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:	Sullivan Centre
Name of provider:	Health Service Executive
Address of centre:	Cathedral Road, Cavan
Type of inspection:	Unannounced
Date of inspection:	21 July 2023
Centre ID:	OSV-0000494
Fieldwork ID:	MON-0040964

About the designated centre

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

The designated centre provides care and support to meet the needs of both male and female older persons. It provides residential accommodation for 18 long term-care residents and three residents requiring short-term care/respite. The philosophy of care is to provide a quality residential service to older people who have a diagnosis of dementia and who are mobile. The ethos, culture, practices and procedures of the centre reflects a person-centred approach that promotes independence and functioning to the residents' highest potential. Meaningful expression is facilitated by occupational, recreational, physical and sensory stimulation. Management and staff aspire to these values by being open to new ideas and ways of working, demonstrating a commitment to effective communication, teamwork and developing practice to reflect a shared vision of residents' care. The centre is a single storey building located in an urban area.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	18

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Friday 21 July 2023	10:15hrs to 18:30hrs	Catherine Rose Connolly Gargan	Lead
Thursday 27 July 2023	09:30hrs to 18:30hrs	Brid McGoldrick	Lead
Thursday 27 July 2023	09:30hrs to 18:30hrs	Gordon Ellis	Support

What residents told us and what inspectors observed

Overall, the inspectors found on this inspection that residents living in this designated centre were not adequately supported and facilitated to enjoy a good quality of life and to live the best life that they could. The inspectors found that residents were not supported and facilitated to choose where they spent their day. Residents' quality of life and their rights to independently choose where they spent their day were impacted by restrictions on their access to the gardens and their communal dining room after 17:00hrs. In addition there were limited opportunities for them to engage in meaningful social activities. The inspectors observed that interactions by staff with residents in one of the two sitting rooms were predominantly focused on providing care interventions for residents and there was limited evidence of meaningful person-centred interactions and conversations with them by staff.

Most residents who spoke with the inspectors expressed their satisfaction with the service and were content in their environment. However, others were not satisfied that they were unable to go outside into the gardens and into the dining room in the evening as they wished. The inspectors observed and spoke with with these residents who were were not satisfied with not being able to access the outdoor and the dining room as they wished. The inspectors observed that restriction on one resident's access to the outdoors combined efforts being made by a staff member to divert them away from the door was causing their distress to escalate. These residents told the inspectors that they did not know why their access was restricted. Staff told the inspectors that they routinely locked the doors to the secure outdoor garden when 'it is raining'. In addition, they explained that the dining room door was routinely locked when catering staff finished in the evening as there was not enough staff available to supervise residents in the dining room after this time.

Inspectors were told that there was no member of staff with overall responsibility for coordinating residents' social activities and that care staff facilitated residents' activities as part of their role. The schedule of daily activities happening on the day were written on a white board in each of the two sitting rooms. Outside of mealtimes and visits by relatives, most of the residents were observed to spend their day in one of the two sitting rooms with the television on and listening to music. The social activities available on the day did not offer any choice to residents who preferred to participate in more active group activities. On day one of the inspection, an inspector observed that hand and foot massages was taking place for residents in one of the sitting rooms while they listened to music. Although scheduled, massage did not take place in the other sitting room. Residents in the second sitting room were supported by staff to play a game of drafts, a game of chess and to participate in a game of skittles. The inspector observed that although these games were not scheduled to take place on the day, residents willingly participated and were obviously enjoying playing these games together. Some residents liked to read the local newspaper published each week and were happy to

discuss local items and news with staff and inspectors.

An inspector was told that residents were supported by staff to visit the local town and local places of interest and events. Although residents were unable to discuss these outings in much detail, the inspectors saw photographs of some of the residents enjoying being out and about in the local community.

Residents' accommodation in the designated centre was arranged on ground floor level around a central garden. A second large secure garden was provided to one side of the premises. Work had taken place since the last inspection in this garden and included laying of a rubber surface on footpaths, re-painting of fences and the walls and work on the flowerbeds. The inspector observed that both gardens provided residents with interesting and therapeutic outdoor spaces which some residents enjoyed spending much of there time in and sheltered seating areas were available in both gardens for residents use as they wished. A glasshouse was available to residents in one of the gardens and one resident liked to keep the tomato plants growing in it watered. Raised flower beds with a variety of colourful flowers and shrubs growing in them was available in the other garden. As part of an art project, residents were interviewed by artists who painted colourful murals on the walls around the central garden that were themed on the residents' interests and previous occupations.

Inspectors observed that refurbishment works were underway in one part of the building but did not impact on residents' circulating areas or communal space within the centre. However, the works impacted on the provision of sluicing and laundry facilities. Inspectors observed that repainting and redecorating in all parts of the residents' lived environment including their bedrooms was completed. Different colours and murals on the circulating corridor walls provided residents who liked to walk with purpose with variety and points of interest in their environment. Inspectors observed that residents' bedroom were painted in different colours and residents had been supported to personalise their bedrooms with photographs of their families and other personal items.

Inspectors observed that residents did not have a means to summon assistance in their bedrooms. While, there was a call bell facility, the leads and attachments were removed.

Inspectors observed that residents last main meal each day was at 16:00hrs and the dining room was locked at 17:00hrs. The inspectors were told by a member of the catering staff that they locked the dining room door on finishing work each day as staff were not available to supervise residents in the dining room after this time.

The next two sections of the report describe the provider's levels of compliance with the Health Act 2007 and the Care and Welfare Regulations 2013. The findings in relation to compliance with the regulations are set out under each section.

Capacity and capability

This was an unannounced risk inspection carried out over two days by inspectors of social services to assess compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). On this inspection, inspectors reviewed the actions completed by the provider to bring the centre into compliance with the regulations since the last inspection in October 2022. The inspectors found that the provider had made significant improvements to the residents' lived environment with refurbishment and redecoration of their bedrooms, communal areas and the outdoor gardens. Further building work was underway to reconfigure the storage and utility areas. Fire safety works including replacement of a number of fire doors had also been completed. Notwithstanding the positive improvements made since the last inspection, the inspection found that compliance with the regulations was not sustained and non-compliances were found in the majority of the regulations assessed on this inspection.

This inspection found that management and oversight of this service was not effective and the quality assurance processes in place did not ensure that this service was safe, appropriate and met the needs of the residents.

The inspectors found that the service provided to residents was not aligned to the centre's statement of purpose and registration conditions. Management and oversight by the provider had not ensured effective care delivery and the quality and safety of the service for residents. The provider had not ensured that risks associated with the works that were underway to the premises on the days of this inspection were identified and appropriately managed to ensure all risks to residents' safety and care delivery were identified and effectively mitigated. As a result, the inspectors found that residents were not adequately protected from risk of infection and their fire safety was not assured. Furthermore, oversight of residents' care, support and quality of life was not of a good standard on this inspection.

The registered provider of Sullivan designated centre is the Health Service Executive (HSE). The provider is represented by a service manager who also has regional responsibility for a number of other services. As a national provider involved in operating residential services for older people, this centre benefits from access to and support from centralised departments such as human resources, information technology, staff training and finance. The person in charge reports to and has senior clinical support at a regional level from the service manager. Local clinical support and deputising arrangements for absences by the person in charge were not in place at the time of this inspection as the clinical nurse manager position was vacant. This senior local management role had been vacant for a number of months and as a consequence, the weakened local management structure was negatively impacting on oversight of the standards of care and supports provided to residents. In addition, risk to residents' health and welbeing were not effectively mitigated. For example, sufficient supports and resources were not in place to manage residents at risk of choking.

The numbers and skill mix of staff working in the centre on a daily basis was not

adequate and the staff resources that were available were not being used effectively. For example, there was inadequate numbers of staff with appropriate skills to provide social care and activities for the residents in line with their capacities and choices. The staffing resources required at night to meet residents' evacuation needs, as identified in a fire safety risk assessment completed in the centre were not provided.

Records showed that staff had access to mandatory training in fire safety, safeguarding residents from abuse and safe moving and handling procedures. However, staff did not have access to training and support to develop their skills and competencies with providing person-centred care and with supporting residents who experienced responsive behaviours. This is a repeated finding from the inspections completed in May and October 2022.

Staff had completed the required training in infection prevention and control specific to their role, however, the inspector found that a number of staff practices were not in line with the best practice standards and the supervision of staff was not effective in this area. The system of supervision did not ensure that infection prevention and control standards were maintained at all times. Infection prevention and control practices in some areas on the days of the inspection were not consistent with the required standards and this had not been identified by senior staff through the centre's staff supervision processes. This is a repeated finding from the inspection in May 2022.

Regulation 15: Staffing

The provider had not ensured there was adequate numbers of staff with appropriate skills to meet the needs of residents. This was evidenced by the following findings;

- appropriate supervision of a resident who engaged in behaviours that posed a risk to their health and well being was not in place.
- there was insufficient staff available to supervise residents in the dining room after 17:00hrs and as a result residents were not permitted to access the dining room after this time.
- students on work placement were not adequately supervised
- residents with responsive behaviours that posed a risk of harm to other residents were not appropriately supervised at all times in the sitting room
- appropriate supervision was not in place to supervise residents at mealtimes and in particular for those residents at risk of choking
- there was no formalised deputising arrangements while the person in charge was on scheduled leave.

Judgment: Not compliant

Regulation 16: Training and staff development

Some staff did not have access to appropriate training in line with their roles and responsibilities. This was evidenced by:

- 15 staff had not completed training in infection prevention and control standard precautions. For example only six out of the 39 staff working in the centre had completed training in prevention and control of clostridium difficile infection.
- training for staff to ensure they had appropriate knowledge and skills to manage residents' responsive behaviours had not been facilitated. This is a repeat finding from the last inspection in October 2022.

Staff were not appropriately supervised according to their roles to ensure high standards were maintained in the following areas;

- to ensure documentation of residents' care plans were completed to a high standard
- to ensure that residents' individual choices to access the outdoor gardens and the dining room were respected by staff.

Judgment: Not compliant

Regulation 21: Records

The records of residents' the special diets that needed preparation for residents and maintained in the centre's kitchen were not up-to-date.

Residents' records were stored on open shelves and were not held securely. These was no effective system to catalogue records belonging to individual residents stored in this area.

Judgment: Substantially compliant

Regulation 23: Governance and management

The registered provider had failed to ensure that resources in the centre were planned and managed to ensure person-centred, effective and safe services. The management structure in place was not clearly defined with clear lines of accountability and responsibility, in line with the centre's statement of purpose. The provider had failed to ensure the service had sufficient staffing resources to;

- ensure the management structure was maintained in line with the centre's statement of purpose. This impacted on effective governance and oversight of the service. For example, the clinical nurse manager position was vacant for a number of months staff levels to ensure effective support and supervision of the nursing and health care staff teams.
- failure to maintain staffing levels. The staffing levels at night time had not been revised following a fire safety risk assessment which identified a requirement for four staff each night to ensure residents safety in the event of a fire. Currently there are three staff rostered. There were limited activities for residents, the diversionary therapy role was vacant. The role of hairdresser was also vacant which meant that residents had infrequent access to this service.

The oversight and management of risk in the centre was not effective. Consequently, there were poor systems in place to identify, manage and respond to risk. This was evidenced by;

- a failure to risk assess the works in progress in the centre. There were no risk assessments completed to identify and appropriately mitigate risks such as dust, noise, aspergillosis and fire.
- a failure to plan for both effective sluicing and laundry arrangements while works were in progress. Inspectors found that inadequate sluice and laundry facilities were available
- a failure to implement the centre's risk management systems to identify and respond to the risk of residents choking. No risk assessment as to level of supervision and equipment that was required to ensure these residents' safety was in place. Inspectors were advised that a registered nurse would supervise at meal times, however, inspectors found that this did not consistently take place.
- failure to implement policies and procedures designed to protect residents. There was poor oversight and response to a safeguarding incident. A root cause analysis was not completed to identify learning and mitigate risk of recurrence.
- failure to implement effective communication systems to ensure key clinical information regarding residents' care needs were effectively communicated to all staff. For example, household staff are not included in handover and as a result there was conflicting information with the infection prevention care plan information for a resident. In addition, the resident list used to inform resident's dietary requirements in the kitchen was not up dated.
- failure to ensure access to allied heath professional for residents assessed at risk. The centre did not have access to a dietician for residents since September 2022.
- failure to oversee infection prevention and control and fire safety measures in the designated centre. The inspectors' findings are detailed under regulations 27: Infection control and 28: Fire precautions
- failure to ensure residents' safe nutritional intake. Residents had unsupervised access to two unlocked refrigerators in the dining room. This posed a risk to residents with needs for modified consistency food and fluids to ensure their safety and welbeing. This risk was not assessed and

effectively mitigated.

The quality assurance systems in place for monitoring the quality and safety of the service were not effective and consequently most of the inspectors' findings on this inspection had not been identified by the provider through their oversight and auditing processes. Action plans were not consistently developed to address the deficits that were identified in some audits by the provider and evidence of completion of the action plans developed was limited.

Judgment: Not compliant

Regulation 31: Notification of incidents

A potentially communicable infection and a safeguarding incident were not notified within three working days to the Chief Inspector, as required by the regulations. Not all restrictive practices in place were notified in the report submitted to the Chief Inspector for quarter one 2023, as required. For example, doors to the garden were routinely locked during rain showers and restricting residents access to the outdoors, and the doors to the residents' dining room were locked after 17:00hrs each day.

Judgment: Not compliant

Regulation 3: Statement of purpose

The registered provider did not update the designated centre's statement of purpose and function to reflect :

- the changing dependencies of residents accommodated in the centre. The admission criteria for the centre required that residents would be independently mobile. However, a number of residents were not mobile on the days of this inspection.
- the changes made to the purpose of some rooms in the centre. For example, one room was identified as a dining space, however it was re purposed as an oratory on this inspection. Furthermore, a room was being converted to a store in which there were a number of electrical panels.

The fire procedures outlined in the statement of purpose did not align with what inspectors were told on the day of inspection or the centre's fire policy

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

The registered provider had failed to implement both the safeguarding and infection prevention and control policies and procedures.

Judgment: Substantially compliant

Quality and safety

Overall, inspectors found that residents' clinical and nursing care needs were being met to a satisfactory standard. Whilst staff knew residents well, inspectors observed that residents' daily routines did not always reflect the individual preferences of the residents. Residents were no longer restricted into two separate units within the centre, and they could choose to spend time in either side of the centre or in either of the two sitting rooms. However, an institutional culture persisted where staff continued to refer to the two sides of the building and the sitting rooms as gender specific. In addition, intermittent restrictions on residents' access, and daily routines were not person-centred or informed by appropriate assessments and were negatively impacting on residents' lives. Restrictive practices prevented residents from accessing the outdoors in rainy weather and the dining room after 17:00hrs each evening and as a result limited residents' opportunities to enjoy a meaningful life in the centre. This was having a negative impact on residents' rights, quality of life and well being and did not uphold their rights to determine how and where they spent their day.

Residents were provided with good standards of nursing care and had access to timely health care from their general practitioner (GP) who attended the centre on three days each week. There was also good access for residents to most allied health professional services and psychiatry services which optimised their health and clinical well being. However, residents' did not have timely access to a dietician and they also experienced delays with accessing occupational therapy specialist services.

Residents' bedrooms and communal rooms were on ground floor level and each resident was accommodated in a single bedroom, some of which had en-suite toilets and shower facilities. The provider ensured that each resident had shelf space to display their photographs and other items since the last inspection. It was evident from works completed since the last inspection that the provider was working to develop the environment to become a dementia-friendly space, ensuring a familiar and therapeutic environment for residents.

For the most part, residents were provided with satisfactory standards of clinical care to meet their needs. A review of residents' care documentation found that information was not always accurately completed. For example, a residents fluid intake chart was incomplete and therefore could not be used to by staff to assess

this residents' fluid intake.

Residents were supported to access their local community with arranged outings to places of interest and events. Residents had access to televisions, radios and newspapers, but limited meaningful social activities were facilitated within the centre for residents by staff to ensure residents were supported to participate in social activities to met their interests and capacities. This was a repeated finding from previous inspections.

Inspectors found that that staff did not consistently provide appropriate support and care for those residents who may display responsive behaviours (how residents who are living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). As a result some residents' behaviours were not appropriately managed by staff and effectively de-escalated. Staff practices in relation to restrictions on residents' access in their lived environment were not in line with the national restraint policy.

Although measures were in place to ensure residents were safeguarded from abuse, poor oversight of implementation of these measures did not ensure they were effective. The inspectors were not assured that residents' risk of abuse, including institutional abuse was recognised and appropriately addressed.

While it is acknowledged the provider had completed some fire safety works that had been identified in the provider's own fire safety risk assessment, not all recommendations had been completed and additional fire risks had been identified by the inspectors on this current inspection. As a result, the registered provider was failing to meet the regulatory requirements on fire precautions in the centre and had not ensured that residents were protected from the risk of fire.

The provider must make significant improvements in order to comply with the regulations. The inspectors found uncertainty in the following areas:

- Fire containment in some areas of the centre
- Deficiencies with some fire doors,
- Inadequate evacuation procedures,
- Fire precautions
- Lack of emergency lighting to some exterior areas,
- Lack of fire safety management and fire risk awareness, which could lead to serious consequences for residents in an emergency.

These are outlined in detail under Regulation 28: fire precautions.

Inspectors found that the provider did not comply with Regulation 27 and the National Standards for infection prevention and control in community services (2018). Weaknesses were identified in infection prevention and control oversight, risk management, and environmental and equipment management. Inspectors found from talking with staff that further training was required to ensure staff are knowledgeable and competent in the management of residents with clostriduim difficile. The provider has installed a number of clinical hand wash sinks convenient to the point of care for staff use. However, not all hand hygiene procedures by staff

were effective. Residents were supported to access vaccines to reduce their risk of contracting COVID-19, influenza and pneumonia.

Regulation 12: Personal possessions

Residents had access to and were supported to maintain their own personal clothing and possessions. The provider had fitted corner shelving, a storage unit over each resident's sink, provided each resident with a drawer unit, and refitted their wardrobes since the last inspection. This action ensured residents had adequate surface space to display their photographs and other items in addition to adequate storage space for their clothing.

Laundering of residents' personal clothing was carried by an external laundering service.

Judgment: Compliant

Regulation 17: Premises

The provider had not ensured that all parts of the premises were appropriate to the number and needs of residents and in accordance with the centre's statement of purpose.

Store rooms numbered 40, 41 and 42 on the designated centre's floor plans were being refurbished at the time of this inspection. The rooms for laundering flat mops and the sluice room were also being refurbished. The laundry room and sluice were still in use but were not fit for purpose. For example, the floor covering in both these rooms was removed and the remaining floor surfaces were not in a clean state and could not be effectively cleaned. With the exception of the bedpan disinfection machine in the sluice room and a domestic-type washing machine in the laundry, both rooms were stripped of any fixtures and fittings and the under surface of parts of the wall was exposed.

Adequate and appropriate storage was not available for catering equipment and as a result residents' communal space in the dining room was reduced by storage of two catering trolleys and two large refrigerators in the residents' dining room. The refrigerators were used by catering staff for storing various perishable food and fluids that had been prepared for use during the day.

Ventilation was not adequate in the nurses clinical room where they prepared and stored medications and other clinical equipment.

Paint was missing over the windows in a number of residents' bedrooms due to

removal of the curtain poles, following fitting of new blinds on these windows.

Judgment: Not compliant

Regulation 27: Infection control

The registered provider had not ensured effective governance and oversight arrangements were in place to ensure the sustainable delivery of safe and effective infection prevention and control measures. This was evidenced by the following findings;

- measures including completion of appropriate risk assessments were not in place to mitigate infection risks to residents posed by the building works and use of facilities in the building site to meet residents' needs.

The environment and equipment was not managed in a way that minimised the risk of transmitting a health care-associated infection. This was evidenced by;

- a hand hygiene sink was not available in the sluice room to facilitate effective hand hygiene following transportation and placement of contaminated bedpans in the bedpan decontamination machine in the sluice facility on day one of the inspection and there were no sluice room facilities available on day two of the inspection.
- the covering on the floors of the sluice and laundry rooms were removed and the wall surfaces in both these rooms were damaged and the masonry was exposed in a number of areas. These rooms were dusty and visibly unclean and posed a risk of cross infection to residents
- used bedpans awaiting decontamination were stacked directly on the floor of the sluice room and there was no shelving available for storage of clean bedpans and urinals on day one. On day two of the inspection, there were no sluicing facilities or laundry facility (to wash floor mops) as building work was taking place in these rooms. There were no arrangements in place for staff to decontaminate equipment in the interim of the works in progress. This increased the risk of environmental contamination and cross infection. The works were planned to take 12 weeks to complete.
- urinals were placed directly on the floor by a toilet in a communal shower/toilet and on the floor by a sink in another communal shower room. This presented a risk of cross contamination.
- the precautions to control and prevent spread of a potentially communicable infection were not adequate. For example, not all staff had attended training on controlling and preventing cross infection of a known potentially communicable infection in the centre. Assurances were not available that all staff in contact with this infection completed appropriate and effective hand hygiene procedures.
- two mattress covers viewed were worn and could not be effectively cleaned
- there was no cleaning schedule for ventilation vents, fans and shower drains.

A number of these were found to be unclean on the second day of this inspection.
- actions were found to be necessary to ensure that cleaning and disinfection processes were effective. For example, commode and shower chairs viewed by the inspectors were not clean.
- a blood spill kit was not available for staff use in the event of a spillage of blood or bodily fluids.

Judgment: Not compliant

Regulation 28: Fire precautions

The registered provider was failing to meet the regulatory requirements on fire precautions in the centre and had not ensured that residents were protected from the risk of fire. The provider was non-compliant with the regulations in the following areas:

Day-to-day arrangements in place in the centre did not provide adequate precautions against the risk of fire. For example:

- Inspectors observed a chair blocking a fire door. This created a potential fire risk and could potentially compromise a protected means of escape in the event of an evacuation
- Immediate actions in regard to fire risks had to be issued to the provider on the day of the inspection in relation to inappropriate storage practices. For example, in the Communications room, the inspectors observed the storage of flammable items. This was brought to the attention of the person in charge and the items were removed.
- In a residents smoking area, the inspectors noted a lack of a fire blanket, smoking apron, ashtrays and a call bell.
- In a clinical room, the inspectors noted oxygen cylinders were being stored in an inappropriate manner as they were not secured.
- A room that contained numerous electrical panels and wall units was being used as a storage area. The inspectors were not assured that due to the presence of these electrical panels that this room was suitable as a storage area.

The provider needed to improve the means of escape for residents and emergency lighting in the event of an emergency in the centre. For example, the procedure in regard to access to a key to operate all of the green break glass units throughout the centre in order to release cross-corridor fire doors was not suitable. The inspectors were advised that only one key was available which was kept at the nurse's station. However, staff were not familiar with this procedure when asked to demonstrate for the inspectors. In cases of emergency, appropriate override arrangements must be in place to reduce the risk of delays and to maintain a clear

means of escape. This requires a review by the provider`s competent person.

A fire exit that lead to a rear car park required a key to unlock the final fire exit. The inspectors noted that not all staff members carried a copy of this key on their person and a copy of the key was not located adjacent to the fire exit door in a break-glass unit. Furthermore, the inspectors noted there was a lack of emergency directional signage (running man sign) above a cross corridor door to direct staff and residents to a fire exit from the conservatory area in the event of fire. This could potentially cause confusion and panic in the event of a fire evacuation

Externally, in an enclosed garden and to the rear of the centre, adequate emergency light was not provided for to illuminate a path to a safe area from the centre during a night time evacuation, this required a review. Furthermore, an exit gate from the enclosed garden was fitted with a padlock and the only one key was kept with the nurse on duty to unlock the gate. There was no process in place to ensure the handover of this key was passed on to the staff member coming on duty. As a result, appropriate arrangements to maintain a clear means of escape were not in place. This created a potential risk for staff and residents to become trapped in the garden in a fire emergency.

The inspector observed a fire exit that lead to a rear car park area was indicated as a designated fire exit on the evacuation floor plans and had an emergency fire exit fitted above the fire exit door. However, the area was not suitable to bring residents in the event of an evacuation as there was no designated assembly point, the area was an active car park and was beside a public road. This required a review.

The provider needed to improve the maintenance of the fire equipment, means of escape and the building fabric. For example, the procedure in order to access all fire extinguisher throughout the centre along corridors required a key. The inspectors were advised that only one key was available which was kept at the fire panel. A risk assessment of this method was not available nor was it documented in the providers` fire policy. Furthermore, there was no procedure in place to ensure the key would not be misled. This combined with the inappropriate procedures in regard to operating fire door override systems created a significant risk to residents in an emergency and required a review by a competent person.

Several areas in the centre were noted to have utility pipes or ducting that penetrated through the fire-rated walls and ceilings (walls and ceilings built in a way to provide a certain amount of fire resistance time). Appropriate fire sealing measures were required in these areas.

The majority of fire doors in the centre were well fitted and maintained to a good standard. However, on day one of the inspection it was noted that a dining room door adjacent to a means of escape would not close fully and was held open due to a kitchen extractor fan. This created a potential risk for fire and smoke to easily spread as the dining room was not separated by fire rated construction from the kitchen. In addition to this, two corridor compartment fire doors and a sitting room fire door did not close fully when released. Furthermore, doors located between adjoining bedroom walls did not appear to meet the criteria of fire rated doors.

At the main entrance, the inspectors noted the opening direction of the main entrance doors, which was a designed fire exit, opened to the interior side and not in the direction of escape. This could cause a delay and impede instant egress from the centre in the event of an evacuation.

In addition, the provider needs to review fire precautions throughout the centre. Deficiencies identified in regard to fire doors had not been identified on the in-house routine checks of fire doors. From a review of records there was no evidence to demonstrate that fire doors were being individually checked.

During the inspection, the inspectors noted significant construction works were being carried out in the centre. From a review of fire safety policies and procedures, the inspectors concluded there was no policy or procedures available to be followed when construction works were being carried out in the centre. The provider had not identified or assessed the risk of fire prior to or during the ongoing construction works in the centre. This created a potential significant risk to the safety of the residents in the centre.

Fire evacuation drills were taking place and the majority of staff had up-to-date fire training. However, a number of staff did not demonstrated appropriate awareness of the action to be taken in the event of a fire emergency. As a result, further fire drill practice is required in order to further support staff to protect residents from the risk of fire.

From an assessment of residents' personal emergency evacuation plans (PEEPs) the inspectors noted they were not sufficiently detailed and did not include the use of additional aids/sedatives (including night time) for specific residents who required them. These residents would require a staff member to alert them to a fire emergency especially during sleeping conditions. Furthermore, the peeps had not been updated to reflect the changing mobility needs of some residents. For example, some residents who were in the maximum category of dependency were indicated as being mobile. This could cause confusion in an emergency situation.

Arrangements for containment of fire and detection in the event of a fire emergency in the centre required improvement by the provider. For example, the inspectors noted the dining room and the kitchen are not separated by adequate compartmentation. This was evidenced by the lack of containment between the kitchen and the dining room due to a large opening used to provide access to the kitchen and to facilitate serving food. A kitchen is a high risk area and should form a 60 minute fire rated compartment. This created a potential risk for fire and smoke to spread easily into the dining room where residents who can have a mixture of dependencies would be located on a daily basis.

From a review of the provider`s own fire safety risk assessment it was recommended that a more invasive survey of the compartment walls to roof junctions is undertaken to determine the level of fire stopping between the block wall and roof finishes. The person in charge could not confirm that this had been carried out or the outcome of this survey and as such the inspectors were not assured that adequate compartmentation was provided for in the centre.

While the centre is provided with an L1 category fire detection alarm system, the inspectors noted some rooms in the centre were lacking detection. For example, a store room in a multi-purpose/dining room, a W.C. and an assisted bathroom were missing detection.

The provider failed to provide adequate arrangement for evacuating all persons in the designated centre and the safe placement of residents in the event of a fire emergency. For example, from a review of the provider evacuation policy and fire drills, it stated that one staff member was required to stay at the front door while the two remaining staff members evacuated the compartment where the source of the fire was identified. As the centre is a dementia specific unit, a staff member was not rostered on duty to supervise the evacuated residents who have dementia. In addition to this the provider`s own fire safety risk assessment indicated that four staff members would be required for a nine bedded compartment. The inspectors noted the two largest compartments in the centre are registered to accommodate nine residents in each compartment. Drills reviewed indicated extended evacuation times of the largest compartments, which would suggest a deficiency in the evacuation procedures. This required a review

From a review of the available evacuation aid equipment, the inspector noted there was a lack of evacuation sledges that would be required for four maximum residents in the event of an evacuation. Furthermore, evacuation sledges were stored in a locked room that required a key code and not all staff knew the key code to access the evacuation aid. This would potential create a confusion and delay the evacuation of residents in a fire emergency. In addition to this, some staff were unaware that there was more than two evacuation sledges in the centre.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Comprehensive assessments were completed that identified each resident's care and support needs, but the information in some residents' corresponding care plans reviewed by the inspector did not clearly detail their care and support needs in line with their individual preferences and usual routines. This posed a risk that this pertinent information would not be communicated to all staff. For example, one resident had a hearing impairment and used hearing aids but their care plan did not detail their preferred routine with wearing the hearing aids. As a result, staff did not ensure that this resident wore their hearing aids to listen to the music DVD playing as part of the social activity programme for residents on the day of inspection.

The information in the care plans was not based on appropriate assessment. For example, two residents needing support from staff with maintaining their hydration did not detail their preferences regarding their fluid intake or the amount of fluid requirement for each day. The inspector observed that the records of their fluid intake recorded on the day previous to the inspection did not give assurances that

their hydration needs were met or that low fluid intakes were identified by staff and appropriately addressed. This is a repeated finding from the last inspection.

Care plans were not reviewed or updated when a resident's condition changed. For example, a care plan for a resident whose mobility had deteriorated did not have their care plan updated to reflect the additional intervention and equipment required to aid their mobility.

Although there was evidence that residents' care plans were reviewed in consultation with them and their representatives, there was no information available regarding the details of the review that took place or if any changes were made. This is a repeated finding from the last inspection.

Judgment: Substantially compliant

Regulation 6: Health care

Residents' access to a dietician was not assured. For example, one resident with significant unintentional weight loss was not appropriately referred to a dietician and continued to lose weight. In addition, a small number of residents required referral due to their deteriorating condition and there had been no access or referral pathways to dietician services available since Sept 2022.

Judgment: Not compliant

Regulation 7: Managing behaviour that is challenging

The inspector found that some residents' experiencing responsive behaviours were not appropriately supported by staff and the documentation of the responsive behaviours experienced by residents was incomplete. This meant that this information was not available and effectively utilised to comprehensively inform residents' individual care and support needs.

The restrictive practices in place in the centre did not reflect best practice guidance and did not ensure that restraints were used in the least restrictive manner and for the minimum amount of time required. For example;

- Residents' unrestricted access to the outdoor gardens was dependant on weather conditions and residents' access was restricted to the communal dining room after 17:00hrs each day. Doors to the outdoor gardens were intermittently locked by staff and could not be independently opened by residents. This is a repeated finding from the inspection in May 2022. A risk assessment was not in place for each resident to record what the risks were and what non-restrictive interventions were in place to manage the risk prior

to implementing restraints such as locked doors.

Judgment: Not compliant

Regulation 8: Protection

The registered provider failed to take reasonable measures to protect residents from abuse and to provide for appropriate and effective safeguards to prevent abuse. This was evidenced by the;

- failure to recognise and respond appropriately to an allegation of abuse. A root cause analysis was required to ensure learning from incident and to ensure a similar incident did not recur.
- failure to recognise and manage institutional practices in the centre that negatively impacted on residents' self determination and wellbeing.

Judgment: Not compliant

Regulation 9: Residents' rights

Residents' right to exercise choice in how and where they spent their day was not respected. Resident's daily routines were largely determined by staff working in the centre and did not reflect individual preferences of residents and did not reflect flexible routines as determined by individual residents on a daily basis.

Residents were not provided with adequate opportunities to engage in meaningful social activities that met their interests and capacities.

Residents' right to make individual choices was not respected. For example, residents' choice to go outside was taken away from them by staff whenever it rained. Furthermore, residents' the arrangement in place was that residents' teatime meal was served to them at 16:00hrs and the kitchen and dining room were closed at 17:00hrs by the catering staff at the end of their working day. There no evidence available that the provider had reviewed this arrangement to ensure residents' rights were respected and that they were satisfied with this arrangement.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Not compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Not compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Sullivan Centre OSV-0000494

Inspection ID: MON-0040964

Date of inspection: 27/07/2023

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**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: To ensure compliance with Regulation 15 Staffing compliance will be met by the following: 1. CNM2 will commence duty on the 20th of November 2023 and in the interim deputizing arrangements are in place. 2. An Enhanced Care Package has been put in place for a resident whom engaged in behaviours that posed a risk to their health and well-being. This enhanced care package will be reviewed ongoing to ensure that the needs of the resident are maintained 3. A review of the staffing allocations and residents supervision needs has taken place. This has resulted in residents having access to the dining room at all times 4. All residents living in Sullivan Centre can now have access to the Dining-room at any time during the day or night. 5. Students on work placement are now supervised by an appropriate member of staff at all times during their placement. This will be monitored on an ongoing basis by the Person in Charge 6. Two staff members are allocated to each sitting room to provide appropriate supervision to residents. 7. During meal times a staff nurse and Health Care Assistants are now assigned to the dining room. This ensures that residents are supervised and supported at meal times. Individual risk assessments have been completed for those residents whom have swallow difficulties. This risk is communicated to all staff at the daily safety pause	
Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
To ensure compliance with Regulation 16: Training and staff development. Compliance will be met by the following:

1. 97% of staff have completed IPC Standard Precautions Training. The remaining staff will complete the training by the 31st of October 2023.
2. 97% of staff have now completed the Prevention and Control of C-diff Training. THE remaining staff will complete the training by 31st October 2023.
3. 91% of staff working in the Sullivan Centre have received Focused Interventions Training and Support (FITS) in dementia. This training has been designed to significantly improve the quality of life, opportunities and engagement for people living with dementia. Training dates are being sourced through the CNME for the remaining staff.
4. An additional two training programmes have been sourced by the Person in Charge and Provider which will support all staff in the management of Residents with responsive behaviours.
• Responsive Behaviour Training will be provided to all staff by an external facilitator. This will be completed by the 31st of October 2023.
• PMCB - Prevention and Management of Complex Behaviour-training will commence in November 2023
5. The Person in Charge and the Provider have developed an Annual Audit Schedule. As part of this audit schedule care plans will be audited on a monthly basis. This will ensure that residents care plans are completed to a high standard. Following the care planning audit time bound action plans will be developed and actioned. The findings of these audits will be communicated to all staff at the staff meetings
6. On a monthly basis the Person in Charge completes the National Quality Care Nursing Metrics. This will further strengthen the governance within the centre assuring that residents care plans are of a high standard
7. The Practice Development Officer has commenced a Person Centred Care planning programme for all nursing staff. All nursing staff will have completed the training by the 31st of October 2023
8. Ongoing engagement continues with HR in the recruitment of the Clinical Nurse Manager II position. This position will be filled by the 20th of November 2023. This will further strengthen the governance arrangements within the centre
9. Residents now have access to the outdoor gardens based on individual choice.
10. The dining room door is now open at all times which allows residents to access same as per their choice

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
To ensure compliance with Regulation 21: Record. Compliance will be met by the following:
1. Resident records of special dietary requirements are now all up to date and are

displayed in the Main Kitchen for Chefs and Catering Staff.
2. A template is in place which captures resident's dietary needs. This template is forwarded to the catering staff which alerts them to changes in resident's dietary needs. The Person in Charge will completed on going reviews of residents dietary needs to ensure the information in the kitchen is up to date
3. Resident records are now stored in a locked store. A review of the resident's records has commenced within the centre. As appropriate residents records will be archived and removed to secure storage or destroyed in line with HSE Policy on Record Retention and Destruction. This will be fully completed by the 31st of October 2023

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
To ensure compliance with Regulation 23: Governance and management. Compliance will be met by the following:

1. The vacant CNM2 position has now been recruited and the successful candidate will commence duty on the 20th of November 2023. In the interim deputizing arrangements are in place and this is clearly identified on the roster
2. Following inspection, a third HCA has now been rostered on night duty. This ensures that four staff members are rostered on night duty
3. The works have been completed in the sluice and the laundry rooms as of the 28th of September 2023.
4. 2 Staff members are allocated 10.30 to 5pm Monday to Sunday to provide meaningful activities.
5. Residents have access to an external hair dresser fortnightly or as required.
6. Risk assessment for Inhalation and exposure to dust particles during works completed on 28th July2023. PIC or senior nurse oversees this on their daily walk- about.
7. Risk assessment for exposure to Aspergillus due to works carried out on 21st July 2023.
8. Risk Assessment in relation to Fire Risk due to works completed on 28th July 2023. Daily Fire checklist in place during works.
9. Two staff members are allocated to each sitting room to provide appropriate supervision to residents.
10. During meal times a staff nurse and Health Care Assistants are now assigned to the dining room. This ensures that residents are supervised and supported at meal times. Individual risk assessments have been completed for those residents whom have swallow difficulties. This risk is communicated to all staff at the daily safety pause
11. All staff have completed the Safeguarding Vulnerable Adults at Risk of Abuse online Training on HSELand. The Person in Charge has sourced face to face training for staff in Safeguarding. This will commence from the 12th of October 2023
12. Safeguarding Vulnerable Adults at Risk of Abuse is now a standing Agenda item in

the Centre's Daily Safety Pause and at team meeting
13. The Person in Charge reviews all incidents on a weekly basis and formally reviews incidents on a monthly and quarterly basis as to determine and monitor any trends that are occurring. This allows the Person in Charge and the management team to discuss any patterns of concerns and allows for the development of timely quality improvement plans.
14. The CHO1 Safeguarding Team have been notified of the Safeguarding Incident. A Formal Safeguarding Plan was submitted to Safeguarding Team and a Letter of Closure received as of the 24th august 2023
15. The centre will continue to liaise directly with the social work team and the safeguarding and protection team CHCDLMS regarding all incidents of a safeguarding nature. These services provide advice, support and onsite support. Two member of the Safegaurding team will complete a site visit to the centre on the 16th October 2023.
16. A template is in place which captures resident's dietary needs. This template is forwarded to the catering staff which alerts them to changes in resident's dietary needs. The Person in Charge will completed on going reviews of residents dietary needs to ensure the information in the kitchen is up to date
17. Each day following handover the staff nurse on duty communicates any update, changes to resident's infectious status and any outbreaks of any infectious diseases to the cleaning staff.
18. Residents now have access to Dietetic Services through an external agency
19. The two fridges located in the dining room have now been removed
20. The Person in Charge and the Provider have developed an Annual Audit Schedule. As part of this audit schedule care plans will be audited on a monthly basis. This will ensure that residents care plans are completed to a high standard. Following the care planning audit time bound action plans will be developed and actioned. The findings of these audits will be communicated to all staff at the staff meetings
21. The Centre's two IPC Link Nurse Practitioners now carry out a weekly audit focusing on an identified area, any areas of concern will have a QIP completed with identified timeframes for closeout. The audit process will be supported by the IPC CNS. The PIC will maintain oversight of these audits.
22. The IPC CNS will continue to complete unannounced site visits to the centre. The IPC CNS will continue to complete external MEGS audits.
23. The nominated Nurse in Charge carries out quality care walk–about, three times throughout the day i.e. .09:00. 13:00 and 15:00 hrs, which focuses on observation of; residents health and well-being, residents engagement/activities, person centered moments/staff engagement, person centered language and environment, residents meals, safe environment, health & safety, door checks and medication management. Positive observation and areas for improvement are identified, any areas of concern which can be dealt with at the time are actioned immediately, other areas for improvement are recorded on the action plan which identifies date, noncompliance, action plan required, the responsible person, the due date and progress of corrective actions. The PIC will maintain oversight of these of this process.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
To ensure compliance will Regulation 31: Notification of incidents. Compliance will be met by the following:
• The Person in Charge has notified the Chef inspector of the infection and safeguarding incident as of the 24th of July 2023
• The Person in Charge will ensure that all restrictive practices in place are notified to the Chef inspector as per the quarterly notification process

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
To ensure compliance will Regulation 3: Statement of Purpose. Compliance will be met by the following:
1. The registered provider and the Person in Charge has completed a review of the Statement of Purpose as of the 8th of September 2023. The Provider shall review and revise the statement of purpose at interval of not less than one year or as required
2. The Statement of purpose has been updated to include the review of residents' placement in the Centre, when there is a deterioration in their mobility status. This may result in the resident moving to another designated centre to meet their needs following consultation with the residents and their nominated person
3. Room 37 has been returned to a multi- purpose room /prayer room.
4. The room which contains a number of electrical panels is not being used as a store room. This room is now empty. The Person in Charge/nominated person will complete a daily review of the room to ensure no storage is placed in the room

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
To ensure compliance will Regulation 4: Written policies and procedures. Compliance will be met by the following:

1. Safe-Guarding and Infection Prevention and Control Policies and Procedures are fully implemented in the Centre. Both these policies have been re-issued to all staff on the

14th August 2023.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
To ensure compliance will Regulation 17: Premises. Compliance will be met by the following:

1. The refurbishment is now complete in the sluice room, laundry room and clean commode store room as of the 28th of September 2023
2. The two fridges in the dining room have now been removed
3. A manual ventilation system is in place in the form of a vent. This is maintained in an open position on an ongoing basis. There is also two windows in the Clinical room which are also opened on a daily basis. This ensures appropriate ventilation
4. The repainting above the windows in the Resident's bedrooms shall be completed by 31st of October 2023.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
To ensure compliance will Regulation 27: Infection control. Compliance will be met by the following:

1. Risk assessment have been completed in relation to Dust, Noise, Fire, and Aspergillus for the construction works taking place in the centre. This was carried out in conjunction with IPC CNS, the external contractor and the PIC.
2. Meg audits will be completed on a weekly basis for the duration of the works. This audits will allow for action plans to be completed with time bound actioned plans.
3. Prior to the commencement of the Phase 2 works a schedule meeting has taken place on the 2nd of October with all stakeholders (Estates, Architect, eternal contractor, IPC team, Registered Provider, Person in Charge, Clinical lead of Quality and Risk). A plan of works were completed and submitted to DCOP on the 10th of October 2023. Ongoing scheduled meetings will take place with all stakeholders for the duration of the works
4. A clinical Hand Wash Basin is now available in the Sluice Room
5. Washing Machine is now available and in use for washing floor mops
6. The Centre has in place a cleaning and decontamination schedule for all resident equipment. The Health Care Assistants are responsible for completion of this cleaning schedule and signing same. This will be monitored by the Person in Charge on an

ongoing basis
7. 97% of staff have completed IPC Standard Precautions Training. The remaining staff will complete the training by the 31st of October 2023.
8. 97% of staff have now completed the Prevention and Control of C-diff Training. THE remaining staff will complete the training by 31st October 2023.
9. 100% of staff working in Sullivan Centre have completed their Hand Hygiene Training.
10. Damaged mattresses have been removed and replaced
11. Ventilation Vents, Fans and Shower Drains have been cleaned and have been added to the cleaning Schedule. The Person in Charge will monitor same on an ongoing basis
12. Blood Spill Kit is now in place in the Centre.
13. The Centre's two IPC Link Nurse Practitioners now carry out a weekly audit focusing on an identified area, any areas of concern will have a QIP completed with identified timeframes for closeout. The audit process will be supported by the IPC CNS. The PIC will maintain oversight of these audits.
14. The IPC CNS will continue to complete unannounced site visits to the centre. The IPC CNS will continue to complete external MEGS audits with time bound quality improvement plans

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

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

To ensure compliance will Regulation 28: Fire precautions. Compliance will be met by the following:

1. A daily check of all means of escape doors is carried out by the nurse in charge. A record of same is maintained in the nursing station
2. The room which contains electrical panel boxes and shelves is no longer being used as a storage area. This room is now empty. The Person in Charge provides daily walk arounds to ensure there is no storage in this room
3. The Centre now has a Fire Blanket wall mounted in the resident's smoking area. An Ash Tray is now provided in the resident's smoking area. Smoking Aprons and call bell are in place. Currently there are no residents who smoke living in the Centre.
4. The Oxygen cylinder is stored securely in the Clinical Room on the appropriate storage trolley as provided by the Company. The cylinder is chained securely to the Trolley.
5. A review of the emergency lightening at the means of escape has been completed on the 11th of October 2023. Additional lightening will be in place by the 27th of October 2023
6. Keys have been sourced from Master Fire to activate the green box at the fire doors to

release the doors in the event of an emergency where there is a system failure. Each staff member have been issued with an individual key (which must be kept on their person at all times while on duty). A key for the green box is also attached to the Medication Keyring, held on the person of the staff nurse on duty (day and night).
7. The key for the back fire exit door is now located in a break glass unit on the door
8. Emergency directional signage above cross corridor door have been reviewed and additional signage has been provided to direct staff and residents to a fire exit from the conservatory area in the event of a Fire.
9. A key to the exit gate from the enclosed garden is now available within a keypad padlock on both sides of the exit gate allowing for a clear means of escape in the event of a fire emergency.
10. The provider requested the fire officer to complete a review of the fire exit that leads to the rear car park. Following this review the Fire Officer has advised that this must remain as a secondary means of escape. A fire assembly point is now in place. A risk assessment has been completed and placed on the centres risk register. This risk has been communication to all staff at the daily safety pause. The risk assessment has also been included in the centres Fire Policy. This has been communicated to all staff at the daily safety pause.
11. Wall mounted key boxes have been fitted beside each of the fire extinguisher units allowing all staff (day and night) access to keys to access fire extinguishers in the event of a fire.
12. An external contractor has been appointed to address issues in relation to pipes. This will be completed by the 31st of October 2023.
13. Following a review by the fire officer a 60 minute fire rated separation between the main kitchen and the residents dining area will be provided by way of a combination of 60 minute fire resisting construction incorporating a 60 minute fire shutter. A tender is being drawn up for these works and works are to be completed by year end 2023
14. The sitting-room fire door is now closing properly when released
15. The Fan in the Main Kitchen is now connected into the Centre's Fire System. In the event of localised detection of a fire in the main kitchen and /or dining-room the Fan will cut off and stop. This will prevent the suction / pull on the dining-room door and allow it to close fully.
16. The centre has drawn up a weekly Fire Door check list, including all fire door numbers which are been checked and signed by a member of the Maintenance Department on a weekly basis. This commenced on the 18th of September 2023
17. All recommendations from the Providers Fire Safety Risk assessment has been completed as of May 2023.
18. New Fire detection alarm systems have been installed in the multi-purpose dining room, a W.C and an assisted bathroom. This was completed on the 25th of September 2023
19. All resident's Personal Emergency Evacuation Plans have been updated to include additional aids and sledges. The PEEPS now identifies the means of evacuation of day and night time. The PEEPS also includes the fire escape route by which the resident is to be evacuated
20. The centre now has four staff rostered for night time duty ensuring safe and timely evacuation in the event of fire.
21. Fire Sledges have been wall mounted in the bedrooms of residents with decreased mobility and increased dependency levels allowing for safe and effective evacuation of these residents in the event of an emergency. PEEPs have been updated to reflect same.

Fire policy updated to reflect the use of fire sledges.
22. The Centre has developed a Fire Safety Induction Template for all new HSE and agency Staff. This will be completed and signed off by the PIC or the senior nurse on duty and the staff member on their first day of employment in the Centre.
23. The Centre has implemented a daily Fire Panel Check. This is completed by the nurse on duty.
24. The supply and fitting of emergency lighting to illuminate a path to a safe area from the Centre during a night time evacuation will be completed by 31st October 2023
25. A Fire Risk assessment has been completed in relation to significant construction works in the Centre. Daily checking and recording on the removal of covers from Smoke detectors during the works in the Centre are completed. These checks are carried out by the Staff Nurse on Duty and stored in the nurses station
26. Weekly Fire evacuation Drills are carried out in the Centre

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
To ensure compliance will Regulation 5: Individual assessment. Compliance will be met by the following:
1. A full review of all residents' individual assessments and care plans has commenced within the centre facilitated by the Practice Development Facilitator
2. The Practice Development Facilitator has commenced a Person Centred Care planning programme for all nursing staff. All nursing staff will have completed the training by the 31st of October 2023
3. The Person in Charge and the Provider have developed an Annual Audit Schedule. As part of this audit schedule care plans will be audited on a monthly basis. This will ensure that residents care plans are completed to a high standard. Following the care planning audit time bound action plans will be developed and actioned. The findings of these audits will be communicated to all staff at the staff meetings

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
To ensure compliance will Regulation 6: Health care. Compliance will be met by the following:

1. Residents have now access to a Dietician through an external agency

2. Residents based on individual assessment are now referred to the dietitian as per individual clinical need. Residents have been assessed as of the 11/10/2023

Regulation 7: Managing behaviour that is challenging	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
To ensure compliance will Regulation 7: Managing behaviour that is challenging. Compliance will be met by the following:

1. The dining room door is now open at all times which allows residents to access same as per their choice
2. The door to the internal and external gardens are open from 8am-8pm daily to allow residents individual choice to access the outdoor garden and the internal garden.
3. The nominated Nurse in Charge carries out quality care walk–abouts, three times throughout the day i.e. .09:00. 13:00 and 15:00 hrs, which focuses on observation of; residents health and well-being, residents engagement/activities, person centered moments/staff engagement, person centered language and environment, residents meals, safe environment, health & safety, door checks and medication management. Positive observation and areas for improvement are identified, any areas of concern which can be dealt with at the time are actioned immediately, other areas for improvement are recorded on the action plan which identifies date, noncompliance, action plan required, the responsible person, the due date and progress of corrective actions. The PIC will maintain oversight of these of this process
4. The Person in Charge has commenced a review of the care and the care plans of those residents who are presenting with responsive behaviours within the designated centre. This review will ensure that residents have been assessed in line with their needs. Behavioural support plans will be updated for those residents whom require same
5. 91% of staff working in the Sullivan Centre have received Focused Interventions Training and Support (FITS) in dementia. This training has been designed to significantly improve the quality of life, opportunities and engagement for people living with dementia. Training dates are being sourced through the CNME for the remaining staff.
6. An additional two training programmes have been sourced by the Person in Charge and Provider which will support all staff in the management of Residents with responsive behaviours.
7. Responsive Behaviour Training will be provided to all staff by an external facilitator. This will be completed by the 31st of October 2023.
8. PMCB - Prevention and Management of Complex Behaviour-training will commence in November 2023

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
To ensure compliance will Regulation 8: Protection. Compliance will be met by the following:
1. All staff have completed the Safeguarding Vulnerable Adults at Risk of Abuse online Training on HSELand. The Person in Charge has sourced face to face training for staff in Safeguarding. This will commence from the 12th of October 2023
2. Safeguarding Vulnerable Adults at Risk of Abuse is now a standing Agenda item in the Centre's Daily Safety Pause and at team meeting
3. The Provider meets with the Person in Charge on a monthly scheduled basis. At this meeting Safeguarding is a stand-alone agenda. This allows for all safeguarding incidents to be discussed and shared learning identified
4. The PIC will ensure that that any incident or allegation of abuse is investigated in a timely manner. The chief inspector will be informed of all safeguarding incidents within three working days
5. The Person in Charge reviews all incidents on a weekly basis and formally reviews incidents on a monthly and quarterly basis as to determine and monitor any trends that are occurring. This allows the Person in Charge and the management team to discuss any patterns of concerns and allows for the development of timely quality improvement plans
6. The designated centre will continue to liaise directly with the social work team and the safeguarding and protection team CHCDLMS regarding all incidents of a safeguarding nature. These services provide advice, support and onsite support. Two member of the Safegaurding team will complete a site visit to the centre on the 16th October 2023.
7. Safeguarding vulnerable Adults at Risk of Abuse is now a standing Agenda item in the Centre's Daily Safety Pause, to include Recognizing, Responding and Reporting of witnessed, disclosed and concerns of abuse.
8. The nominated Nurse in Charge carries out quality care walk–about, three times throughout the day i.e. .09:00. 13:00 and 15:00 hrs, which focuses on observation of; residents health and well-being, residents engagement/activities, person centered moments/staff engagement, person centered language and environment, residents meals, safe environment, health & safety, door checks and medication management. Positive observation and areas for improvement are identified, any areas of concern which can be dealt with at the time are actioned immediately, other areas for improvement are recorded on the action plan which identifies date, noncompliance, action plan required, the responsible person, the due date and progress of corrective actions. The PIC will maintain oversight of these of this process.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:

To ensure compliance will Regulation 9: Residents rights. Compliance will be met by the following:

1. All residents living in Sullivan Centre can now access the Dining-room freely at any time during the day or night.
2. The door to the internal and external gardens are open from 8am daily to allow residents individual choice to access the outdoor garden and the internal garden
3. A resident's survey in relation to meaningful activities has commenced within the centre. This involves resident's views and preferences on activities. Following this review the Person in Charge will review the activity schedule and activities within the centre to ensure they meet the residents needs
4. Each day two Health Care Assistants are scheduled to provide meaningful activities to residents. This commenced on the 28th August 2023
5. A review of resident's meal times has taken place to ensure resident's needs are met. Scheduled meal times are as follows- breakfast starting from 8.30 hours, Lunch at 12.30hours, evening tea at 16.30 hours and residents evening supper is served from 20.30 hours.
Residents based on preference can have meals outside of the allocated meal times. This ensures person centre care practices and choice for residents.
Snacks and light refreshments are available to residents throughout the day and at nighttime based on resident's preferences.
6. A review of the centres Meal Menu has been completed. This review now allows for a three week rolling menu in place.
7. Daily menus are displayed on all dining room tables and on a white board in the dining room.
8. Chefs will continue to meet with the residents as to determine their preferences and satisfaction with meals and the new meal plans. This will allow for changes to take place to the meals/meal plans based on resident's preferences. These interactions will be recorded in the chefs diary and discussed with the Person in Charged at the scheduled planned meetings
9. Resident's satisfaction survey has commenced within the centre. The findings of same will be implemented and will be used to develop the annual report.
10. Meal time experience observational audits remain ongoing within the centre. These audits have been added to the annual audit schedule which has been developed within the centre. The findings of these audits will allow for time bound quality improvement plans to be developed. The findings will also be discussed with the staff at the safety pause and at team meetings
11. The provider has requested the development of a bespoke Person Centred Cultural Change Programme for all staff to be delivered by the Centre of Nursing and Midwifery Education. This will address any intuitional cultural practices within the centre. This is scheduled to commence in Quarter 1 2024. In the interim the provider has requested the Practice Development Facilitator to deliver onsite training to all staff in Person Centred Care

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	21/07/2023
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	31/10/2023
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	20/11/2023
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and	Not Compliant	Orange	11/10/2023

	needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.			
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	31/10/2023
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Substantially Compliant	Yellow	27/07/2023
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Substantially Compliant	Yellow	31/10/2023
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	21/07/2023
Regulation 23(b)	The registered	Not Compliant	Orange	20/11/2023

	provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.			
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	20/11/2023
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	28/09/2023
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment,	Not Compliant	Orange	04/08/2023

	suitable building services, and suitable bedding and furnishings.			
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	30/09/2023
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	04/08/2023
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	30/09/2023
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Orange	04/08/2023
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting,	Not Compliant	Orange	04/08/2023

	containing and extinguishing fires.			
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 residents.	Not Compliant	Orange	04/08/2023
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose relating to the designated centre concerned and containing the information set out in Schedule 1.	Substantially Compliant	Yellow	09/09/2023
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	24/07/2023
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.	Substantially Compliant	Yellow	14/08/2023
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment	Substantially Compliant	Yellow	31/10/2023

	referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.			
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Substantially Compliant	Yellow	31/12/2023
Regulation 6(2)(c)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the care referred to in paragraph (1) or other health care service requires additional professional expertise, access to such treatment.	Not Compliant	Orange	11/10/2023
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.	Not Compliant	Orange	21/07/2023

Regulation 7(2)	Where a resident behaves in a manner that is challenging or poses a risk to the resident concerned or to other persons, the person in charge shall manage and respond to that behaviour, in so far as possible, in a manner that is not restrictive.	Not Compliant	Orange	21/07/2023
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.	Not Compliant	Orange	21/07/2023
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Orange	24/07/2023
Regulation 8(3)	The person in charge shall investigate any incident or allegation of abuse.	Not Compliant	Orange	31/10/2023
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and	Not Compliant	Orange	14/08/2023

	capacities.			
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	21/07/2023
Regulation 9(4)	The person in charge shall make staff aware of the matters referred to in paragraph (1) as respects each resident in a designated centre.	Not Compliant	Orange	21/07/2023