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:	Phoenix Park Community Nursing Units
Name of provider:	Health Service Executive
Address of centre:	St Mary's Hospital, Phoenix Park, Dublin 20
Type of inspection:	Unannounced
Date of inspection:	26 January 2022
Centre ID:	OSV-0000476
Fieldwork ID:	MON-0035395

About the designated centre

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

Phoenix Park Community Nursing Units can accommodate 146 residents, both male and female over the age of 18. The registered provider is the Health Service Executive and is located on the St. Mary's Hospital Campus, Phoenix Park in Dublin. The centre consists of two purpose-built buildings,Teach Iosa (100 beds) and Teach Cara (46 beds). Both buildings have two storeys, and are divided into six units. Residents of all levels of dependency can be accommodated in the centre, and 24 hours nursing care is provided. There are a range of multidisciplinary staff who strive to promote person centred care and aim to implement evidence based quality care for all residents.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	130

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 26 January 2022	09:00hrs to 16:45hrs	Deirdre O'Hara	Lead
Thursday 27 January 2022	08:45hrs to 16:45hrs	Deirdre O'Hara	Lead
Wednesday 26 January 2022	09:00hrs to 16:45hrs	Jennifer Smyth	Support
Thursday 27 January 2022	09:00hrs to 16:45hrs	Jennifer Smyth	Support

What residents told us and what inspectors observed

This unannounced inspection took place over two days. Inspectors spoke with several of the residents living in the centre and spent periods of time observing staff and resident engagement in communal areas. The overall feedback from residents was that Phoenix Park Community Nursing Unit was a pleasant place to live and that they felt well cared for by staff. Inspectors observed a pleasant, relaxed atmosphere throughout the inspection. However management systems did not ensure the quality and safety of the services provided in the areas of governance and management, training and development, records, complaints, and fire precautions.

When inspectors arrived at the centre they were guided through the infection prevention and control measures necessary on entering the designated centre. These processes were comprehensive and included a signing-in process, hand hygiene, the wearing of face masks, and checking for signs of COVID-19. The same process was implemented with visitors and evidence of COVID-19 vaccination was also sought before admittance to the centre.

The centre was homely, and generally well maintained and spacious. It was located in two buildings a short walk from each other. Each building was laid out over two floors, with lifts and stair cases to give access between floors. Communal spaces were observed to be comfortable, companionable spaces and residents were observed to be using them to partake in activities, read newspapers, watch television or chat with each other. Inspectors observed that communal areas and hallways in the centre were decorated with artwork by residents.

There was an excessive amount of signage on resident bedroom doors, this was seen to be an institutional type practice in residents home. Examples of this were signs instructing staff to knock before entering or signs to instruct staff to clean their hands before leaving a room. Other signs such as instructions on the type off PPE needed to care for residents, were on doors where residents did not have any infection.

The centre was furnished to a good standard throughout. Many residents had availed of the option to personalise their own bedroom and inspectors observed that residents' bedrooms were decorated with photographs, artwork and ornaments of their choosing. Most residents mentioned that they were happy with their room environments. However action was needed to ensure that all residents had adequate space to store their personal belongings. One resident spoken to stated they had not enough space to store their belongings. Their personal effects were seen to be stored on the floor at their bedside. Some residents' beds were seen to be left in raised position following cleaning. This meant that those residents may not have access to their bed. Inappropriate storage of equipment in assisted bathrooms was seen and one bath and the taps of a sink were broken. This resulted in these rooms not being readily available for resident use.

Small group activities were running with all sessions seen to be well attended by residents. There were two activity staff allocated to each unit where they provided arranged activities over seven days each week. A variety of appropriate and suitable indoor and outdoor communal areas was available and accessible.

Residents were complimentary of staff, and inspectors observed a number of positive interactions between staff, residents and visitors. It was evident that staff were knowledgeable about residents' needs, and were observed to be respectful, kind and caring in their approach.

Records indicated that residents were supported to maintain contact with their families and friends. Activity staff were involved with the booking system for visiting. Residents told inspectors they were delighted to have visits in their home again. Contact with the community was seen where a local group made rugs, shrugs and activity cushions, which were seen to be used for bingo prizes. Resident were seen to use and enjoy them throughout the centre.

A sample of activities on offer were flower arranging, nail painting, exercise classes, board games and jigsaws. Reminiscence therapy was done through photograph, travel books, old films, life stories and rummage box. Residents with cognitive impairment were scheduled to use SONAS therapy and were seen to enjoy using an interactive 'magic table'.

The provider had introduced a 'life café' where residents came together with staff to discuss life, love and loss. These took place on a monthly basis in each unit with plans to increase the frequency of these events, to three weekly. While resident meetings had not taken place regularly this was a forum that resident also used to make suggestions with regard to the running of the centre. Discussion with residents confirmed that they felt safe in the centre and that they were aware of how to raise a concern or a complaint.

Residents were observed to have good access to radios, telephones, newspapers and interactive tablets. Inspectors observed staff chatting to residents about current affairs and local matters at a meal times. Residents said they enjoyed the food on offer and there were snacks and drinks available in each unit. Menus were displayed clearly in dining areas and staff assisted residents to make informed choices.

The next two sections of the report will describe in more detail the specific findings of this inspection in relation to the governance and management of the centre, and how this impacts on the quality and safety of the service provided to residents.

Capacity and capability

Residents received good care and support from staff and had access to a variety of private and group recreational opportunities. However action was required related to governance and management systems to ensure that services provided were

effectively monitored and that they were consistently safe and appropriate for the residents. These included training and staff development, written policies and procedures, records, complaints and notification of incidents.

The centre is operated by Health Service Executive, who is the registered provider.The centre was managed by a management team who were focused on improving resident's well being and life. Inspectors noted there had been three senior management meetings held in 2021. During this period there has been a number of changes to the management structure.

The inspectors were not supplied with complete staff training records, these records were requested on six occasions over the two day inspection. Records that were provided showed many staff were not up-to-date in mandatory training, such as fire, manual handling procedures and safeguarding residents from abuse. There were no management systems in place to effectively monitor training received and required by staff who worked within the designated centre.

The provider completed a suite of clinical and environmental audits monthly to monitor the care and service delivered. A nursing quality metrics summary report for 2021 demonstrated a 92.3 to 100% results in these audits. Medication safety audit findings were fed back to the Drugs and Therapeutic Committee. Practice development staff met with the clinical nurse managers to discuss findings and reflect on learning.

There were failures in the management systems to ensure that resident care and services were provided in a safe and sustainable way. In the senior management meeting minutes provided for 2021, there were no references made to areas such as maintenance, fire or staff training.

While the statement of purpose included the organisational structure, the provider had not updated this document with all the information set out in the certification of registration. This was addressed during the inspection.

Action was required by the registered provider to review policies and procedures at intervals not exceeding three years. A number of policies identified key personnel no longer in position, for example the complaints policy, the emergency contingency plan and the fire safety policy. The visiting policy was last revised in 2015 and current practice was not reflected in this policy. This is further discussed in Regulation: 4 Policies and Procedures.

The two persons in charge managed the day to day running of the centre. They had knowledge of the assessed needs and support requirements for each of the residents. They were well supported by six clinical nurse managers. The centre's day and night staffing rosters were reviewed. From this review and observations throughout the day, inspectors saw that sufficient staff were on duty to meet the assessed needs of the residents. There were no nursing or health care staff vacancies at the time of the inspection. All staff were supervised by the senior nursing management team who were rostered to work both day and night, over seven days.

The inspectors noted that the annual review of the service for 2020-2021 was completed. However the annual review was not readily available to residents living in the centre. It specified a number of quality improvement plans for 2021, such as non-pharmacological approaches to support residents with responsive behaviours.

Although the Chief Inspector had been notified by the person in charge, of some incidents required under Regulation 31: Notification of incidences, they did not include all incidences when restrictive practice had been used. The provider did not recognise psychotropic medication as a chemical restraint in their quarterly notifications. Sensor alarms were also not recognised as environmental restraints. This is further discussed under Regulation 31: Notification of incidents.

The records of four staff were reviewed and two did not contain the documents as required by the regulation, including Garda Síochána vetting disclosures within six months of employment, references and personal contact information.

Records were not kept in a manner that was safe and secure, inspectors observed during the two days of inspection, residents nursing notes were left unattended at nurses' desks and in holders along corridors. A nursing assessment was displayed in most residents' rooms on the wall or wardrobe with information private to the resident. Medical records were stored in unlocked filing cabinets.

The provider did not have an up-to-date complaints policy and the complaints procedure was not displayed prominently in the centre. The most up-to-date complaints register was not available to inspectors on inspection, despite been requested on six occasions during the inspection. The complaints register presented had complaints relating to 2020. No complaints were recorded for 2021 and 2022.

Inspectors were informed of more recent complaints during the previous 12 months were resolved through conversations with staff and residents. These complaints were not recorded. They related to complaints regarding excessive temperature of a bedroom, insufficient storage and wheelchair accessibility. Records of one complaint opened on the 11 May 2020 was still in progress, there was no recording of an outcome. This meant that satisfaction levels of the complainant and the outcome of complaints were not recorded, or measures required for improvement.

Regulation 15: Staffing

There were sufficient staff numbers and an appropriate skill-mix to meet the assessed needs of residents and for the design and layout of the centre.

Judgment: Compliant

Regulation 16: Training and staff development

Complete records were not available in relation to training and staff development. From incomplete records reviewed, a large number of staff had not received mandatory training in safeguarding. No staff training records were available for fire safety.

Judgment: Not compliant

Regulation 21: Records

Two of the four staff files reviewed were found not to meet the requirements of Schedule 2 of Statutory Instrument 415 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) (Amendment) Regulations 2013.

- In one staff file, garda vetting was not in date from staff member's employment start date and there was no contact information and no employment history recorded.
- Two staff files were missing written references.

Resident medical records were seen to be insecurely stored in unlocked filing cabinets. In addition, nursing notes with personal information about residents was kept in an unsafe manner, they were seen to be left unattended on the desks in nursing stations.

Judgment: Not compliant

Regulation 22: Insurance

There was insurance in place against injury to residents and against other risks including loss or damage to a residents property.

Judgment: Compliant

Regulation 23: Governance and management

Management systems in place in the centre were not sufficiently robust to ensure consistent and effective oversight of services.The governance and management monitoring systems in relation to fire, maintenance and training were insufficient to

ensure that services were provided in a safe and sustainable way. For example:

- There was no system to escalate outstanding maintenance requests made by staff, for example one fire exit door was left buzzing for nine months, there was no escalation.
- The registered provider did not have a robust training record system for monitoring or recording staff training. Complete training records were not available over the two days of inspection. This meant that there was no management system to identify the staff who required mandatory training.
- The monitoring systems in place to ensure fire safety were not sufficient, for example the integrity of fire doors were not included in the fire checks. Audits and checks in place did not identify the areas of non-compliance found on inspection.
- Systems to monitor complaints failed to identify the gaps in the complaints register.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose contained all the required information set out in Schedule 1 of this Regulation: Information to be included in the statement of purpose.

Judgment: Compliant

Regulation 31: Notification of incidents

The registered provider failed to notify the Chief Inspector of all occasions where restraint was used. Chemical and all environmental restraints, such as the use of bed and chair alarms were not included in the quarterly reports returned to the Chief Inspector.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The following gaps in practice identified by inspectors required action,

- The current complaints register was not available to inspectors on the day of inspection.

- The registered provider failed to ensure all complaints and the results of any investigation into the matters complained of and any actions taken on foot of the complaint are fully and properly recorded.
- The complaints procedure was not displayed in a prominent position in the centre.
- The provider failed to investigate all complaints promptly for example, in the complaints register provided, a complaint received on 11 May 2020, remained open.
- A record of all complaints was not kept including details of the investigation into the complaint, the outcome of the complaint and whether or not the complainant was satisfied.

Judgment: Not compliant

Regulation 4: Written policies and procedures

The registered provider failed to review policies and procedures at intervals not exceeding three years and where necessary, review and update them. Twelve policies were reviewed, of these, 5 were overdue for revision, for example

- Complaints policy was dated February 2015, which identified key personnel who were no longer in position.
- Fire Safety policy was last revised in 2017.
- Visiting policy was dated 2015, current practice was not reflected in this policy.

Judgment: Substantially compliant

Quality and safety

Overall, residents received a good standard of care and services and a number of residents told inspectors that they were well supported by staff while living in the centre. Inspectors were assured that residents' medical and health care needs were being met. However, action was required to ensure that the services provided were consistently safe and appropriate for all residents' identified needs. These findings are discussed under the respective regulation such as; individual assessment and care plan, managing behaviour that is challenging, fire precautions, premises and infection control.

The provider had made some improvements to the premises since the previous inspection to accommodate appropriate communal space on Setanta unit. This positively impacted on the lived experience for resident living on this unit. However,

further action was required to ensure that the premises was brought into compliance with the regulations with regard to general maintenance and appropriate storage in corridors and assisted bathrooms.

The premises of the designated centre was appropriate to the number of the residents. It was noted that the provider had reduced resident occupancy in the centre, leaving five rooms vacant in one area should an outbreak of COVID-19 occur and isolation facilities be required. Action was needed with regard to timely completion of maintenance issues such as broken taps, a bath, a damaged fire doors, a wall and flooring. There was also inappropriate storage in corridors and sluice rooms.

From a fire safety perspective, the physical premises was inspected and the fire safety management system records reviewed. Inspectors found that the centre was laid out in a manner that provided residents and staff with an adequate number of escape routes and fire exits. Alternative escape routes were available throughout. However, inspectors were not assured that the provider had sufficient oversight of fire precautions within the centre.

Inspectors noted that all units were provided with an emergency lighting system, fire detection and alarm system and fire fighting equipment throughout, Action was required to ensure that maintenance of fire doors met the required standard and that emergency direction signage was in place, at appropriate points, to ensure the safety of residents. There was excessive buzzing sound coming from one exit door leading to a courtyard that had been reported as needing repair since April, 2021. This impacted on the quality of the lived experience for residents. Another fire door had been reported as broken eight days prior to the inspection. These were repaired on the second day of the inspection.

Complete fire training records were not available on the two days of inspection. This is further discussed in Regulation 16: Training and staff development. Access to fire extinguishers was blocked by a flower arrangement in one unit and the obstruction was removed during the inspection.

While comprehensive pre-admission assessments were done for residents, not all care plans were created within 48 hours of admission and there were gaps in the provision of three residents care plans to guide staff to safely support residents. For example assistance required for personal hygiene and mobility and direction for staff to support residents who were on specialised diets.

A register of restrictive practice used was maintained. However there were gaps seen in consent practices for the use of sensor mats. Additionally, behaviour support plans, did not always direct staff when to use PRN medicines (medicines to be taken when required) to ensure that it was used as a last resort when other measures had been exhausted. However, there good examples to show that the provider was taking steps to reduce the use of bedrails. Interactions between staff and residents showed that residents responded well to redirection by staff should they present with responsive behaviour.

Medical care was overseen by two geriatric consultants and regular reviews of care

were completed in consultation with residents and their families, if appropriate. The health and well-being of residents was promoted and residents were given appropriate support and access to health professionals to meet any identified health care needs. The national health screening program was available to those residents who qualified for them.

There was evidence of good infection prevention and control practice in the centre, however, there were gaps in practice such as terminal cleaning, inappropriate storage of clinical equipment, dressings and food items.

There had been a recent COVID-19 outbreak in the centre but there were no detected cases of COVID-19 in the centre during the inspection. It mainly effected staff. Early detection allowed the provider put in measures to prevent onward transmission of the virus. Staff were aware of their role in minimising the spread of infection to other areas of the centre.

An effective social programme with a variety of meaningful activities for occupation and engagement was being implemented. Action was required with regard the location of a smoking shelter which impacted on the resident rights to having a facility for recreation in comfort.

Records indicated that residents were supported to maintain contact with their families and friends. Visits had resumed where residents were seen to have visits with their relatives and friends in their own room or visiting areas around the centre.

The person in charge had made arrangements to ensure residents had access to and retained control over their personal property, possessions and finances. All residents had access to secure storage for their possessions. However there were gaps in the provision of adequate space for residents to store their possessions in some multi-occupancy bedrooms.

Although the emergency plan was out of date, the provider had a risk management policy which identified the hazards and assessment of risks which were regularly reviewed. The measures and actions were in place to control the risks identified.

Regulation 11: Visits

Visiting was facilitated in many areas in the centre and was well managed in line with the most recent Health Protection Surveillance Centre (HPSC) guidance.

Judgment: Compliant

Regulation 12: Personal possessions

There were gaps in the provision of adequate space for residents to store their clothing and other personal possessions in some two multi-occupancy bedrooms. Residents belongings were seen to be stored in suitcases and bags on the floor beside their bed.

Judgment: Substantially compliant

Regulation 17: Premises

The following areas of the premises did not conform to the matters set out in Schedule 6 of the regulations to ensure that the environment was safe and cleaning was effective:

- Valid servicing records for bedpan washers were not available to ensure that they had been serviced.
- The flooring on some corridors were cracked and damaged.
- The work counter and door in the clinical room in Bebhin unit was damaged.
- Tiling behind the toilet in the assisted bathroom in Tara unit was loose and coming away from the wall.
- Taps at one hand wash sink in an assisted bathroom were broken.
- There was excessive storage in some sluice rooms which could impede access to facilities in these rooms, such as bed pan washers and sinks.
- Inappropriate storage in assisted bathrooms of equipment that was either broken or no longer needed.
- Hoists were seen to be inappropriately stored in nurses' stations and one was being charged on the corridor which residents used.
- There were gaps in temperature monitoring records for medication fridges and one fridge was not clean.
- The covering on a chair in Setanta activity room was heavily worn and could not be effectively cleaned.

Judgment: Substantially compliant

Regulation 26: Risk management

Inspectors found the emergency plan for the designated centre was last revised in 2018. Key personnel and their contact numbers included in this plan were for staff who had since left their positions. This meant that in the event of an of an emergency, the most up-to-date information for key personnel was not available to staff.

Judgment: Substantially compliant

Regulation 27: Infection control

There were gaps in practice which did not assure that the registered provider was in compliance with the National Standards for Infection Prevention and Control in Community Services 2018. For example:

- Despite the large size of the building, storage space on the units was limited. Food, drinks and cleaning chemicals were stored together with medical supplies on most units. There was excessive storage on floors in these rooms. This practice posed a cross infection risk.
- Two staff were seen to wear hand jewellery which meant that staff could not effectively clean their hands.
- There were no cleaning schedules for soft furnishing such as curtains.
- One bedroom that inspectors were told was vacant and had been cleaned, contained items from the previous resident.

Judgment: Substantially compliant

Regulation 28: Fire precautions

There were a number of areas of concern regarding the adequacy of fire precautions in the centre and action was required to comply with the requirements of the regulations to ensure that residents and staff were adequately protected from the risk of fire. The registered provider was not taking adequate precautions against the risk of fire in the following areas:

- One fire door had a defective door closing device which was not addressed immediately.
- Oxygen cylinders were found to be stored in an insecure manner in treatment rooms in both buildings.
- Inspectors were not assured that adequate means of escape was provided throughout the centre. In both buildings, there was insufficient directional escape signage in areas such receptions and the nurses stations, to ensure directions of escape and exits were readily apparent. Some directional signage was obscured with other signs.
- Procedures and fire plans were faded and unclear, with no room numbers, exit or assembly points shown on the fire floor plans.
- There was no clear indication of fire compartments.
- The fire map in one unit was not positioned beside the fire panel which could delay the response to a fire.
- Inappropriate storage of furniture seen in refuge areas prevented the use of these areas in the event of a fire.

From a review of evacuation drill records, inspectors were not assured that staff

working in the centre were adequately prepared for the procedure to be followed in the case of fire and for the safe and timely evacuation of residents. For example

- There had been five simulated fire drills in 2021 for the six units This consisted of one night time fire drill, where three staff attended. On the four day time fire drills, the number of staff in attendance ranged from four to eight staff. This meant that not all staff had attended fire evacuation drills.
- One new member of staff had not received instruction with regard to fire safety or the steps to take in the event of a fire.

Inspectors were not assured in relation to making adequate arrangements for maintaining all fire building services. Evidence showed the following:

- Large gaps were seen between fire doors, doors not closing completely, with evidence of damaged fire strips.
- A laundry door in Teach Iosa was observed to be propped open, even when unattended. Staff reported this was due to extreme high temperatures in the room.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

There were gaps in care planning records to ensure that there was an updated care plan in place for all residents' identified needs. For example:

- A mobility care plan in place for a resident who was at risk of falls was not developed within 48 hours of admission.
- There was no personal hygiene care plan for another resident who required assistance with this activity on admission.
- A resident who had difficulty with swallowing had no care plan, even though staff were using thickeners in drinks given to the resident.
- Another resident was being given a textured diet but there was no nutrition care plan to guide staff.

Judgment: Substantially compliant

Regulation 6: Health care

Residents were observed to have good access to health care services including occupational therapy, physiotherapy, speech and language therapy, dietetics, optometry, dentistry, mental health services, clinical psychology and tissue viability

nursing.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Gaps in records and practice were seen in the following areas:

- In two of three care plans seen, there was no clear direction for staff when to use prn (as required) psychotropic medicine to support residents with responsive behaviours.
- Consent records were not available for the use of bed, chair and floor sensor alarms for residents. The person in charge was not assured that the residents or their family members consented to their introduction and use.

Judgment: Substantially compliant

Regulation 8: Protection

The registered provider had taken the reasonable measures to protect residents. Concerns viewed were investigated in a timely manner. Any incident or allegation made and subsequent recommendations that came out of them were seen to be actioned.

Judgment: Compliant

Regulation 9: Residents' rights

There was good access to an activity program and advocacy services were advertised. However, the the rights of residents who wished to smoke was impacted by a shelter being placed a distance from the centre. This meant that these residents who were seen to smoke in garden areas, had no protection from the weather.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Not compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Substantially compliant
Regulation 34: Complaints procedure	Not compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Substantially compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management	Substantially compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Phoenix Park Community Nursing Units OSV-0000476

Inspection ID: MON-0035395

Date of inspection: 27/01/2022

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 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:

There is a requirement for staff to have access to training appropriate for the service. The delivery of this requirement has been affected predominantly due to restrictions imposed by Covid 19.

As the campus and education rooms have undergone extensive renovations to be complaint with Infection Prevention and Control and Covid 19 social distancing standards. This has resulted in a temporary lack of suitable training space .There has also been a restriction on the numbers of staff permitted at each training session due to IPC guidelines due to the size of the rooms available for training on site during the renovations.

In order to address the items raised in the inspection, the service plans includes the following:

• Safeguarding training: is now available on www.HSEland.ie, via an online module Safeguarding adults at risk of abuse. All Clinical Nurse Managers will ensure staff under their remit, who are due or overdue, for this training are to have it completed by end of Q2 2022. The Principle Social Worker has provided 1 session to the Health and Social Care Professionals and 3 sessions to international nurses during their orientation.

Fire training records have been updated and fire training has commenced for 2022, dates confirmed until July 2022. General Basic Fire training and fire extinguisher training is completed in the one session. Fire Evacuation (fire drill) training is to be completed every 12 months. This is achieved by conducting fire drills/mock fire drills completed by the person in charge of the unit (ward) on a monthly basis and includes a reflection on learning acquired and actions required to address any delays or items found in the drills. Record of staff attendance is kept at ward level

The fire officer will complete a fire drill on each ward yearly to guide and inform staff on duty at that time and the information is cascaded to the rest of the staff of the unit.

• Face to face Restraint/ Restrictive devices training dates secured for April and May 2022.

• MAPA training: Training dates for five staff to attend Train the Trainer MAPA instructors course secure for May 2022 (one staff member is renewing her training), this will help increase our numbers of staff available to deliver the training. Training dates confirmed for staff from June 2022.
• Professional Development Plans will continue to be completed yearly and rolled out for all nursing grades in the service.
• CPR: training continues regularly each month.
• Manual handling training: this training will be out sourced to increase training numbers over the coming months and catch up on training required to be in date. All new staff receive manual handling on induction.
• All staff to continuing to do www. HSEland.ie training in relation to IPC
• Refresher Hand hygiene training and observational hand Hygiene audits of 5 moments of Hand hygiene rolled out at ward level by IPC link Practitioners who have completed HSE National IPC link practitioner programme.
• Training records will be a fixed item on meeting agendas for CNMs and Ward meetings.
• Training records: review of the training records found that the excel record document is not user friendly to read due to its size. The PIC has assigned a staff to work on this to reduce in size, and to reflect mandatory training firstly . Each ward will keep a log and this will be updated by CNM's when staff produce certificate of attendance and will be emailed to ADON at the end of each month for review.
• Fire train attendance records pertaining to PPCNU will be sent to ADON as soon as possible after training to update the PPCNU training record.

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
Garda Vetting and written references : All new entrants are not issued a contract without up to date Garda Vetting and satisfactory references obtained by HSE recruitment. Upon agreeing a start date with a new employee with the PIC , HR manager must be informed by the PIC and the HR manager will request information from recruitment to be sent to the service to be placed on the physical staff file stored on site. An audit of all staff files will be undertaken by HR in 2022.

All filing cabinets containing resident's files have been checked to ensure they can be locked, These filing cabinets are to be kept in the CNM office not out at nurses stations. CNM's to ensure that resident's personal details are not stored with the care plans but instead in a separate folder in the CNM office, the care plans will be stored securely at nurses station.
Audit of medical record keeping will form part of the Quality and Patient Safety Walk Rounds commencing in 2022.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Clearly defined roles in place in relation to governance over areas of Maintenance and Fire Quarterly PPCNU management meetings are scheduled for remainder of year, these will be attended by persons responsible for Fire and Maintenance,
Training records: Document too large, PIC has assigned a staff to work on this to reduce in size, reflect only mandatory training. It will be updated by CNM's when staff produce certificate of attendance and will be emailed to PIC at the end of each month.
Fire train attendance records pertaining to PPCNU will be sent to PIC as soon as possible after training to update the PPCNU training record.
Checking of the integrity of the Fire Doors has been added to the fire audit checklist

Complaints Officer information updated on residents notice boards.
Each quarter an update on all complaints will be presented at Quality and Patient Safety meeting to ensure that all complaints and results of any investigation into the matters complained of and any actions taken on foot of the complaint are fully and properly recorded and acted upon in a timely manner.
All outstanding records of complaints from 2020 have been updated and closed off

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
CNM's to report on all restrictive devices including, bed rails, lap belts, posey alarms and PRN psychotropic drugs monthly to ADON/PIC.
PIC will then report these to HIQA on Quarterly notifications.
Discussion took place at the Drugs and Therapeutics Committee meeting on 14/04/2022 regarding improving the written directions for nursing staff regarding when to administer PRN psychotropics. The psychotropic medication proforma in use has been redevised and will be in use when agreed upon by all stakeholders. It includes assessment of the impact of psychotropic medication changes, the non-pharmacological measures currently in place, the level of risk to the resident and rationales for decisions pertaining to decreasing, stopping or maintaining the drug regime. Methods to improve communication in relation to psychotropic administration will be discussed at the next Nursing/Medical meeting in June 2022. Audit of PRN psychotropic medication use will be completed in Q2 by the medical team.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
Management will ensure that all HSE Your Service Your Say (YSYS) information are clearly and prominently displayed on residents notice boards by 30th April 2022.
All information displayed on the Campus pertaining to Complaints/Complaints officer will be updated by 31st May 2022
PPCNU Complaints / Compliments will be separated from Campus record by 31st May 2022
Each quarter an update on all complaints will be presented at QPS meeting to ensure that all complaints and results of any investigation into the matters complained of and any actions taken on foot of the complaint are fully and properly recorded.
All outstanding complaints from 2020 will be updated and closed off.

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
Complaints policy is the HSE ,YSYS but a local addendum is currently being developed to inform who to contact in the service.
Fire safety policy has been reviewed and signed off by Hospital manager.
Visiting policy for under review. PSW is updating same currently.
Please note due to COVID we were following the Public Health Visiting guidelines for Residential Services which were changed and updated regularly. Please refer to https://www.hpsc.ie/

Regulation 12: Personal possessions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
The service recognize that the residents personal possessions, mementoes , souvenirs and photographs tell a life story.
The service is examining opportunities to reconfigure/ reduce beds in multi occupancy rooms and as a result will increase storage space in people's bedrooms for their personal

possessions.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The service is responsible to ensure that the equipment is in safe working order and maintained appropriately. An inventory of equipment on each ward to be completed by Clinical Nurse Manager with the assistance of the equipment coordinator and sent to ADON's by 31st May 2022
The Bed pan washer identified in the inspection has now been serviced, and there are records of all servicing of the 6 bed pan washers in the PPCNU.
The cracked flooring identified during the inspection has been replaced .Each CNM has been informed to complete a weekly walk round of their ward and identify any item that needs to be brought to the attention attention of maintenance to address any item for attention including new cracks found in the floor. A repair schedule of flooring is underway by external contractors to address identified faults.
In relation to the counter top in Bebhinn unit, this has been assessed and is being addressed by the maintenance department.
The tiling in toilet in Tara has been redone and works completed. The broken taps repaired.
All items for case have been removed from sluice rooms and disposed of.
All old, broken equipment inappropriately stored in bathrooms has been removed and discarded.
There is an issue identified in relation to the storage for hoists and management is exploring options to increase storage space on units.
A Cleaning rota for medication fridges will be maintained on all wards by the CNM.
A chair that was found has a heavily worn covering in Setanta has been cast and all items for the case has been addressed on each ward.

Regulation 26: Risk management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management:
PPCNU Emergency plan will be updated without delay by the PIC and will include the names and contact details of the key personnel to contact in the event of an emergency and will be agreed upon by the Policy committee members and promptly disseminated to all staff by 10th June 2022. In the interim, the switch have the contact details of senior hospital management for the PIC and Out of Hours nursing manager to contact as a temporary arrangement.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:

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To be compliant with the National Standards of Infection Prevention and Control, the following actions will be taken.

The is one storeroom allocated in each ward, the CNMs will review the volume of the ordering of stock so that overstocking is avoided.

Each ward will review and divide out the storage of food, drinks, and cleaning chemicals to ensure these items are no longer stored in the same space.

The Laundry supervisor to complete a cleaning schedule for all curtains in consultation with IPC guidance.

Refresher hand hygiene is being rolled out in all departments reminding staff re bare below elbow policy.

A walk round was completed of vacant rooms to ensure cleanliness and personal items from the vacant room seen by HIQA inspectors have been removed. All rooms are on a cleaning schedule.

Regulation 28: Fire precautions	Not Compliant

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

Storage units for portable oxygen cylinders have been ordered and awaiting delivery

A walk round was completed by the Hospital Manager and Estates and a review of the signage was completed. The fire direction signage will be increased in required areas by May 2022.

The fire maps have been updated. New holders ordered for A3 size fire plans to be displayed. A list of room numbers is displayed beside the fire plans.

The Fire compartments will be clearly indicated on fire plans.

The PICs will ensure that there will be no inappropriate storage of furniture in refuge areas.

Fire drills will continue to be held monthly in each ward and records kept of each drill.

All fire doors have been serviced and all damaged fire strips have been replaced.

We have added the integrity of doors on to the weekly fire checklist. An SLA is being secured to address the fire door maintenance required.

Hospital management is looking at options for the laundry room in Teach Iosa, vents are to be installed and the door is to be kept closed while not in use.

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:
Assurance is required that a comprehensive assessment of the person's health and personal social care needs are identified and an appropriate care plan devised in a timely manner.
To provide assurance of achieving this compliance indicator, when a person is admitted to the service the CNMs will ensure that all staff nurses complete the assessments and care plans required within the 48 hr deadline. For quality assurance, the CNM will be provided with the completed care plan for her/his review and sign-off.
In conjunction with our auditing team and as part of our continuing efforts to maintain high-quality standards of nursing documentation, the approach to auditing of care plans is being reviewed and a more frequent schedule of care plan auditing will commence by May 2022
Each staff nurse is the Primary care nurse for a cohort of residents and his/ her responsibility is to ensure all care plans are updated 3 monthly.
Nursing metrics are completed monthly by CNMs and reviewed by the assigned PIC to that ward. The audits will monitor adherence to these standards.

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
Each primary care Nurse to ensure that all interventions for residents who display behaviors that challenge are documented clearly in the care plan, in particular the use of PRN psychotropic medications. The issues related to psychotropic medications were discussed at the local Drugs and Therapeutic meeting on 14/04/22. General guidance concerning the use of all PRN medications will be adhered to and monitored through local medication audit processes. Discussion took place at the Drugs and Therapeutics Committee meeting on 14/04/2022 regarding improving the written directions for nursing staff regarding when to administer PRN psychotropics. The psychotropic medication proforma in use has been redevised and will be in use when agreed upon by all stakeholders. It includes an assessment of the impact of psychotropic medication changes, the non-pharmacological measures currently in place, the level of risk to the resident, and rationales for decisions pertaining to decreasing, stopping, or maintaining

the drug regime. Methods to improve communication concerning psychotropic administration will be discussed at the next Nursing/Medical meeting in June 2022. An audit of PRN psychotropic medication use will be completed in Q2 by the medical team.

The use of the bed, chair, and floor sensors to be included in the restrictive devices consent section of the care plan. It is assumed that all residents can give consent but if they are unable to, and in line with the recently updated National Consent Policy decisions in their best interest will be made. It will be best practice that families will be included in this decision-making as they are unable to give actual consent under current Irish Legislation until the Capacity Act is fully enacted.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
PPCNU operates a NO Smoking Policy for all residents. There is currently one resident who smokes.
There is a smoking shelter approximately 12 metres from the door of the unit but despite encouragement, our resident prefers to stand/sit outside the door of the ward in the garden Management accepts the resident choice not to use the shelter. The resident is facilitated to smoke and remain dry when the weather is bad.

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 12(c)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that he or she has adequate space to store and maintain his or her clothes and other personal possessions.	Substantially Compliant	Yellow	31/07/2022
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	30/06/2022
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises	Substantially Compliant	Yellow	30/06/2022

	which conform to the matters set out in Schedule 6.			
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Not Compliant	Orange	31/05/2022
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	31/07/2022
Regulation 26(2)	The registered provider shall ensure that there is a plan in place for responding to major incidents likely to cause death or injury, serious disruption to essential services or damage to property.	Substantially Compliant	Yellow	30/06/2022
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Substantially Compliant	Yellow	31/07/2022
Regulation	The registered	Not Compliant		22/04/2022

28(1)(a)	provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.		Orange	
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	31/07/2022
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.	Substantially Compliant	Yellow	31/07/2022
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire	Not Compliant	Orange	31/07/2022

	control techniques and the procedures to be followed should the clothes of a resident catch fire.			
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.	Substantially Compliant	Yellow	31/05/2022
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.	Substantially Compliant	Yellow	31/07/2022
Regulation 28(3)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place in the designated centre.	Not Compliant	Orange	22/04/2022
Regulation 31(3)	The person in charge shall provide a written	Substantially Compliant	Yellow	22/04/2022

	report to the Chief Inspector at the end of each quarter in relation to the occurrence of an incident set out in paragraphs 7(2) (k) to (n) of Schedule 4.			
Regulation 34(1)(b)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall display a copy of the complaints procedure in a prominent position in the designated centre.	Substantially Compliant	Yellow	31/05/2022
Regulation 34(1)(d)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall investigate all complaints promptly.	Not Compliant	Orange	31/05/2022
Regulation 34(1)(f)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall ensure that the nominated	Not Compliant	Orange	31/05/2022

	person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.			
Regulation 34(2)	The registered provider shall ensure that all complaints and the results of any investigations into the matters complained of and any actions taken on foot of a complaint are fully and properly recorded and that such records shall be in addition to and distinct from a resident's individual care plan.	Not Compliant	Orange	31/05/2022
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Substantially Compliant	Yellow	31/08/2022
Regulation 5(1)	The registered provider shall, in so far as is	Substantially Compliant	Yellow	30/06/2022

	reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).			
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Substantially Compliant	Yellow	22/04/2022
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.	Substantially Compliant	Yellow	22/04/2022
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Substantially Compliant	Yellow	30/04/2022