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

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| Name of designated centre: | Ballinderry Nursing Home |
| Name of provider: | Ballinderry Nursing Home Limited |
| Address of centre: | Ballinderry, Kilconnell, Ballinasloe, Galway |
| Type of inspection: | Unannounced |
| Date of inspection: | 04 July 2023 |
| Centre ID: | OSV-0000318 |
| Fieldwork ID: | MON-0040355 |

## About the designated centre

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

Ballinderry Nursing Home is located in a rural setting, a short drive from the village of Kilconnell and 13 kilometres from the town of Ballinasloe. It is a single storey over basement purpose built premises that is registered to accommodate 44 residents. The centre provides continuing care, convalescent and respite care to residents primarily over 65 years who may have low to maximum care needs. Residents have a choice of areas where they can spend time during the day. There are several sitting rooms, a dining room and outdoor garden space available for use by residents. Bedroom accommodation consists of 14 single and 15 double rooms. The centre aims to provide a quality of life for residents that is appropriate to their care needs and is stimulating and meaningful.

**The following information outlines some additional data on this centre.**

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| Number of residents on the date of inspection: | 34 |

## 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 |
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| Tuesday 4 July 2023 | 09:30hrs to 19:00hrs | Rachel Seoighthe | Lead |
| Tuesday 4 July 2023 | 09:30hrs to 19:00hrs | Gordon Ellis | Support |

## What residents told us and what inspectors observed

Overall, the inspectors found that the residents were content with living in the designated centre and comfortable in the company of staff, who were observed to be attentive to residents' needs. Residents feedback was positive and inspectors heard comments such as 'the staff are very good here'. One resident told the inspectors that they hoped to live in the centre for 'as long as possible'. Although some actions were required to bring the premises into compliance with the regulations, the centre's environment was homely and welcoming.

This was an unannounced inspection which was carried out over one day. The person in charge was not available in the centre on the day of the inspection. Following an opening meeting with the nurse in charge, the inspectors were guided on a tour of the premises which gave them the opportunity to meet with residents and staff as they prepared for the day.

Ballinderry Nursing Home provides long term and respite care for both male and female adults with a range of dependencies and needs. The centre is a purpose-built single storey building situated in Ballinasloe, Co Galway. The designated centre is registered to provide care for a maximum of 44 residents. There were 34 residents living in the centre on the day of the inspection. Resident bedroom accommodation was provided in single and twin bedrooms, some with en-suite facilities.The inspectors saw that some bedrooms were personalised, with items such as family pictures and soft furnishings. There were two large sitting rooms with sufficient seating to ensure residents had comfortable communal spaces. An oratory was available for resident use. Inspectors observed an enclosed garden which was accessible via one sitting room and was decorated brightly to encourage resident interest and activity.

The corridors in the centre were long and wide and provided adequate space for walking. Handrails were in place along both sides of all corridors, however the inspectors observed that safety grab rails were not in place in all communal bathrooms and this did not ensure residents safe mobility.

On the day of this inspection, inspectors observed that staff were working hard to provide care and support for residents. Many of the residents were observed to spend their day going between one of the two sitting rooms. A number of residents remained in the reception area where they socialised with staff, visitors and their fellow residents. A small number of residents stayed in their bedrooms. Staff were observed assisting residents with their care needs, as well as supporting them to mobilise to different communal areas within the building. It was evident from interactions that staff knew the residents' backgrounds and needs well. Residents were very complimentary of staff and the management team and knew them by name.

Inspectors observed a large dining room with sufficient seating for resident comfort.

Inspectors observed that residents could eat their meals at their own pace and at times that were convenient for them. Inspectors observed that staff took extra time to ensure a dessert prepared for one resident was presented to the residents exact taste. Positive comments were heard in relation to the quality of food and one resident told the inspectors that they had gained a healthy amount of weight since they had come to live in the centre.

Although the atmosphere in the centre was bustling, the inspectors observed that residents were not rushed and staff from all departments took opportunities to engage with residents. Inspectors observed numerous occasions where staff took time away from their duties, to socialise with residents in communal areas and in the corridors. The inspectors observed some residents were taking exercise independently, while others were participating in a quiz on the afternoon of the inspection. Residents with high support needs spent time in the quieter communal sitting room.

Overall, the premises was clean and well maintained. However, the inspectors noted that some equipment and furnishings were in need of repair. Furthermore, the organisation of a number of storage rooms was very cluttered and resident equipment was not segregated from general supplies. Inspectors observed that there was also storage of residents' assistive equipment and supplies in a staff toilet and in the sluice room. This posed a risk of cross infection.

Inspectors observed visitors attending the centre on the day of the inspection. Residents were facilitated to receive visitors as they wished. A designated visitors' room was available if residents wished to meet their visitors in private.

The next two sections of the report will present the findings in relation to governance and management in the centre and how this impacts on the quality and safety of the service being delivered. The areas identified as requiring improvement are discussed under the relevant regulations.

## Capacity and capability

This was an unannounced risk inspection to monitor the provider's compliance with the Health Act 2007 (Care and Welfare of Residents in designated Centres for Older People) Regulations 2013 as amended. Inspectors found that the current governance and oversight of the designated centre was not effective and did not ensure that care and services were provided in line with the centre's statement of purpose. In addition, the risk management processes were not effective in ensuring that risks were identified and mitigated, particularly in relation to fire safety. Following this inspection, the provider was required to submit an urgent action plan to ensure that adequate fire precaution systems were in place in the centre.

Ballinderry Nursing Home Limited is the registered provider of Ballinderry Nursing Home. The management structure consists of a person in charge and a general

manager. The person in charge was supported in their role by an assistant director of nursing. The person in charge also oversaw the work of a team of nurses, health care assistants, administration, maintenance, domestic and catering staff.

The person in charge was not present on the day of the inspection. Inspectors found that the deputising arrangements in place in the event of the absence of the person in charge for the centre were not robust and did not provide assurance that there would be adequate oversight of the service if the person in charge was not available. The statement of purpose submitted to the Chief Inspector detailed arrangements in place for the assistant director of nursing (ADON) to deputise in the absence of the person in charge. However, inspectors found that these arrangements were not in place on the day of the inspection. Furthermore, inspectors found that there were no clinical management hours available to deputise for the person in charge in their absence, as the ADON was allocated full-time to the provision of direct nursing care, due to a shortage of staff nurses. A review of staffing rosters by inspectors demonstrated that the number of registered nurses employed in the centre was not in line with the levels committed to by the provider in the centre's statement of purpose. This is a repeated finding from previous inspections.

The management systems in place were not effective and did not ensure that the service provided to residents was safe, appropriate and consistent. For example, records of management meeting minutes available demonstrated that risks in relation to staff nurse shortages, which were impacting on the quality and safety of care, had been discussed on various dates with the senior management team. However, this risk had not been addressed by the provider. Furthermore, meeting records evidenced concerns that the clinical management hours available did not support the implementation of a robust auditing system. This was evidenced by audit records provided to the inspectors, which demonstrated that two audits had been completed since the previous inspection in 2022. There was no evidence that quality improvement plans were progressed following either audit.

Although, there was a varied training programme in place which included access to both online and face to face training, a review of staff training records indicated gaps in the completion of mandatory fire training. As a result, the inspectors could not be assured that all staff had received appropriate training to respond effectively to a fire safety emergency.

Residents' contracts of care reviewed did not include a breakdown of the resident contribution towards their accommodation charge. Furthermore, contracts reviewed did not include the terms relating to the occupancy of the bedrooms in which the residents would reside in the centre.

A sample of staff files were examined and they contained all of the requirements as listed in Schedule 2 of the regulations. Vetting disclosures in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 were in place for all staff.

## Regulation 15: Staffing

On the day of inspection, there was adequate staff available to meet the needs of the residents taking into consideration the size and layout of the building.

The failure of the registered provider to ensure sufficient staffing resources were in place to ensure the on-going safe and effective delivery of care to residents is actioned under Regulation 23, Governance and management.

Judgment: Compliant

## Regulation 16: Training and staff development

Staff were not appropriately supervised to ensure that they carried out their work to the required standards. This was evidenced by the following findings;

- Residents' care planning records were not adequately completed to inform their care and support needs.
- Poor supervision of fire safety practices as evidenced by fire doors held open throughout the inspection.
- Poor supervision of infection control practices as evidenced by the findings under Regulation 27.

Judgment: Substantially compliant

## Regulation 21: Records

Not all residents' records were held securely. Documentation relating to residents was being stored in boxes and an unsecured filing cabinet in an unlocked office, which also contained network electrical equipment. Due to the items being combustible, storage of these items in this room posed a risk in a fire event as well as not ensuring that the documents were stored in a safe and appropriate space. Inspectors requested that action was taken immediately to relocate the records to a secure area, and this action was completed promptly by the management team.

Judgment: Substantially compliant

## Regulation 23: Governance and management

The management structure that was in place at the time of the inspection did not reflect the management structure set out in the provider's statement of purpose and did not clearly set out roles and responsibilities for all areas of care provision. This was evidenced by:

- The deputising arrangements in place while the person in charge was on leave were not robust. These arrangements consisted of the assistant director of nursing or the most senior nurse on duty being designated as the person in but maintaining responsibility for the nursing care needs of all of the residents accommodated in the centre. No additional clinical support was provided while the person in charge was on leave, therefore the deputising staff member could not fulfil the role of person in charge.

The registered provider did not ensure that the service had sufficient staffing resources in place to;

- Meet the assessed care and supervision needs of the residents . The person in charge had identified a requirement for additional nursing staff and escalated this to the registered provider in February 2023. However, the additional staffing resource had not been put in place.

The communication and auditing systems in place were not effective and did not ensure that the service provided to residents was safe, appropriate and consistent.

The systems in place to identify and manage risk were not effective. This was evidenced by the following findings;

- risks found on the day of inspection in relation to infection control, as detailed under Regulation 27, had not been identified and managed.
- risks identified in relation to fire safety precautions ,as discussed under Regulation 28, had not been identified and managed.

Judgment: Not compliant

## Regulation 24: Contract for the provision of services

Inspectors reviewed a sample of contracts for the provision of services. Contracts reviewed did not include the breakdown of the resident contribution towards their accommodation charge.

The type of room made available to the resident upon admission was not recorded on some of the contracts for example, if it was a single or double occupancy room.

Judgment: Substantially compliant

## Regulation 3: Statement of purpose

The registered provider had a Statement of Purpose in place which included the information set out in Schedule 1 of the regulations. However, this document had not been updated to reflect the current whole time equivalent (WTE) of staff within the service.

Judgment: Substantially compliant

## Quality and safety

Overall, the inspectors found that residents were looked after by a caring staff team and residents were content with the service they received. However, the provider had failed to address a number of non-compliances' following the previous inspection, which were impacting on the quality of life and safety of residents who lived in the centre.

In the absence of satisfactory assurances regarding residents' safe evacuation in the event of a fire emergency, the provider was asked to submit an urgent compliance plan by 10 July 2023. In addition, staff training on fire safety was incomplete and inspectors found that staff knowledge of fire evacuation procedures did not reflect the centre's own evacuation procedure.

While it is acknowledged the provider had completed some fire safety works that had been identified in the providers`own fire safety risk assessment dated September 2021, there was still a number of fire risks outstanding 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. Inspectors found uncertainty over fire doors, visual deficiencies in the building fabric, inadequate evacuation planning, inappropriate storage of flammable and combustible materials along escape routes, poor signage, lack of fire training and out-dated evacuation floor plans, which could lead to serious consequences for residents in an emergency. These are outlined in detail under Regulation 28: Fire precautions.

Although the majority of residents had timely access to their general practitioners (GPs), records showed that a small number of residents were not allocated a GP, this arrangement did not ensure that residents timely access to medical services. Residents who did not have a GP relied on ad hoc visits from an out of hours GP service. This is a repeated finding from repeat inspections. Furthermore, the

provider had not ensured that residents had timely access to occupational therapy professional expertise to meet their needs. This was impacting on the quality of life of residents who needed specialist seating assessments to promote their comfort and wellbeing.

Inspectors reviewed a sample of resident files and found evidence that resident's assessments were completed within 48 hours of admission to the centre, in line with regulatory requirements. Resident's assessments informed care plans, in line with their preferences and wishes. However, a review of a sample of care plans found that the interventions required to deliver appropriate clinical care to the residents was not clearly described and care plans were not updated to reflect changes in residents care needs. As a result, care plans did not provide staff with adequate guidance and direction to provide safe and appropriate care as needed for the resident

The provider had not ensured that the environment was managed in a way that minimised the risk of transmitting a health care associated infection. Infection prevention and control practices in the centre were not in line with the national standards. This is discussed further under Regulation 27.

Inspectors found a number of areas of premises where paintwork on a number of wall was damaged and floor surfaces were damaged in resident bedrooms and utility rooms. There were a number of designated storage rooms in the centre, however the segregation of supplies in these rooms was not effective and inspectors observed that items were not organised and stored appropriately to ensure that good standards for infection prevention and control were maintained.

Residents' meetings were convened and issues raised for areas needing improvement were addressed. Minutes of residents meetings indicated that residents were consulted about the quality of activities and the quality and safety of the service, the quality of the food. Meeting records demonstrated that residents were happy with the quality of the service provided. Residents had access to television, radio, newspapers.

Residents' wishes in relation to their preferred religious practices were recorded and respected. A local priest attended the centre on a regular basis to celebrate Mass. Other religious and pastoral services could also be made available if required. Residents were also supported to attend the oratory within the centre.

Measures were in place to safeguard residents from abuse. All staff interactions with residents observed by the inspectors were kind and caring.

Inspectors found that the registered provider had ensured that visiting arrangements were in place for residents to meet with their visitors as they wished.

## Regulation 11: Visits

Visiting within the centre was being facilitated and inspectors saw a number of residents receiving visitors in their bedrooms or in communal rooms.

Judgment: Compliant

## Regulation 17: Premises

A review of the premises confirmed that the following areas were not kept in a good state of repair as required under Schedule 6 of the regulations:

- Paint was damaged or missing on a number of wall surfaces in resident bedrooms. This meant that these surfaces could not be effectively cleaned.
- Floor covering in several resident bedrooms and in the sluice room was damaged. This finding did not ensure these surfaces were adequately maintained or that effective cleaning procedures could be completed.
- Cushion surfaces on each of the armchairs provided in the prayer room were torn.
- The laminate surface of one sink unit appeared to be damaged.
- grab rails were not in place in all resident bathrooms, as required under Schedule 6 of the regulations

There was a lack of suitable storage space in the designated centre. This was evidenced by;

- The storage of maintenance equipment and supplies in a room designated for linen storage.
- The storage of residents hoists, slings and wheelchairs in a staff toilet.
- The storage of resident incontinence wear in an office.
- The storage of large quantities of oxygen in the nurses treatment room.

Inspectors found that the function of a number of rooms had been reassigned and were not in line with the detail of the centres' statement of purpose and floor plans of the centre, submitted by the Provider in June 2023.

Judgment: Not compliant

## Regulation 27: Infection control

Inspectors found that some procedures were not consistent with the standards for the prevention and control of health care associated infections;

- A number of slings were observed to be stored on hoists after use and not returned to the resident's room or a suitable storage area. This increased the risk of cross-contamination.

- There was evidence of communal use of products such as soap bars. This posed a risk of cross infection.
- There was an open bin on a cleaning trolley in use and this posed a risk of cross infection as this item of equipment was moved around all areas of the centre during cleaning.
- Storage was not segregated into separate storerooms and residents' assistive equipment was stored with cleaning and clinical supplies in the sluice room, this increased risk of cross contamination.
- Open top refuse bins were observed in most communal toilets and in twin bedroom en-suite facilities. These findings did not support recommended waste management procedures and posed a risk of cross infection.

Judgment: Substantially compliant

## Regulation 28: Fire precautions

The provider was required to take urgent action to ensure measures were in place to safeguard residents and others from risk of fire.The service 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:

- The inspectors observed inappropriate storage of oxygen cylinders in a treatment room. In addition to this, the inspectors identified storage of flammable items stored beside a mains power unit in the administration office. In both incidents, this created a potential fire risk-if a fire did develop, it would be accelerated by the presence of these items. An immediate action was issued to the person in charge who organised for the items to be removed.
- In the kitchen and oratory room, the inspectors noted fire doors were propped open. This resulted in the door closer mechanism being interfered with, which rendered the fire doors ineffective in regard to containing a fire.
- In a treatment room, access to a fire extinguisher was obstructed by the storage of lighting tubs which were left in front of the fire extinguisher.
- The inspectors noted gas pipework located in the kitchen and a laundry room were not highlighted or labelled to indicate the presence of a gas pipe.

The means of escape for residents and emergency lighting in the event of an emergency in the centre was not adequate. For example, one designated fire exit for use in the event of an evacuation, was through a smoking shelter, and another fire exit for use by kitchen staff was through a cluttered utility room used for storage related to the running of the kitchen. In both situations, the escape routes were not suitable in the event of an emergency.

There was a lack of emergency directional signage (running man signs) above some

cross corridor doors. In the event of an emergency, this lack of signage could cause confusion and could delay an evacuation. Furthermore, in the basement area there was a significant lack of emergency directional signage to indicate the evacuation routes from the basement areas to the final fire exits.

Externally, emergency lighting and directional signage was missing along some fire exit routes to direct and illuminate the route of escape in the event of a fire evacuation at night-time.

The maintenance of the fire equipment, means of escape and the building fabric was inadequate. For example, Inspectors observed inappropriate storage of items underneath a staircase and in a corridor located in the basement area. This compromised the protected means of escape from these areas. Inspectors also noted escape from a small outdoor space, adjacent to a sitting room, was compromised as the gate from this area was locked. Furthermore, full length curtains were found to be fitted above some final fire exits. These may create a potential obstruction and delay in the event of an emergency.

Some of the required maintenance servicing records for the fire detection alarm system and the emergency lighting system were not available on the day of the inspection. As a result, the inspectors were not assured the fire equipment were being regularly serviced 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), and these required appropriate fire sealing measures.

In addition, the provider did not ensure robust fire precautions throughout the centre. While the inspectors were informed that some fire safety works identified in the provider`s own fire safety risk assessment had been completed, deficiencies in regard to fire doors had not been progressed or completed. Furthermore, daily and weekly checks of fire doors and means of escape, while recorded and up-to-day, did not identify the fire risks that were identified on this inspection.

There were inadequate arrangements in place for staff to attend fire training. From a review of fire training records, the inspectors noted that not all staff had up-to-date fire safety training. Furthermore, records of staff attendance at fire safety training did not reference all staff. At the time of the inspection, the provider had fire safety training sessions planned for some staff members during July 2023 which were aimed at ensuring that all staff had completed fire safety training.

A review of the record of simulated fire evacuation drills found that drills were not scheduled at suitable intervals and did not provide adequate details. Drills were unclear in regard to; where the source of the fire was located, the number of staff that took part or just observed, the type of evacuation aids used and the learning outcomes.

There was no evidence of completion of a full compartment evacuation drill using the lowest staffing numbers rostered. A drill dated April 2023 was only based on 11

residents and not the 15 residents who are able to be accommodated in a compartment. Furthermore, some staff when spoken with did not demonstrate appropriate knowledge of fire evacuation procedures to be followed in the event of a fire emergency.

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, the inspectors were not assured that adequate staffing resources were available during the night time hours to evacuate all persons in the designated centre. The centre is registered for 44 residents. At the time of the inspector there were three staff members on night duty for the current 34 residents. Inspectors were not assured that residents in the rest of the centre would be adequately supervised during an evacuation in the remaining areas of the centre.

From an assessment of a sample of residents' personal emergency evacuation plans (PEEPs), inspectors noted that some PEEPs were not up-to-date and did not accurately reflect the required evacuation aids and levels of assistance for some residence. For example, one resident required three staff members to assistance in an evacuation, however it was indicated that only two were required. In addition to this, PEEPs for one resident was not included in the current records held in a fire box. This could cause confusion in an emergency situation.

Furthermore, the procedure of using bed sheets and a hoist to move high dependency residents during an evacuation had not been risk assessed. From a review of residents' evacuation aids, the inspector noted there was a significant lack of ski sheets and wheel chairs required in the event of an evacuation for some residents.

There were inadequate arrangements for containment of fire and detection in the event of a fire emergency in the centre . For example, the inspectors were not assured of the ability of a selection of fire doors to contain the spread of smoke and fire. This was evidenced by the following findings; a number of fire doors had door-closer mechanisms missing, non-fire rated ironmongery, fire door seals missing and some fire doors were damaged. Gaps were noted at the bottom and between some doors and fire smoke seals had been painted over rendering them ineffective to contain smoke.

Furthermore, a number of fire doors did not meet the criteria of a fire door and did not close fully when released. These deficiencies posed a significant risk to residents in the event of a fire. In addition to this, a fire door between a kitchen and a treatment room appeared to not meet the criteria for a 60 minute fire rated door. The inspectors were not assured by the fire rating of the enclosure that formed the nurse's station, which was in use as an office.

There was inadequate gas detection in the laundry area located in the basement area and detection was lacking in a store room.

An urgent compliance plan was issued to the provider in regard to;

- reviewing evacuation procedures,

- the suitability of evacuation aids
- fire evacuation drills of the largest compartments when staffing levels are at their lowest.

The displayed procedures to be followed in the event of a fire were not on display throughout the centre. Fire evacuation floor plans were missing from the main fire panel for people working in the centre to be able to easily follow and reference in the event of a fire. Fire evacuation procedures were also not on display in most areas of the centre. Fire evacuation plans were not up-to-date as some rooms had recently been repurposed. For example, a staff toilet was now in use as a store room and a cleaners store was now in use as a staffing changing area. This could cause confusion and loss of valuable time in the event of a fire emergency.

Judgment: Not compliant

## Regulation 29: Medicines and pharmaceutical services

Inspectors were not assured that medicinal products were stored securely in the clinical room at the time of inspection. Medication stock was stored on open shelving and the clinical room door was found to be unlocked at intervals during the inspection.

Medicinal products such as out-of-date eye-drops ands topical ointments, were not segregated from other medicinal products which were in use.

Judgment: Substantially compliant

## Regulation 5: Individual assessment and care plan

Inspectors reviewed a sample of resident files and found that individual assessment and care planning was not in line with the requirements of Regulation 5. For example;

- Information providing assurances that each resident's social activity needs were assessed to ensure they were supported to continue to pursue their interests in line with their capabilities was available. However, a review of a sample of care plans found that some did not have an appropriate social care plan to address their needs, preferences and wishes.
- A number of resident care plans were not formally reviewed at four monthly intervals, as required under the regulations. For example, several skin integrity and mobility care plans had not been formally reviewed.

Judgment: Substantially compliant

## Regulation 6: Health care

Inspectors were not assured that residents living in the centre had access to appropriate medical care. For example,

- Records viewed by the inspectors demonstrated that three residents who were admitted to the service between 2022 and 2023 did not have access to a general practitioner (GP) of their choice.

Inspectors were not assured that residents had access occupational therapy services in a timely manner, for example one resident with complex care needs was required to remain on bed rest as they had not been referred for a reassessment of their specialist seating.

Judgment: Substantially compliant

## Regulation 8: Protection

Measures were in place to safeguard residents from abuse. Staff had completed up-to-date training in the prevention, detection and response to abuse.

Judgment: Compliant

## Appendix 1 - Full list of regulations considered under each dimension

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

| Regulation Title | Judgment |
|---|---|
| **Capacity and capability** | |
| Regulation 15: Staffing | Compliant |
| Regulation 16: Training and staff development | Substantially compliant |
| Regulation 21: Records | Substantially compliant |
| Regulation 23: Governance and management | Not compliant |
| Regulation 24: Contract for the provision of services | Substantially compliant |
| Regulation 3: Statement of purpose | Substantially compliant |
| **Quality and safety** | |
| Regulation 11: Visits | Compliant |
| Regulation 17: Premises | Not compliant |
| Regulation 27: Infection control | Substantially compliant |
| Regulation 28: Fire precautions | Not compliant |
| Regulation 29: Medicines and pharmaceutical services | Substantially compliant |
| Regulation 5: Individual assessment and care plan | Substantially compliant |
| Regulation 6: Health care | Substantially compliant |
| Regulation 8: Protection | Compliant |

# Compliance Plan for Ballinderry Nursing Home OSV-0000318

## Inspection ID: MON-0040355

## Date of inspection: 04/07/2023

**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 16: Training and staff development | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 16: Training and staff development:<br>All Care plans have been reviewed and updated to include residents preferences and their social activities included to continue their social interests, preferences and wishes. Nurses have reviewed all Key to me details on each resident.<br><br>ADON will continue regular spot checks on care plans.<br><br>Fire awareness training has been provided to 11 staff members on the 07/07/23. We have 4 new HCA and 2 nurses which training has been arranged for and any remaining staff members will be included on that date. 14/09/2023<br><br>In the new management structure we have implemented regular checks to monitor supervision and all staff will have full induction training when starting.<br><br>All infection control procedures have been reiterated to all staff during handovers and staff meetings and any additional training / support will be available to staff if required.<br><br>(Complete, 14/09/2023) | |
| Regulation 21: Records | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 21: Records:<br>All residents information / records have been secured and are now stored securely in file room. | |

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| All current residents files are stored securely in treatment room in locked filing cabinets All nursing staff have been advised that these cabinets are to be locked at all times. |

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| Regulation 23: Governance and management | Not Compliant |

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| Outline how you are going to come into compliance with Regulation 23: Governance and management:<br>A management structure is now in place in the event that the PIC is absent annual leave / sick leave, In this event the ADON / senior nurse will be acting as PIC as per SOP. During this time the PIC will be supernumerary.<br><br>We continue ongoing recruitment to obtaining necessary staff. 2 part time nurses have been recruited and 4 new HCA are starting in the month of August 23.<br><br>The ADON has been designated 12 hrs a week to fulfil his supervisory role in relation regulation 27 Infection control and Regulation 28 Fire precautions .<br><br>The ADON will be responsible for reviewing and updating the communications and auditing systems to ensure that the service provided to residents is safe and appropriate and consistent going forward.<br>(Complete) |

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| Regulation 24: Contract for the provision of services | Substantially Compliant |

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| Outline how you are going to come into compliance with Regulation 24: Contract for the provision of services:<br>After reviewing the contract of care we have updated current contracts with the breakdown of fees with regard to Fair deal and Residents contribution when information is received and included the room number and occupancy.(Complete) |

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| Regulation 3: Statement of purpose | Substantially Compliant |

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| Outline how you are going to come into compliance with Regulation 3: Statement of purpose:<br>We have updated and displayed the new SOP including review WTE.(Complete) |

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| Regulation 17: Premises | Not Compliant |

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| Outline how you are going to come into compliance with Regulation 17: Premises:<br>After conducting a general maintenance inspection any defect in flooring / paintwork / laminated surfaces are being rectified by the 01/10/23.<br><br>Chairs in Oratory have been removed for reupholstery on the 29/08/23. completion date 05/09/23.<br><br>Sluice room has been solely designated for dirty items only and other items have been removed. (Complete)<br><br>Grab rails in all residents bathrooms have been inspected and additional rails if needed will be installed (08/09/2023)<br><br>All maintenance items have been removed from linen room and all housekeeping / maintenance staff have been instructed that no other items other than linen to be stored in linen store. (Complete)<br><br>Staff toilet area in storage room has been discontinued and removed, this has been converted to storage only for wheelchairs / hoists & slings.<br><br>Oxygen have been relocated out of treatment room and off site to secure shed. (Complete)<br><br>Rooms / areas have been reassigned and are been used only for the purpose stated as per SOP / floor plan. (Complete) |

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| Regulation 27: Infection control | Substantially Compliant |

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| Outline how you are going to come into compliance with Regulation 27: Infection control:<br>The importance of prevention of cross contamination has been reiterated at all handovers and during recent staff meetings with regard to slings hoists wheelchair cushions cleaning disinfecting between usage and stored correctly between uses. |

(Complete)

All cleaning station bins have been order and expected 31/08/2023.

Sluice room has been solely designated for dirty only and other items have been removed. (Complete)

All residents to have their own supply of toiletries as per infection control policy and all HCA nursing staff have been reminded on the importance of preventing cross contamination. (Complete)

Staff toilet area in storage room has been discontinued and removed, this has been converted to storage only for wheelchairs / hoists & slings. (Complete)

Weekly IPC audits are being conducted and any issues identified will be addressed.

| Regulation 28: Fire precautions | Not Compliant |
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Outline how you are going to come into compliance with Regulation 28: Fire precautions: rovider / Management have reviewed and assessed all areas of Regulation 28 and have initiated a robust action plan / audits to resolve any issues that were raised after and during the inspection on the 4/7/2023 with the support and advise from the HSFC.(Complete)

The maintenance man has been designated to inspect all fire doors / means of escape and equipment, to ensure they are clear at all times and overhead lighting to be inspected and maintained weekly and any faults or maintenance required to be carried out immediately. (Complete)

All means of escape including (Basement under stairs) has been cleared and a check list will be documented daily to ensure safe means of escape. Clear signage has been put in place to keep the area clear at all times.

All means of escape including (Small Kitchen utility store) has been cleared and a daily check list has been put into the for the kitchen staff to mark.

Signage has been installed to ensure it is kept clear at all times. The designated fire exit for the kitchen is through the main fire exit in the dining room as per floor plan.

Smoking area door will be removed and been risk assessed by Ignite Fire services and deemed safe for
means of evacuation.

Emergency lighting has been checked and 2 new exits overhead emergency lights in

corridors installed / outdoor lighting will be installed to ensure safe means of escape. ( as per attached emergency lighting system certification Sean Gavin electrical Ltd ) Outdoor light (24/10/23)

New signage has been purchased and erected as required including basement. (Complete)

Oxygen have been relocated out of treatment room and off site to secure shed. (Complete)

Flammable materials have been removed from under source of ignition (Fuse board). (Complete)

Flammable items in the dining / conservatory / bedrooms (full length curtains have been removed) (Complete)

Any spaces / holes located on wall / ceilings will be sealed by maintenance on the 08/09/2023.

Flame Stop subcontractors have been instructed to identify and seal all areas that penetrate through the fire rated walls and ceiling using appropriate fire sealant. (31/01/24)

After conducting regular and ongoing fire drills and full compartmental evacuations in the designated centre with 3 staff as per night time simulation, we are confident that we have sufficient staff at night to safely evacuated full compartmental wing using a progressive horizontal compartmental evacuation which in turn would not leave other residents in the designated center unsupervised for any length of time.

Small outdoor garden space (Butterfly Garden) has been upgraded with a key lock box with code to ensure safety of residents and safe means of escape.

Fire awareness training has been provided to 11 staff members on the 07/07/23. We have 4 new HCA and 2 nurses which training has been arranged for and any remaining staff members will be included on that day. All staff have been provided with yearly staff training in regards to fire awareness and prevention and now includes Evacuation aids training. (14/09/2023)

We have drafted a new fire drill report sheet to detail evacuations and the results to improve on any systems in place. We are executing monthly mock evacuations. Full compartmental drills using the lowest amount of staff available (night) are also carried out. (Complete)

PEEPS have been reviewed and are including all residents evacuation needs and are continuously reviewed on new admissions and long term residents are updated accordingly. (Complete)

Evacuation aids have been purchased and installed ski sheets / ski sledge and all residents beds have been colour coding as per PEEPS. (Complete)

After assessment we have discontinued the use of sheets and hoist during evacuation and will install all beds with ski sheets and we have installed a ski sledge to aid in evacuation. We are confident we now have sufficient aids in place to perform a full compartmental evacuation. Through the engagement and recommendations from Ignite Fire services.
All staff will be training in the use of all evacuation aids by Ignite Fire services. (31/10/23)

18 ski sheets have already been purchased and fitted as per PEEP's. Another 26 ski sheets ordered to cover all beds in the centre

A full fire door inspection will be conducted by Flame Stop any doors / defects that require repair or refurbishment / replacement to come into compliance with fire regulation 28 will be carried out on all doors. Office enclosure will also be included in the fire stop audit to ascertain the fire rating and alternation that need to be made will be carried out.

Gas detection alarm has been installed in the Laundry Area (Basement) and store room and kitchen.

An overall risk evaluation will be carried out to identify any risks / hazards and control measures put in place as required to eliminate / mitigate / control risks identified.

Monthly risk assessments will be performed in all areas in the designate centre.

3 members of management staff have been enrolled in fire warden training on the 21/09/2023. This include the ADON.

Provider / Management have reviewed and assessed all areas of Regulation 28 and have initiated a robust action plan / audits to resolve any issues that were raised after and during the inspection on the 4/7/2023 with the support and advise from the HSFC.

Fire door leading from treatment room to kitchen will be upgraded to a 60 minute fire door. Nurse station / office door will be updated to a 30 minute fire door on the 14/09/2023.

Signage has been erected to notify staff of gas pipes and switch off points for gas,
Gas detection alarms have been fitted in kitchen / laundry.

Our current fire service provider has updated contract to include lighting maintenance and servicing history and will be serviced quarterly.

Fire procedures and exits signage have been displayed throughout the designated Centre and below the fire alarm panel using new floor plan.

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| Regulation 29: Medicines and pharmaceutical services | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
Doors to open shelving in the treatment room will be enclose on 14/09/2023 to all medicine and pharmaceutical related products.

Regular medication audits are being carried out and medication trolley has been audited by the ADON.

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| 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:
All Care plans have been reviewed and updated to include residents preferences and their social activities included to continue their social interests, preferences and wishes. Nurses have reviewed all Key details on each resident.

ADON will continue regular spot checks on care plans. (Complete)

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| Regulation 6: Health care | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 6: Health care:
We have consulted with local G.P he has agreed to take on the any residents that are without a G.P.

Residents that require occupational therapy or any other services will be assessed and referred accordingly in a timely fashion. (Complete)

## 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 |
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| Regulation 16(1)(b) | The person in charge shall ensure that staff are appropriately supervised. | Substantially Compliant | Yellow | 18/09/2023 |
| 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 | 09/10/2023 |
| Regulation 21(6) | Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible. | Substantially Compliant | Yellow | 08/09/2023 |
| 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 | Not Compliant | Orange | 30/11/2023 |

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| | the statement of purpose. | | | |
| Regulation 23(b) | The registered 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. | Not Compliant | Orange | 30/11/2023 |
| 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 | 30/11/2023 |
| Regulation 24(1) | The registered provider shall agree in writing with each resident, on the admission of that resident to the designated centre concerned, the terms, including terms relating to the bedroom to be provided to the resident and the number of other occupants (if any) of that bedroom, on which that resident shall reside in that centre. | Substantially Compliant | Yellow | 30/09/2023 |

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| Regulation 24(2)(b) | The agreement referred to in paragraph (1) shall relate to the care and welfare of the resident in the designated centre concerned and include details of the fees, if any, to be charged for such services. | Substantially Compliant | Yellow | 30/09/2023 |
| 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. | Substantially Compliant | Yellow | 31/10/2023 |
| Regulation 28(1)(a) | The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings. | Not Compliant | Orange | 31/01/2024 |
| Regulation 28(1)(b) | The registered provider shall provide adequate means of escape, including emergency lighting. | Not Compliant | Orange | 31/01/2024 |
| Regulation 28(1)(c)(i) | The registered provider shall | Not Compliant | Orange | 31/01/2024 |

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| | make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services. | | | |
| Regulation 28(1)(c)(ii) | The registered provider shall make adequate arrangements for reviewing fire precautions. | Not Compliant | Orange | 31/10/2023 |
| Regulation 28(1)(d) | The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire. | Not Compliant | Orange | 18/09/2023 |
| 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 | Not Compliant | Orange | 14/10/2023 |

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| | designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire. | | | |
| Regulation 28(2)(i) | The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires. | Not Compliant | Orange | 31/01/2024 |
| 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 | 25/08/2023 |
| 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 | Yellow | 11/09/2023 |
| Regulation 29(4) | The person in charge shall ensure that all medicinal products dispensed or supplied to a resident are stored securely at the centre. | Substantially Compliant | Yellow | 20/10/2023 |
| Regulation 03(2) | The registered provider shall | Substantially Compliant | Yellow | 25/08/2023 |

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| | review and revise the statement of purpose at intervals of not less than one year. | | | |
| Regulation 5(2) | The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre. | Substantially Compliant | Yellow | 25/08/2023 |
| 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 | 25/08/2023 |
| 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 | Substantially Compliant | Yellow | 25/08/2023 |

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| | concerned and where appropriate that resident's family. | | | |
| Regulation 6(2)(a) | The person in charge shall, in so far as is reasonably practical, make available to a resident a medical practitioner chosen by or acceptable to that resident. | Substantially Compliant | Yellow | 15/09/2023 |
| 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. | Substantially Compliant | Yellow | 25/08/2023 |