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:	St. Brendan's High Support Unit
Name of provider:	Mulranny Day Centre Housing Limited
Address of centre:	Mulranny, Westport, Mayo
Type of inspection:	Unannounced
Date of inspection:	13 December 2022
Centre ID:	OSV-0000389
Fieldwork ID:	MON-0038392

About the designated centre

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

St. Brendan's High Support Unit is a purpose-built facility which can accommodate a maximum of 33 residents. It provides care to dependent persons aged 18 years and over who require long-term residential care or who require short term respite, convalescence, dementia or palliative care. Care is provided for people with a range of needs: low, medium, high and maximum dependency. This centre is situated in the village of Mulranny on the N59 Newport to Achill road and just off the Great Western Greenway. It is part of a supported housing complex and day care service operated by Mulranny Day Centre Housing Limited. The building is split level over two floors with lift access to the upper floor. Bedroom accommodation for residents is available on both floors and consists of single and double rooms. A variety of communal space is available for residents to use during the day and includes two sitting rooms, a dining area, an oratory and visitors' room. The centre is set in spacious grounds and overlooks the sea.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	21

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 13 December 2022	10:15hrs to 16:30hrs	Catherine Rose Connolly Gargan	Lead
Tuesday 13 December 2022	09:45hrs to 16:30hrs	Gordon Ellis	Support

What residents told us and what inspectors observed

Overall, the inspectors found that the majority of 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 for assistance and support. Staff interactions with residents were observed to be caring, gentle and respectful throughout the day of this inspection.

The inspectors met with many of the residents during the inspection. Overall feedback from residents was mostly positive regarding the quality of their lives and the care they received in the centre. Residents told the inspector that they felt safe and secure, were well cared for and that the food they were provided with was of 'very good' standard and that the food was 'top notch' and 'couldn't be faulted'. Residents told the inspectors that staff were always available and willing to assist them when they needed help during the day or at night. One resident said that they were 'not lonely anymore' and that they loved 'chatting' with staff. Some residents said they were from the locality and were 'happy' that they could continue to live in the area they were very familiar with. The inspectors were told that one resident's house in the community was visible from the front door of the centre and staff were observed assisting this resident to go out to the front of the centre to see their house. Some residents had returned to the locality from abroad and one resident said it was a 'wish they had that was now granted' and they were getting used to being back living in the village.

Staff kept residents informed of the social events taking place in the local village and these event notices were displayed in the centre. Some residents went to the local market, Achill and a cultural event in the village and were also supported to go out for coffee and lunch. However, one resident told inspectors that they did not have enough opportunities to engage in social activities that interested them. The inspectors were told by the person in charge that they were aware of this resident's needs and were assisting them with accessing social activities and hobbies to meet their interests and capacities.

There was a view of the sea and the beach located opposite the centre from one of the residents' sitting rooms and from several residents' bedrooms. A number of residents spoke to the inspectors about their 'love of the sea' and beautiful coastline views.

The centre was a split level designed building located on an elevated site on the edge of a small seaside village. Residents' accommodation was arranged over both floor levels and four newly created bedrooms located on the upper ground floor were available for inspection. Inspectors observed that a room on the upper ground floor registered for the purpose of a visitor's room was now furnished as a single en suite bedroom and was being occupied by one resident. This was not a registered bedroom at the time of the inspection and the provider was in breach of their

registration conditions.

Two bedrooms on the lower ground floor were occupied by two residents in each and all other bedrooms including the four new bedrooms were furnished to accommodate one resident in each bedroom.

The inspectors observed that the centre's oratory on the lower ground floor was re-purposed as a visitor's room. Nine residents in the West Wing of the lower ground floor shared a communal shower and this meant that there was only one shower available to meet the needs these nine residents at the time of the inspection.

Inspectors observed that although the provider had replaced the floor covering on the main corridor and in the clinical storeroom on the lower ground floor, the flooring in several residents' bedrooms was damaged and worn and in need of replacement. In addition, paint on the walls and on some wooden surfaces was missing and damaged in a number of areas along the corridors and in some residents' bedrooms. The inspectors were told that these works were planned to be done.

Inspectors observed that both sitting rooms were bright and spacious and while one sitting room was well used, only a small number of residents spent time in the second sitting room. One resident sitting by a fireplace which did not have a fire burning in it told inspectors that they felt cold. Inspectors observed that this room with full height ceilings and several windows felt cooler than the rest of the centre.Three residents told inspectors that they preferred to sit in the reception area during the day and their wishes were seen to be respected. One of these resident also chose to eat their meal in the reception area and this resident's preference was facilitated by staff.

A reception desk/nurses' station area was located between the centre's lobby reception/lobby and the residents' sitting room. A counter-top perimeter wall surrounded this area. Inspectors observed that staff worked on a computer and used the phone for communicating and receiving residents' personal information. Although background music was playing on a radio in this area their conversations could be clearly heard by the inspectors and other persons passing by or sat in the sitting room or in the reception/lobby area.

The activity coordinator was observed facilitating a variety of one-to-one activities for residents including board and card games, hand massage and nail painting. One resident was enjoying knitting. A music DVD was playing on the television in the sitting room and although a small number of residents were clearly enjoying this, other residents were not interested and were either unoccupied for most of the day or asleep. Two residents told inspectors that they were bored and did not have any interest in the music.

Inspectors observed that staff wore face masks at all times including when providing direct care to residents. Alcohol hand gel dispensers were readily available along corridors for staff use and staff were observed to perform hand hygiene as appropriate.

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

Capacity and capability

This was an unannounced inspection carried out in response to a representation made by the provider to the Chief Inspector regarding her proposed decision for renewal of the designated centre's registration and to assess the provider's progress with completion of the compliance plan from the inspection completed in May 2022. This assessment included fire safety precautions in the designated centre. The provider had recently applied for registration of 27 beds that included seventeen single bedrooms, two twin bedrooms, change of purpose of a visitor's room to a single bedroom and five bedrooms in a refurbished area of St Brid's wing. The inspectors found that provider had breached the conditions of their registration by changing a room registered as a visitor's room to a single bedroom and admitting a resident to that bedroom.

Inspectors found that actions to strengthen the centre's governance, management and oversight systems had been put in place and although not compliant on this inspection, there was evidence that the provider was now focused on bringing the centre into regulatory compliance to ensure that the service provided to residents was safe, appropriate and effectively monitored. Accountability and oversight of clinical care of residents was assured with the appointment of a full time person in charge who meets regulatory requirements. The roles and responsibilities of all staff were defined and their roles and responsibilities were identified and were known by staff.

Inspectors found that ten of the twenty seven actions identified in the compliance plan from the inspection in May 2022 had been completed. As a result, Regulations 3; Statement of Purpose and 29; Medicines Management were found to be in compliance on this inspection. Although not completed, all seventeen of the remaining actions identified in the compliance plan from the previous inspection had been progressed and were at varying stages of completion. The actions taken by the provider had reduced the level of non compliance in the majority of the regulations assessed. However, Regulations 9: Residents' Rights, 12: Personal Possessions, 15: Staffing, 17; Premises, 23: Governance and Management and 28; Fire Precautions were found not compliant again on this inspection. This evidenced failure by the provider to take adequate action to ensure residents' safety and quality of life by completing the necessary actions to bring the centre into compliance. Significant focus and resources were now required to bring the centre into full compliance with the regulations and to ensure the safety and well-being of the residents accommodated in the designated centre.

The registered provider of St Brendan's High Support Unit is Mulranny Day Centre

Housing Limited. The board of the company consists of eight voluntary directors. The company chairperson is the registered provider representative who maintained a presence in the centre and was involved in its day-to-day operations. The new person in charge was appointed in on 22 August 2022 and facilitated this inspection.

The centre had experienced a significant turnover of staff in 2022 and not all staff vacancies were filled to ensure there was sufficient staff to meet the needs of 27 residents in accordance with the provider's application for renewal of the centre's registration. On the day of the inspection there was sufficient staff available to meet the clinical needs of the 21 residents in the centre, however, there were not sufficient staff with appropriate skills to meet the social needs of residents as outlined in the centre's statement of purpose.

While, both mandatory and professional development staff training was taking place, records showed that not all staff were up to date with completion of their mandatory training requirements in fire safety and safeguarding residents from abuse. In addition, staff had not attended training to ensure they had appropriate knowledge and skills to competently assess residents' needs, develop effective care plans and to care and support residents with responsive behaviours (how residents who are living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).Training in these areas was scheduled in the coming weeks.

There was a low number of documented complaints, and procedures were in place to ensure any complaints received were managed in line with the centre's policy.

The provider had arrangements for recording accidents and incidents involving residents in the centre and notifications were submitted as required by the regulations.

Systems were in place to ensure all new staff who joined the service completed induction training and staff working in the centre had satisfactory Garda Vetting in place. The provider was a pension agent for one resident and procedures were in place to ensure this process was managed according to the legislation and best practice.

Regulation 15: Staffing

Inspectors found that although, there were adequate numbers of appropriately skilled staff available to meet the clinical needs of the 21 residents in the centre on the day of this inspection, the staffing resources provided did not ensure the social care needs of residents were being met.

Although there were adequate numbers of staff to meet the clinical needs of the 21 residents on the day of inspection, there were not sufficient staff available to meet the needs of six additional residents in accordance with the provider's representation

made to the Chief Inspector for registration of 27 beds.

Judgment: Not compliant

Regulation 16: Training and staff development

Although in progress, the provider had not ensured that all staff had access to mandatory and appropriate professional development training in line with their roles and responsibilities. This was evidenced by;

- Four staff had not attended safeguarding training. Inspectors were told that this training was scheduled to take place for these staff in the days following the inspection.
- Staff had not been facilitated to attend training on assessment and care planning. The person in charge told inspectors that this training was scheduled to occur in January 2023 and in the interim, the person in charge was supporting staff with assessment and care planning activities.
- Staff had not attended training in care of residents with responsive behaviours. Inspectors were told that this training was scheduled to occur in the days following the inspection.

Judgment: Substantially compliant

Regulation 23: Governance and management

Inspectors found that although some improvements had been made since the previous inspections in 2022,the management and oversight of the service was not effective in maintaining compliance with the Health Act 2007 (Care and Welfare of resident in Designated Centres for Older People) Regulations 2013 and ensuring the service were delivered in line with the centre's statement of purpose.

This was evidenced by the number of regulatory non compliances found on this inspection and the provider's failure to address the non compliances found on the previous two inspections. For example,

- Notwithstanding actions taken by the provider to complete their compliance plan and bring the centre into compliance with the regulations since the inspections in 2022, this inspection found that the provider had failed to take appropriate actions and to provide the resources required to bring the centre into full regulatory compliance. As a result the inspectors found repeated non -compliances in a number of regulations as set out in this report including the overall maintenance and refurbishment of the premises and fire safety precautions.

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 prevention as detailed under Regulation 27 had not been satisfactorily addressed and residents continued to be at risk of cross infection.
- risks identified in relation to fire safety precautions as discussed under Regulation 28 had not been identified and managed.

An annual review report on the quality and safety of the service for 2021 was not available.

Judgment: Not compliant

Regulation 31: Notification of incidents

A record of accidents and incidents involving residents that occurred in the centre was maintained. Notifications and quarterly reports were submitted within the specified time frames and as required by the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

The complaints procedure was displayed in the centre. The local policy included the designated complaints officer, the appeals process and the nominated person to oversee the process in line with regulatory requirements.

There were two complaints recorded in the complaints record for 2022 and both were closed to the satisfaction of the complainants. The person in charge confirmed there were no open complaints. Complaints were investigated and managed without delay and in line with the centre's policy.

Judgment: Compliant

Quality and safety

Overall, the inspectors found that residents were looked after by a staff team who knew them very well. Work was in progress to ensure that residents' needs were comprehensively assessed and that effective and person-centred care plans were

developed to clearly direct staff on the care interventions they must complete to meet residents' needs. Inspectors found that the standards of residents' care and timely access to healthcare and allied health specialist had improved since the previous inspection. Records showed that effective arrangements and systems were in place to ensure treatment and care recommendations made by members of the multidisciplinary team were implemented and monitored.

The provider had made significant progress in relation to fire safety since a previous inspection on 22 July 2021. The inspectors noted a fire door assessment had been carried out on all fire doors in the centre and suitable repairs had been completed. Improvements to the fire detection alarm system was evident by the presence of additional fire detectors and emergency lighting to areas. Fire stopping works had been carried out to areas that previously required attention and a newly constructed sub-compartment had been formed to reduce a large compartment.

From a review of staff fire safety training records, two staff had not completed up-to-date fire safety training. The inspectors were given assurances that this was scheduled. Personal emergency evacuation plans for residents were comprehensive and suitably detailed. Fire drills reviewed on the day of the inspection indicated that fire drills were being carried out regularly and staff spoken with had a good knowledge of fire evacuation procedures to follow in the event of a fire emergency. Furthermore, weekly in-house checks were being carried out and were up-to-date with faults recorded and acted upon.

In relation to the new extension, minor improvements and assurances were required, which were subsequently provided following the inspection. For example,

- Staff have yet to train and carry out an evacuation to test the evacuation procedures and to ensure that staff were familiar with the new layout.
- Floor plans showing compartments and fire exit routes were not displayed in this area.
- Minor holes were found in a fire door on a corridor and metal fire tags were absent from new fire doors in order to identify their fire rating.
- A design/commissioning certificate for the electrical installation and also for the emergency lighting system were not available on the day of the inspection.
- A revised fire safety certificate with fire drawings technical report were not available on the day of the inspection.
- A providers' plan for the designated centre when admissions start to be accepted into the new extension was not available on the day of the inspection to indicate a review of staffing levels in relation to location of residents based on their dependency levels and the number of residents in each compartment.
- The self-closure unit on the fire door to the laundry was not operating correctly and required adjustment. This was addressed on the day of inspection.

The centre was laid out with a sufficient number of escape routes and exits. The inspectors saw evidence of a full audit of the fire doors throughout the designated

centre and recommended improvements works had been completed. Of the fire doors reviewed, the inspector noted most were well fitted. However, some deficiencies were identified on this inspection in relation to fire doors, means of escape emergency light and emergency directional signage, which are detailed under regulation 28. Fire precautions

Only some service records were available for the various fire safety and building services on the day of the inspection. For example, quarterly maintenance certificates for the fire detection alarm system, the emergency lighting system and the annual certificate for the fire detection alarm system was not available for review. These were subsequently submitted following the inspection.

There was a fire safety management plan and emergency fire action plan in place. These were found to be comprehensive and informed robust fire safety management of the centre.

On the day of this inspection, residents' accommodation was arranged on lower and upper ground floor levels in seventeen single and two twin bedrooms. Access between the floors was provided by a ramp and a lift both of which were accessed from one of the communal sitting rooms. Handrails were in place on both sides of the ramp.The inspectors found that the layout of the two twin bedrooms negatively impacted on residents' privacy when carrying out personal activities. In addition, storage facilities in these bedrooms for residents' clothing were not adequate and were not easily accessible to the residents. In addition, the absence of suitable shelf surfaces in these bedrooms meant that the residents were unable to display and store personal items such as photographs and mementos.

A new enclosed outdoor area with outdoor seating had been developed for residents but due to key code door locks this area was not accessible to residents without the assistance of staff to open the doors.

Residents' sitting and dining accommodation and a visitor's room were located on the lower ground floor level and residents' bedrooms and a visitor's room were located on the upper ground floor. The provider's representation to change the purpose of Room 18 from a visitor's room to a single resident bedroom with full en suite facilities was assessed by inspectors. Due to the layout of this bedroom and limited storage facilities, inspectors found that this room could only meet the needs of a resident who was independently mobile on a short term admission basis.

The centre premises was arranged into three areas with 'East' and 'West' wings on the lower ground floor and 'St Brids' on the upper ground floor. Five single bedrooms with full en suite facilities and a sluice were available for inspection in a newly refurbished area of St Brids wing on the upper ground floor. The inspectors found that the five bedrooms were fully furnished, contained all necessary fittings and were completed to a good standard. The inspectors' findings are discussed under regulations 9; Residents' Rights and 17, Premises in this report.

Although a secure nurses' office was available. nurses worked at the nurse's station in the reception area and could be overheard talking with other health care professionals when on the telephone. As a result, there was a risk that residents'

personal information and privacy would not be maintained.

Notwithstanding the infection prevention and control improvements implemented following the inspection in May and August 2022, further actions were required to ensure residents' safety from risk of infection. These findings are discussed under Regulation 27; Infection Control.

Opportunities for residents to engage in meaningful social activities each day in the centre were dependant on staff with appropriate skills being available which did not happen every day. Therefore, further resources and actions were required to ensure that each resident had access to meaningful occupation in line with their preferences and ability to participate.

Residents' meetings were convened and records of these meetings showed that residents were supported and encouraged to be involved in the running of the centre. Issues raised by residents as needing improvement were addressed and residents' suggestions were valued. Residents had access to local and national newspapers.

Overall, residents at risk of experiencing responsive behaviours were well supported by staff. However, behaviour support care plans did not provide sufficient detail to guide staff on the most effective support strategies to ensure that a consistent approach was utilised by all staff. Furthermore staff had not been facilitated to attend training to inform their care and the support needs of residents with responsive behaviours.

While staff demonstrated a commitment to minimal restraint use, not all practices and procedures supported residents' choices.

Measures were in place to safeguard residents from abuse. However records showed that a significant number of staff had not completed their mandatory safeguarding training. Residents who spoke with the inspectors confirmed that they felt safe in the centre. The inspectors observed that interactions with residents by staff were caring and respectful.

Regulation 11: Visits

There were no restrictions to residents' families and friends visiting them in the centre. Residents could meet their visitors in private outside of their bedroom in the visitor's room if they wished to do so. Visits by residents' families and friends were encouraged and practical precautions were in place to manage any associated risks to ensure residents were protected from risk of infection.

Judgment: Compliant

Regulation 12: Personal possessions

Residents in two twin bedrooms did not have suitable shelf surface space to display their personal photographs and other items, if they chose to do so.

Residents in two twin bedrooms could not maintain control of their personal clothing and possessions due to the following;

- Although, each resident's clothes were stored in a separate wardrobe in two twin bedrooms, the wardrobes did not provide sufficient space to store items of clothing and other personal items. In addition the wardrobes were located outside of the residents' bed spaces and access to these wardrobes was hindered by the layout of the bedrooms and the location of the privacy curtain fittings. This arrangement did not ensure that each resident could access their belongings easily and keep their personal items secure.

The wardrobe in bedroom 18 did not provide reasonable space for a resident receiving care on a long-term basis to store their clothing and other possessions.

Judgment: Not compliant

Regulation 17: Premises

Notwithstanding improvements made to the premises since the last inspection, the design and layout of areas of the designated centre did not meet the needs of the residents and a number of areas did not conform to Schedule 6 of the regulations. This was evidenced by the following findings;

- Two bedrooms (numbered 15 and 16) with two residents in each bedroom on the day of inspection were not laid out in a way that facilitated each resident to rest in a chair by their bedside. One side of each bed was placed against an adjacent wall and the amount of circulation space available between the bed and screen curtains did not provide assurances that each resident's privacy and dignity would be maintained during transfer procedures to/from their chair to their beds.
- Room number 18 was registered as a visitor's room but was set out as a single bedroom with full en-suite facilities on the day of inspection. Inspectors found that one side of the bed in this bedroom was placed along an adjacent wall. The layout of this bedroom did not provide sufficient space for suitable storage facilities, access for a residents with mobility aids or for assistive chair or hoist equipment to support a resident's needs.
- Nine residents shared one shower facility on the west wing of the lower ground floor level unit. The inspectors were told that plans were in place to install an en suite shower facility in one of the bedrooms in this area which would reduce the number of residents using this shower facility to eight.

- While, the inspectors were told that weekly temperature checks were completed in communal and bedroom areas, evidence of checks were not made available to the inspectors and the environmental temperature in one resident sitting area was cooler than the rest of the centre and was not comfortable for residents.
- Floor covering in several bedrooms was damaged and in need of repair/replacement. This finding did did not ensure these surfaces were adequately maintained or that effective cleaning procedures could be completed.This was a repeated finding from previous inspection.
- There was inadequate ventilation in a sluice room and a malodour was evident. One leg of the bedpan disinfection unit in this sluice room was resting on an open drain. This was also a finding from the last inspection and had not been adequately addressed.
- Wall surfaces in the reception area, in a number of residents' bedrooms, along some corridors and on wooden doorframes and bedroom doors were scuffed and had paint missing and required repair and repainting.This was a repeated finding from previous inspection.
- Two communal shower facilities did not have handrails provided to support residents' independence and safety. Although, handrails were fitted on adjacent walls in some toilets, grabrails were not fitted on each side of these toilets to support residents' independence and safety.

Judgment: Not compliant

Regulation 18: Food and nutrition

Residents were provided with a varied and nutritious diet and residents confirmed that they could have alternatives to the menu offered if they wished. A process was in place to ensure residents' special dietary requirements were known by catering staff and dishes were prepared in accordance with residents' assessed needs, preferences and the recommendations of the dietician and speech and language therapist.

Residents meals were served in the dining room which facilitated all residents to dine together if they wished. There was sufficient staff available in the dining rooms at mealtimes to assist residents as needed. Residents who wished to eat their meals in their bedrooms or residents who were unable to go to the dining rooms were appropriately assisted without delay. Refreshments were available throughout the day and fluid and food intake by residents at risk of malnutrition and dehydration was closely monitored.

Judgment: Compliant

Regulation 27: Infection control

Although actions taken by the provider since previous inspections reduced residents' risk of infection, further actions were necessary to ensure compliance with regulation 27: Infection control. For example:

- An open drainage outlet used to drain a shower trolley was protruding up from the floor in a communal shower used by residents and posed a risk to residents. .
- There was evidence of black discolouration along the border of the wall tiles in one communal shower. This did not provide assurances that this surface was effectively cleaned.
- A hazardous waste bin was not available in one sluice room and therefore there was a risk that potentially hazardous waste would not be appropriately segregated.
- Although, hand washing facilities were available in the nurses' office/treatment room area, clinical hand wash sink that meet current recommendations were not available for staff use in the treatment room and within close proximity to the point of care within the centre. The inspectors were told that the sinks in the resident's rooms were dual purpose used by residents and staff. This finding did not support effective hand hygiene, increased the risk of cross infection and is a repeated finding from the previous inspection.

Judgment: Substantially compliant

Regulation 28: Fire precautions

At the time of inspection, Improvements were required to comply with many of the requirements of the regulations. The service was non-compliant with the regulations in the following areas:

The provider needs to improve the means of escape for residents and emergency lighting in the event of an emergency in the centre. For example, the inspectors observed a full length blind above a designated fire exit door. This could cause confusion and a delay in the event of a fire emergency.

Furthermore, emergency directional signage required a review. The inspectors noted a running man sign was absent above some doors in a corridor, a running man sign was pointing in the wrong direction and another running man sign was not illuminated. This could cause confusion in the event of a fire event.

The provider needs to improve the maintenance of the means of escape. For example, the inspectors observed bins being stored along an external escape route. This has the potential to compromise a means of escape in the event of a fire emergency. In the internal corridors, the inspectors noted linen trolleys were being stored over the course of the entire inspection. Corridors are used as a means of

escape and should not be cluttered. This could cause an obstruction and delay evacuation in the event of a fire.

In addition to this, a corridor door, when in the open position was blocking access to a designated fire exit located at the top of an access ramp. This designated fire exit will be inaccessible to residents who need to evacuate from this area in the event of a fire. This requires a review by the provider

The inspectors were not assured that gates from an enclosed garden would be readily openable in the event of an evacuation and ultimately to the fire assembly point located to the front of the centre. These gates should be readily openable to provide adequate means of escape and to avoid residents having to potentially re-enter the centre in the event of a fire emergency.

Arrangements for containment of fire in the event of a fire emergency in the centre required improvement by the provider. While a fire door assessment and fire door repairs had been carried recently, the inspectors identified some deficiencies. For example, a number of fire doors had non-fire rated screws fitted, gaps were noted underneath some bedroom doors and some doors didn't have a latch fitted in order to secure a door in the closed position. Furthermore, some fire doors did not close fully when released, a store room door had been fitted with an inappropriate door handle and lock, and another store room door was partially missing a smoke seal.

The displayed procedures to be followed in the event of a fire lacked detail and clarity for people working in the centre to be able to easily follow in the event of a fire. For example, floor plans on display did not indicate the location of evacuation areas on the floor in question (compartment and sub-compartment boundaries) suitable for phased evacuation of residents from a high-risk area to a low-risk area on the same floor (horizontal phased evacuation). While each compartment was numbered, nevertheless, it was not clear where the compartment boundaries started and ended. This would form part of the procedure to be followed by staff in the event of a fire in this centre, and, therefore, could cause confusion and loss of valuable time in the event of a fire emergency.

Furthermore, floor plans on display in compartment six were not up-to-date. For example, the floor plans did not show an accurate layout of this area and doors were also missing from the floor plan. In addition to this, a door into the kitchen/dining area was labelled as an FD60s but on the plan it was indicated as an FD30s. The provider is required to review floor plans to ensure they are up-to-date and coordinated accordingly.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Residents were protected by safe medicines management procedures and practices. Residents had access to a pharmacist who supplied residents' medicines. The

pharmacist was facilitated to meet their obligations to residents and they were now completing monthly audits of medication in the centre. Medicines including medicines controlled by misuse of drugs legislation were stored securely. Balances of controlled medicines were checked by two staff nurses at work shift changeovers and were correct. Medicines requiring temperature controlled storage were stored in a refrigerator and the temperature was checked twice daily.

Procedures were in place for return of unused or out-of-date medicines to the dispensing pharmacy. All multi-dose medicines were dated on opening to ensure recommended use periods were not exceeded.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

The inspectors reviewed a sample of residents' care documentation and that action was necessary to ensure that the information in residents' behavioural support and falls prevention care plans were updated to ensure the care interventions that staff must provide is communicated to all staff.

Although, improvements were found in care planning since the last inspection the information in some residents' care plans did not clearly reference the residents' individual preferences, wishes and usual routines and was not person-centred.

Whilst inspectors were given assurances that residents and their families were involved in residents' care plans reviews and were informed of any changes to residents' care, there was limited documentation detailing consultation with residents or/and their family, as appropriate, in the care planning process.

Judgment: Substantially compliant

Regulation 6: Health care

Although, inspectors were assured that residents received the correct medicines, medication administration in the centre did not reflect a high standard of medicine administration practices in accordance with professional guidelines issued by An Bord Altranais agus Cnaimhseachais. The inspectors found that nursing staff were administering medicines in the absence of the following prescription information;

- medicines administered as a crushed preparation were not individually prescribed to instruct administration in that format.

While, residents' timely access to the range of specialist practitioners to support their care needs was evident on this inspection, there was a delay in one resident's

access to a tissue viability nursing specialist service to review this resident's significant skin disorder that was been aggravated by continence issues. For example, a referral was sent to the tissue viability nursing service on 02 December 2022 and a review had not been completed up to the time of this inspection.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

A small number of residents experienced episodes of responsive behaviours and although, a positive approach was taken by staff with managing any behaviors experienced by residents, a number of staff working in the centre had not attended training, to ensure they had up-to-date knowledge and skills, appropriate to their roles, to respond to and manage residents' responsive behaviours.

Judgment: Substantially compliant

Regulation 8: Protection

Measures were in place to ensure residents were safeguarded from risk of abuse and that all incidents, allegations or suspicions of abuse were addressed and managed appropriately. All staff members were facilitated to attend training on safeguarding residents from abuse. Staff who spoke with the inspector were aware of their responsibility to report any allegations, disclosures or suspicions of abuse and were familiar with the reporting structures in place.

Judgment: Compliant

Regulation 9: Residents' rights

Residents right to privacy was impacted by the layout of two twin bedrooms. The layout of these bedrooms did not allow for ease of access by staff to both sides of the beds to carry out care and transfer procedures without encroaching on the other resident's bed space. This meant that residents could not carry out personal activities such as personal care in private.

The doors from the centre to a newly developed enclosed outdoor area for residents' use were secured by a key-code which meant that residents could not choose to access this outdoor space as they wished without a member of staff being available to open the key coded exit door for them.

Inspectors found that some residents did not have regular opportunities to participate in meaningful activities that met their interests and capacities. Residents' records reviewed evidenced that some residents had not participated in any social activities for several days. This was in part due to how staff organised activities when they were on duty. For example, one activity coordinator focused on facilitating one-to-one social activities which met the needs of residents with dementia and residents unable or who did not wish to participate in group based activities, but did not meet the needs of more able and active residents. When on duty, the second activity coordinator focused on facilitating group activities that were suitable for more active and able residents. This arrangement meant that not all residents could participate in meaningful and suitable social activities each day.

A reception desk/nurses' station area was located between the centre's lobby reception/lobby and the residents' sitting room. A counter-top perimeter wall surrounded this area. Inspectors observed that staff worked on a computer and used the phone for communicating and receiving residents' personal information. Although background music was playing on a radio in this area their conversations could be clearly heard by the inspectors while in the sitting room and in the reception/lobby area.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Not compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for St. Brendan's High Support Unit OSV-0000389

Inspection ID: MON-0038392

Date of inspection: 13/12/2022

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 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • Structures are in place to oversee adequate number of staff to meet all the needs of 24 long term residents and 1 respite resident. • Staff level are regularly reviewed and changed in accordance with the dependency levels of the residents to meet all their needs. • There are no staffing vacancies in St Brendan's since 7th Dec 2022.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • All Staff have completed safeguarding training. • All staff have completed Responsive Behaviour Training. • All Staff Nurses & Managers have completed Care Plan & Assessment Training. • All Link Nurses have been facilitated training to support and develop their link role. • Full Training schedule plan in place for 2023 to develop staff roles and responsibilities.	
Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Full assessment of Infection Control and Cross Infection has been conducted and action plan in place.
• Fire Certificates submitted & varied by Fire Authority
• Review had been completed following Covid-19 outbreak in 2022 and this is available.
• Annual Review report will be available form 2022 going forward.

Regulation 12: Personal possessions	Not Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
• Action has been taken to reduce one of the twin rooms to single occupancy.
The other room will be reduced to single once our new rooms are opened. This will facilitate all residents to have easy access and control to their personal clothing & processions in sufficient sized wardrobes.
• Shelf surfaces have been provided for residents to use for personal items as they wish.
• The wardrobe in Room 18 will provide sufficient space for an ambulant resident for short-term respite or convalescence care.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• (As Above) Action has been taken to reduce one of the rooms to single occupancy.
The other room will be reduced to single once our new rooms are opened.
• Room 18 will reside an ambulatory resident for a short-term respite or convalescence care as per SOP.
• The installation of the En-Suite shower facilities will be developed. The exiting activities room will be converted into an en-suite room for Bedroom 1. Reducing the number of residents to 8 accessing on shower facility to be compliant with Regulation 17. The providers aim is complete this 31st August 2023.
• Temperature room checks are conducted on a weekly basis throughout the whole building. These are monitored and any deceits will be dealt without delay. This record is available on request.
• The floor covering will be upgraded. A company has been sourced and quotes provided. The providers aim is to complete this 31st August 2023. Complying with Regulation 17 Part 3(e).
The flooring will be reviewed on a monthly basis. There is a system in place for reported areas requiring attention and these will be reviewed and actioned in order of priority.

• Ventilation has been improved in sluice room. The source of the malodor has been addressed and eliminated.
Bedpan washer has been moved off drain.
• Redecorating – This has been addressed. All wall surfaces throughout the building have been repaired and repainted. This is reviewed on a monthly basis. There is a system in place for reported areas requiring attention and these are reviewed and actioned in order of priority.
• Handrails have been fitted to shower rooms.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
• The open drainage pipe has been capped off.
• All tiles have been cleaned & monitored as part of a weekly inspection and monthly audit.
• Hazardous waste bin is in slice room.
• Clinical HBN 10 hand washing sinks are to be fitted to the Dining Area & Link room to provide convenient access at the point of care for all staff. The provider aims to be compliant with Regulation 27 by 31st August 2023.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• Blind as been removed from designated fire door.
• All escape signage & lighting now meet the regulation standard.
• No bin or linen trolleys are stored in escape route and this is monitored daily.
• The external door in question has been addressed with the fire officer and completed. The external door in question is not a designated fire exit door. The designated fire door is located top of the ramp is the exit door on the river side which leads to a place of total safety. Any signage to indicate this is a fire exit door has been removed.
• The gates in the external gates have been included in fire alarm activation and open to provide adequate means of escape in the event of an evacuation.
• All maintenance with regards to the containments of fire have been acknowledged and an action plan implemented. The provider aims for this to be completed 31st March 2023.
• Floor plans in the designated centre provide clarity in the event of a fire to ensure safe evacuation.
• Updated Floor plans can be seen compartment 6.

• The door into the kitchen/dining room will be reviewed by fire officer and reported. The correct 'FD' rating will be updated and reflect in floor plan. The provider will reviewed with engineer and up-dated accordingly by 31st March 2023.

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: • Care Plan & assessment training completed by all Nurses and Managers. • Care plans updated to reflect individuals needs & preferences.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care: • All medicines administered as a crushed preparation are individually documented. These are prescribed and reviewed by GP & Pharmacist as of Review 6th Dec 2022. • Referral review system in place to ensure timely response from referrals made on behalf of residents.

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: • All training on managing behaviour that is challenging is up-to-date. There has been a decrease in Responsive behaviour incidents due to effective formal & on the spot training.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• Action has been taken to reduce one of the rooms to single occupancy.
The other room will be reduced to single once our new rooms are opened.
• The key pad on the external door out to the enclosed garden will be removed. This will enable residents to choose to access this outdoor space as they wish.
• Activities co-ordinate will be supported by care staff to facilitate all residents to participate in activities as they wish.
Training for all staff is being sort after and the person in charge aims to have this facilitated in order to comply with regulation by 31st March 2023.
• All staff have had further GDPR and confidentiality training and there is a notice in the Reception area as a constant reminder to protect our resident's rights.
The provider has enforced that no discussions regarding residents will be conducted in the reception area. All Conservations will be carried out in the clinical room or office to comply with regulation 9.

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(a)	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 a resident uses and retains control over his or her clothes.	Not Compliant	Orange	30/04/2023
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	Not Compliant	Orange	30/04/2023

	and other personal possessions.			
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	17/01/2023
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	31/01/2023
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.	Not Compliant	Orange	30/04/2023
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	31/08/2023
Regulation 23(a)	The registered	Not Compliant	Orange	31/03/2023

	provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.			
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Substantially Compliant	Yellow	28/02/2023
Regulation 23(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.	Not Compliant	Orange	31/01/2023
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the	Substantially Compliant	Yellow	31/08/2023

	prevention and control of healthcare associated infections published by the Authority are implemented by staff.			
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Substantially Compliant	Yellow	31/01/2023
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	31/01/2023
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	31/01/2023
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	Orange	31/01/2023
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for	Substantially Compliant	Yellow	31/01/2023

	a resident no later than 48 hours after that resident's admission to the designated centre concerned.			
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Substantially Compliant	Yellow	31/01/2023
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.	Substantially Compliant	Yellow	31/01/2023
Regulation 6(2)(c)	The person in charge shall, in so far as is reasonably practical, make available to a	Substantially Compliant	Yellow	31/01/2023

	resident where the care referred to in paragraph (1) or other health care service requires additional professional expertise, access to such treatment.			
Regulation 7(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.	Substantially Compliant	Yellow	31/01/2023
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Substantially Compliant	Yellow	31/01/2023
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Substantially Compliant	Yellow	31/01/2023
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities	Not Compliant	Orange	30/04/2023

	in private.			