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:	Firstcare Beneavin Lodge
Name of provider:	Firstcare Beneavin Lodge Limited
Address of centre:	Beneavin Road, Glasnevin, Dublin 11
Type of inspection:	Unannounced
Date of inspection:	19 October 2021
Centre ID:	OSV-0000117
Fieldwork ID:	MON-0034225

About the designated centre

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

The centre offers long and short term care for adults and respite care and convalescence for adults over 18 years old including individuals with a diagnosis of dementia. The designated centre provides 70 beds in a purpose-built premises which is divided into two units: Botanic on the ground floor and Iona unit on the second floor. There is an enclosed courtyard garden which is accessible from the ground floor. The centre is located close to local amenities and public transport routes. There is a large car park at the front of the building.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	49

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 19 October 2021	08:40hrs to 17:50hrs	Niamh Moore	Lead
Tuesday 19 October 2021	08:40hrs to 17:50hrs	Sarah Carter	Support

What residents told us and what inspectors observed

From what residents said and from what the inspectors observed, the overall feedback from residents spoken with was that they were content with the care they received within Firstcare Beneavin Lodge. However, findings of this inspection identified a number of non-compliances with the regulations. These concerns related primarily to the governance and management arrangements and the oversight of infection prevention and control measures within the centre. In addition, there was a need for a review of the social and recreational provisions for residents within the centre.

This was an unannounced inspection and on arrival at the centre, inspectors were met by a Clinical Nurse Manager (CNM) who guided them through the infection prevention and control measures necessary on entering the designated centre. This included a COVID-19 risk assessment and ensured the wearing of personal protective equipment (PPE) such as face masks, temperature checking and hand hygiene prior to starting the inspection. While this was in place for visitors, observations by inspectors showed that for some staff their PPE use and hand hygiene required review.

Following a short opening meeting, inspectors were guided on a tour of the premises with the person in charge. The centre is a purpose built facility based on a campus with two other nursing homes belonging to the registered provider. The building comprised of two floors, the ground floor and the first floor. Resident's accommodation was mainly provided within single bedrooms with three twin bedrooms on the ground floor. All bedrooms within the centre have en-suite facilities. Bedrooms were seen to be personalised with resident belongings and residents spoken with confirmed they were happy with their accommodation. There were a number of communal rooms and areas available within the centre, including numerous secure outdoor courtyards.

The reception area of the centre had a cage with a budgie and also a fish tank which assisted to create a homely environment. However, observations during the on-site inspection found that some rooms and areas of the centre internally and externally were not clean with areas of wear and tear visible.

On the 20 September 2021, the centre had notified the Chief Inspector of Social Services of a COVID-19 outbreak in the centre. At the time of inspection, the designated centre was cohorted into four separate areas containing residents with detected, suspected and not detected COVID-19.

There were 49 residents in the centre on the day of the inspection. Inspectors recognised that this was a difficult and challenging time for the residents, management and staff due to the outbreak of COVID-19 within the designated centre. However, inspectors found the quality of life and care provided to residents

on both floors of the centre needed significant improvement.

Inspectors found that the impact of the COVID-19 outbreak clearly affected residents in the areas where COVID-19 was not detected with restrictions on meeting other residents to socialise and to enjoy their surroundings. Inspectors observed that staff in these areas did not have the same restrictions. Staff were seen to move between these areas through different entry and exit points, despite inspectors being told there were set entry and exit points to limit staff movement between areas. Furthermore, inspectors saw two staff who were working in the designated centre and were also scheduled to work in other units on the campus.

Inspectors were told that healthcare assistants (HCA) were tasked with completing one-to-one activities with residents in their bedrooms. However, due to the volume of their own duties, apart from one occasion where inspectors observed a HCA assist a resident to paint their nails, inspectors did not observe group or planned one-to-one activities happening. The focus for the HCA team was to ensure all residents were safe, provided with assistance with meals, answer all call bells and were to assist with the household team to provide enhanced cleaning schedules. While sufficient staffing levels were seen, the majority of interactions observed were task orientated and concentrated on care tasks. The notice board within this area displayed information for activities which were not up-to-date. Inspectors were told that the centre currently had a vacancy for an activity staff member and there was not sufficient staff to provide all residents with activities.

The dining area for the ground floor which was not in use throughout the inspection, was seen to be set up to allow for social distancing with nice wipe-able table clothes to facilitate cleaning. The feedback from residents in relation to the food offered in the centre was positive. Inspectors observed menus displayed in communal areas which included a choice of main meal for the lunchtime and evening meal. Inspectors observed that residents were mainly dining in their bedrooms, however some communal dining was observed for snacks and drinks. The person in charge told inspectors that residents were asked their food preferences the day before, however if a resident changed their mind they could also do this on the day of the meal.

Visiting had resumed under the advice of the Health Service Executive (HSE) public health team in the days prior to inspection. Inspectors witnessed a member of staff reminding a resident from the ground floor of their upcoming visit. The centre had suitable areas allocated to visiting on the ground floor to facilitate visits. However as will be described below, the 14 residents who lived in the upper area had no access to these facilities, as they could not access the elevators in the building. In addition, residents within this area could not go downstairs to access the garden for fresh-air.

Most staff who spoke with inspectors were knowledgeable about residents and their needs. However, two agency staff members spoken with had not received a sufficient induction prior to commencing their shift that day.

The next two sections of the report present the findings of the 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

While there were some effective management systems in this centre, ensuring good quality clinical care was being delivered to the residents, inspectors were not assured that the provider had sufficient oversight and adequate systems in place regarding the overall governance and management of the centre. Inspectors also had concerns in relation to infection control and residents' rights which are outlined further in the next section of this report. An urgent action plan was issued to the provider following the inspection regarding governance and management, infection control and residents' rights. The registered provider provided adequate assurances that these matters were being addressed following the inspection.

Firstcare Beneavin Lodge Limited is the registered provider for Firstcare Beneavin Lodge. The management team consisted of the registered provider, an operations manager and the person in charge. The current person in charge commenced their post in May 2021. Inspectors found that there was insufficient support for the person in charge to respond to residents needs and to ensure sufficient oversight and supervision of staff. The management team were available to the person in charge. However, roles and responsibilities of some managers were not clearly defined. In addition, evidence provided on the day of inspection was that senior management had not visited the centre since the recent COVID-19 outbreak began.

At the time of the COVID-19 outbreak, the Chief Inspector had received regular updates, including the person in charge being in receipt of advice and support from the local public health team. Measures in place to manage the COVID-19 outbreak in the centre included sufficient supplies of personal protective equipment (PPE), increased staffing numbers on duty to ensure that the increased direct care needs of residents were met. In addition, residents were cohorted into different zones of areas. It was noted that there were daily outbreak control meetings taking place which were attended by the person in charge, staff from the HSE and representatives from the management team.

The person in charge was supported in their role by a team of two clinical nurse managers (CNMs), nurses, healthcare assistants, an activity coordinator, catering, household and administrative staff. During the outbreak, the centre also received additional staffing from the registered provider to assist with the segregation of different areas, such as the addition of two CNMs to increase supervision of the four new areas. However, inspectors found that in addition to agreed staff members working within the centre for a set period of weeks, there were some staff who were working across different homes on the day of the inspection. This arrangement required review to ensure it minimised the risk of the infection spreading throughout the campus.

Inspectors found that overall the staffing numbers and skill mix of clinical staff on

the day of inspection was adequate to meet the needs of residents. However, improvements were required in the management of the centres resources to ensure the effective delivery of care in accordance with the statement of purpose. For example:

- Inspectors were told that there was a vacancy for an activity staff member which was open since July 2021.
- There was inadequate supervision and oversight of the induction of agency staff members.
- Inspectors were not assured that short-term leave was being managed effectively. For example, inspectors were told that one activity staff member and two members of housekeeping were not available on the day of inspection and there was no additional cover provided for these roles. In addition, inspectors were told short-term cover for training held on the day of inspection included the sharing of staff between this centre and another centre on the campus.

Regular management and clinical meetings were seen to take place to discuss key performance topics for the centre, such as residents, complaints, incidents and accidents and the facilities. Despite this, inspectors found that the provider needed to improve its management systems to ensure that the service provided was safe, appropriate, consistent and effectively monitored. For example, regular clinical audits were taking place and were accompanied by action plans. However action plans were not signed off as completed, limiting the assurances that issues identified had been effectively addressed. Evidence was seen where a premises walk through completed on 03 August 2021 identified that the courtyard required immediate attention. In addition, a finding of a Health and Safety audit identified that cellotape needed to be removed on some posters and replaced with blue tac. Inspectors found that there had not been sufficient action taken to respond to these findings as they were still evident on the day of inspection. Infection prevention and control auditing in place did not identify that some areas of the building were unclean.

An annual review of the quality and safety of care delivered to residents had taken place for 2020. There were quality improvement plans for 2021 identified in areas such as a plan to complete a full building review with the facilities team. There was no evidence that the review was completed in consultation with residents and their families.

Regulation 15: Staffing

On the day of inspection, there was insufficient staffing levels to ensure that residents received adequate activities and provisions for recreation. Inspectors observed that only one individual activity took place for one resident on the day of the inspection.

Judgment: Substantially compliant

Regulation 23: Governance and management

There were inadequate governance and management systems to ensure the service provided was safe, appropriate, consistent and effectively monitored as evidenced by:

- Inadequate cover for short-term leave was seen within the centre.
- Poor oversight of the induction of agency staff members.
- Audit tools not being sufficiently robust to identify findings that inspectors found on the day of inspection. Due to the outbreak within the centre, the provider was completing daily monitoring of PPE to include mask wearing and hand hygiene. However, inspectors findings of poor mask wearing and hand hygiene on the day of inspection had not been identified during these increased audits.
- Quality improvement plans following audits did not drive learning or improvements being made in response to audit reports for the premises and infection control.

An annual review of the quality and safety of care delivered to residents was completed for 2020. However, this review did not incorporate feedback or consultation with residents and their families.

Judgment: Not compliant

Quality and safety

Overall, the provider was delivering good quality clinical care and support to residents. Improvements were seen since the last inspection relating to care planning and managing responsive behaviours. In addition, residents had good access to healthcare. However, inspectors had concerns in relation to residents' rights, the premises and infection control measures within the centre. Improvements required in relation to governance arrangements have been discussed in the preceding section of this report.

A wide selection of residents' care plans were reviewed. The care plans reviewed contained clear goals and information to guide staff interventions and were person-centred. A range of clinical risk assessments had also been completed. Residents whose needs changed, for example because of the development of a new condition or a fall, had updated risk assessments and the care plans had been adjusted to reflect their changed needs. All residents detected with COVID-19 had an

appropriate documented plan in place to manage this aspect of their care.

Residents' healthcare needs were attended to by general practitioners (GPs). Nursing staff informed inspectors that the GP service was contactable and responsive. Inspectors were told that as a result of the COVID-19 outbreak, no health and social care professionals were attending the centre to review residents, but were contactable by phone. Inspectors were told that residents who were eligible received their COVID-19 booster vaccine recently.

Residents had recreational and social care plans that indicated important information about their preferences and interests. However, there was no evidence in resident records of their attendance and/or engagement levels in any recreational activity in the days preceding the inspection. As discussed within this report, there was insufficient staffing resources in place to meet resident recreational needs on a one-to-one basis.

Inspectors spent time observing residents with dementia and their engagement with staff. Inspectors observed a range of interactions between staff and residents. These interactions were mostly person-centred and respectful. However a staff member was observed interacting in a disrespectful manner in the management of a resident's responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). Inspectors requested the intervention of the person in charge.

There were sitting rooms available on the ground floor, environments that offered a somewhat homely feel with subtle wall decorations, low lighting and access to patios and terraces. The external terraces and patio areas were uninviting and required maintenance, and regardless of the weather were not inviting clean spaces for residents to get some air or spend time outdoors.

The physical environment in the centre had not been maintained to effectively reduce the risk of infection. Inspectors observed facility-wide issues related to the maintenance of surfaces, finishes and flooring which were worn and poorly maintained and could not be effectively cleaned. In addition to the premises works required, inspectors found that the management of equipment required review. For example, there were two small bins at the staff smoking area which were overflowing and some shower chairs seen had visible rust and did not allow for effective cleaning.

Inspectors observed that the registered provider had processes in place to ensure protocols relating to infection prevention and control were being observed and practised by the staff team. These measures included guidance on COVID-19, health and safety premises audits, access to PPE and hand sanitiser within the centre. Antigen testing was also seen to be completed for agency staff to detect their COVID-19 status prior to starting work within the centre. Inspectors observed that staff tried to ensure that residents were able to keep themselves safe in the current environment. For example, inspectors' observed some staff prompting and assisting residents to carry out good hygiene. Inspectors spoke with housekeeping staff who

were knowledgeable about their roles and responsibilities to keep the centre clean.

Further improvement for infection prevention and control within the centre was required, as inspectors found that there was inconsistent application of measures. For example:

- Signage of the zoning within the centre required review as the beginning of the COVID-19 detected area was inappropriately marked. While there were signs indicating the entrance with PPE provisions, it was unclear where the entrance started as there were two rooms immediately preceding this area which were used by staff members of the COVID-19 detected area.
- Throughout the on-site inspection, inspectors observed that face masks were not being worn correctly, including one staff member within communal areas without a face mask. Inspectors also saw staff wearing watches, jewellery below the elbow and with painted fingernails, which meant they could not effectively clean their hands.
- Areas across the designated centre were seen to be unclean. Gaps were seen in cleaning schedules. Inspectors were told that the person covering the household supervisor role did not have access to the cleaning schedules and checklists.
- A review of single-item use within the centre was required. Inspectors were not assured that all residents who required the assistance of a hoist had access to their own slings.

Inspectors observed that residents in the COVID-19 detected area of the centre had access to communal areas and were seen to spend time with staff and fellow residents. Inspectors were told that residents were dining and living within their bedrooms only and access to these spaces was restricted by infection prevention and control measures. Televisions were widely available and almost every resident's bedroom had the television switched on. Residents were seen seated close to televisions in their bedrooms. Residents were observed throughout the day watching TV in their rooms or sleeping. One resident played a musical instrument and had engaged in that activity in their own room. Despite the best efforts of staff, residents were without social contact for significant periods of time throughout the day. As a result, inspectors found that residents' did not have sufficient opportunities to participate in activities in accordance with their interests and capabilities. In addition, some residents did not have access to the outdoors.

Regulation 17: Premises

The premises and environment were not maintained to a high enough standard to ensure the effectiveness of infection prevention and control processes and to promote a safe and comfortable living environment within the centre. Internally the building displayed signs of wear and tear and external parts of the building were not in a good state of repair. For example, paving stones were noted to be slippy underfoot and required cleaning. There was evidence of cigarette smoking in areas

that were not designated smoking areas. Gutters around the first floor of the building had not been cleaned and emptied and were overflowing with water, broken patio furniture had been moved to one-side but not disposed of, all of which gave the external areas an untidy and uninviting appearance.

Judgment: Substantially compliant

Regulation 27: Infection control

Improvements were required in infection prevention and control processes in the designated centre. For example:

- Inappropriate storage had the potential to lead to cross-contamination, such as a clean linen store room had a linen trolley stored with items of dirty laundry within it.
- Some equipment, furniture and paintwork was worn and defective and as a result could not be effectively cleaned and decontaminated.
- Signage did not clearly indicate the entrance / exit from the COVID-19 detected area.
- Staff hand hygiene and mask usage practices required review.
- A review of the cohorting of staff in separate units including the entrance and exit points of different areas required review to ensure that measures in place mitigated against the potential spread of infection within the centre and across the campus. For example, instructions which limited the access to the main elevator were misinterpreted by management staff and the instruction posted on the signage itself was not being adhered to.
- The oversight of cleaning schedules required review as a number of areas and items within the centre were seen to be dirty.
- There were gaps seen in staff monitoring logs to identify signs and symptoms of COVID-19.
- Refresher training with regard to single use items such as wound dressings was required.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Each residents' needs were assessed on admission and at regular intervals thereafter. Staff used a variety of accredited assessment tools to complete an assessment of each resident's needs, including risk of falling, malnutrition, pressure related skin damage and mobility assessments. These assessments informed care plans to meet each resident's needs. The interventions needed to meet each resident's needs were described in person-centred terms to reflect their individual

care preferences. Inspectors found that the recording of the resuscitation status of each resident had been completed. The electronic documentation system in place was clearly laid out and the information was easily retrieved.

Judgment: Compliant

Regulation 6: Health care

Residents had access to a GP throughout the outbreak of COVID-19. There was evidence of communication with the medical team on receipt of a confirmed diagnosis of COVID-19.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

There was a clear policy in place to guide staff to manage the care of residents who experienced responsive behaviours. Care plans were in place which outlined the needs of the residents identified.

Restrictive practices were assessed for and documented as per the centres policy.

Judgment: Compliant

Regulation 9: Residents' rights

Improvements were required to ensure residents' rights were respected in relation to activity provisions, access to the outdoors and to visitors. For example:

- Inspectors found that the 36 residents of the COVID-19 not detected areas did not have sufficient opportunities to participate in activities in accordance with their interests and capacities. Evidence was noted in gaps in activity records for residents and from observations that residents were bored on the day of inspection. The inspectors were not assured that residents were receiving sufficient recreational and social input. Notwithstanding the COVID-19 outbreak status, no alternative resourcing was put in place to meet residents' recreational needs on a one-to-one basis.
- 14 residents in the COVID-19 not detected area did not have access to the outdoors or to receive visitors.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 27: Infection control	Not compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Firstcare Beneavin Lodge OSV-0000117

Inspection ID: MON-0034225

Date of inspection: 19/10/2021

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • There are two Social Care Lead positions within the team, with one of those roles being recruited to at the time of the inspection. One candidate has been successful in the interview process and will commence the role in Jan 2022. The PIC, supported by the HR team, is actively recruiting to fill the second position of Social Care Leader, with scheduled interviews in Dec 2021, and it is anticipated that this role will be filled by the end of Jan 2022. • While this process is underway, staffing has been reviewed to facilitate the daily allocation of a HCA as activity coordinator for the home, with this person having no other duties and responsible for carrying out the activities as per the weekly planner. This is delegated on the roster and reviewed daily by the CNMs. • If unplanned leave occurs, a range of options are available and used to ensure adequate staffing that includes continuity of resident's activities – these options include staff nominating to complete extra shifts when available, agency use, and direct care hours by CNM and ADON as required. • The allocated HCA (as per above) will allocate time daily to document all planned activities residents participated in which is recorded in EPIC, and all other purposeful activities recorded by each staff member. • The CNMs/ADON will conduct a weekly Activity Audit to measure engagement of residents, planning and implementing the planned activities, reporting the outcomes and any follow-on actions to the PIC. • The CNMs/ADON continue the QUIS audits, with immediate feedback to the staff that addresses continuous improvement and learning opportunities, with outcomes reported weekly to the PIC. • The existing agency induction form has been revised and now includes a daily review and sign off component– whereby on commencement of the shift, all agency staff receive an induction from the S/N on duty - including floor plan, fire policy, IPC measures and residents care needs. Induction forms are signed by the S/N and agency staff and reviewed daily by CNM with oversight from the ADON. • Staffing levels are continuously reviewed with ongoing recruitment in consultation with HR. The Roster is planned at least 2 weeks in advance, whereby staff may avail of	

additional shifts should the roster require extra staff. If a shift does have extra unallocated hours due to short term staff absences, agreed agency staff cover is provided, along with the option of home staff nominating for extra shifts.
• The PIC and ADON review the roster, scheduled commitments and requirements (e.g. scheduled training) each Friday afternoon for the upcoming week to ensure adequate staffing is in place across all departments.

Regulation 23: Governance and management	Not Compliant

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

• There is a clearly defined management structure in place with the PIC supported by an Assistant Director of Nursing, a new position from 26.10.2021, along with the existing two full time Clinical Nurse Manager (CNM) roles.
• Senior management support from the Regional Team as well as National Management team - includes an experienced team of staff in the following roles: Regional Director, Associate Regional Director, Director of Admissions, HR Manager, Quality Improvement team – as well as the COO/RPR.
• The Statement of Purpose has been updated to detail all changes. The most current version of the Statement of Purpose (SOP) was submitted to HIQA on 23rd December 2021.
• All staff are fully aware of reporting lines, roles and responsibilities with a range of meeting and communication structures in place including monthly Governance meetings that include the Regional Team.

Regulation 23 (c)

Along with the above, the PIC monitors that all services provided are safe and effective by analyzing audits carried out by ADON/CNM/TL on a regular basis.

• Established new systems are in place which incorporate daily reporting by the CNM/ADON to PIC.
• Governance meetings are carried out monthly with senior management and the in-house management team.
• The in-house management team have attended additional Clinical Audit training that ensures coherence and understanding in the processes of auditing, analysis, implementing and reviewing actions.
• As per Regulation 27 below, a range of reviews, audit and governance processes have been implemented – such as an amendment of the hand hygiene audit tool which is completed daily by the CNM and Team Lead, with agreed minimum random audit of staff per week. Any issues are addressed immediately with the staff member to take actions

that rectify the issue identified.
• Further processes have been put in place as part of the daily handover and documentation such as a daily check of staffs' uniform and general appearance which is reviewed daily by ADON and PIC.
An audit of the compliance of this process and documentation is carried out by the PIC/ADON monthly and any non-conformances identified are addressed immediately. These findings are discussed at monthly Governance meetings.
• The Daily handover checklist form is included in the handover to ensure all staff are reminded about IPC measures and proper use of PPE on a daily basis.
• All cleaning schedules are reviewed weekly by the PIC/ADON with the Household Supervisor and all completed cleaning schedules are filed in DON's office.
• The process for staff monitoring (temperature and wellness check) has been reviewed with each staff member documenting their checked temperature and declaration of being symptom free prior to commencement of shift. The morning log is checked daily by CNM/ADON to ensure all staff have completed the process and documentation, with immediate action to rectify any issues. A second temperature and symptom monitoring check are completed by an allocated nurse on each floor, and appropriate actions taken as required.
• Regular spot checks are carried out by ADON /DON to ensure that staff are following the safe practice.

Regulation 23 (e)

• Feedback and input into the management of the facility from residents and families is sought and welcomed by the PIC, RPR and team.
• Feedback through the Residents' Committee, and individual feedback from residents and families, are utilized by the PIC, and assist the management team, to proactively address improvements.
• An Annual satisfaction survey was provided to all residents and their families by the provider. Analysis of the feedback will be completed in late January 2022 and an action plan will be derived.
• The information from this survey along with the other feedback will be incorporated into the Annual review. The annual review is due to be finalised in January 2022 and will clearly outline resident and family feedback and any actions that arise are documented in the plan.
• Actions within the Annual Plan will be on the Residents' Committee agenda throughout the year and their feedback documented in the minutes for the PIC and RPR to review.
• Items arising from residents and families feedback will be tabled at the Governance meeting and shared with the Regional Team.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• A planned environmental (interior and exterior) review was completed whereby all

identified renovation work was completed by 6th December 2021
• The exterior work included cleaning of all exterior areas, repair and replacement of garden furniture and was completed by 16th November 2021. The external courtyard and patio areas are accessible to all residents. General cleanliness of both interior and exterior areas of the home are also checked monthly during the environmental review and audit by the PIC/ADON.
• The Household Manager and PIC have completed a full review of practices, schedules, products, knowledge and learning requirements for this team with agreed roster adjustments and further training in place.
• The deep clean schedule has been revised. Cleaning schedules, including regular deep cleans, are in place with auditable records.
• Agreed audits and regular reporting structure from the household and maintenance team are in place.
• All cleaning staff, and night staff, have access to and follow an agreed daily cleaning schedule and on inspection by the CNM/ADON are signed off. These completed records are filed in the PIC's office for ease of access.
• The PIC/ADON completes a monthly environmental audit of to identify and address any cleanliness, household, equipment or maintenance issues. The findings, actions taken and any other supports required are reported to the Regional Director and at the monthly governance meeting.
• All staff are reminded daily at handover, along with signage being in place, to only utilize designated staff smoking areas. Random checks are completed and feedback provided to staff at the time, and included in the monthly environmental audit.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
• Appropriate storage areas were identified and all clean items (clean linen) are stored off the floor in a designated storage room. A storage area is also identified for the storage of dirty laundry. Monitoring of storage is included in the environmental audit, which is completed by the PIC/ADON monthly.
• Identified worn and defective furniture and equipment have been removed. New furniture has been purchased and is replacing old furniture on a phased basis.
• A review of the current training, which addressed IPC best practices, wearing of PPE, hand hygiene, uniform policy was completed. In addition, IPC training with an external provider was delivered to senior staff during our recent outbreak. The PIC and team will continue to be supported by the Training Coordinator who arranges all required training, including IPC, and updating the training matrix regularly with monthly monitoring by the ADON/PIC ensuring all staff have access to training as per the requirements.
• As outlined under Regulation 23 above, the hand hygiene audit tool has been amended to include nailcare, nails varnish & jewellery, with a daily check by the CNM. Any issues/breaches are addressed immediately with the staff member. A daily check of staffs' uniform and general appearance has been added to the daily hand over sheet,

and reviewed daily by the PIC/ADON to ensure appropriate actions have been taken. An audit of the compliance with this process and documentation is carried out by the PIC/ADON monthly and any non-conformances/breaches are identified and addressed immediately. These findings are discussed at monthly Governance meetings.
• The daily handover checklist form is included in the handover to ensure all staff are reminded about IPC measures and proper use of PPE on a daily basis.
• All cleaning schedules are reviewed by the PIC/ADON with the Household Supervisor and all cleaning schedules are stored in DON's office.
• When a staff member presents for duty at the designated staff entrance, they check their temperature and declare they are symptom free, prior to commencement of shift. The morning log is checked daily by CNM/ADON to ensure all staff have completed the process and documentation, with immediate action taken to rectify any issues. A second temperature and symptom monitoring check are completed by an allocated nurse on each floor, and appropriate actions taken as required.
• All staff have been trained on "The Single Use symbol" and this has been included in the daily hand over sheet and is audited during the daily handover.
• An outbreak review meeting was held with PIC, ADON and Senior Management to discuss the events and learnings from the recent outbreak.
• A new Isolation Unit has been identified, discussed and agreed with the Regional Director. A copy of the floorplans with the identified isolation areas and all signage is ready and available in the Outbreak preparedness box.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: Regulation 9 (2) b

• At the time of the inspection, the home was experiencing an outbreak, with some staff on unplanned short-term leave, and the staff prioritised the safety and wellbeing of the resident's daily care needs. Since the inspection, the home is no longer in outbreak and all regular practices and access to indoor and outdoor areas within the home has resumed.
• While the vacancy for Social Care Leader is being recruited, one HCA has been allocated daily (supernumerary to other care requirements) to deliver activities as per the weekly plan, and in line with resident's choices and feedback.
• The CNMs have been delegated to monitor and observe the activities on a daily basis, and complete a weekly activity audit which are analysed by the ADON for feedback to the PIC; and agreement for further actions if/when required. This includes reviewing documentation and feedback from residents entered to EPIC post activity.
• Group activities are continuing with social distancing measures in place, including external entertainers; with these external resources included as part of the weekly audit.

Regulation 9 (3) a

• Family visits are facilitated for all residents in line with the relevant and time specific IPC and national guidelines; this includes external outings with families in line with resident wishes and IPC guidelines.
• All residents have access to a range of services from Physiotherapy and OT delivered in line with IPC guidelines and Public Health advice; with further consultation on continuity plans from the external provider should the home experience an outbreak in the future.
• All usual activities, dining experiences and use of all areas of the building (including internal and external gardens) are in place, available and fully utilised by residents across the home as per the home's processes of stepping down the outbreak procedures while adhering to all current and relevant IPC guideline.
• After our internal outbreak review, the PIC and senior management team identified a different area on the ground floor within the home to be identified as an isolation zone for future use should that be required. The use of this ground floor area as isolation area ensures that residents from the 1st floor are able to use all lifts and therefore access the garden areas at all times. This is currently being discussed with local public health team and our contingency plan will be updated to reflect any changes. This will be completed by end of December 2021.
• As per Regulation 23 above, resident and family feedback, including a recent survey, will be incorporated into 2022 Annual plan.

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 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Substantially Compliant	Yellow	31/01/2022
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	06/12/2021
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines	Substantially Compliant	Yellow	31/01/2022

	of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.			
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	Red	21/10/2021
Regulation 23(e)	The registered provider shall ensure that the review referred to in subparagraph (d) is prepared in consultation with residents and their families.	Not Compliant	Orange	31/01/2022
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Not Compliant	Red	21/10/2021
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in	Not Compliant	Red	21/10/2021

	activities in accordance with their interests and capacities.			
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Not Compliant	Red	21/10/2021