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:	Heather House Community Nursing Unit
Name of provider:	Health Service Executive
Address of centre:	St Mary's Health Campus, Gurranabraher, Cork
Type of inspection:	Unannounced
Date of inspection:	28 August 2024
Centre ID:	OSV-0000714
Fieldwork ID:	MON-0039018

About the designated centre

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

Heather House Community Nursing Unit is a purpose built, two storey premises. It was opened in 2011 and a 60-bedded extension was added in 2023. It is located on the grounds of St. Mary's Health Campus on the north side of Cork City. The centre is registered to accommodate 85 residents in three units, namely, Daisy on the first floor of the existing building, and Poppy and Lily in the new extension. Daisy is a 25 bedded unit with 17 single bedrooms, two twin bedrooms and one four bedded room; all of the bedrooms are en suite with shower, toilet and wash hand basin. Lily and Poppy are 30-bedded units. Each unit has its own sitting room, dining room and quiet room. Additional communal space include the quiet visitors' room alongside the main entrance, the prayer room, main activities room and the water lily games room. Residents have free access to two enclosed gardens with walkways around the house and one sheltered smoking area. Heather House Community Nursing Unit provides 24-hour nursing care to both male and female residents whose dependency range from low to maximum care needs. Long-term care is provided.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	63

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 28 August 2024	09:00hrs to 17:30hrs	Breeda Desmond	Lead
Wednesday 18 September 2024	09:50hrs to 18:15hrs	Niall Whelton	Support

What residents told us and what inspectors observed

From the inspector's observations and from speaking with residents and relatives, it was evident that residents were supported to enjoy a good quality of life. The inspector met many residents living in the centre and spoke with 10 residents in more detail. The inspector also met one visitor during the day. The relative spoken with said that staff were kind and caring to both the resident and family members and regularly spoke with the family involving them in the resident's care. The visitor reported improvement in their relative's condition, that they were always dressed so well and involved in activities; staff also knew when the resident wanted a 'duvet day' and facilitated that as well. Residents spoke positively about the management and staff in the centre. Observation throughout the inspection showed that staff were respectful, kind and actively engaged with residents; residents knew staff by name including the person in charge with whom they were very familiar.

On arrival for this unannounced inspection, the inspector completed the centre's risk management procedures which included a signing in process and hand hygiene. An opening meeting was held with the person in charge. Heather House Community Nursing Unit is a two-storey building situated on St Mary's Campus, Gurranabraher; the campus also accommodates community care, primary care, day services and a minor injuries unit.

The designated centre is registered for 85 beds and accommodation comprises a 60 bedded extension with adjoining corridors on both floors connecting the existing and new building. Primrose unit on the ground floor (GF) of the old building was temporarily closed for refurbishment and was appropriately sealed prohibiting unauthorised entry as well as protection regarding risk associated with dust particles. The three units open were Daisy (25 bedded) on the first floor (FF) of the old building, and Lily (GF, 30 bedded) and Poppy (FF, 30 bedded) new building. The new main entrance was wheelchair accessible and opened into an expansive hallway with the new extension to the right and older building to the left. The family room was located here and had a kitchenette, furnishings and en suite facilities. The Glass room upstairs was a beautiful space for families to meet with residents in private.

Lily and Poppy were self-contained units and all bedrooms were single en suite bedrooms. There were low low beds, pressure relieving mattresses, specialist chairs, and all rooms including the assisted bathroom, had overhead hoists to assist residents when transferring from bed to chair or chair to shower. Orientation signage to rooms such as the day room and dining room were displayed to ally confusion and disorientation. Daisy was a self-contained unit with 17 single, two twin and one four-bedded multi-occupancy bedrooms, all with full en suite facilities of shower, toilet and wash-hand basin. Bedrooms could accommodate a bedside locker and armchair. Residents in single bedrooms had double wardrobes for storing and hanging their clothes; residents in twin and multi-occupancy four-bedded rooms

had only access to single wardrobes. While the person in charge advised that new wardrobes were ordered, these would not be ready for installment until 2025.

The inspector observed that residents' bedrooms were decorated in accordance with residents' choice and preference; some had plants, flowers, mementos from home, posters, paintings, soft furnishings and fairy lighting to brighten their bedroom space. Outside each bedroom in the new wing there were presses with glass frontage where residents had mementos such as photographs, small ornaments and posters identifying their room. Call bells were seen to be fitted in bedrooms, bathrooms and communal rooms. There were no call bells in the smoking shelter, garden and balcony spaces for residents, staff or visitors to call for assistance if required. Additional toilet and specialist bath facilities were available on each floor. Communal spaces comprised the dining room, small quiet sitting room and a second larger sitting room. Significant improvement was noted in communal day rooms with the addition of paintings, soft furnishings and ornamentation making rooms homely and welcoming. Murals were painted on walls of woodland and arctic scenes, and residents art work and art work donated by the Mens' Shed was displayed throughout, and looked really well.

Additional communal areas on the ground floor beyond the reception area included the prayer room, the activities room, and Waterlily social centre with bookshelves with a variety of books and games. Also located on this corridor were administration and nursing administration offices, the hairdressers' room and main kitchen. The internal courtyard in the new extension could be accessed from several points; this space was poorly maintained. This was the only outdoor space for the three occupied units, as the garden area outside Primrose was not available during construction works. The smoking shelter was re-located to this courtyard; it had a fire extinguisher, heater, electronic devise for lighting cigarettes, but there was no fire apron, fire blanket or call bell; these were in place on the second day of inspection. Residents could independently access this space with push-button controls, both inside and outside. Upstairs, there were balconies for residents to sit out and enjoy the fresh air; one balcony had a protective awning that enabled garden furniture to be in place; this furniture was new and looked lovely. As the other balcony did not have an awning, there was no garden furniture here. Re-enforced glass was mounted on top of walls to ensure residents safety while at the same time allowing for un-obstructed views of the city.

The inspector observed breakfast and dinner mealtimes. Three residents were seen to have breakfast in Poppy dining room and staff provided appropriate assistance as required. The radio was playing with appropriate channel selected and volume at a pleasant sound. On Daisy, tables were set prior to residents coming for their meal. While there were adequate staff to provide assistance in the dining room, trays to serve residents in their bedrooms were prepared 10 minutes before other staff were available to bring meals to these residents.

An external company provided meaningful activation on each unit on a daily basis. A variety of activity was seen on each unit throughout the day including one-to-one and group interaction. Activities staff spoken with showed good insight into residents and their personal preferences such as poetry reading, and reading a book

on the Irish civil war for another resident. She explained the music residents prefer which she played for them. She had pictures for another resident who was profoundly deaf so that they could play bingo and reported that they really enjoyed being involved in the bingo. New 'magic' tables were installed in the main day rooms on Poppy and Lily; these are interactive games which enhanced interaction and co-ordination of residents, in particular, people diagnosed with a cognitive impairment.

The sensory room was a lovely calm space where residents could enjoy relaxed sensory time. While there was large occupational therapy room, with fully equipped kitchen, the room had not been furnished with tables or chairs to enable activities such as baking for example.The information relating to the hairdresser displayed was updated on inspection to include details on the days the hairdresser is on site.

Emergency evacuation floor plans were displayed on each unit and had points of reference, emergency exits and fire equipment identified. A complaints procedure was displayed behind the door by the lift; the administrator explained that a new easy accessible version was available and awaiting frames to display it. The complaints procedure was shown to the inspector and was much easier to follow and accessible to residents and would be displayed in a more prominent position.

Hand sanitisers were available on corridors and residents' bedrooms had clinical handwash sinks. Dirty utility rooms were securely maintained as they contained sharps. One unit did not have a storage unit for disposable urinals and a large box of urinals were stored on the sink drainage. Three container inserts of a cleaning trolley were seen on the sluice hopper sink.

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

Capacity and capability

This was a two-day unannounced 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. Day two was conducted by an inspector of fire and estates to look at fire safety in the centre. Overall, the inspection found that there was a defined management structure in place but further oversight of the service was required. The inspector reviewed the actions from the previous inspection and found that some actions were completed and others had not been taken. Further action was required to comply with the regulations in relation to residents' personal possessions, the premises, fire safety, policies and procedures, food and nutrition and managerial oversight on day duty at weekends. These will be detailed under the relevant regulations of this report.

Heather House Community Nursing Unit is a residential care setting operated by the Health Services Executive (HSE). The centre is currently registered to accommodate

85 residents but there were just 63 residents living in the centre on the day of the inspection. While the unit is registered for 85 beds, to date, the maximum number of residents that have been accommodated is 64 residents, with the remaining 21 beds remaining unoccupied. Regarding the management structure, the person in charge worked full-time in the centre and was supported by an assistant director of nursing (ADON), three Clinical Nurse Managers 2 (CNMs), CNM3's on night duty, a team of nursing, health care, household, and catering staff.

At a more senior level, governance was provided by a general manager for older persons, who represented the registered provider. The service also had support from centralised departments such as finance, human resources, fire and estates, and practice development. There was evidence of good communication via quality and patient safety meetings, to discuss all areas of governance.

The inspector found that the levels of staff, at the time of inspection, were sufficient to meet the care needs of the residents living in the centre. Clinical nurse managers provided clinical supervision and support to staff on each unit Monday to Friday. CNM3 provided managerial oversight on night duty. The ADON and CNMs were all on duty Monday to Friday, and did not rotate to provide managerial cover at the weekends. While senior enhanced nurses were rostered on duty each weekend, and the person in charge and ADON provided an on-call rota, there was no on-site managerial cover during the day at the weekends so a review of resource allocation was required.

There was a schedule of clinical audits in place in the centre to monitor the quality and safety of care provided to residents. Arrangements were in place to provide supervision and support to staff through staff supervision, induction processes and formal performance appraisals. However, further managerial oversight was required in areas of the service which are outlined under Regulation 23, Governance and management.

Most documents requested were made readily available to the inspector throughout the inspection, however, despite several requests for a fire report relating to newly identified fire risks in the existing building, this report was not provided by the registered provider. Consequently, following the inspection, the regulator formally wrote to the registered provider requesting this document, in addition, a second day of inspection was arranged with a focus on fire precautions.

As part of fire risk management, additional controls were put in place by the person in charge which included fire watch personnel from an external company; one during the day and two at night, whose only role was to provide support should an emergency evacuation be required. On the second day of inspection the inspector identified that the fire watch personnel did not have the requisite fire safety training. The requirements of the role was that fire watch personnel attend the Heather House CNU in-house fire safety training. The person in charge facilitated staff training cognisant of the change in compartment information; as the risks were not specified or quantified, she was unable to implement other possible precautions

within her remit. This and other fire safety precautions are further discussed under Regulation 28, Fire precautions.

The directory of residents was updated following the findings of the previous inspection and had the required information as specified in the regulations. Regular management meetings took place to discuss key operational issues at the centre. The person in charge had good insight into the identification and management of both clinical and non-clinical risk in the centre. Accidents and incidents in the centre were recorded, appropriate action was taken, and they were followed up and reviewed. Incidents, as detailed under Schedule 4 of the regulations, were appropriately notified to the Chief Inspector of Social Services.

Regulation 14: Persons in charge

The person in charge was full time in post; she had the necessary qualifications as required in the regulations. She actively engaged with the regulator, was knowledgeable regarding the role and responsibility as specified in the regulations, and engaged in the operational management and administration of the service.

Judgment: Compliant

Regulation 15: Staffing

There were appropriate staffing levels to the size and layout of the centre and assessed needs of residents.

Judgment: Compliant

Regulation 16: Training and staff development

The training matrix was reviewed and showed that mandatory training was up to date for all staff. Additional training was scheduled to ensure that training remained in date. One CNM3 was trained to provide Dementia training; a senior enhanced staff nurse provided training in safety awareness and three HCAs were being trained to provide manual handling and lifting training. Two staff provided food safety training on site.

Judgment: Compliant

Regulation 19: Directory of residents

The directory of residents was comprehensively maintained in line with paragraph 3 of Schedule 3 of regulatory requirements.

Judgment: Compliant

Regulation 23: Governance and management

Management systems, as required under Regulation 23(c), were not sufficiently robust to ensure the service provided was safe, appropriate, consistent and effectively monitored, specifically:

- despite several requests on both days of inspection for the technical fire assessment report, the provider did not make the document available to the regulator
- while the fire assessment was completed 01/08/24, the identified risks had not been quantified to enable appropriate remedial action to be taken in accordance with the degree of risk
- there was lack of action taken to the provision of suitable storage for residents in twin and multi-occupancy bedrooms as identified on numerous previous inspections of the centre; this is further outlined under Regulation 12: Personal Possessions,
- there was a lack of oversight of some Schedule 5 policies and procedures as these were not updated following the findings of the last two inspections to ensure compliance with Schedule 5
- even though there was a large managerial team for this service, there was a lack of appropriate allocation of these resources to ensure on-site managerial oversight of the service at weekends.

Regarding risk:

The following required attention to mitigate possible associated risk:

- there were no call bells in the garden, balconies and smoking shelter to enable residents, staff or visitors call for assistance should they require help. These were put in place by the second day of inspection.

Judgment: Not compliant

Regulation 31: Notification of incidents

A review of incidents and accident records showed that relevant notifications were timely submitted to the Chief Inspector.

Judgment: Compliant

Regulation 34: Complaints procedure

At the time of the inspection, an easy accessible complaints procedure was made available to residents and was re-located to a prominent position, as specified in the regulations.

Judgment: Compliant

Regulation 4: Written policies and procedures

A number of Schedule 5 policies and procedures had not been updated to reflect current legislation and National Standards, this was a repeat finding from previous inspections:

- the temporary absence and discharge policy did not include information relating to the temporary absence for treatment to another healthcare facility
- the policy relating to provision of information to residents did not have the specific information as required under Regulation 20
- the admissions and communication policies were out of date as they were last reviewed in 2019
- the safety statement required updating to reflect the current governance structure
- the policy relating to the handling and disposal of unused or out-of-date medicines was not available.

Judgment: Substantially compliant

Quality and safety

Overall, residents were supported and encouraged to have a good quality of life in Heather House and they had access to appropriate social activities and GP services. Residents spoke positively about the care and attention they received. Notwithstanding the positive findings, action was required in relation to the

premises, personal possessions, fire safety, food and nutrition and allied health services. These areas are further detailed under the relevant regulations.

Residents had comprehensive access to general practitioner (GP) services, to specialist health professionals and out-patient services. Residents' records showed that comprehensive pre-admission assessments were carried out for each resident. Residents' nutritional and hydration needs were assessed with monthly weights as part of their nutritional oversight. However, action was required to ensure that there was further supervision of mealtimes in the centre, which will be further outlined under Regulation 18. Residents had access to private allied health services such as occupational therapy and physiotherapists, this was not a timely service and negatively impacted residents' ability to access specialist equipment for example and is further discussed under Regulation 6, Health care.

A sample of residents' assessments and care plan records were reviewed. Residents physical, psychological and social care needs were comprehensively assessed on admission to the centre using validated assessment tools. The outcome of the assessments informed the development of care plans. However, there were mixed findings with care planning which is further discussed under Regulation 5, Individual assessment and care plan.

Arrangements were in place for the service to provide compassionate end-of-life care to residents in accordance with resident's preferences and wishes. There was a dedicated family room in the centre to provide families with facilities to be with their relative during their end of life. Staff had access to specialise palliative care services for additional support and guidance, to ensure residents' end-of-life care needs could be met.

Residents who required supportive equipment to communicate were provided with such equipment. Residents were supported to continue to practice their religious faiths and had access to newspapers, radios and televisions. Information and contact details of advocacy services were displayed. The person in charge facilitated residents to access advocacy services and care documentation supported this evidence.

Residents had access to a variety of activities on a daily basis. An external company was on site Monday to Fridays and named staff were allocated to activities on weekends. Residents meetings were facilitated every three months and the person in charge had oversight of residents' meetings.

Residents had personal emergency evacuation plans to provide information on the individualised assistance they required in an emergency. A fire safety risk assessment, completed in November 2022 had identified risks, primarily in relation to fire containment, fire compartment boundaries, sealing of breaches in fire rated construction and fire rated glazing, and fire door sets. Condition 4 was applied to the registration to address all identified fire safety risks. The provider had completed a programme of fire safety work and sign-off was submitted to the Chief Inspector. While the provider had applied to remove Condition 4, at the time of the inspection,

additional work was being carried out in relation to the fire containment in the Daisy and Primrose units.

During investigative opening-up work prior to commencing premises upgrade works in Primrose, further deficits to fire compartment boundaries were identified in Primrose and subsequently Daisy. A schedule of contractor's items for remediation was generated on 01 August 2024 with risks identified, however, to date, the level of risk was un-quantified and so, the degree of risk was unknown to the centre. The associated technical fire report was repeatedly requested on the first day of inspection but was not received from the relevant department.

On the second day of inspection, the number of residents in Daisy had reduced to 16; this was to facilitate disruptive work on the floor below, and as a consequence, had reduced the risk on the first floor owing to the reduced number of residents to evacuate. The inspector was informed this was for a period of three weeks and residents would be returning to Daisy. Staff spoken with were aware of the risk on the first floor and explained to the inspector the revised evacuation strategy. The fire watch staff spoken with, however, had not received training and did not know the evacuation procedure.

Regarding the premises, improvements were seen regarding the decoration of the premises since the previous inspection. Storage areas were identified in the new extension facilitating storage of hoists and wheelchairs in discreet locations. While issues were identified in several bedrooms regarding water leakage, appropriate measures were implemented to address these findings including specialist contractors and infection prevention and control specialists. Nonetheless, issues were identified with the premises and are further discussed under Regulation 17, Premises.

As part of the remedial fire works being undertaken and other infection control issues, the person in charge had liaised with public health (PH). A review of the premises and services was undertaken by the consultant in PH, microbiologist and infection control nurse specialist and the necessary actions implemented to mitigate any associated risk.

Regulation 11: Visits

Visitors were seen coming and going throughout the day. There were no restrictions to visiting. There was ample private space for visitors to meet their relative in privacy such as the family room, Glass room, balconies and seating areas, as well as residents' bedrooms if preferred. Staff were seen to engage with relatives and welcome them to the unit in a friendly and social manner.

Judgment: Compliant

Regulation 12: Personal possessions

The wardrobe space available to residents in the twin and four-bedded multi-occupancy rooms was not in line with a human rights based approach to living in a residential care setting, as wardrobe space comprised a single wardrobe which did not provide adequate hanging or storage space for residents. This has continued to be a repeat finding over all inspections undertaken in Heather House.

Judgment: Not compliant

Regulation 13: End of life

While there was no resident receiving end of life care at the time of inspection, a sample of care plans reviewed showed that staff had discussed this care with residents or their next of kin, if appropriate. Information was detailed regarding the wishes and preferences of residents, such as whether they wished to remain in the centre or be transferred to acute care for example, along with other personal information to inform care should the resident's condition deteriorate.

Judgment: Compliant

Regulation 17: Premises

There were a number of areas that required action to ensure the premises met the needs of residents:

- the secure outdoor courtyard was poorly maintained where walkways were un-kept, weeds and shrubbery were overgrown and the garden furniture was covered in debris [this was the only outdoor space available for residents, as the Primrose garden was under construction]
- privacy screens in twin and four-bedded multi-occupancy bedrooms could not be used independently by some residents as they were heavy, cumbersome and had several brakes that would need to be released to move; someone with a mobility aid or in a wheelchair would not be able to use these
- additional advisory signage was not available to identify the appropriate method to enter the garden and balconies
- the hairdresser room was not adequately ventilated as it did not have a window or mechanical ventilation and required the door to be left open when in use

- the retractable folding partition in the day room was not secured when opened. Should a resident lean on it for support, it would move and may result in injury.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Action was required to ensure residents were served their meal appropriately:

- trays to serve residents in their bedrooms were prepared 10 minutes before staff were available to bring meals to these residents, consequently, meals would not be served at the optimum temperature for residents to enjoy.

Judgment: Substantially compliant

Regulation 26: Risk management

A review of the risk management policy was necessary as the specified risks as identified in Regulation 26 were not all detailed.

Judgment: Substantially compliant

Regulation 27: Infection control

The following required attention to ensure appropriate infection control practices:

- a large container of disposable urinals was stored on the sink in one dirty utility room and could possibly be contaminated by water or other fluids being disposed of which would increase the risk of cross contamination
- insert containers of the cleaners' trolley were left on the sluicing hopper sink which could lead to cross contamination
- on day 2, the inspector observed two areas in Daisy unit where the fabric of the building was opened up as part of the construction work at ground floor; a section of plasterboard to a shaft in the linen room and a hole in the compartment floor in the electrical room. These areas were not cleaned after the work and construction dust remained, which may present a risk to residents if vulnerable to this type of dust.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Recent identified fire safety risks were not quantified to determine the level of risk to residents in the Daisy Unit at first floor. While proactive mitigating measures had been taken, without quantifying the risk, the provider could not be assured if the control measures were sufficient. Owing to other work on the premises in the newer section, a date by when the fire safety work would commence and finish was not available.

The measures in place to safely evacuate residents and the drill practices in the centre required action. The inspector saw three drill records and these detailed issues arising and learning by staff on the subsequent drill. Not withstanding this:

- the fire watch staff on duty on the second day of inspection had not received training and did not know the evacuation procedure
- evidence of full compartment evacuations were not seen in the records provided to the inspector. The drill records available included estimated times for the full evacuation of the 25 beds,
- aside from training, there was no evidence to show that drills and evacuations, in particular, Daisy unit (25 beds) were completed to be assured that it could be completed safely and timely in view of the necessary full floor evacuation as part of the temporary measures to mitigate the newly identified fire risks.

Action was required to ensure adequate containment and detection of fire, for example:

- the fire safety assessment, dated 01 August identified that fire compartments may not be effective. While interim mitigating measures had been implemented, there was no definitive date for commencement of the upgrade works to fire compartment boundaries in Primrose.

The arrangements for providing adequate means of escape including emergency lighting were not effective:

- the emergency lighting externally did not provide sufficient coverage to guide safe escape towards the assembly point
- the assembly point identified to the inspector was not provided with signage, and may cause confusion during a fire evacuation.

Improvements were required regarding the arrangements in place for maintaining fire equipment, means of escape, building fabric and building services:

- there was a hole cut in the floor between Primrose on the ground floor and Daisy on the first floor to facilitate works; the hole had not been refilled following the work, impacting fire containment,
- service reports for the emergency lighting and fire detection and alarm system were not available in the centre for review and were submitted subsequent to the inspection; these records are required to be in the centre. Both systems had not been serviced since February of this year; they require servicing quarterly,
- the inspector observed some deficits to fire doors, such as gaps which were impacting fire containment. There were proposals for a fire door company to audit and service fire doors, however there was no date by when this would commence.

While fire safety notices were displayed for visitors, the procedures to follow in the event of a fire were not prominently displayed in the centre, to guide and inform staff.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

A sample of prescription, medication administration and controlled drug records were examined. These were seen to be comprehensively maintained and in line with professional guidelines. Discontinued drugs remained in the drug fridge for several months and these were returned to the pharmacy by the nurse when identified on inspection.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Assessments and care plans were reviewed and showed mixed finding. Information included in care plans were identified care needs, but did not have the supporting information to deliver individualised care. For example, two residents had additional care needs included in the care plan, however, there was no information as to how those need could be supported to enable best outcomes for the resident.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had access to private allied health services such as physiotherapy and occupational therapy as these (HSE) services were not available to residents in Heather House CNU; accessing these services were currently untimely. While the registered provider funded the allied health assessment, recommendations made by a private service such as the occupational therapist regarding equipment for example, were not always followed through by the HSE to provide this equipment.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Residents had access to a variety of activities on a daily basis. An external activities company was on site three days a week and a named member of staff was rostered to facilitated activities on the other days. Residents were seen to go out with staff and with family members and told inspectors that this was a regular occurrence.

Posters were displayed for the planned 'Multi-cultural Day' celebrations on 6 September with a BBQ planned and staff will wear their native dress and people spoken with were looking forward to the party and hoping the weather would be kind.

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 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Not compliant
Regulation 13: End of life	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 26: Risk management	Substantially 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 9: Residents' rights	Compliant

Compliance Plan for Heather House Community Nursing Unit OSV-0000714

Inspection ID: MON-0039018

Date of inspection: 18/09/2024

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 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

• Fire and safety risk assessment has been completed for the Daisy unit by an external company and the same was submitted to HIQA on 07/11/2024. Proposed completion of the remedial works in the Daisy unit will be Q4 of 2025.

• The provision of storage in both the twin and 4 bed rooms has been considered by the service, and the design team have been engaged to propose solutions for additional storage. As the fabric of the building is currently going through substantial refurbishment work, this provision will be addressed during these works in both Daisy unit.

• All Schedule 5 Policies are being reviewed and updated as per the regulation, this action will be completed by 18.11.2024.

• Please see the management team structure, this ensures there is management oversight at all times.

o Clinical Nurse Managers provide clinical supervision,support to staff ,facilitate inhouse and external appointments for the residents ,liaising with other services etc on each unit Monday to Friday.

o CNM3 provides managerial oversight on night duty Monday to Sunday.

o Senior Enhanced Nurses are rostered on duty each weekend, and the person in charge and ADON provides an on-call rota .

o The Senior Enhanced Nurse contract duties states that the Senior Enhanced Nurses are expected to participate in clinical governance structures within the local / regional / national clinical governance framework therefore they are rostered for weekend management cover with the senior management on call sytem. There is a management roster available in the units which included after hours, weekend and bank holiday cover and on call details.

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
• Updated version of the temporary absence and discharge policy including information relating to the temporary absence for treatment to another healthcare facility in availble in the centre for reference since 19.09.2024.

• Updated version of the policy relating to provision of information to residents with the specific information as required under Regulation 20 is availble in the centre for reference since 19.09.2024.

• The admissions and communication policies are under review by the clinical development coocordinator and the same is reviewed locally by the HHCNU management. These will be finalised by 18.11.2024.

• The safety statement was updated on 19.09.2024 to reflect the current governance structure of HHCNU.

• The policy relating to the handling and disposal of unused or out-of-date medicines is available in the Medication Management policy.

Regulation 12: Personal possessions	Not Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
• The provision of storage in both the twin and 4 bed rooms has been considered by the service, and the design team have been engaged to propose solutions for additional storage. As the fabric of the building is currently going through substantial refurbishment work, this provision will be addressed during these works in both Daisy unit.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises: • The courtyard was maintained well and presentable for the residents from 20/09/2024. There is a schedule of twice a year by an external company to maintain the garden and hedges in HHCNU ,however in 2024 due to the unexpected mould infestation situation aroused in the Lilly suite (ground floor) and as a part of the deconstruction and reconstruction of the affected rooms ,the construction company had to create bubbles from the windows of the bedroom out to the courtyard to ensure an air lock system. This process was completed at around the 3rd week of August 2024. Therefore we have waited for the bubbles to be in place for the maintenance of the courtyard and the garden with an active quote from the servicing company. • Privacy screens of the twin and four bedded room in the multi occupancy rooms will be replaced with Telescopic curtains. This provision will be addressed with refurbishment work in Daisy unit. • There are additional advisory signs which says "press to open" is placed near all wheel chair access buttons (internal and external) in HHCNU to provide a visible and effective means of communication of the message to our residents and other service users how to use the wheel chair access button for exit and egress . • All staff in all units and external staff are informed to secure the retractable screen with wheel locks all the time when they are in use. • Heat Recovery Ventilation unit will be installed to serve the hairdresser room by Feb 2025.	
Regulation 18: Food and nutrition	Substantially Compliant
Outline how you are going to come into compliance with Regulation 18: Food and nutrition: • All the staff in all units are communicated via safety pauses and handovers about meals for residents in the bedrooms shall not be taken out from a hot trolley and kept in a serving trolley until the staff are ready to serve them in the room for the residents. • Supervision in the meal time of Daisy unit is addressed with the plan of having one nurse must attend the dining room during the meal times with residents and HCAS according to the numbers of residents in the dining area and dependency levels. • Spot checks and adhoc audits will be continued be completed by the CNM or ADON for the unit.	

Regulation 26: Risk management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management:
• Updated HHCNU Local Risk Management policy is now available in the service including all specified risks identified in Regulation 26.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
• The disposible urinals are stored in a metal rack. Staff are reminded at regular meetings of this requirement.

• All housekeeping staff are instructed not to remove insert containers of the cleaners' trolley.

• HGC Hot Works Permits are filled out if any planned works may generate heat or sparks. This is important as the fire alarm on ground floor (Heat detection) & first floor (Heat & Smoke detection) are live.

HGC Live area Permits are filled out by the contractor proposing to carry out the works and signed off on completion following the appropriate checks have taken place to ensure the live hospital has been left safe, clean & tidy & temporary or permanent fire stopping is in place.

HSE onsite Permit are filled out the contractor proposing to carry out the works and signed off on completion. This permit once filled out correctly and RAMS are in place and approved will be signed off by the HSE Maintenance department on site. This permit needs to be closed by the contractor when the work is complete.

Regulation 28: Fire precautions	Not Compliant

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

• The reason for the delay between Q1 and Q2 testing of the fire detection and alarm system was, the ongoing works to update the drawings on site and the configuration of the panel to ensure that the information was correct. If a test had been completed before these works, the updating of the TOC (Asset Register) on the panel would have overwritten the records. Once these works had been completed and the updated TOC uploaded, we completed a full test of the devices on 13/09/2024.

• In relation to the Emergency Lights testing, the contractor company have only completed one Quarterly test at this point, as there was ongoing works on the light system on site. Once these works had been completed and the lights commissioned we completed our first Quarterly test in early October 2024. The 3 hour Annual Inspection is due in Q4.

• The procedures to follow in the event of a fire are now prominently displayed in the respective nurses station to guide and inform staff since 01/10/2024.

• There is a full compartment evacuation drill conducted on 15/11/2024 with 14 beds (number of residents occupied in the unit at the time of the drill as the rest of the residents are relocated to Poppy unit) and the same is attached for your reference.
• The service has completed simulated evacuation drills in the Daisy unit as a part of the measures to mitigate the newly identified risks however those drill records are available with estimated times for the full evacuation and the same is attached for your reference. Therefore we have conducted a full compartment evacuation drill on 15/11/2024 with 14 beds (number of residents occupied in the unit at the time of the drill as the rest of the residents are relocated to Poppy unit)
• Assembly point is clearly identified and signage is in place at the front of the main building of Heather House CNU.

• In relation to a hole cut in the floor between Primrose on the ground floor and Daisy on the first floor to facilitate works; the hole had not been refilled following the work, impacting fire containment"- The hole was filled with fire pillows on 19/09/2024 and the new HSE permit system is in place for the oversight of the works completed by the sub-contractors of HGC.

• The Fire Evacuation Assistant staff are now fully trained with the changed fire strategy of the Daisy unit .The HHCNU management has access to the training records for the Fire Evacuation Assistant staff which are satisfactory and in line with their job expectation in assisting the staff in the evacuation process in the event of a fire.

• The fire door survey will be completed by the external company for the second floor by November 2024. 1st and 2nd floor of new extension will be completed by Q1 of 2025.

• Emergency lighting will be installed along the escape route from the exit doors to the assembly point and also to extend the existing low voltage intelligent emergency lighting system to cover the external route to the Muster point by Q1 of 2025.

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 the residents care plans and assessments are to be reviewed by the staff nurses and audited by CNM3s on a regular basis.

• Documentation audits have been completed by the service and are ongoing as required.

• Further Care Plan Training is ongoing for all nurses. This is provided by the Clinical Development Coordinator.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:

Appropriate medical care and health care is available to all residents in HHCNU. In the event of untimely access to same, private allied professionals are accessed.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 12(c)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that he or she has adequate space to store and maintain his or her clothes and other personal possessions.	Not Compliant	Orange	30/10/2025
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.	Substantially Compliant	Yellow	10/10/2024
Regulation 18(1)(c)(i)	The person in charge shall ensure that each	Substantially Compliant	Yellow	29/08/2024

	resident is provided with adequate quantities of food and drink which are properly and safely prepared, cooked and served.			
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	28/08/2024
Regulation 26(1)(c)(i)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control abuse.	Substantially Compliant	Yellow	04/09/2024
Regulation 26(1)(c)(iii)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control accidental injury to residents, visitors or staff.	Substantially Compliant	Yellow	04/09/2024
Regulation 26(1)(c)(iv)	The registered provider shall ensure that the risk management policy set out in Schedule 5	Substantially Compliant	Yellow	04/09/2024

	includes the measures and actions in place to control aggression and violence.			
Regulation 26(1)(c)(v)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control self-harm.	Substantially Compliant	Yellow	04/09/2024
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	15/10/2024
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Substantially Compliant	Yellow	30/03/2025
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Substantially Compliant	Yellow	30/11/2025
Regulation 28(1)(c)(ii)	The registered provider shall make adequate	Not Compliant	Orange	30/11/2025

	arrangements for reviewing fire precautions.			
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.	Substantially Compliant	Yellow	22/10/2024
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Orange	01/10/2024

Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	30/03/2024
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.	Substantially Compliant	Yellow	13/11/2024
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	01/10/2024
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.	Substantially Compliant	Yellow	25/10/2024
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where	Substantially Compliant	Yellow	25/10/2024

	necessary, review and update them in accordance with best practice.			
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	30/09/2024
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	18/12/2024