing behaviour that is challenging, such as the ABC (Antecedent, Behavior, and Consequence) assessment and the '7-day behaviour monitoring log' for functional analysis, inspectors saw that these were not always implemented into the practice and used according to the centre's own policy. Furthermore, although some residents had behavioural care plans in place, these were generic and not person-centred. For example, the care plans did not detail the triggers that were observed to lead to these behaviours, types of patterns, and distraction techniques used by the staff members to ensure the safety of residents and staff.

Judgment: Substantially compliant

Regulation 8: Protection

Inspectors were not assured that two complaints in respect of safeguarding allegations and seven safeguarding incidents were recognised and appropriately investigated and that all reasonable measures were implemented to protect all residents from abuse. This risk was compounded by the lack of supervision observed as a result of shortage of staff.

Judgment: Not compliant

Regulation 9: Residents' rights

While there was evidence that residents' rights were generally upheld in the centre, areas for improvement were identified, for example;

- On the first evening of the inspection, the inspector observed more than 10 residents who did not have a call-bell placed nearby in bed or elsewhere to be able to call for assistance if and when required. This did not support residents' right to exercise choice

- Staff shortages in the evening impacted on the residents tea round being delayed.
- Inspectors observed where a resident was assigned to receive one-to-one care; this was not in place, and the resident was observed to be walking around without receiving support with their activities according to their interests and abilities.
- A shower list was in use in the centre. Inspectors were not assured residents were offered a shower daily as inspectors observed a resident asking to be added to the shower list, which was not person-centred practice.
- Medications were given to residents during meal times, and staff who spoke with inspectors confirmed that this was a common practice. This practice did not support residents' rights to enjoy their meals uninterrupted and did not promote a relaxed and dignified mealtime experience for all residents.
- There was no privacy lock on the door in the en-suite of room 2A; this was a shared room that impacted the privacy and dignity of the residents.

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 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Hazel Hall Nursing Home OSV-0000049

Inspection ID: MON-0042236

Date of inspection: 08/05/2024

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:
The Registered Provider has reminded the PIC of the responsibility to exercise clinical judgment and respond effectively to feedback from all stakeholders to ensure the staffing and skill mix in place at the Centre is always appropriate and sufficient to meet the needs of the Residents.

The Registered Provider has instructed the PIC to ensure there is sufficient staffing at all times and to report any and all gaps in current and future staffing to the Registered Provider so that immediate remedial action can be taken.

The Registered Provider has instructed the PIC that an effective pre-admission assessment must be carried out to ensure residents who require special 1:1 care are only admitted once additional staff are recruited, vetted and available to avoid compromising the existing staff complement and to avoid any lapses in special care and supervision for the prospective resident requiring special 1:1 care.

The Registered Provider has worked with the Person in Charge to review rosters in detail. Staff providing special 1:1 care are assigned 24/7/365 and are clearly marked on the day and night rosters to ensure all parties know that the staff member marked is assigned exclusively to the care of the resident requiring special 1:1 care.

The Registered Provider implemented new triangulated reporting systems to ensure the effective and real-time monitoring of the appropriateness of staffing levels and to intervene and take remedial action where any gaps are identified or where feedback is obtained.

The Registered Provider recognises the importance of suitable staffing on Residents and on Staff and is happy to ensure that staffing is at all times appropriate.
Following inspection, the Registered Provider nominated a team to recruit additional staff to support suitable staffing. This was effective and the Registered Provider has been able to provide additional staff to support existing staff. Recruitment continues.

The Registered Provider is reviewing rounds, inspection and spot check records to ensure that gaps in staff are more easily identified and more efficiently addressed by the Person in Charge.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

The Registered Provider implemented new triangulated reporting systems to ensure the effective and real-time monitoring of the appropriateness of staffing levels and to intervene and take remedial action where any gaps are identified or where feedback is obtained. The Registered Provider recognises the importance of suitable staffing on Residents and on Staff and is happy to ensure that staffing is at all times appropriate. Following inspection, the Registered Provider nominated a team to recruit additional staff to support suitable staffing. This was effective and the Registered Provider has been able to provide additional staff to support existing staff. Recruitment continues. The Registered Provider is reviewing rounds and spot check records to ensure that gaps in staff are more easily identified and more efficiently addressed by the Person in Charge. An oven, stored temporarily in the large day room, with the permission of the Residents who share that room, shall be removed on 2nd July 2024. A risk assessment is completed in the interim.

Enhanced rounds, inspections and spot checks will ensure improvements in the day to day management of risks and the Person in Charge will actively seek any oxygen tanks/concentrators left in bedrooms within her rounds. The smoking shed, which was being used for therapeutic purposes and not smoking, due to the fact that there were no smoking residents in that unit, has been removed.

Vacuum cleaners were removed from the electrical cupboard and a lock placed on the door for safety on the day of inspection.

The Registered Provider has reviewed the Infection Prevention and Control audit with the Person in Charge and the Person in Charge will now better capture the clinical IPC information thereon as discussed with the Inspectorate at feedback. This will be reviewed by the Registered Provider Representative as part of her overall monthly audits.

Training was provided to nursing staff to support them with the documentation required for behaviour that is challenging. Extensive work was carried out to ensure a person centred approach to care planning in this area, including the capturing of triggers to the behaviours, the patterns involved and the distraction and de-escalation techniques that staff can use for each individual resident to ensure everyone's safety at these times.

An extensive review of care plans was carried out and enhanced auditing completed to ensure all residents care plans are in place, appropriate, accurate and up to date. Safeguarding plans were commenced for all Residents living within the Abbey High Dependency Unit and any other Residents as required. MDRO/Infection Control Care Plans are expanded, adding guidance for healthcare staff and allied health care. Fire

safety care plans are in place for all residents. Checks carried out to ensure allied health care referrals are documented in respective care plan section. The Nurse Management Team is currently reviewing the pre-admission assessment to ensure all relevant information is collected, captured and recorded prior to admission. All comprehensive assessments and care plans are updated and RGN staff are provided with instruction on ensuring Comprehensive Care Plans in place for all Residents within 48 hours as per statutory guidelines. Care planning training has been delivered to nursing staff to support them. Medication Management care plans now reflect any requirements for covert/crushed medications which will be updated routinely and ad hoc as required.
The Registered Provider has brought the matter of statutory notifications to the attention of the Person in Charge. The Registered Provider has provided the Person in Charge with all of the guidelines available on submitting statutory notifications. The Person in Charge has committed to ensuring that all notifications are submitted within the given timeframe. The Registered Provider has implemented robust, triangulated reporting systems to ensure she is made aware of all notifiable events to allow her to supervise the Person in Charge in the submission of all notifications.
The Inspectorate was informed at inspection that the Centre was in the midst of a complete changeover of pharmacy suppliers at the time of inspection. The Centre's Clinical team ensured the GP's digital signature was in place for all resident's prescriptions and covert and crushed medication status was reviewed, with GP approval obtained as needed.
Medication storage was reviewed and overstock of medicines, and out of date medicines, were removed and returned to the pharmacy. Individual resident storage areas for medicines was commenced in line with the valuable suggestions of the Inspectorate.
A full length lockable door, for the Abbey Medication Unit will be fitted in the next days, with a full lock included. Thermometers were installed in medication storage areas. A new stock register was commenced for stock medications such as antibiotics and emergency medicines. Oral nutritional supplements are stored in clinical rooms.
Nursing staff will be allocated to carrying out comprehensive medication checks going forward. The new pharmacy supplier will carry out auditing as per statutory requirements.
The Registered Provider brought the matter of statutory notifications to the attention of the Person in Charge. The Registered Provider has provided the Person in Charge with all of the guidelines available on submitting statutory notifications. The Person in Charge has committed to ensuring that all notifications are submitted within the timeframe. The Registered Provider has implemented robust, triangulated reporting systems to ensure she is made aware of all notifiable events to allow her to supervise the PIC in the submission of all notifications.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:

The Registered Provider has brought the matter of statutory notifications to the attention of the Person in Charge. The Registered Provider has provided the Person in Charge with all of the guidelines available on submitting statutory notfications. The Person in Charge has committed to ensuring that all notifications are submitted within the timeframe. The Registered Provider has implemented robust, triangulated reporting systems to ensure she is made aware of all notifiable events to allow her to supervise the PIC in the submission of all notifications.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The Registered Provider regrets there were broken and discarded items in the side lane during inspection awaiting the delivery of a waste skip. These items are removed.

The hoist, which is regularly PAT tested and the room wired to the fire alarm system was removed from the deep cleaned room to a permanent storage area as agreed during inspection with the Inspectorate.

A refurbishment plan is in place to tackle maintenance tasks and décor. The Abbey Suite is the next area to undergo refurbishment as per the plan. A hand wash sink is ready for installation in the Clinical Room and contractors are due out within the next week to install same.

Emergency call bells were reviewed and any issues rectified. The Person in Charge reminded staff to ensure all call bells are within reach of residents who are in bed.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
As per the Centre's refurbishment plan, five hand wash sinks will be fitted upon delivery around the building to support staff with hand hygiene. The Person in Charge has provided instruction to staff on hand hygiene and has dedicated equipment to carry out hand hygiene audits frequently. A hand wash sink is ready for installation into the Clinical Room The Person in Charge arranged for the systematic cleaning and disinfection of the dressing trolley between uses. The Person in Charge provided instruction to staff not to store anything on the floor of the sluice room. Rounds have evidenced staff adherence to the plan. All Residents have their own washing basin within their room and spare basins are disinfected and stored in the allocated storage

area. The Person in Charge ensures daily inspections to ensure no items are stored on the floor. The area behind the washing machines and dryer was cleaned and the laundry and external storeroom were deep cleaned and placed on a routine cleaning schedule. A thorough declutter and deep clean of both clinical rooms was carried out. Two sets of vitals trays were allocated to eat unit, adhering to Infection Prevention and Control. All unnecessary items were removed from the Clinical Rooms. A tray was allocated for phlebotomy purposes. The renewal of floor surfacing is included in the Centre's refurbishment plan. There is a medications fridge and a specimen fridge available in the Clinical Room. The Person in Charge consulted with staff to ensure no oxygen masks or prongs are left in Resident's bedrooms without the need for doing so. The Person in Charge will monitor this, and the cleanliness of all masks and nasal prongs during rounds, inspections and spot checks. Each Resident has a glucometer assigned to them; clearly labelled. IPC Rounds, Inspections and Spot Checks continue.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: The oxygen tank that was left in a resident's bedroom following oxygen therapy was removed immediately during inspection and the nursing team was reminded to remove oxygen tanks and concentrators immediately after use. Signage is in place to indicate use and alert staff. Oxygen tanks are now segregated between 'Empty' and 'Full'.

The 'smoking area' that an ex-smoking resident used to 'smoke' a Nicorette inhaler, has now been removed as per the suggestions of the inspectorate.

Vacuum cleaners were removed from the electrical cupboard on the day of inspection and a lock fitted for safety.

The 'flammable liquid' found in the boiler room was confirmed not to be a flammable liquid. In any case, it has been removed.

The Registered Provider and Facilities Manager explained the process of the planned replacement of the fire compartment in line with the Resident Safety Improvement Scheme to the Inspectorate on the day of inspection. The Registered Provider continues to work towards the planned replacement as per the Centre's Fire Safety Strategy and Refurbishment Plans.

Penetrations in the ceiling and flooring of external storage were checked and sealed.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
The Inspectorate is aware that at the time of inspection, the Centre was in the midst of a complete changeover of pharmacy suppliers and associated documentation and recording systems. The Centre's Clinical team ensured the GP's digital signature was in place for all resident's prescriptions and cover and crushed medication status was reviewed, with GP approval obtained as needed.
Medication storage was reviewed and overstock of medicines, and out of date medicines, were removed and returned to the pharmacy. Individual resident storage areas for medicines was commenced in line with the valuable suggestions of the Inspectorate.
A full length, lockable door for the Abbey medication unit is due to be fitted.
Thermometers were installed in medication storage areas. A new stock register was commenced for stock medications such as antibiotics and emergency medicines. Oral nutritional supplements are stored in Clinical Rooms.
Nursing staff will be allocated to carrying out comprehensive medication checks going forward. The new pharmacy supplier will carry out auditing as per statutory requirements.

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:
An extensive review of care plans was carried out and enhanced auditing completed to ensure all residents care plans are in place, appropriate, accurate and up to date.

Safeguarding plans were commenced for all Residents living within the Abbey High Dependency Unit and any other Residents as required.

MDRO/Infection Control Care Plans are expanded, adding guidance for healthcare staff and allied health care. details for carers and/or other heath care workers.

Fire safety care plans in place for all residents.

Checks carried out to ensure allied health care referrals are documented in respective care plan section.

The Nurse Management Team is currently reviewing the pre-admission assessment to ensure all relevant information is collected, captured and recorded prior to admission.

All comprehensive assessments and care plans are updated and RGN staff are provided

with instruction on ensuring Comprehensive Care Plans in place for all Residents within 48 hours as per statutory guidelines.

Care planning training has been delivered to nursing staff to support them.

Medication Management care plans now reflect any requirements for covert/crushed medications which will be updated routinely and ad hoc as required.

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
Training was provided to nursing staff to support them with the documentation required for behaviour that is challenging. Extensive work was carried out to ensure a person centred approach to care planning in this area, including the capturing of triggers to the behaviours, the patterns involved and the distraction and de-escalation techniques that staff can use for each individual resident to ensure everyone's safety at these times.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
The Registered Provider Representative discussed with the inspectorate at the time of inspection the challenges and limitations it faces with the national safeguarding systems and the risks these poses to Residents within its care.

All required notifications were submitted to the Inspectorate.
The Registered Provider reviewed staffing levels with the Person in Charge to ensure that Residents with Behaviours that Challenge are appropriately supervised in order to protect all Residents from harm.
The Registered Provider brought the matter of statutory notifications to the attention of the Person in Charge and brought to her attention the requirement to recognize safeguarding incidents, investigate and take appropriate action, and submit statutory notifications in a timely manner.
The Registered Provider provided the Person in Charge with all of the guidelines available to support her to safeguard.
The Person in Charge committed to engage in refresher training in safeguarding, ensure that all incidents and potential incidents are investigated with actions taken where required to ensure the safety of Residents, report to the Registered Provider and submit

statutory notifications in a timely manner to the Inspectorate.
The Registered Provider has implemented robust, triangulated reporting systems to ensure she is made aware of all notifiable events to allow her to ensure the PIC has submitted the required notifications.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Emergency call bells were reviewed and any issues rectified. The Person in Charge reminded staff to ensure all call bells are within reach of residents who are in bed. The Person in Charge completes compliance checks during rounds, inspections and spot checks.

The Registered Provider has reminded the PIC of the responsibility to exercise clinical judgment and respond effectively to feedback from all stakeholders to ensure the staffing and skill mix in place at the Centre is always appropriate and sufficient to meet the needs of the Residents. The Registered Provider implemented new triangulated reporting systems to ensure the effective and real-time monitoring of the appropriateness of staffing levels and to intervene and take remedial action where any gaps are identified or where feedback is obtained. The Registered Provider recognises the importance of suitable staffing on Residents and on Staff and is happy to ensure that staffing is at all times appropriate.
Following inspection, the Registered Provider nominated a team to recruit additional staff to support suitable staffing. This was effective and the Registered Provider has been able to provide additional staff to support existing staff. Recruitment continues. The Registered Provider is reviewing rounds, inspection and spot check records to ensure that gaps in staff are more easily identified and more efficiently addressed by the Person in Charge.
Residents are asked daily if they wish to take a shower. The Person in Charge has removed the old practice shower list.
Mealtimes are protected and medications are now administered outside of mealtimes.
A privacy lock was fitted to the bathroom in Bedroom 2A.

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 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Red	16/05/2024
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	31/10/2024
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to	Not Compliant	Orange	31/12/2024

	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	31/12/2024
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.	Not Compliant	Orange	31/10/2024
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 suitable bedding and furnishings.	Not Compliant	Orange	31/12/2024
Regulation 28(2)(i)	The registered provider shall make adequate	Not Compliant	Orange	31/10/2024

	arrangements for detecting, containing and extinguishing fires.			
Regulation 29(5)	The person in charge shall ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.	Substantially Compliant	Yellow	30/07/2024
Regulation 29(6)	The person in charge shall ensure that a medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident shall be stored in a secure manner, segregated from other medicinal products and disposed of in accordance with national legislation or guidance in a manner that will not cause danger to public health or risk to the environment and will ensure that the product concerned can no longer be	Substantially Compliant	Yellow	30/07/2024

	used as a medicinal product.			
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.	Not Compliant	Orange	30/06/2024
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.	Not Compliant	Orange	30/07/2024
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	31/10/2024

Regulation 7(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.	Substantially Compliant	Yellow	30/07/2024
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Orange	30/06/2024
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Not Compliant	Orange	
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Not Compliant	Orange	30/06/2024
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Not Compliant	Orange	31/07/2024