<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Heather House Community Nursing Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000714</td>
</tr>
<tr>
<td>Centre address:</td>
<td>St Mary's Health Campus, Gurranabraher, Cork.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>021 4927950</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:barbara.ryan1@hse.ie">barbara.ryan1@hse.ie</a></td>
</tr>
<tr>
<td>Type of centre:</td>
<td>The Health Service Executive</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>Health Service Executive</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Patrick Ryan</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>John Greaney</td>
</tr>
<tr>
<td>Support inspector(s):</td>
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</tr>
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<td>Type of inspection:</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>48</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
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About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

▪ Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
▪ Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider’s compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

▪ to monitor compliance with regulations and standards
▪ to carry out thematic inspections in respect of specific outcomes
▪ following a change in circumstances; for example, following a notification to the Health Information and Quality Authority’s Regulation Directorate that a provider has appointed a new person in charge
▪ arising from a number of events including information affecting the safety or wellbeing of residents.

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.
Compliance 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 Quality Standards for Residential Care Settings for Older People in Ireland.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

<table>
<thead>
<tr>
<th>From</th>
<th>To</th>
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</thead>
<tbody>
<tr>
<td>26 July 2016 08:45</td>
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</tr>
<tr>
<td>27 July 2016 08:45</td>
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The table below sets out the outcomes that were inspected against on this inspection.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Our Judgment</th>
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<tbody>
<tr>
<td>Outcome 02: Governance and Management</td>
<td>Non Compliant - Major</td>
</tr>
<tr>
<td>Outcome 03: Information for residents</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 04: Suitable Person in Charge</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 05: Documentation to be kept at a designated centre</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 07: Safeguarding and Safety</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 08: Health and Safety and Risk Management</td>
<td>Non Compliant - Major</td>
</tr>
<tr>
<td>Outcome 09: Medication Management</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 10: Notification of Incidents</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 11: Health and Social Care Needs</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 12: Safe and Suitable Premises</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 13: Complaints procedures</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 18: Suitable Staffing</td>
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</tr>
</tbody>
</table>

Summary of findings from this inspection

Heather House Community Nursing Unit is a two storey premises located on the grounds of St. Mary’s Health Campus on the north side of Cork City. The centre is registered to accommodate 50 residents in 34 single bedrooms, four twin bedrooms and two four bedded rooms.

This inspection was a monitoring inspection and was carried out over two days. During the inspection, the inspector met with a number of residents, relatives and staff members. The inspector observed practices and reviewed records such as nursing care plans, medical records, accident and incident logs, policies and procedures and a sample of personnel files.

Overall the inspector found that care was provided to an adequate standard. Residents had access to the services of general practitioners, including out-of-hours.
Residents also had access to allied health services and there was evidence of regular review. The premises was bright, spacious and clean throughout. There was adequate communal space, secure outdoor space and adequate sanitary facilities. There was evidence of on-going review of the quality and safety of care and evidence of action where required improvements were identified. There was, however, no annual review of quality and safety to ensure that such care was in accordance with relevant standards set by HIQA.

Improvements were required in the area of risk management and particularly in the management of smoking. A number of residents smoked. The inspector reviewed the risk assessments of a sample of these residents and found that they did not adequately identify the risks of injury from smoking on an individual basis for each resident. There was inadequate supervision of residents while they smoked and incident records indicated that there were a number of incidents relating to residents smoking unsupervised. The inspector also observed residents smoking unsupervised and on one occasion it was evident that at least one of these residents required supervision to ensure no injuries were sustained. There were two designated smoking shelters on the grounds of the centre and there was also a shelter that had previously been designated for smoking but had been decommissioned, as it did not provide for adequate supervision of residents. On the first day of the inspection the inspector observed that a resident was smoking beside this shelter, unsupervised. There was evidence that this area was used as a smoking area, as there were numerous cigarette ends strewn on the ground. Due to the concerns of the inspector, an immediate action plan was issued to immediately address the risks associated with smoking.

Other improvements were also required in relation to risk management. For example, incident records indicated that vials of local anaesthetic were removed from the emergency trolley and found in the bathroom close to the nurses' station. On another occasion a number of paracetamol were also found in a bathroom. While it was never confirmed, it was assumed that this had been done by a resident. Based on a review of the incident forms, the inspector was not satisfied that adequate controls were put in place following these incidents to minimize the risk of reoccurrence.

Other required improvements included:
- inadequate process of consultation with residents
- personnel records were incomplete
- the assessment for the use of bedrails was not sufficiently objective
- hoists and slings were stored in bathrooms
- fire doors were held open with chairs
- prescriptions were not always signed
- notifications were not always submitted as required
- the complaints notice on display required more detail

The action plan at the end of this report identifies where improvements are needed to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland.
Outcome 02: Governance and Management

The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.

Theme:
Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
There were adequate resources available to support the delivery of care. There was a clearly defined management structure. The person in charge was also person in charge of another designated centre, Farranlea Road Community Nursing Unit, which was located approximately four kilometres from Heather House. The person in charge reported to a general manager, who was also responsible for a number of other Health Service Executive (HSE) centres. The person in charge was supported by three clinical nurse manager 2s (CNM 2). Two of the clinical nurse managers were based on the units, overseeing the day to day care of residents, while the third was responsible for administration. An assistant director of nursing was temporarily assigned to Farranlea Road Community Nursing Unit and was expected to be absent for a number of months.

There was a comprehensive programme of audits on issues such as restraint, accidents and incidents, hygiene, kitchen, medication management and care plans. There was evidence that issues identified for improvement were addressed. There was, however, no annual review of the quality and safety of care as required by the regulations. Additionally, there was an inadequate process of consultation with residents. Residents meetings had ceased and had only recommenced in April 2016. Minutes of that meeting were reviewed by the inspector and while issues raised in relation to catering were addressed, there was no evidence that other issues raised, such as activities and laundry, were addressed.

Judgment:
Non Compliant - Major

Outcome 03: Information for residents

A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided.
for that resident and the fees to be charged.

Theme:
Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
There was a residents' guide available in the centre that included a summary of the services and facilities available, the procedure respecting complaints and the arrangements for visits. A blank contract of care is usually issued with the residents' guide.

Each resident had a contract of care that was signed and dated. Services such as chiropody and pharmacy were included in the weekly fee at no additional charge to residents.

Judgment:
Compliant

Outcome 04: Suitable Person in Charge
The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:
Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
The centre was managed by a registered nurse who worked full time and had the required experience in the area of nursing of the older person. As stated in Outcome 2, the person in charge was also responsible for one other designated centre. Throughout the days of the inspection the person in charge clearly demonstrated that she had sufficient clinical knowledge and a sufficient knowledge of the legislation and of her statutory responsibilities.

The person in charge was engaged in the day to day governance and operational management of the centre. The person in charge visited the centre each day for a number of hours, however, the greater percentage of time was spent in the other centre. The inspector was satisfied that the centre was managed by a suitably qualified and experienced manager.
Judgment:
Compliant

Outcome 05: Documentation to be kept at a designated centre
The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:
Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
Records were kept secure but easily retrievable. At the last inspection it was identified that the Directory of Residents did not contain all of the information required by Schedule 3 of the regulations, such as address and telephone number of next of kin and general practitioner (GP) or time and cause of death, where relevant. On this inspection it was identified that the directory was amended to include all of the required information. However, due to an error, the gender of each resident was not recorded for the most recent admissions.

It was also identified at the last inspection that records of financial transactions did not contain signatures of residents, where relevant. This was satisfactorily addressed.

A review of personnel records indicated that not all of the requirements of the regulations were met. For example, there was not always photographic evidence of identity or verified references, including one from the most recent employer available for all staff. Evidence of nurse’s professional registration with the relevant professional body was available.

Judgment:
Non Compliant - Moderate

Outcome 07: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a
positive approach to behaviour that challenges. A restraint-free environment is promoted.

**Theme:**
Safe care and support

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
There was an up-to-date policy on the prevention, detection and response to abuse. Training records indicated that all staff had received up-to-date training on recognising and responding to abuse. Staff members spoken with by the inspector demonstrated adequate knowledge of what to do in the event of suspicions or allegations of abuse. Based on records viewed by the inspector, where there were suspicions or allegations of abuse, HIQA was notified as required by regulations and an adequate investigation was undertaken. Residents spoken with by the inspector stated that they felt safe in the centre. Based on a sample of records viewed by the inspector there were adequate systems in place to safeguard residents' money.

There was an up-to-date policy in relation to the management of responsive behaviour (also known as behavioural and psychological signs and symptoms of dementia). Staff members spoken with by the inspector were knowledgeable of individual resident’s needs and how to alleviate responsive behaviour and how to prevent the behaviour escalating. Not all staff, however, had received up-to-date training in responsive behaviour.

There was a policy in place on the management of restraint. The only forms of restraint in use were bedrails. Records indicated that residents were assessed prior to the use of bedrails, however, the inspector was not satisfied that the assessment process was sufficiently robust. For example, the assessment tool in use did not guide staff in making an objective assessment in relation to the safety of using bedrails on individual residents. In addition, following incidents where residents may have exited the bed while bedrails were in place, there was an inadequate reassessment taking into account the increased risk of injury to residents should they attempt to climb over or around bedrails.

**Judgment:**
Non Compliant - Moderate

**Outcome 08: Health and Safety and Risk Management**
The health and safety of residents, visitors and staff is promoted and protected.

**Theme:**
Safe care and support
Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
There was an up-to-date safety statement. There was an emergency plan detailing what to do in the event of emergencies such as loss of power, loss of water and the safe evacuation of residents. There was a risk management policy and associated risk register that addressed the issues specified in the regulations.

Improvements were required in the overall management of risk in the centre. For example, a number of residents smoked. While a risk assessment was in place for each of these residents, it was generic in nature and did not incorporate an assessment of the physical and psychological capacity of each resident to smoke independently or otherwise. Some residents were allowed to retain control of cigarettes and lighters while these were retained by staff on behalf of other residents for safety reasons. A review of incident records indicated that a resident that did not have access to cigarettes or lighters for safety reasons was found at night time smoking in the bedroom of a resident that did have access to these. Another incident record identified that a resident had "scorched" hair, and while the source of the scorching was never verified, it was reasonably assumed that it had happened when another resident was lighting this resident's cigarette. Another incident form indicated that a resident had sustained wound to their hand on two separate occasions. It was assumed that both of these wounds were as a result of burns, and this was confirmed by the GP for one of these incidents. During the inspection the inspector observed residents smoking unsupervised on a number of occasions. On one occasion the inspectors observed a resident that was not permitted access to a lighter, borrowing a lighter from another resident and lighting a cigarette. Both of these residents were not supervised while smoking and ashes were seen to be falling on to one of the resident's trousers.

There were three smoking shelters on the grounds of the centre, all of which contained a fire blanket and two contained a fire extinguisher. Following the last inspection, one of these shelters was decommissioned due to its location, which made it difficult for staff to observe residents when they smoked. On this inspection residents were seen to smoke beside this shelter, unsupervised. It was also found on the last inspection that a suitable call bell system was not in place in the smoking shelters for residents to alert staff should they need assistance. Since then, a door bell like system was installed, however, the inspector was not satisfied that this was adequate, as unlike the nurse call system, the bell does not continue to ring until it is answered by staff. An immediate action plan was issued on the day of the inspection to put in place adequate assessment and supervision of residents that smoked.

Other improvements were also required in relation to risk management. For example, incident records indicated that vials of local anaesthetic were removed from the emergency trolley and found in the bathroom close to the nurses’ station. On another occasion, a number of paracetamol were also found in a bathroom. While it was never confirmed, it was assumed that this had been done by a resident. Based on a review of the incident forms, the inspector was not satisfied that adequate controls were put in place following these incidents to minimise the risk of reoccurrence.
Adequate measures were in place for the prevention and control of infection such as wash hand basins and hand gel dispensers located at suitable points throughout the centre. Personal protective equipment such as glove and aprons were available and were seen to be used by staff. Some improvements, however, were required as hoists and slings were seen to be stored in bathrooms even though alternative suitable storage facilities were available.

Suitable fire safety equipment was provided. Fire safety equipment was serviced annually and the fire alarm and emergency lighting were serviced quarterly. There were checks to ensure fire exits were unobstructed and that fire doors were functioning appropriately. Records indicated that all staff had received up-to-date fire safety training. Staff members spoken with by the inspector were knowledgeable of what to do in the event of a fire. Fire drills were most recently held in May and June of 2016 and records indicated that they were held annually rather that six monthly as required. Some fire doors were seen to be held open with equipment such as litter bins and chairs, which is not in compliance with good fire safety practice.

**Judgment:**
Non Compliant - Major

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**Outcome 09: Medication Management**

*Each resident is protected by the designated centre’s policies and procedures for medication management.*

**Theme:**
Safe care and support

**Outstanding requirement(s) from previous inspection(s):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
There was an up-to-date medication management policy that addressed the ordering, prescribing, storing and administration of medicines. There were adequate procedures in place for management of medicines requiring special control measures. Medication administration practices observed by the inspector were in compliance with relevant professional guidance. There were adequate measures for the disposal of unused and out-of-date medicines. Prescriptions were reviewed regularly by the resident’s GP and by the pharmacist. There were regular audits of medication management practices. A recent audit had identified that not all prescriptions had been signed by a GP. The audit also identified that there were not always nurses' signature associated with the administration of all medicines and it was not recorded that this medication had been refused or withheld at these times. These issues had not been addressed on the days of this inspection.

**Judgment:**
Non Compliant - Moderate
<table>
<thead>
<tr>
<th><strong>Outcome 10: Notification of Incidents</strong></th>
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<tbody>
<tr>
<td>A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.</td>
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</tbody>
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**Theme:**
Safe care and support

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
While most notifications required to be submitted to HIQA were submitted and within the required timeframe, there were some gaps. For example, a resident was found outside the urgent care centre after exiting the centre unaccompanied and unnoticed. The required notification was not submitted in relation to this incident. Additionally, not all notifications required to be submitted on a quarterly basis were submitted.

**Judgment:**
Non Compliant - Moderate

<table>
<thead>
<tr>
<th><strong>Outcome 11: Health and Social Care Needs</strong></th>
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</thead>
<tbody>
<tr>
<td>Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.</td>
</tr>
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</table>

**Theme:**
Effective care and support

**Outstanding requirement(s) from previous inspection(s):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
Residents received a comprehensive assessment on admission and at regular intervals thereafter. Residents were assessed using validated assessment tools for issues such as falls risk, pressure sore risk, moving and handling, and nutrition. Where issues were identified on assessment these were addressed in care plans. Based on a sample of care plans reviewed these were personalised and provided adequate guidance on the care to be delivered. However, some required updating to reflect current needs. For example, the care plan for one resident with diabetes indicated that the resident should have their blood sugar level tested weekly but this was not being done. The inspector was informed that at the instruction of the GP, a less frequent blood test was being used to monitor the resident's blood sugar levels, but this was not reflected in the care plan.
Residents had good access to the services of GPs that visited the centre frequently. Records indicated that residents were reviewed regularly. Out-of-hours GP services were also available. Residents had access to allied health and specialist services such as psychiatry, speech and language therapy, dietetics, occupational therapy and chiropody.

There were three staff members responsible for coordinating activities and at least one was present in the centre each day of the week, including weekends. On two to three days each week there were two staff members available for activities. Most activities were facilitated in the activities room on the ground floor and residents from the two units were assisted to attend. The programme of activities included board games, reading, indoor or outdoor bowls, music and a prayer group. The activity programme was flexible and guided by residents’ preferences. The centre had access to transport and on the days when there were two staff members on duty for activities, some residents were taken on outings to local amenities. A therapy dog also visited the centre once a week.

**Judgment:**
Substantially Compliant

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**Outcome 12: Safe and Suitable Premises**

The location, design and layout of the centre is suitable for its stated purpose and meets residents’ individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

**Theme:**
Effective care and support

**Outstanding requirement(s) from previous inspection(s):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
Heather House Community Nursing Unit is a two storey premises located on the grounds of St. Mary’s Health Campus on the north side of Cork City. The first floor can be accessed by both stairs and lift.

Overall the centre was bright, clean, spacious and decorated to a good standard. The centre is registered to accommodate 50 residents. Resident accommodation on each floor comprises 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. There are overhead hoists in each of the bedrooms. The bedrooms were adequate in size for a bed, bedside locker and a chair for each resident. Many of the bedrooms were personalised with resident’s personal belongings and possession, including pictures and paintings. Residents had adequate wardrobe space and there was lockable storage in
each of the bedrooms.

There were adequate sanitary facilities separate from the residents' bedrooms, including a specialised bath on each floor. Communal space comprised two sitting rooms and a dining room on each floor. On the administration wing of the premises which housed various administration offices, there was also a large activities room, an oratory, and a hairdresser's room. There was a visitor's room located at the main entrance.

Resident had access to suitable outdoor space on the ground floor and residents on the first floor were assisted to access this space, weather permitting. There was a laundry room, which was predominantly used for cloths and mops, as most laundry was done by an external contractor.

Maintenance records indicated that equipment such as hoists, beds, mattresses and the lift had preventive maintenance carried out at suitable intervals. Training records indicated that all staff had up-to-date training in manual and patient handling.

**Judgment:**
Compliant

### Outcome 13: Complaints procedures
The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

**Theme:**
Person-centred care and support

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
There was a policy and procedure for making, investigating and handling complaints in the form of Health Service Executive (HSE) written complaints procedure, “your service, your say”. The policy is displayed in the main reception area and is also outlined in the statement of purpose and function and in the residents’ guide. There was also a local complaints procedure which detailed the person in charge as the complaints officer and the general manager as the person responsible for independent appeals. While there was a notice on display, it did not provide adequate detail of how to contact the complaints officer and did not outline the appeals process.

The inspector reviewed the complaints log, which detailed the complaint, the outcome of the complaint and whether or not the complainant was satisfied with the outcome of the complaint.

Residents and relatives told inspectors that they had easy access to the CNM and person
in charge and the nurses on duty and felt they could report any complaints or concerns to them and these would be dealt addressed.

**Judgment:**
Substantially Compliant

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### Outcome 18: Suitable Staffing

**Theme:**
Workforce

**Outstanding requirement(s) from previous inspection(s):**
Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**
The inspector reviewed the planned and actual staff roster and noted that there were adequate staff numbers on the days of the inspection to meet the needs of the residents. The person in charge informed the inspector that staffing levels and skill mix is kept under constant review in relation to the needs of the residents.

Residents and relatives spoken with by the inspector were complimentary of the staff and the care they provided. Training records viewed by the inspector indicated that there was ongoing programme of training. In addition to mandatory training that has been addressed under the relevant outcomes, staff had attended training on issues such as dementia, end of life care, open disclosure, activities, nutrition and medication management.

Care staff training and education records reviewed by the inspectors confirmed that a number of care staff had achieved a Further Education and Training Award Council (FETAC) level 5 award or above. The inspector was satisfied that the education and training available to staff enabled them to provide care that reflects contemporary evidence based practice. Evidence of nurse’s professional registration with the relevant professional body was available.

**Judgment:**
Compliant
Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

John Greaney
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report

<table>
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<th>Centre name:</th>
<th>Heather House Community Nursing Unit</th>
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<tr>
<td>Centre ID:</td>
<td>OSV-0000714</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>26/07/2016</td>
</tr>
<tr>
<td>Date of response:</td>
<td>23/08/2016</td>
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Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 02: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no annual review of the quality and safety of care as required by the regulations.

1. Action Required:
Under Regulation 23(d) you are required to: Ensure there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
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.

**Please state the actions you have taken or are planning to take:**
The Annual Review will be completed by Sept 30th 2016.

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**Proposed Timescale:** 30/09/2016  
**Theme:**  
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
There was an inadequate process of consultation with residents and where issues were raised there was inadequate evidence that they were addressed.

**2. Action Required:**  
Under Regulation 23(e) you are required to: Prepare the review referred to in regulation 23(1)(d) in consultation with residents and their families.

**Please state the actions you have taken or are planning to take:**  
The review referred to in regulation 23(1)(d) will be completed by September 30th 2016.

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**Proposed Timescale:** 30/09/2016

**Outcome 05: Documentation to be kept at a designated centre**

**Theme:**  
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
The gender of each resident was not recorded in the Directory of Residents for the most recent admissions.

**3. Action Required:**  
Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

**Please state the actions you have taken or are planning to take:**  
The Directory of Residents has been amended to reflect the gender of the residents most recently admitted.
Proposed Timescale: 02/08/2016

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A review of personnel records indicated that not all of the requirements of the regulations were met. For example, there was not always photographic evidence of identity or verified references, including one from the most recent employer available for all staff.

4. Action Required:
Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

Please state the actions you have taken or are planning to take:
A full review of all personnel files is underway and will be completed by Oct 31st 2016, to reflect what is required under regulation 21 (1), schedules 2,3 & 4.

Proposed Timescale: 31/10/2016

Outcome 07: Safeguarding and Safety

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Records indicated that residents were assessed prior to the use of bedrails, however, improvements were required, for example:
• the assessment tool in use did not guide staff in making an objective assessment in relation to the safety of using bedrails on individual residents
• following incidents where residents may have exited the bed while bedrails were in place, there was an inadequate reassessment taking into account the increased risk of injury to residents should they attempt to climb over or around bedrails.

5. Action Required:
Under Regulation 07(3) you are required to: Ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.

Please state the actions you have taken or are planning to take:
The records of residents who have bedrails in place will be reviewed to ensure individual risk assessments are fully completed; this includes an assessment checklist prior to considering restraint. Where bed rails are necessary they are only applied in accordance with National Policy “Towards a Restraint Free Environment in Nursing Homes”
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The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all staff had received training in responsive behaviour.

6. **Action Required:**
Under Regulation 07(1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.

Please state the actions you have taken or are planning to take:
Since the inspection training has been sourced in the Management of Behaviours that Challenge. It is to be facilitated on Sept 21st 2016. There will be a gradual roll out of this training to all staff over a phased basis.

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<th><strong>Outcome 08: Health and Safety and Risk Management</strong></th>
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The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Other improvements were also required in relation to risk management. For example:
- incident records indicated that vials of local anaesthetic were removed from the emergency trolley and found in the bathroom close to the nurses station
- a number of paracetamol were found in a bathroom.
While it was never confirmed, it was assumed that this had been done by a resident. Based on a review of the incident forms, the inspector was not satisfied that adequate controls were put in place following these incidents to minimise the risk of reoccurrence.

7. **Action Required:**
Under Regulation 26(1)(d) you are required to: Ensure that the risk management policy set out in Schedule 5 includes arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.

Please state the actions you have taken or are planning to take:
Following consultation with the GP’s, Pharmacist and Nurse Prescribers the decision has been reached to remove the emergency drugs on the units as no personnel on site are
qualified to give front line drugs. Medication management training is ongoing for staff nurses.
A review of all incidents will be conducted by management on a monthly basis and the learning will be documented and disseminated to all staff.
Proposed Timescale: August 2nd 2016 and ongoing

### Proposed Timescale: 02/08/2016

#### Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Hoists and slings were seen to be stored in bathrooms even though alternative suitable storage facilities were available.

8. **Action Required:**
Under Regulation 27 you are required to: Ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.

Please state the actions you have taken or are planning to take:
The hoists have been removed to the correct storage areas. Staff education will be ongoing to continue this practice.

### Proposed Timescale: 02/08/2016

#### Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Fire drills were most recently held in May and June of 2016 and records indicated that they were held annually rather that six monthly as required.

9. **Action Required:**
Under Regulation 28(1)(e) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and residents are aware of the procedure to be followed in the case of fire.

Please state the actions you have taken or are planning to take:
Staff training has been carried out / planned over the following 3 months. An audit of training records is currently taking place to capture untrained staff. Further staff training will be organised pending the results of this audit. Training will be organised for staff at six monthly intervals.
Proposed Timescale: September 1st and Ongoing
**Proposed Timescale:** 01/09/2016  
**Theme:** Safe care and support  

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
Some fire doors were seen to be held open with equipment such as litter bins and chairs, which is not in compliance with good fire safety practice.

**10. Action Required:**  
Under Regulation 28(2)(i) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

**Please state the actions you have taken or are planning to take:**  
All staff have been advised that the practice of holding doors open is not best practice. This will be monitored by management ongoing. “Fire door guards” have been sourced for doors and will release automatically in the event of the fire alarm being activated.

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**Proposed Timescale:** 02/08/2016  
**Theme:** Safe care and support  

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
Improvements were required in the overall management of risk in the centre. For example:

- risk assessments for smoking were generic in nature and did not incorporate an assessment of the physical and psychological capacity of each resident to smoke independently or otherwise
- incident records indicated that a resident that did not have access to cigarettes or lighters for safety reasons was found at night time smoking in the bedroom of a resident that did have access to these
- a resident had "scorched" hair, and while the source of the scorching was never verified, it was reasonably assumed that it had happened when another resident was lighting this resident's cigarette
- a resident had sustained wounds to their hand on two separate occasions. It was assumed that both of these wounds were as a result of burns, and this was confirmed by the GP for one of these incidents
- the inspector observed residents smoking unsupervised on a number of occasions
- the inspector observed a resident that was not permitted access to a lighter, borrowing a lighter from another resident and lighting a cigarette. Both of these residents were not supervised while smoking and ashes were seen to be falling on to one of the resident's trousers.
11. **Action Required:**
Under Regulation 28(1)(a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.

**Please state the actions you have taken or are planning to take:**
The risk assessment tool in use has been amended and now reflects the physical, cognitive and individual risks associated with each resident who smokes. Residents who had previously been assessed as having the cognitive ability to hold lighters have been engaged with and are encouraged by staff to surrender lighters. This will be supported by the installation of “flameless lighters” which have been sourced by management and will be installed in the two designated smoking shelters, to reduce the use of lighters. The third decommissioned shed has been removed. Designated smoking times are scheduled and supervised. All residents who partake in smoking have a smoking apron available to mitigate risk, and will be encouraged to use them. Smoking cessation education for residents has been sourced and is scheduled for Sept 16th 2016.

**Proposed Timescale:** 30/09/2016

**Theme:**
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
It was found on the last inspection that suitable call system was not in place in the smoking shelters for residents to alert staff should they need assistance. Since then a door bell like system was installed, however, the inspector was not satisfied that this was adequate, as unlike the nurse call system, the bell does not continue to ring until it is answered by staff.

12. **Action Required:**
Under Regulation 28(1)(a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.

**Please state the actions you have taken or are planning to take:**
A suitable call system is being researched by the management team that will require it to be reset following activation.

**Proposed Timescale:** 30/09/2016

**Outcome 09: Medication Management**

**Theme:**
Safe care and support
The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A recent audit had identified that not all prescriptions had been signed by a GP. The audit also identified that there were not always nurses' signature associated with the administration of all medicines and it was not recorded that this medication had been refused or withheld at these times. These issues had not been addressed on the days of this inspection.

13. **Action Required:**
Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident’s pharmacist regarding the appropriate use of the product.

Please state the actions you have taken or are planning to take:
The GP’s have been consulted and requested to adhere to the policy in place in relation to medication management. There is ongoing training in place for medication management for nurses, in collaboration with the pharmacist and the GP service. An audit of the service will be conducted in 4 months time.
Proposed Timescale: August 2nd 2016 & December 31st 2016

**Proposed Timescale:** 31/12/2016

### Outcome 10: Notification of Incidents

**Theme:**
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
While most notifications required to be submitted to HIQA were submitted and within the required timeframe, there were some gaps. For example, a resident was found outside the urgent care centre after exiting the centre unaccompanied and unnoticed. The required notification was not submitted in relation to this incident.

14. **Action Required:**
Under Regulation 31(1) you are required to: Give notice to the chief inspector in writing of the occurrence of any incident set out in paragraphs 7(1)(a) to (j) of Schedule 4 within 3 working days of its occurrence.

Please state the actions you have taken or are planning to take:
The management team will comply with the regulations in relation to mandatory notifications.

**Proposed Timescale:** 02/08/2016

**Theme:**
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all notifications required to be submitted on a quarterly basis were submitted.

15. Action Required:
Under Regulation 31(3) you are required to: Provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of any incident set out in paragraphs 7(2) (k) to (n) of Schedule 4.

Please state the actions you have taken or are planning to take:
Management will ensure that notifications are submitted on required dates.

Proposed Timescale: 02/08/2016

Outcome 11: Health and Social Care Needs

Theme:
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some care plans required updating to reflect current needs. For example, the care plan for one resident with diabetes indicated that the resident should have their blood sugar level tested weekly but this was not being done. The inspector was informed that at the instruction of the GP, a less frequent blood test was being used to monitor the residents blood sugar levels, but this was not reflected in the care plan.

16. Action Required:
Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident’s family.

Please state the actions you have taken or are planning to take:
All care plans have been reviewed will continue to be updated at four monthly intervals and more frequently to reflect any changes to their care.

Proposed Timescale: 09/08/2016

Outcome 13: Complaints procedures

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in
the following respect:
While there was a complaints notice on display, it did not provide adequate detail of how to contact the complaints officer and did not outline the appeals process.

17. **Action Required:**
Under Regulation 34(1)(b) you are required to: Display a copy of the complaints procedure in a prominent position in the designated centre.

**Please state the actions you have taken or are planning to take:**
The notice on display in relation to complaints has been amended to reflect detail requested. It also identifies the details of the Registered Provider as the contact person to whom an appeals process should be addressed to.

**Proposed Timescale:** 11/08/2016