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:	Waterford Residential Care Centre
Name of provider:	Health Service Executive
Address of centre:	St Patrick's Way, Waterford, Waterford
Type of inspection:	Unannounced
Date of inspection:	11 January 2023
Centre ID:	OSV-0007792
Fieldwork ID:	MON-0038716

About the designated centre

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

Waterford residential care centre is a new purpose built centre set out over two floors. It is built to a high specification and consists of two units of 30 providing a total of 60 beds. The units were named after local Waterford areas surrounding the centre. Ferndale ward: has 28 continuing care beds and 2 respite beds and Farronshoneen ward has 28 continuing care beds and 2 respite beds. All of the bedroom accommodation is provided in single full ensuite bedrooms. There are a number of sitting room and dining rooms in each of the units and additional multipurpose rooms including activity rooms and quiet/ visitor rooms. The variety of communal spaces provided adequate space and choice for residents. There were also other areas along corridors with seating for use by residents. Facilities shared between all units include a large function room, a tranquil room, a hairdresser room, a treatment room, laundry, meeting rooms, overnight room for families, offices, visiting areas and a number of secure outdoor areas. Residents and families also have access to large communal area's near the entrance and in the atrium of the building.
Waterford Residential Care Centre provides 24 hour care for Female & Male residents who require various levels of nursing care from continuing care, rehabilitation and respite care. There is a good ratio of nurses on duty during the day at night time. The nurses are supported by care, catering, household and activity staff. Medical and allied healthcare professionals provide ongoing healthcare for residents.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	57

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 11 January 2023	09:30hrs to 18:30hrs	Noel Sheehan	Lead
Wednesday 11 January 2023	09:30hrs to 18:30hrs	Niall Whelton	Support

What residents told us and what inspectors observed

The overall feedback from residents was that management and staff were kind and caring and that they were happy living in the centre which was homely and met their needs. Inspectors observed that residents appeared to be well cared for, which was further reflected in residents' comments that their daily personal care needs were met. Residents, where possible, were encouraged to be as independent as possible and inspectors observed residents moving freely around the corridors and communal areas throughout the day.

The inspectors arrived to the centre unannounced in the morning. Following an opening meeting the inspectors were accompanied on a tour of the premises, where the inspectors also met and spoke with residents in their bedrooms and in the various day rooms. Waterford Residential care is a purpose built centre designed and laid out to a high specification. The centre, as currently configured, was set out over two floors and consists of two units (Ferndale ward and Farronshoneen ward) providing a total of 60 beds.

All bedroom accommodation is provided in large single full en-suite bedrooms. Bedrooms were fitted out with a comfortable chair, bedside locker and a large wardrobe, overhead hoists and call bells. There are a number of sitting room and dining rooms in each of the units and additional multipurpose rooms including activity rooms and quiet/ visitor rooms. The inspectors saw and residents confirmed that the variety of communal spaces provided adequate space and choice for residents. There were also other areas along corridors with seating for use by residents. The activity rooms included a kitchenette which made the room homely and could be used for baking and other activities. Facilities shared between all units include a large function room, a tranquil room, a hairdresser room, a treatment room, laundry, meeting rooms, overnight room for families, offices, visiting areas and a number of secure outdoor areas. Residents and families will also have access to large communal area's near the entrance and in the atrium of the building.

The environment was well maintained and exceptionally clean. The corridors were sufficiently wide to accommodate walking aids and handrails were installed in all circulating areas. The layout and the signage in the centre helped to orientate residents and facilitate them to move around the building independently. The bedrooms were homely and very personalised. Some residents had brought in their personal furniture and memorabilia. Many residents had pictures of their families framed in their rooms.

The design of the building ensured that the outdoor areas and courtyards were accessible to residents on all levels. The outdoor areas were landscaped to a high standard and included secure furniture. Many bedrooms had doors opening directly onto the courtyard areas. Previous inspection reports had identified that many of the bedrooms adjacent to the courtyard areas were over looked which resulted in a lack of privacy for the residents when the curtains were open. On this inspection the

inspectors observed that privacy screens on the glass to allow residents see out had been installed on all bedroom windows adjacent to courtyard areas.

The building was on a sloping site and access to ground level externally was available at both floors. There were also escape stairways and an evacuation lift to assist evacuation from the upper level. Staff relayed to inspectors that vertical evacuation was not part of the procedure and if required to assist immobile residents down the stairs, there was no means to do so. The evacuation lift was available, but did not form part of the evacuation strategy. There was no operational procedures displayed for the evacuation lift; the inspectors saw signage which indicated not to use lifts in the event of a fire.

The doors to bedrooms were not effective fire doors and heat seals were not provided around the sides and top of the doors. Large gaps were noted where the door leafs met. The doors to day spaces were similar to the bedroom doors. Staff were very clear that the procedure to evacuate a bedroom required the opening of a flush bolt at the top of one of the doors to allow the evacuation of a bed and subsequently were required to close each door leaf and lock the flush bolt again to ensure the door stayed closed to contain a fire. As the building was designed in accordance with standards for a health care facility rather than a residential facility, the bedroom corridors were not fully fire protected from bedrooms and day spaces. There was oxygen shut off points at the main nurse station within each unit, however it was not clear among staff and management at what stage the oxygen would be shut off, and who would do it, in the event of a fire.

The inspectors had an opportunity to observe residents' dining experience on the day of inspection. The report of the previous inspection carried out in June 2021 found that evening meals were being served at 16:15 pm, which was only three hours after lunch. On this inspection the inspectors noted teas being served at the later and more appropriate serving time of 17:00 pm. Food served was wholesome and there was adequate staff to support the residents during meal time. Residents had a choice of menu for the day. Inspectors observed staff assisting residents in a discrete and sensitive manner during meal times. Residents were complementary about the food they received in the centre.

Residents were seen to enjoy the activities observed on the day of the inspection with plenty of friendly conversation and good humoured fun happening between residents and staff. The activities on offer included singing/karaoke, imagination gym, arts and crafts. The inspectors were told that the activities programme runs over seven days of the week. The inspectors observed activities staff carrying out one to one activities with residents who chose to stay in the bedrooms throughout the day. The inspectors observed Mass, which takes place in the atrium, every Wednesday afternoon and is celebrated by a priest from St. John's parish. The activities coordinators were instrumental in maintaining links with the local community. The inspectors were told about the recent Imagine Arts Festival held in the centre, which was a special occasion for residents and staff alike. It was evident that social excursions were an important part of life for the residents. There were pictures of special occasions throughout the centre and it was clear that every effort was made to ensure residents lived a full and enjoyable life, to the best of their

abilities. However, residents continued not have access to WiFi in the centre.

Staff promoted a person-centered approach to care and were observed to be kind and respectful towards residents. Inspectors observed resident and staff engagement throughout the inspection, and found that it was evident that staff knew residents well and residents were comfortable and relaxed in the presence of staff.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted the quality and safety of the service being delivered to residents.

Capacity and capability

There were good overall governance systems in this centre, which is evidenced in the high levels of compliance found on this inspection. The registered provider ensured that the service was appropriate to the needs of the residents. Strong leadership and a well-established staff team focused on maintaining a safe and comfortable environment for residents, whilst also respecting their individual rights and preferences.

This was an unannounced inspection which took place over one day. The purpose of the inspection was to assess ongoing compliance with the regulations and standards following an application by the registered provider to renew the registration of the centre. The provider had applied to increase the occupancy of the designated centre to 80 beds by re-designating the 20 bedded Grange unit from short term, rehabilitation to long term residential care. The information supplied with the application was reviewed during the course of the inspection. Overall, the compliance plan following the previous inspection in June 2022 had been actioned and there were sustained levels of compliance seen with respect to most of the regulations assessed. However, this inspection found that the registered provider had not ensured that there was an effective system of fire safety management in place and consequently, action was required to bring the centre into compliance with fire safety requirements as discussed under Regulation 28 below. The Inspectors also found that commitments given previously by the registered provider to address fire safety issues had not been met. A restrictive condition had been attached to the registration of this centre to comply with regulation 28, Fire Precautions, due to concerns identified on a previous inspection. The date for achieving compliance with regulation 28 had been extended to 31 May 2022 on the basis of an application by the registered provider that compliance would be achieved by this date. Despite this extension to the time frame the HSE had still not complied with condition 4 of the registration of this centre. The Inspectors found that the designated centre was not being operated in compliance with condition 04 of registration. The centre is currently registered to provide accommodation for 60

residents, and there was 57 residents living in the centre on the day of inspection.

The registered provider of Waterford Residential Care Centre centre is the Health Service Executive (HSE). This premises was first registered as a designated centre for older persons in March 2020 and replaced St. Patrick's Hospital. There is a clearly defined management structure in place and both staff and residents were familiar with staff roles and their responsibilities. The person in charge (PIC) is an assistant director of nursing (ADON) and has responsibility for overseeing the designated centre. The PIC reports to a director of nursing (DON). The DON has oversight of the designated centre but is also responsible for rehabilitation services and integrated care services, which are located on the same campus. Both the DON and PIC were available to support the inspection. The PIC is supported by a team of nursing, health care, catering, activity and maintenance staff. Housekeeping services are provided by an external company, as are laundry services. The DON reports to a manager for older person services that in turn reports to a general manager for older person services. The service is also supported by centralised departments, such as human resources and fire and estates.

This inspection included a focused review of fire precautions. Strong fire safety management was observed during the inspection and staff demonstrated a good knowledge of aspects of the centres fire safety; this was not sufficiently mitigating the risk of fire and improvements were required. Vertical evacuation was not part of the escape strategy. The risk of requiring vertical evacuation was reduced owing to the configuration of the building which allowed horizontal escape from most areas. However, staff were not prepared for the scenario where vertical evacuation would be required.

Owing to the type of doors to bedrooms and day rooms and the absence of fire automatic closers, the inspectors were not assured that there was adequate arrangements in place for containment of fire and consequently adequate means of escape. The safety and protection of residents relied on sustained fire safety management measures and on staff intervention to ensure doors would be closed to contain fire. Furthermore, the doors to bedrooms and day spaces were routinely open which was the residents expressed choice, however they were not being held open in a manner that would ensure they automatically closed in the event of a fire

The service was appropriately resourced with staffing levels in line with that described in the statement of purpose. Staff reported it to be a good place to work and there was low turnover of staff. Staff meetings and shift handovers ensured information on residents' changing needs was communicated effectively. There was evidence that staff received training appropriate to their roles and staff reported easy access and encouragement to attend training and to keep their knowledge and skills up to date. This enabled staff to provide evidence-based care to residents.

There were good clinical management systems in place to monitor the quality and safety of the service. A schedule of clinical and environmental audits evaluated key areas such as infection control procedures, residents' documentation and medication management. The quality of care was monitored through the collection of weekly data, such as monitoring the use of antibiotics and psychotropic medications and the

incidence of wounds and falls. Analysis of the information gathered through these systems was used to inform the development of quality improvement plans. Audits and improvement plans were discussed at the quality and safety committee meetings and at wider staff meetings across all departments, which were held regularly. Minutes of these meetings evidenced a sharing of information, including updates in relation to residents' needs, audits and relevant COVID-19 updates. Residents, families and staff were given opportunities to feed back on the service. There was evidence of good communication through a variety of forums to discuss all areas of governance.

Staff had access to a programme of training that was appropriate to the service. Important training such as fire safety and the management of behaviours that challenge was completed for staff. The inspector was assured that staff were appropriately supervised by senior staff in their respective roles and that there was appropriate on-call management support available at night and at weekends.

Records of clinical incidents occurring in the centre were comprehensive and included learning and measures to prevent recurrence. A record was kept of all potential and actual clinical and environmental risks and this record identified appropriate control measures in place to mitigate the occurrence of these risks. However, action plans were not comprehensive enough to drive quality improvement.

Registration Regulation 4: Application for registration or renewal of registration

The registered provider had failed to submit a completed application to renew the registration of the centre within the necessary timeline by the chief inspector in contravention of section 48(3) of the Health Act 2007.

Judgment: Not compliant

Regulation 14: Persons in charge

The person in charge was a registered nurse with the required managerial and nursing experience in keeping with statutory requirements. She and her management team were actively engaged in the governance, operational management and administration of the service. The person in charge demonstrated a commitment to the development of oversight and quality improvements ensure the provision of a safe and effective service.

Judgment: Compliant

Regulation 15: Staffing

From a review of staff rotas and from speaking with staff and residents, the inspector was assured that the registered provider had arrangements in place to ensure that appropriate numbers of skilled staff were available to meet the assessed needs of the 57 residents living in the centre on the day of the inspection.

The registered provider was requested to submit an admissions and staffing plan in advance of registration of the extra 20 beds in the Grange Unit.

Judgment: Compliant

Regulation 16: Training and staff development

Overall, staff had access to a programme of training that was appropriate to the service. The inspectors were assured that staff were appropriately supervised by senior staff in their respective roles and that there was appropriate on-call management support available at night and at weekends. However action is required on the following matters to ensure full compliance with regulation:

- There was no system of ongoing staff appraisal in place.
- Further training on fire safety was required to include procedures for vertical evacuation.

Judgment: Substantially compliant

Regulation 21: Records

Residents' records evidenced daily nursing notes with regard to the health and condition of the residents and treatment provided.

Inspectors were advised that staff records required under Schedule 2 of the regulations were maintained electronically with limited access by management. Other than Garda vetting, requested records were not available to either the inspectors, the DON or the PIC during the inspection and so were not available for inspection.

Judgment: Not compliant

Regulation 23: Governance and management

The provider had a well-defined governance and management structure in place that identified clear lines of authority and accountability. Inspectors found that the registered provider had worked hard to improve systems and oversight of the quality and safety of the care delivered to residents within the designated centre. Inspectors saw that the majority of the issues found at the last inspection had been addressed by the provider. However the systems in place did not always ensure that the service provided was consistently and effectively monitored;

- Clinical audits including infection control, care planning and restraint were provided to the inspectors for review. There was no time-bound action plans for implementation or review. Audit action plans were not comprehensive enough to drive quality improvement.
- There was no evidence of cascade of learning from audits or reviews of care through the governance structure.
- There was no evidence of follow up or action plans in some instances where issues had been raised by residents meetings or at a recent internal catering meeting.
- The registered provider had not ensured that there was an effective system of fire safety management in place and consequently, actions were required to bring the centre into compliance with fire safety requirements as discussed under Regulation 28 below.
- Ineffective fire doors to bedrooms and day spaces, combined with the absence of automatic self-closing devices, the registered provider was not ensuring adequate containment of fire and consequently adequate means of escape.
- The Inspectors found that the designated centre was not being operated in compliance with condition 04 of registration which allowed the registered provider until May 2022 to complete works to address fire safety.

Judgment: Not compliant

Regulation 3: Statement of purpose

There was a written statement of purpose prepared for the designated centre and made available for review. It was found to contain all pertinent information as set out in Schedule 1 of the regulations and accurately described the facilities and the services provided.

Judgment: Compliant

Regulation 31: Notification of incidents

A record of all incidents occurring in the centre was maintained and all required notifications were submitted to the Chief Inspector within the time frames as stipulated in Schedule 4 of the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

A clear complaints procedure was in place and this was displayed prominently in the centre. The record of complaints was reviewed by the inspector. These records identified that complaints were recorded and investigated in a timely way and that complainants were advised of the outcome of their complaint. A record of the complainant's satisfaction with how the complaint had been managed was also documented.

Judgment: Compliant

Regulation 4: Written policies and procedures

The policies required by Schedule 5 of the regulations were in place and up-to-date in line with regulatory requirements.

Judgment: Compliant

Quality and safety

It was evident that staff knew the residents very well and this knowledge was reflected in the resident's individualised care plans which were developed with the resident or their representative where required. Care plans were implemented and reviewed on a regular basis, reflecting residents' changing or additional needs. Residents had access to a GP of their choice, local geriatricians and palliative care services. The health of residents was promoted through ongoing medical review and nursing assessment using a range of validated tools. These assessments included skin integrity, malnutrition, falls and mobility. GP's provided regular medication reviews and the overall management of medications in the centre was good. Medication errors, when they did occur, were documented and analysed to inform

ongoing improvements.

The inspectors noted many good practices in relation to fire safety. The management team were implementing quality improvement measures. For example, there were plans to apply demarcation on the floor at each compartment boundary to assist staff during evacuation. The doors to bedrooms had a sign affixed to prompt staff to close the door during evacuation.

Fortnightly fire walk arounds were conducted with selected members of staff to familiarise staff with evacuation protocols, fire safety practices and fire alarm panel controls. Frequent evacuation drills were taking place and the simulated evacuation of a fire compartment demonstrated swift evacuation. The configuration of the building meant that there was an adequate number of exits and escape routes were available in alternative direction. Horizontal evacuation procedures were robust, however the mode for vertical evacuation was not adequate.

Notwithstanding effective fire safety management practices, the inspectors were not assured that the building provided adequate containment of fire and afforded adequate means of escape for residents who were assessed as being of high dependency and staff. As the building was designed in accordance with standards for a health care facility rather than a residential facility, the escape corridors were not adequately protected from the effects of a fire in bedrooms and day spaces.

The findings relating to fire safety are set out in greater detail in Regulation 28 Fire Precautions of this report.

The design and layout of the centre promoted an unrestricted environment for residents who were encouraged to mobilise freely and had access to an enclosed courtyard from two sides of the corridor. Staff were seen to be supportive and encouraging in their interactions with residents. There was sufficient communal space for residents to partake in group activities, and privately if they wished. There was a programme of activities in place and activities were provided seven days a week with three dedicated activity staff employed.

There was evidence of a positive approach to the management of residents with responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). Care records viewed showed that behavioural support plans were developed based on residents' individual needs. Inspectors saw evidence where the least restrictive measure was in place and observed staff using distraction and diversion techniques appropriately.

Inspectors reviewed a number of restrictive practices. Records reviewed indicated that where residents had a restrictive practice in place such as bed rails or a sensor alarm, there was a risk assessment and care plan in place to evidence its use.

The centre was clean on the day of inspection. Furthermore, residents were complimentary about the cleanliness of the centre. Infection control audits were identifying a small number of issues. Staff were observed to be wearing personal protective equipment (PPE) such as face masks appropriately. Access to hand

washing sinks were easily available and a sufficient supply of wall-mounted alcohol hand sanitiser was available at key locations throughout the centre to support efficient hand hygiene.

Residents' rights were protected and promoted in the centre. Choices and preferences were seen to be respected. Regular resident council meetings were held which provided a forum for residents to actively participate in decision-making and provide feedback in areas regarding social and leisure activities, advocacy and empowerment, and influencing standards of care. Minutes of these meetings were documented.

There was a culture that promoted the welfare of the resident in the centre, supported by appropriate policies and procedures for the prevention, detection and response to abuse. Staff spoken with were clear in their understanding of what constituted abuse and the procedure for reporting information. Residents spoken with stated that they felt safe in the centre and were clear who they could go to should they have any concerns they wished to raise. The centre actively promoted the independence of residents and where restraints, such as bed rails, were in use appropriate risk assessments had been undertaken. Care plans contained assessments and consent forms.

Regulation 11: Visits

There were suitable arrangements in place for residents to receive visitors. The current arrangements did not pose any unnecessary restrictions on residents.

Judgment: Compliant

Regulation 12: Personal possessions

Residents were supported to maintain control of their clothing and personal belongings. Residents had adequate storage space in their bedrooms, including a lockable space for their valuables if they wished. Residents informed the inspectors that they were satisfied with the arrangements in place for the laundering, and prompt return, of their clothing.

Judgment: Compliant

Regulation 17: Premises

The premises were appropriate to the needs of the residents and conformed to the

matters set out in Schedule 6 of the regulations. There was a programme of progressive, ongoing maintenance in place.

Judgment: Compliant

Regulation 18: Food and nutrition

The residents in the centre had access to a safe supply of fresh drinking water at all times. Residents were offered choice at mealtimes and they were provided with adequate quantities of food and drink. Residents weights were monitored on a monthly basis and they were assessed for malnutrition using a validated tool. Specialist advise from dietician and speech and language therapist (SALT) were also incorporated in care plans for residents with high risk of malnutrition and dysphagia (swallowing difficulty)

Judgment: Compliant

Regulation 26: Risk management

There was a risk management policy in place to inform the management of risks in the centre. This contained reference to the five specified risks as outlined under regulation 26.

Judgment: Compliant

Regulation 27: Infection control

The registered provider ensured that the the procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority were implemented by staff. Up-to-date training had been provided to all staff in infection control, hand hygiene and in donning and doffing of PPE. Regular staff briefings took place to ensure staff were familiar and aware of the ongoing changes to guidance from public health and the Health Service Executive (HSE).

Judgment: Compliant

Regulation 28: Fire precautions

The registered provider was not taking adequate precautions, nor effectively reviewing fire precautions:

- the stage during evacuation, and the identified person to shut off, the piped oxygen supply was not determined
- there was a device fitted to the fire door of two waste rooms to prop open the fire door; these did not release on activation of the fire alarm
- the fire door between the two laundry rooms was propped open with a linen trolley

The means of escape were not adequate:

- the rear area was not provided with an adequate route of escape once evacuated from the building; the only way out of this area required going across a sloped grass area and through a narrow gate
- the external routes were not provided with adequate emergency lighting
- the escape path to the rear had a bench and seating obstructing the escape route
- an escape route from the grange area led to an area with a gate locked with a padlock

The arrangements for maintaining fire equipment were not adequate:

- two fire doors within compartment boundaries couldn't close
- gaps were observed to fire doors; some to fire risk rooms and some fire compartment doors
- the door closer to a store in the kitchen area was disconnected

The arrangements for the containment of fire were not adequate:

- the doors fitted to bedrooms and some of the day spaces would not effectively contain fire and smoke to protect escape routes during evacuation. The activities rooms, used by residents for cooking, did not have effective fire doors.

The arrangements in place for evacuating residents were not adequate

- there was confusion regarding the procedure to shut off the piped oxygen supply; it did not form part of the evacuation procedures displayed and was not evident in fire drill reports
- the procedure for vertical evacuation was not part of the evacuation strategy. Most residents at the upper level were assessed as being of high dependency; the mode of evacuation was bed evacuation and if required there was no means to assist residents down the stairs
- the procedure expected of staff when evacuating a resident from their room was onerous, time consuming and increased the risk of doors not being closed during evacuation.

The evacuation procedures displayed do not include the procedure to shut off the

oxygen supply.

The fire safety features detailed above also apply to the Grange Unit.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Resident care plans were seen to be detailed and person-centred, and were informed by an assessment of clinical, personal and social needs. A comprehensive pre-admission assessment was completed prior to the resident's admission to ensure the centre could meet the residents' needs. A range of validated assessment tools were used to inform the residents care plans.

Care plans were formally reviewed at intervals not exceeding four months. Where there had been changes within the residents' care needs, reviews were completed to evidence the most up to date changes.

Judgment: Compliant

Regulation 6: Health care

The medical and nursing needs of residents were well met in the centre. There was evidence of good access to medical practitioners, through residents' GP's and out-of-hours services when required. Systems were in place for residents to access the expertise of health and social care professionals through a system of referral, including speech and language therapists, dietician services and tissue viability specialists. An in-house physiotherapy service supported individual physiotherapy assessments.

There was a low level of pressure ulcer formation within the centre, due to the appropriate delivery of evidence-based, preventative skin assessments and regular monitoring for pressure-related skin damage. Residents who were admitted with pressure ulcers or other wounds, were appropriately referred to an in-house specialist wound care nurse who is is on-site three days per week, for additional expertise.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Records showed that where restraints were used these were implemented following risk assessments and alternatives were trialled prior to use. There was a progressive reduction in the use of bedrails in the centre since the last inspection.

At the time of inspection there was a small number of residents that had responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment). Care plans reviewed were person centered and guided care.

Judgment: Compliant

Regulation 8: Protection

The registered provider took all reasonable measures to protect residents from the risk of abuse. For example;

- An updated safeguarding policy was in place. Staff spoken with were knowledgeable regarding what may constitute abuse, and the appropriate actions to take, should here be an allegation of abuse made
- Prior to commencing employment in the centre, all staff were subject to Garda (police) vetting
- The inspectors verified that there was secure systems in place for the management of residents' personal finances. The centre was not acting as a pension agent for any resident
- The registered provider facilitated staff to attend regular training in safeguarding of vulnerable persons
- When required, residents were supported to access independent advocacy services.

Judgment: Compliant

Regulation 9: Residents' rights

Overall, residents' right to privacy and dignity were well respected. Residents were afforded choice in the their daily routines and had access to individual copies of local newspapers, radios, telephones and television. Independent advocacy services were available to residents and the contact details for these were on display. There was evidence that residents were consulted with and participated in the organisation of the centre and this was confirmed by residents council meeting minutes, satisfaction surveys, and from speaking with residents on the day.

A schedule of diverse and interesting activities were available for residents. This schedule was delivered by dedicated activity staff over seven days. The inspectors

reviewed the range of activities on offer to the residents and noted that these reflected residents interests' and capabilities. Residents continued not have access to WiFi throughout the centre.
Judgment: Substantially 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	
Registration Regulation 4: Application for registration or renewal of registration	Not compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Waterford Residential Care Centre OSV-0007792

Inspection ID: MON-0038716

Date of inspection: 11/01/2023

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**
Registration Regulation 4: Application for registration or renewal of registration	Not Compliant
Outline how you are going to come into compliance with Registration Regulation 4: Application for registration or renewal of registration: Due to a number of changes with senior positions in Older Persons Services resulted in notifications landing in redundant email boxes. This has been addressed and resolved, so as to allow a timely application in respect of renewals and applications.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: · Staff appraisals are scheduled to commence on a regular basis from the week commencing 6th March 2023. Appraisals are planned as follows: · Clinical Nurse managers appraised by DON and ADONs · All other disciplines by their line managers and ADON · Currently planned for 2 appraisal meetings per week. · Fire officer to organise further fire training to incorporate vertical evacuations in WRCC. Scheduled for March / April 2023. · Online fire Safety Training available and accessible to all staff- Line managers to notify Staff in advance of training expiry dates- Immediate & Ongoing.	

Regulation 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: · Plans in place for Director of Nursing and Assistant Directors of nursing of each site to have access to 'Therefore' (HSE online staff records system). Separate files relevant to HIQA specific relevant information to be created within each employees folder.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: · On 24th of January 2023 at CNM meeting DON met with Clinical Nurse Specialist Infection prevention and control nurse, who agreed to conduct infection prevention and control audit in conjunction with CNMs. · A plan in place by Director of Nursing and Assistant Directors of Nursing to review the audit action plans and to disseminate the learning from audits. · New Section added to agenda at monthly CNM meetings – CNMs to present audit feedback and action plans. · At the meeting Action plans will be discussed and a plan of implementation and review of progress of implementation will be taking place, formally documented through minutes of the meeting. · Director of nursing to meet with Activity coordinator on a monthly basis to review, discuss, provide feedback and action plan for the minutes from residents meeting. · Activities coordinator to be invited to attend the residents right section of CNM meetings to present minutes of residents' monthly meeting and to discuss any areas where she needs management input to assist her with action plans and implementation. · In relation to regulation 28 compliance Plan of work in progress – A project planning and onsite implementation committee has formed. Weekly meetings in relation to the same are Ongoing. Onsite implementation committee meetings to commence on 6th of March 2023. · Commitment given to Retrofit – all fire doors to be rectified with self-closing devices within WRCC. An expected time frame of work plans submitted on Friday the 10th of February to the chief inspector for review.	
Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
· Technical service was contacted to remove the device fitted to the fire door of two waste rooms as this did not release on activation of fire alarm. An alternate option being added instead by technical service- Immediate.
· Removed linen trolley/any other equipment obstructing fire doors and advised staff not to obstruct fire doors with any equipment- Immediate and ongoing.
· Plan in place to remove section of railings/ fence at the back of Ferndale unit in order to create an exit route and fire evacuation assembly point at the service entrance- expected completion of this work by August 2023.
· Technical service was contacted on 13/2/2023 to organise an improved lighting to escape paths- Immediate and ongoing.
· All benches and seating furniture removed from escape routes- Completed.
· Regarding fire door noncompliance- This is issue is included in project plans for fire regulation 28 and to retrofit all fire doors in WRCC to meet compliance.
· Door closure disconnected to a store in kitchen area- Actioned through technical service- Immediate and ongoing.
· Arrangement for containment of fire – Same addressed and included in project plan to comply with regulation 28 and to bring all fire doors to rectify to the required standard.
· A plan of actioned has been agreed to replace the fire doors and commencement to begin in March, expected completion of full project is August 2023.
· In regards to shutting off oxygen in the event of fire – See response from fire officer below:
Shutting off the 02 supply is a secondary action best undertaken following a dynamic risk assessment of the Officer in Charge of the responding fire service.

In the event of a fire in the WRCC, staff are responsible for the safe and effective evacuation of themselves and their patient as a priority. The shutting off of a compartment or department/ward supply may potentially harm other patients on 02 in adjacent compartments which are unaffected by the fire.
For this reason it is our advice in fire training and strategy in the WRCC for the staff to provide the following:
1. location of the appropriate AVSU serving the fire affected compartment
2. Inform the Fire Service if any other patients still within the WRCC will be compromised by the fire service closing off that AVSU.
3. Staff consider provision of portable/temporary 02 for any patient likely to be affected in these actions.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
· Meetings held with Information and communication department and Working on a solution which we have identified- To establish Wi-Fi connection within WRCC by boosting the broad band with signal – Immediate and ongoing.

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
Registration Regulation 4 (1)	A person seeking to register or renew the registration of a designated centre for older people, shall make an application for its registration to the chief inspector in the form determined by the chief inspector and shall include the information set out in Schedule 1.	Not Compliant	Orange	17/02/2023
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	31/03/2023
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	17/02/2023
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and	Not Compliant	Orange	30/04/2023

	4 are kept in a designated centre and are available for inspection by the Chief Inspector.			
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	31/08/2023
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	31/08/2023
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	31/08/2023
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	31/08/2023
Regulation 28(1)(c)(ii)	The registered provider shall	Substantially Compliant	Yellow	30/04/2023

	make adequate arrangements for reviewing fire precautions.			
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.	Substantially Compliant	Yellow	31/08/2023
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	17/02/2023
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of	Not Compliant	Orange	30/04/2023

	residents.			
Regulation 28(3)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place in the designated centre.	Substantially Compliant	Yellow	30/04/2023
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Substantially Compliant	Yellow	31/05/2023