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:	Tara Winthrop Private Clinic
Name of provider:	Tara Winthrop Private Clinic Ltd.
Address of centre:	Nevinstown Lane, Pinnock Hill, Swords, Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	07 November 2023
Centre ID:	OSV-0000183
Fieldwork ID:	MON-0041534

About the designated centre

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

Tara Winthrop private Clinic is situated close to the village of Swords, Co Dublin. The centre provides nursing care for low, medium, high and maximum dependency residents over 18 years old. The centre is organised into five units made up of 140 beds of which 112 are en-suite bedrooms. There are eight sitting room areas and six dining room areas and at least 15 additional toilets all of which are wheelchair accessible. The centre is set in landscaped grounds with a visitor's car park to the front of the building. It is serviced by nearby restaurants, public houses, library, cinemas, community halls, the Pavilions Shopping Centre, a large variety of local shops, retail park and historical sites of interest and amenity such as Swords Castle, Newbridge House and Demense, Malahide Castle and Demesne.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	121

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 7 November 2023	11:45hrs to 20:30hrs	Lisa Walsh	Lead
Wednesday 8 November 2023	07:55hrs to 16:30hrs	Lisa Walsh	Lead
Tuesday 7 November 2023	11:45hrs to 20:30hrs	Brid McGoldrick	Support
Wednesday 8 November 2023	07:15hrs to 16:30hrs	Brid McGoldrick	Support
Tuesday 7 November 2023	11:45hrs to 20:30hrs	Frank Barrett	Support
Wednesday 8 November 2023	08:00hrs to 16:30hrs	Frank Barrett	Support
Tuesday 7 November 2023	11:45hrs to 20:30hrs	Yvonne O'Loughlin	Support
Wednesday 8 November 2023	07:15hrs to 16:30hrs	Yvonne O'Loughlin	Support

What residents told us and what inspectors observed

The inspection was carried out over two days with day one starting in the afternoon and finishing in the late evening. On day one, following an introductory meeting with the person in charge, chief operating officer and general manager, inspectors walked around the centre and spent time observing interactions in different units and spoke with residents, visitors and staff. When inspectors arrived at the centre in the early afternoon, residents were observed to be up and about in the various areas of the centre. Some residents were eating lunch and others were receiving visitors.

The centre is divided into five units which are set out across two floors. They are referred to as the Lambay unit, Shennick unit, Erris unit, Columba unit and Iona Unit. The Lambay unit, Shennick unit and Erris unit are on the ground floor and each unit has its own day space, dining room and internal garden. The Columba unit and Iona unit are on the first floor and are managed as one unit in the day-to-day running of the centre; sharing the same team of staff, dining room and day space.

Over the course of the two days, inspectors spoke to residents and visitors they met with. Residents' and their visitors reported to inspectors that staff were 'great' and 'excellent' but they are 'run off their feet' and that there is a 'serious lack of staff'. For example, one resident told inspectors that before it felt like being part of a family living in the centre, however, now it feels like staff want to 'get the job done and out' due to insufficient staffing levels. Residents' and visitors reported that there was insufficient staff to assist residents with having showers when they wanted to shower resulting in some of them at times going up to two weeks without a shower. However, resident's were offered body washes during this time which was not their preferred choice. For example, inspectors reviewed a sample of records for residents whose preferred choice was a shower, for three residents who had showered on the day of inspection it had been two weeks since their last shower. Residents also informed inspectors that they were often delayed in getting up and dressed on days when they were leaving the centre to attend other services early in the morning. Residents' and family members reported there were often delays in staff answering call bells with one resident saying that they do not use the call bell, that there was 'no point'. Family members also reported that call bells were 'forever' ringing. A resident described having to phone their relative to phone the centre in order to get assistance from staff at night time as their call bell was not answered. Visitors who spoke to inspectors reported concerns regarding staff moving from units within the centre to cover staff sickness and not knowing the residents needs. Furthermore, on review of a sample of records, inspectors observed instances of staff moving between units within the centre. For example, on one occasion two carers were moved from Erris to Shennick because they were short two carers that day. Visitors also spoke about the turnover of staff with new staff not knowing the needs of the residents.

There was an activity programme in place. Residents and visitors reported that there had been some improvements, since the last inspection, in the type of activities, however, this needed further improvement. On day one of the inspection, inspectors observed that there were lengthy periods of time where some residents were observed sitting in the communal area in the Columba and Iona unit watching television with music playing, without other meaningful activities. On the Lambay unit, there was an exercise class in the afternoon on day one of the inspection and no further activities after this. Residents in the Lambay unit reported that there was some activities provided during the day. They reported that recently there was live music at the weekends which they enjoyed, however there was 'no activities after tea'. Inspectors observed that most residents were in their bedrooms by 6pm in the Lambay unit on day one of the inspection.

Residents and visitors reported that some activities were not appropriate for residents. For example, on the Lambay unit a resident who had a sensory impairment was provided with activities such as bingo and art in which they could not participate.

On the Lambay unit, some residents spoke about their clothes going missing from the laundry as they were away from the designated centre during the day and back in the evening time, after the time when clothes were due to be returned.

Residents meals were well presented and inspectors observed an area where visitors could buy a meal and dine with their loved ones.

Residents' bedrooms were seen to be personalised with residents' own personal belongings, which brought a homely atmosphere to each room. Inspectors observed that the configuration of residents personal floor space in the shared bedrooms had been reviewed since the last inspection and now met the regulatory requirement under S.I. No. 293 of the Care and Welfare Regulations 2016.

The design and layout of the building were observed to be suitable for the needs of the residents cared for within the centre and improvements in relation to maintenance were noted. However, some further maintenance was required and issues in relation to storage remained.

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

Capacity and capability

Overall, the registered provider had failed to provide a safe and effective service for residents that was compliant with the regulations. Inspectors found that improved supervision of staff practices was required in a number of areas to ensure the service provided to the residents upheld their rights and promoted their safety at all

times. There had been a number of new staff and changes in the operational management team. The management systems in place were not effective in ensuring that the care provided to residents was safe and consistent. There were insufficient staff resources to meet the assessed needs of residents.

Due to significant infection control concerns inspectors issued a number of immediate actions on day one of the inspection, which included;

- Removal of large volume of storage from the hydrotherapy room.
- Deep clean of the Shenick and Erris unit.
- Deep clean of the Hairdressing room.
- The need to place fans on a cleaning schedule and cease the use of a fan in a kitchenette on the Erris unit.

This was an unannounced inspection to assess compliance with the regulations, follow up on the compliance plan submitted by the registered provider since the last inspection for Tara Winthrop Private Clinic. The inspection was carried out over two days with four inspectors. Tara Winthrop Private Clinic Limited is the registered provider for Tara Winthrop Private Clinic.

Since the previous inspection a number of issues that were identified in the compliance plan had been addressed, including;

- Recruitment of activity coordinators.
- Fire training had been completed by staff.
- A general manager post was introduced and an extra nurse was added to the night roster.
- Ventilation of the storerooms had improved.
- The layout of the multi-occupancy rooms had been reconfigured to allow residents to have adequate storage and personal space.

However, there were a number of issues identified on the previous inspection that had not been completed in the time frame committed to in the registered provider's compliance plan, these are detailed in Regulation 23: governance and management.

The person in charge had commenced their role in August 2023 and was responsible for the clinical aspects of the day-to-day running of the centre. The person in charge was supported in their role by the the chief operating officer. A new general manager position had been added to the governance and management structure to provide further support to the person in charge and commenced employment in November 2023. They were responsible for the non-clinical aspects of the day-to-day running of the centre.

The registered provider had audit and monitoring systems in place to oversee the service. However, the audit system was not sufficiently robust as it had failed to identify key areas for improvement such as assessments and care plans, the safe use of restrictive practices and poor infection prevention and control practices.

Inspectors found that there continued to be insufficient resources to meet the assessed needs of residents, with over 70% of residents being assessed as having

maximum or high dependency needs. There were previously two assistant directors of nursing (ADON) to support the person in charge but this had been reduced to one ADON due to staff vacancies. Inspectors also observed that there was a vacant clinical nurse manager II (CNM) position within the centre. These vacancies in the governance and management structure impacted in poor supervision of staff and on the care and welfare of the residents. Inspectors found that staffing levels were also insufficient to meet the assessed needs of residents. For example, residents could only shower once a week due to not having enough staff to facilitate showering daily as per their care plan. This is a repeat finding from the previous inspection and further discussed under regulation 15: staffing.

Following a review of records improvements were noted in fire safety and manual handling training. However, further training was required in a number of areas in relation to safeguarding, care planning and assessment and complaints. Further assurances were required in relation to staff supervision to ensure that they were providing safe, quality care, this is further discussed under regulation 16: training and staff development.

Over the two days of inspection, inspectors observed and relayed four notifiable incidents to the management team. However, these were not notified to the Chief Inspector, as set out in Schedule 4 of the regulations.

Regulation 14: Persons in charge

The person in charge had the relevant experience and qualifications to undertake this role. Inspectors found that the person in charge knew the residents and was familiar with their needs. They demonstrated a strong commitment to the provision of a safe and effective service.

Judgment: Compliant

Regulation 15: Staffing

Inspectors were not assured that the provider had the required numbers of staff available with the required skill mix having regard to the size and layout of the centre and the assessed needs of the resident's. This was evidenced by:

- Residents were observed waiting for breakfast to be served and for attention to personal hygiene needs, such as showering, on the Lambay unit. This is a repeat finding from the previous inspection. For example, a resident had asked for support to have a shower and was observed to waiting for a shower over an hour later.
- On the evening of day one, residents on the Lambay unit did not have an opportunity to participate in meaningful activities after 6pm.

- There were no rostered household staff after 4pm daily and a reduction by one household staff member on Sundays. Carers working the night shift were required to carry out cleaning duties at night time which took them away from their caring duties. The impact is reported under regulation 27 Infection control.
- There was only one assistant director of nursing (ADON) to support the person in charge, this had been reduced from two ADONs due to staff vacancies.
- Nurse managers were not rostered to work at the weekend (Saturday and Sunday) with the result that on some weekends a senior staff nurse was assigned to this role. The senior staff nurse was supported by an on call arrangement provided by the director of nursing.
- A clinical nurse manager (CNM) provided oversight to the designated centre nightly, however, on occasion they were required to perform the duties of a registered nurse to cover for unplanned leave. In addition, the CNM who worked the night shift covered breaks which limited the time available to them to oversee the delivery of care.
- The provision of activities was not managed to meet the assessed needs of residents. This is further discussed under Regulation 9; Residents Rights.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff were not appropriately supervised to carry out their duties to protect and promote the care and welfare of all residents. This is a repeat finding from the previous inspection. For example:

- Poor adherence to infection prevention and control standards that included the inappropriate use of cleaning products and implementation of cleaning protocols.
- Poor oversight and management of residents where restraints were being used.
- Poor oversight of newly hired staff.
- The system of rostering at weekends did not ensure effective support or supervision of nursing staff on site.

The findings of this inspection identified that additional training was required in a number of areas:

- Assessment, monitoring and treatment of residents following surgical procedures.
- Recognising, recording and managing the use of restraints in line with national policy, including the supervision and monitoring of residents nursed in tilted chairs.
- Assessment and monitoring of residents displaying inappropriate behaviour.

- Recognising and responding to safeguarding concerns.
- Recognising and responding to complaints.
- Assessment and monitoring of residents with infections.
- Recognising and implementing resident rights.

Furthermore, the induction record did not provide adequate assurance that each new member of staff was deemed to be competent for their role in the centre.

Judgment: Not compliant

Regulation 21: Records

The registered provider failed to ensure that the records set out in Schedule 2 and 3 were kept in the designated centre and available for review on inspection. For example:

- There were no records of money received on behalf of residents, for example, completed pension agent forms for residents were not maintained within the centre.
- A number of residents received additional funding, there was no record available on the days of inspection to set out what care was to be provided for this funding. There was also no record for how this funding was allocated and utilised. This information was requested however, the registered provider was not able to provide it.
- Some aspects of induction records were not available for inspectors to review.
- There was no record of residents being released from restraints in line with their care plan and the national policy.

Judgment: Not compliant

Regulation 23: Governance and management

There was a management structure in place, however some roles within that structure were not well defined and did not provide clarity regarding authority and accountability. This was evidenced by:

- Staff employed by a different registered provider carried out pre-admission assessments for residents moving to live in this designated centre.
- Staff were not familiar with the system of finances and could not provide documentary information relating to funds allocated to individual residents to meet their care needs. Furthermore there was no evidence as to how these

funds were managed and the types of care to be provided for these specific residents.

The management systems reviewed on the day of the inspection did not provide assurances that the service provided was safe, appropriate and consistent. For example:

- The provision of resources did not ensure there were sufficient resources allocated to all areas of the service. While there was a risk assessment carried out in respect of staffing, the actions identified to address the risks were not implemented. Residents continued to be admitted to the centre, during a time when there was a turnover of clinical staff and gaps in the management structure. This is a repeat finding from the previous inspection.
- Systems of supervision did not provide support to staff to carry out their duties to protect and promote the care and welfare of all residents. This was evidenced by staff not implementing infection prevention and control procedures, lack of appropriate assessments for residents in tilted chairs, poor oversight of residents hygiene needs and safeguarding residents from abuse.
- The system of recognising and responding to complaints was not effective.
- Poor oversight of cleaning practices relating to infection prevent and control meant that the standard of cleaning was not adequate.
- The audit system was not sufficiently robust as it had failed to identify key areas for improvement such as assessments and care plans, the safe use of restrictive practices and poor infection prevention and control practices.

Furthermore, there were a number of other issues identified on the previous inspection that had not been completed. For example:

- A review of the assessment process and a new dependency assessment tool was to be introduced and audited monthly. However, issues still remained in relation to the assessment of residents needs and dependency levels.
- Improvements were still required to ensure residents care was delivered in line with their care plan. This is further detailed in Regulation 5: Individual assessment and care plan.
- The number and skill mix of staff continued not give assurance that there was appropriate and adequate staff to meet the needs of the residents with due regard to the size and layout of the centre.
- Cross contamination issues remained in the laundry with clean mops and cloths stored in the dirty area where dirty linen is stored.
- Fire drills did not reflect Vertical evacuation procedures. Following the previous inspection, an urgent compliance plan was issued which requested assurances that adequate arrangements were in place for evacuating all persons in the designated centre and safe placements of residents. The absence of vertical evacuation simulation meant that staff had not practiced evacuations from the first floor using the equipment available reflecting residents dependencies.

- Premises issues relating to storage and maintenance were found on this inspection. Storage and maintenance concerns are a repeat finding.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

Inspectors reviewed records in relation to contracts for the provision of services and found that a number of alterations were required to ensure that these records were transparent and accurate, for example:

- The correct room number was not on each contract.
- Some residents had not been given a written copy of their contract on admission.
- Contracts did not include details of care to be provided in line with funding arrangements.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The registered provider had displayed an accessible procedure for dealing with complaints in prominent positions in the designated centre, however, this did not include all the relevant information regarding the complaints process.

Some complainants did not receive a written response to inform them if their complaint was upheld or not, the reason for this decision, any improvements recommended or details of the review process.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

The registered provider had the required policies and procedures set out in Schedule 5, however, some of these were not implemented in day to day practice. For example, there was a policy which set out the use of restraint, detailing how specialised chairs should only be used where the suitability of the chair for the resident has been assessed and approved by an occupational therapist. However, residents in tilted chairs had not been reviewed by an occupational therapist.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Inspectors observed and informed management of four notifiable incidents that had occurred during the two days of inspection. However, the Chief Inspector did not receive the notifications as set out in Schedule 4 of the regulations. Inspectors requested these incidents were notified, as required, which the person in charge later submitted.

Judgment: Not compliant

Quality and safety

Inspectors were not assured that the systems in place for overseeing the quality and safety of resident's care, ensured that all residents living in the centre were protected by safe practices. Some routines and practices used by staff in the centre did not reflect person centred evidence based practices and were not in line with the centre's policies. Insufficient staff resources impacted negatively on the provision of care for residents. Additional details of issues identified are set out under Regulation 5: Individual assessment and care plan, Regulation 7: Managing behaviour that is challenging, Regulation 8: Protection, Regulation 9: Residents' rights, Regulation 17: Premises, Regulation 27: Infection control and Regulation 28: Fire precautions.

Inspectors reviewed assessments and care plans for residents and found that some residents did not have an assessment of their needs and as a result, appropriate interventions were not always carried out. Improvements were also required to ensure that care was delivered in line with each resident's care plan as outlined further under Regulation 5: Individual assessment and care plan.

Restrictive practices required action as they were not managed in accordance with the national restraint policy and guidelines and the centre's policy. This is discussed in the report under Regulation 7: Managing behaviour that is challenging.

Although staff had access to safeguarding training, inspectors found a number of occasions where incidents had not been recognised as safeguarding concerns. For example, inspectors observed safeguarding concerns involving some residents with a cognitive impairment which would impact their ability to consent to sexualise behaviours. Inspectors were not assured that some residents were protected and that all reasonable measures were in place to safeguard residents from abuse. Residents finance were also not managed in line with best practice. This is further detailed under Regulation 8: Protection.

Inspectors observed practices that were not person-centred and which did not ensure that residents' rights, dignity and choice were promoted at all times in the centre. Although efforts were made to improve the opportunities for recreational and occupational activities, further improvements were required, as detailed under Regulation 9: Residents rights.

The premises were designed and laid out to meet the individual and collective needs of the residents. There was a variety of communal and private areas observed in use by residents on the day of inspection. Inspectors noted that some areas were not used as set-out in the layout maps under which the centre was registered. An internal area identified as "Store 5" had a disused swimming pool inside. This impacted significantly on the safe utilisation of the space. Materials and furniture were stored along the edges of the pool in an unsafe manner. This was all removed on the day of inspection when the issue was highlighted. Although some storage facilities were available, including extensive external storage areas, they were not sufficient and were overfilled. Inappropriate storage was found in the centre. Inspectors noted that some areas of the centre required maintenance attention, and these areas would impact on the residents safety, for example, rusted handrails in Columba and Iona unit bathrooms. These and other findings are outlined under Regulation 17: Premises.

The Inspector identified some areas of good practice in the prevention and control of infection. For example, there was clear identification of resident's that were colonised with a multi-drug resistant organisms (MDRO) and care plans had sufficient detail to enable person centred care and safe practices. Infection prevention and control training and audits were up to-date. However, further improvements were required in relation to education on appropriate antibiotic usage, cleaning and decontamination processes of resident's equipment and surfaces and managing risks to water safety, this is further discussed under Regulation 27.

The records provided on the day of inspection showed that the Emergency lighting, Fire detection and alarm systems, kitchen extract ducting, boilers, laundry equipment and fire suppression systems were maintained and serviced. The provider had taken measures to provide appropriate fire detection in most cases. However, there were some areas identified on the annual certification as requiring additional coverage.

Inspectors found that the registered provider had not taken adequate precautions against the risk of fire. For example, inappropriate storage of combustible materials alongside flammable items was identified. There were individual external storage areas at the rear and side of the centre. These contained items ranging from continence wear, to PPE, to mattresses, resident files, maintenance equipment and cookware. Inspectors noted that there was no fire detection or alarm system in any of the structures.

There were inappropriate containment arrangements. For example, inspectors found missing fire seals on some fire doors, damaged smoke seals, and non-fire-rated ironmongery fitted to others. Bedroom fire doors were not fitted with door closers,

which, as a result, required doors to be kept closed to contain fires. Some doors were found propped open with wedges, and the critical step to close the doors following evacuation, had been missed on several fire drills. Other concerns were identified with fire drills, with inadequate levels of participation for night time staff. These and other fire safety concerns are detailed further under Regulation 28; Fire Precautions.

Regulation 17: Premises

The registered provider did not ensure that the premises of the designated centre was in accordance with the statement of purpose prepared under Regulation 3. For example:

- Changes had been made to the footprint of the centre including;
    - An area of the Lambay unit day space had been constructed as a hoist store area. This was identified as communal space on the floor plans.
    - A large container on site was used by a third party, and not accessible by staff at the centre. Inspectors were informed that this office was not in use by the registered provider.
    - The store room 5 which included the internal pool, required review to assess the use of the area, as it was not suitable for storage in its arrangement at the time of inspection.
    - A cross corridor door was in place beside the entrance to the dining room in the Shenick unit. This was not on the floor plans, and was not reflected in the escape signage.

The registered provider did not, having regard to the needs of the residents at the centre, provide premises which conform to the matters set out in Schedule 6 of the regulations. For example:

- Some areas of the premises required maintenance attention internally:
    - There was wear and tear damage, to floors, walls and ceilings.For example, damaged ceiling tiles near store 2 and the snoozelan in the Shenick/Erris room was in poor condition. Wall covering in a Lambay unit bathroom was in poor condition, with joints not sealed where repairs had been carried out. The light fitting was held closed with cable ties.
    - Fire doors to some rooms were found to have chips and sections missing. The door to a bathroom in the Lambay unit was sticking in the floor.
    - Rusted handrails in bathrooms would impact on the residents who needed to use them in the Columba and Iona units.
- Inappropriate storage was found throughout the centre for example, overfilled store rooms with boxes piled on the floor in the small store room

near the Lambay entrance doors. This would cause difficulty in cleaning these areas, and presented a fire safety risk due to flammable and combustible materials being stored together. External storage was also found to be overfilled with old furniture, unused mattresses, extra PPE and hand gels.

Judgment: Substantially compliant

Regulation 27: Infection control

Infection prevention and control and antimicrobial stewardship governance arrangements did not ensure the sustainable delivery of safe and effective infection prevention and control for example:

- A resident with Carbapenemase-producing Enterobacteriaceae (CPE) was cared for in a room without an attached bathroom, requiring them to be moved to a distant shower room. This increased the risk of spreading infections to others. The bathroom was not reserved for this resident's use, immediate action was taken to address this during the inspection.
- The inspector was informed by a staff member that resident wash bowls used for personal hygiene were incorrectly decontaminated using a bedpan washer with added chlorine tablets. Since bedpan washers are specifically intended for human waste receptacles and require strict adherence to manufacturer's instructions, this practice reduces the effectiveness of the decontamination process. Additionally, two bedpan washers were found connected to a glass cleaner product, further risking environmental decontamination.
- While antibiotic usage was monitored, there was no documented evidence of multidisciplinary targeted antimicrobial stewardship quality improvement initiatives.
- A housekeeper had no knowledge or records of, regularly running water through infrequently used taps and showers this lack of flushing increases the risk of legionellosis for residents.
- The laundry room showed evidence of clean mops and cloths stored in the dirty area where dirty linen is stored, this increases the risk of contaminating clean equipment. This was a repeat finding from the last inspection.

The environment was not managed in a way that minimised the risk of transmitting a healthcare-associated infection. This was evidenced by:

- Shower areas in two of the units were visibly unclean.
- The pantry room used for preparation of food was found to be unclean, immediate action was taken on the day of inspection.
- The hairdressing room was visibly unclean and surfaces showed poor repair.
- The housekeeping trolley was visibly unclean.

Judgment: Not compliant

Regulation 28: Fire precautions

The registered provider did not take adequate precautions against the risk of fire, and did not provide suitable fire fighting equipment. For example:

- Excessive storage of flammable items alongside other combustible materials was found in storage areas in the centre. The policy at the centre is to keep flammable storage separate to other storage.
- There was no fire extinguisher available at the external smoking shed. The nearest extinguisher was inside the main building, which would result in delays to retrieve this extinguisher in the event of a residents clothes catching fire.

The registered provider did not provide adequate means of escape. For example:

- The disabled refuge area in the protected stairwells on the first floor were used to store fall protection mattresses. This would have a significant impact on means of escape in the event of a fire if alternative refuge areas are not available.
- A external escape route to the rear of the Erris unit was very uneven. A sign posted on the wall nearby identified that the path was uneven, but no measures were put in place to ensure a safe means of evacuating from this area of the Erris unit was available,

The registered provider did not ensure, by means of fire safety management and fire drills at suitable intervals, that persons working in the centre and in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of a fire. For example:

- Layout plans posted on walls in the centre did not reflect the layout on the ground. For example, the plans did not show a cross corridor door near the dining room in the Shenick Unit. The layout plans also did not indicate the position of the internal assembly point. This could cause confusion or delays during evacuation in the event of a fire.
- While there was gas detection in place in the laundry, staff were unaware of the procedure to be followed to shut off the gas in the laundry.
- Fire drills were being conducted at the centre but were not reflective of the need for vertical evacuation of residents on the first floor. Records did not show that staff were practicing vertical evacuation down the stairs using the various available evacuation aids as necessary. For example, the use of the evacuation stairs chair.
- Staff rostered for duty at night time were not on the record of fire drill practice. This meant that inspectors could not be assured that issues raised during fire drills, for example, the need to close all doors, were being practiced by staff at times of low staff numbers such as night time staff.

The registered provider did not make adequate arrangements for detecting and containing fires. For example:

- Bedroom doors throughout the centre did not have automatic door closer devices fitted to them. This would mean that a fire in a room with an open door, could spread to other areas of the centre, and smoke and fumes would not be contained for a period on the protected corridors. The failure to close doors in the event of a fire was a recurring issue at fire drills.
- Inspectors could not be assured that doors along the escape route in the Erris and Shenick units, including bedroom, store and sluice room doors, were fire rated doors. The ironmongery fitted to the doors (hinges, handles etc) did not have a fire rating suitable for fire doors. The door to the Shennick Sluice room did not have the required fire rating to provide a protected escape route. This would impact on the containment of fire, smoke and fumes, and would result in less time being made available to staff to evacuate the areas as containment of fires could not be assured.
- The doors to the laundry were being affected during the running of the dryers. When the dryers were operating, suction within the room was causing the doors to stay open. This would impact in containment of fire smoke and fumes in the event of a fire in the laundry.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Action was required to ensure that care plans were reviewed and updated at regular intervals, when there was a change in the resident's condition and following a review by healthcare professionals. For example:

- Residents dependency levels required review. For example, one resident was assessed as being independent, however, they required assistance with mobility and personal hygiene. This is a repeat finding from the previous inspection.
- Some residents did not have assessment of their needs and potential clinical risks thereafter their initial assessment including their dependency levels, proper alignment of limb and circulation checks following bone fracture, pain assessment and risk of falls assessed. For example, two residents who were identified as requiring pain assessment did not have them completed. A resident who was identified as high risk of constipation did not have a care plan to manage this risk.
- Improvements were also required to ensure that care was delivered in line with each resident's care plan. For example some residents' care plans recorded recommended repositioning of residents to prevent skin breakdown however no records were maintained to ensure this intervention was completed.

- Another resident had an intervention identified following a fall however this had not been completed. This was brought to the attention of clinical staff.This intervention may result in the avoidance of potential injury to a resident should they have further falls.
- Other residents' care plans detailed their personal hygiene routine was to shower daily, however, residents reported having to book a time to have a shower up to a week in advance.
- Staff in the centre were not aware of and did not have access to records which evidenced which residents were in receipt of additional care funding arrangements and the types of care to be provided in line with these arrangements.

Judgment: Not compliant

Regulation 7: Managing behaviour that is challenging

Some staff spoken to did not have up to date knowledge and skills, appropriate to their role, to respond to and manage responsive behaviour (how residents living with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment). A number of staff spoken to were not aware of the national policy on the use of restrictive practices.

Responsive behaviours were not appropriately managed within the centre and not in line with the centres own policy. For example, residents who were in tilted chairs were not assessed by an occupational therapist on the use of these chairs. Some of these residents were also observed to have no head or leg support. Residents' care plans noted that they should be repositioned and released from the restraints at 30 minute intervals. However, some resident's were observed to be in tilted chairs for the full days of inspection and staff explained that residents were repositioned three times a day. Inspectors observed and staff spoken with also confirmed that residents remained in the tilted chairs when eating and engaging in activities.

Judgment: Not compliant

Regulation 8: Protection

The registered provider failed to take reasonable measures to protect residents from abuse and to provide for appropriate and effective safeguards to prevent abuse in line with the National Policy for Safeguarding Vulnerable Person at Risk of Abuse 2014. Incidents were observed by inspectors over the two days on inspection and reported to the management team as safeguarding concerns, however, they had failed to recognise these as safeguarding concerns. For example, inappropriate

behaviour was observed between residents with a cognitive impairment which would impact their ability to consent. Furthermore, a safeguarding concern of neglect was reported to inspectors by a resident in relation to being left with their continence requirements not being met for two hours. Inspectors also observed a failure to provide due care and attention to a particular residents manual handling needs. Staff did not identify these incidents as a potential safeguarding concerns and ensure that resident's safety and welfare was promoted.

The provider supported a number of residents to manage their pensions in the centre. However, the management of pensions was not in line with best practice guidelines. For example, the person appointed to manage the resident's pension was no longer employed by the service.

Judgment: Not compliant

Regulation 9: Residents' rights

The inspectors found that resident's ability to exercise choice in their daily routines was limited due to unavailability of staff for example residents who attended day care services and who required to be ready for their bus service and or other transport with a relative had their morning routines conducted in a rushed manner.

Residents were not always provided with opportunities to participate in activities in accordance with their capacities and capabilities. This is a repeat finding from the previous inspection. For example:

- The organisation and availability of social care support was not well managed to ensure that residents were provided with activities in line with their assessed needs. There was insufficient oversight of resources in place to ensure that residents had access to a planned schedule of activities seven days a week particularly from 6pm to 9pm. Residents confirmed and Inspectors observed on the first evening of inspection this to be the case on the Shenick, Erris and Lambay units.
- One resident who was admitted to the centre was accommodated on a unit which they identified to inspectors as not meeting their individual needs. Inspectors found that this resident had been excluded from discussions about their contract.
- Personal possessions were not consistently managed to support residents, a small number of residents told inspectors that their clothes were missing.
- Residents in Columba and Iona were observed to be in tilted chairs which restricted their movements and were not released from this restraint in line

with their care plan, as discussed in detail in Regulation 7: Managing behaviour that is challenging.
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 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Substantially compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Tara Winthrop Private Clinic OSV-0000183

Inspection ID: MON-0041534

Date of inspection: 08/11/2023

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
In order to address the concerns raised by the Inspectors in the inspection report, the Registered Provider, immediately following the Inspection, has committed to the following actions:

1. The Registered Provider undertook a focused review of staffing levels within the Centre (the "Review");
2. The purpose of the Review is to ensure robust procedures to ensure:
(a) the engagement and retention of staffing levels within the Centre in compliance with the Centre's Statement of Purpose as approved or as may be approved by the Chief Inspector;
(b) there is an adequate and appropriate skill mix based on the dependency and needs of all residents in the Centre as approved or as may be approved by the Chief Inspector;
(c) there is an appropriate level of Housekeeping and Social Programme Activities cover within the Centre at all material times, to include evening times, having full regard to shift patterns with same to come into effect on 1 January 2024;
(d) the role and responsibilities of all staff within the Centre are clear and that clear lines of responsibility are in place and understood by all staff members.
3. The Review was completed on 31 December 2023. The Registered Provider:
(a) is assured that it employs sufficient levels of nursing staff within its Centre to deliver clinical care to a maximum of 140 residents, noting that on the day of the Inspection that there were 121 residents in the Centre and the Registered Provider has applied to the Chief Inspector for registration of the Centre as a 136 bedded Centre; and
(b) has commenced a focused recruitment compaign to recruit Healthcare Assistants and to fill vacancies, where they exist, within the Centre, to include the Clinical Nurse Manager position referred to in the report with interview dates for that position already in place; and
(c) has made arrangements for appropriate levels of Housekeeping and Social Programme Activities to be rolled out within the Centre with effect from 1 January 2024.

4. The Registered Provider assures the Chief Inspector that it has put procedures in place

to increase the level of audits to be completed within the Centre to ensure the effectiveness of cleaning within the Centre and the discharge of appropriate cleaning responsibilities by the most appropriate staff at the most appropriate times, noting that cleaning duties within the Centre, of course, remain the responsibility of all staff as is customary throughout healthcare.

5. Further, the Registered Provider assures that it will ensure that there is appropriate nurse management cover in place in the Centre seven days a week, to include weekends. The Registered Provider has put effective systems in place, following the Inspection, to ensure that both the DON and the ADON of the Centre will ensure effective rostering, review and management oversight, with further review and oversight by the Centre's General Manager to ensure the effectiveness of the rostering and its over-sight. Additionally, within this enhanced process, the allocation of staff within the Centre will continue to be reviewed on a daily basis, going forward.

6. Furthermore, by way of further enhanced procedures to assist with CNM oversight within the Centre nightly, consistent and regular reviews will be undertaken of the roles and responsibilities of the night CNM with this role communicated to all staff to ensure clear understanding of the role and function of the night CNM. The detail of who is in charge in the centre on a nightly basis will be displayed clearly on a notice board in the Centre to support clarity and understanding for staff, residents and families alike.

7. Finally, the Registered Provider has committed to the additional rostering of five RGNs at night which includes the complement of CNMs. The Registered Provider assures that this additional commitment of resources will reduce the instances of the CNM within this complement being required to cover breaks. In the event of unplanned sick leave, the Registered Provider assures that within the Centre there are now very clear protocols in place for the use of overtime or agency use to minimise the occurrence as much as possible. The Registered Provider again assures the Chief Inspector that it has put in place an ongoing process of international recruitment for HCA staff for deployment within the Centre.

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
The Registered Provider has commenced a full review of the induction and training processes within the Centre for all staff with particular attention given to key areas highlighted in the inspection report to include cleaning processes, use of restraint, care planning and assessment, with a view to its completion by 31 March 2024. The Registered Provider is committed to putting in place enhanced systems to ensure:

1. Training will be supported through both external providers and internal informal training provided by the management team and wider group team; and

2. An education program for current staff will be developed and delivered as blended learning and face-to-face at ward level.

In addition to the above, a new enhanced induction checklist will be developed for the Centre to be rolled out from 31 January 2024 for all staff.

To address the issue of supervision of nursing staff over the weekend period, the Registered Provider will ensure that there is nurse management cover in place in the Centre 7 days a week. Oversight of this allocation and roster will lie with the Director of Nursing and the ADON in the Centre, with further review and oversight by the General Manager of the Centre, to ensure that all staff are appropriately supervised.

In line with current processed, the allocation of staff in the Centre will continue to be reviewed on a daily basis, as set out in the Centre's Compliance Plan under Regulation 15(1) above.

To support effective governance and supervision within the Centre, the Director of Nursing, Assistant Director of Nursing and General Manager are on site in the Centre, Monday to Friday, and a supernumerary CNM is also on site in the Centre during weekends.

The Registered Provider assures the Chief Inspector that the following enhanced training arrangements will be made within the Centre:

- Assessment and monitoring of residents displaying sexualised behaviours training will be provided for all staff within the Centre by the Centre's Medical Officer. The Registered Provider confirms that this training commenced in December 2023, with ongoing participation for all staff within the Centre. This will be completed by 1 April 2024;

- Recognising and responding to safeguarding concerns. All staff within the Centre have completed online safeguarding training, and this is being supported by on site in person training that is being delivered in the Centre by an external provider to support understanding and engagement with staff. This training will be completed for all staff by 1 June 2024. Safeguarding Designated Officer training is also scheduled for the Director of Nursing and the ADON to ensure they can also support safeguarding processes effectively and safely in the Centre;

- Recognising and responding to complaints. In person training is in progress for all staff in the management of complaints in line with all regulatory requirements. This will be completed for all staff by 1 April 2024; and

- Training is in progress for all staff on resident's rights and a human rights based approach to care within the Centre. This will be completed by 30 March 2024.

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
Following the Inspection and with a view to assuaging the concerns of the Inspector, the Registered Provider has taken the following actions:

1. All records for resident pension agent forms have been completed and are now available within the Centre.

2. The Registered Provider provided detailed information in relation to funding allocation to the Chief Inspector on 24 November 2023

3. The Registered Provider has commenced a review of all induction records for all staff with a view to ensuring that complete records are in place for all current and future staff. The review will be completed by 31 December 2023 and the Registered Provider assures that all new staff members will have documented induction within the Centre.

4. The Registered Provider has completed its review of the documentation of restraint release. Education and training has been provided to all staff members to ensure their understanding of the importance of accurate documentation to reflect their practices within the Centre, with same continuing to provided by the Senior Management team on an ongoing basis to ensure adherence and understanding. Audits will be completed by the Senior Management team on restraint documentation and practice by 28 February 2024, but will continue on a regular ongoing basis, to ensure compliance.

5. The Registered Provider has commenced a full review of records storage in the Centre to ensure full compliance with Regulation 21.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
1. The current roles and responsibilities of the current management team are defined within the Centre, on the basis that the Centre is a designated centre for 140 residents.

2. Clarification of the current roles and responsibilities is confirmed with all members of the team to ensure understanding of authority and accountability. The management team has engaged in focused communication to all staff members to ensure their understanding of the current management and governance structures within the Centre. This will be completed by February 16th 2024.

3. The Registered Provider shall ensure that all pre-admission assessments for residents will be completed by under the direct authority of the Person in Charge of the Centre, in all cases by an appropriate healthcare professional, in line with Regulation 5 of the Care & Welfare Regulation. The pre-admission process will be clearly communicated to all members of the admissions team to ensure understanding with immediate effect. The Registered Provider shall ensure that audits will be conducted on all future resident admissions to ensure appropriate assessments are conducted by an appropriate healthcare professional acting under the direct authority and supervision of the Centre's Person-in-Charge, with such audits to be conducted on an on-going basis and the first of these to be completed by 31 March 2024.

4. Immediately following the Inspection, the Registered Provider ensured that all documentation relating to resident funding allocations was provided to the Chief Inspector no later than 24 November 2023. The Registered Provider assures that all records relation to same are maintained within the Centre and the Centre's management and finance teams have taken steps to ensure that systems are now in place within the Centre to ensure the prompt retrieval of all such record where requested during future inspections of the Centre by the Chief Inspector.

5. The Registered Provider assures to the Chief Inspector its ongoing review and improvement of management systems within the Centre to ensure the continued quality and safe care of all Residents.

6. The Registered Provider assures the Chief Inspector that additional governance resources/controls have been implemented within the Centre. A General Manager has been engaged and commenced in their role 2 days prior to the Inspection. The Senior Management Team is engaging in a process of reviewing elements of oversight such as provision of resources, allocation of resources, risk management processes, increased supervision and supports and improving clinical and operational oversight within the home. A full review of all roles and responsibilities for all staff will be completed by the Chief Operations Officer to ensure that all staff have a clear understanding of their accountability and responsibility. The timeframe for the completion of this review within the Centre is 31 January 2024.

7. A review will be undertaken of complaints within the Centre with a view to identifying gaps within the complaints management process. Additional training will be provided to all staff members to support their competency in management of complaints, with further training provided to the management team to ensure the administrative duties of complaints management are executed in line with the policy in the centre. This exercise will be completed by 1st April 2024.

8. The Registered Provider has, on a continuing basis since 8 December 2023, introduced enhanced oversight systems for infection, prevention and control practices within the Centre, with staff supported by peer led weekly IPC audits and education which is being conducted by a qualified IPC lead. Ongoing review of the findings of all audits will be conducted by the management team and all findings and learning shared with staff at monthly staff meetings to ensure adherence and understanding.

9. Since the Inspection, a process has been introduced to review assessment of dependency. The monthly audits introduced will continue with all findings shared with staff. This will also be supported by ongoing education for all staff to ensure their understanding of the dependency assessments and escalation pathways in place in the Centre if they need clarification when completing any assessments.

10. Training for all staff in relation to care planning and assessments will be provided to ensure their understanding of the process. This will be provided on both a formal and informal basis in the Centre. Increased audits will be conducted on a more frequent basis by the management team to monitor adherence. All feedback will be provided both individually to staff and at general staff meetings. Additional oversight will be provided by the Senior Management team who will conduct monthly audits on care plans and assessments. This exercise will be completed by 31 March 2024 and will continue on an ongoing basis in the Centre.

11. Frequent fire drills will be completed on each unit. Fire drills will be completed on night time staffing levels, in the largest compartment and will include vertical evacuation procedures. This will be overseen on a frequent basis by the Group Managers and Senior Managers to ensure completion of drills.

12. The Registered Provider refers the Chief Inspector to its Compliance Plan under Regulation 21 with a view to assuaging the regulatory concerns expressed in the inspection report by reference to record keeping and storage.

13. Within specific regard to ensuring compliance with Regulation 23, the process for oversight of allocation of funds for residents will be overseen by the Finance Team and Senior Management Team within the Centre. The details of all allocations will be based on a full review of the applicable contract for funding for each resident. All material details will be included in the care plan for each resident to support staff understanding of such allocations. Schedules will be developed for all residents' additional funded services such as physiotherapy to ensure that such services are delivered, and that there is robust oversight of same.

14. With a view to assuaging any concerns that the Chief Inspector may have with regard to the funding of additional services received by a number of residents in our Centre, the Registered Provider assures the Chief Inspector that the care of our Centre's residents and any additional services residents may receive are set out in their individual contracts of care and in their individual care plans. As an example, the contract for care may specify that a resident may receive physio twice weekly for example. This is also documented in the individual care plan. The Registered Provider assures the Chief Inspector that it has taken steps to ensure that all appropriate staff understand this process and how to ensure that care is delivered in line with the outlined care plan.

15. Further, with express focus on care planning we refer the Chief Inspector to our Compliance Plan under Regulation 5. As assured, under Regulation 5 all care plans have been updated and are reviewed on a regular basis and in line with the regulation. The Registered Provider assures that our Centre's Contracts for Care have been reviewed to

ensure that services and fee arrangements are accurately presented.

16. A full timebound review is being undertaken of the quality management processes within the Centre by the management team to review and update auditing processes and procedures. An electronic auditing tool (MEG) is being rolled out in the Centre which will support more robust auditing processes and oversight within the Centre, with greater analysis of findings and quality improvements. Audit training will be provided for all management staff in the Centre and the review and training will be completed by 31 March 2024.

Regulation 24: Contract for the provision of services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 24: Contract for the provision of services:
The Registered Provider assures the Chief Inspector that it is committed to ensuring full compliance within the Centre with its regulatory obligations under Regulation 24.
The Registered Provider has commenced a focused review of its procedures to ensure that written contracts for care concluded by it with its existing and future residents (or agents/lawful representatives) are compliant with all applicable legal/regulatory requirements. This review extends to:

(a) contract signing processes and contract management to ensure that all contracts are appropriately managed and maintained for all residents in line with policy in the Centre; and
(b) a review of the roles and responsibilities of the admissions team and the management team to ensure clear understanding of the accountability for the process.

The Registered Provider, following the completion of the review, will put in place enhanced systems to ensure full compliance with Regulation 24 which will then be reviewed an ongoing basis by the Centre's RPR to ensure adherence with effect from 31 January 2024.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The Registered Provider, following the Inspection, commenced a review of its compliance with Regulation 34. The Registered Provider assures the Chief Inspector that:

(a) the signage within the Centre is intended to be an overview of the complaints process only. We have reviewed it to ensure that it is accessible and brief, as it is not intended to comprehensive; and
(b) all residents in the Centre are provided with a full version of the Centre's complaint policy as part of their admission pack to supplement the signage approach in the Centre.

The Registered Provide further assures the Chief Inspector that:

(i) the Centre's Senior Management team will continue to review the Centre's complaints handling processes within the Centre to identify gaps and to address lacuna or issues within the complaints management process where they are identified; and
(ii) additional training will be provided to all staff members to support their competency in management of complaints, with further training provided to the management team to ensure the administrative duties of complaints management are executed in line with the policy in the Centre.

This exercise will be completed by 28th February 2024

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
The Registered Provider has commenced a review of all policies and procedures within the Centre with a view to identifying gaps and where same are identified, they will be updated to ensure that they are in line with relevant laws, guidance and standards.

The Registered Provider commits to providing the updated policies and procedures to staff members in more accessible formats to promote and support enhanced and better understanding and use within the Centre.

The Registered Provider assures the Chief Inspector of its commitment to provide ongoing training to all staff members in line with all updated policies and procedures within the Centre.

The Registered Provider expects to have its review and updating of policies and procedures completed by 31 January 2024, with same to continue on an ongoing basis, as appropriate.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
The Registered Provider has made arrangements for the focused Education & Training to be provided to the Person in Charge of our Centre and all appropriate senior management team by reference to Regulation 31 of the Care & Welfare Regulations.

The Education & Training will be completed no later than 31 January 2024.

The Education & Training will be delivered no later than 28th February 2024 by an appropriately qualified professional experienced in the provision of advice on statutory notification, investigation and reporting to the Chief Inspector by reference to Regulation 31.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
1. The Registered Provider has developed and continues to roll out an ongoing maintenance programme within the Centre.
2. The Centre's maintenance programme includes the ongoing review of required works by our Group's maintenance manager on a monthly basis.
3. The Registered Provider attended to the replacement of old/damaged ceiling tiles in the Centre before 8 December 2023.
4. The Registered Provider assures the Chief Inspector that the refurbishment of the Centre's Snoozelan Room comprises a necessary part of the Centre's maintenance programme and the refurbishment is scheduled for completion by 31 January 2024.
5. The Registered Provider assures the Chief Inspector that all wall coverings in the Centre's Lambay unit have been revisited and sealed with all work completed before 8 December 2023.
6. The Registered Provider assures that a new light fitting for the bathroom identified by the Inspectors during the Inspection is ordered with fitting expected no later than 31 December 2023.
7. The Registered Provider assures that monthly maintenance checks are completed on all doors within the Centre, and there is a replacement programme in place ensuring that priority doors for replacement or repair are completed in timely fashion.
8. The Registered Provider assures that all handrails that were identified by the Inspectors as matters of concern in the Columba and Iona units will be replaced as part of a project to be completed no later than 31 January 2024.
9. A full review of records storage is underway within the Centre, including the external, secure storage in the Centre, and we refer you to our Compliance Plan under Regulation 21.

The Registered Provider submitted revised plans as part of its re-registration application, following the last inspection.

The container on site that is used by a third party is not accessible to general staff in the Centre. A key is available at reception however the maintenance of the container is the responsibility of the third party.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:

1. The Registered Provider assures the Chief Inspector that it has put in place a programme to ensure that all staff are educated on the care of any resident with an MDRO such as CPE to ensure they clearly understand appropriate standards and enhanced precautions, appropriate for the management of any infection. This will be completed by the Senior Management team with audits conducted to ensure understanding and compliance with best practice. This will be completed by February 28 2024.

2. The Registered Provider has undertaken a project to ensure that any stained wash bowls are disposed of on an on-going basis. Any stained wash bowls were replaced immediately following the Inspection. Increased spot audits will be conducted by the management team to ensure this practice is maintained. All products connected to the bedpan washers were reviewed on the day of Inspection to ensure the correct products are connected. Ongoing supervision and surveillance of these practices will be conducted by the Senior Management team and the Hygiene Manager in the centre.

3. The Registered Provider assures the Chief Inspector that antimicrobial stewardship audits are conducted by the Medical Officer for the Centre on a quarterly basis and the centre will continue with this practice to ensure that the learning from all audits are shared with staff, and any quality improvements required in relation to antimicrobial stewardship is shared with staff. This will be completed by the Medical Officer and will be completed by 31 March 2024.

4. Actions to address environmental cleaning matters were addressed on the day of Inspection - this will continue to be supported by peer led weekly IPC audits and education, including cleaning, which is being conducted by a qualified IPC lead. This was introduced on 8 December 2023 and will continue in the Centre. Ongoing review of the findings of all audits will be conducted by the management team and all findings and learning shared with staff at weekly staff meetings to ensure adherence and understanding.

5. The Registered Provider assures that, with immediate effect, following the Inspection, the Registered Provider ceased the practice within the Centre of adding chlorine tablets

to bedpan washers.

6. The Registered Provider assures that additional training will be provided for staff in relation to antimicrobial stewardship, all nurses are completing an online training course in relation to same, and this will be supplemented by additional in person training delivered by the Senior Management Team. This will be completed by 31 March 2024.

7. There is ongoing supervision of practices through the use of IPC audits, the hygiene manager and General Manager review practice within the home on a regular basis to ensure adherence with policy and process. All staff were communicated with to ensure that they understood this practice was unacceptable and could not continue. Ongoing communication is in place with all staff in relation to this practice by the General Manager.

8. The clean and dirty work-flow processes within the laundry have been reviewed and there is a clear work-flow in place. The process around this is reviewed on a daily basis by the General Manager to ensure adherence to the new process.

9. There is a process in place in the Centre in relation to water flushing of infrequently used water outlets. This process is managed by the hygiene manager in the Centre and additional oversight and sign off of the process is in place with the General Manager. All staff have been clearly communicated with to ensure that they understand the process in place and the responsibility for it so they can clearly communicate this, where requested.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
1. Storage of flammable items has been reviewed within the Centre and combustible items have already been separated from all other items prior to the submission of this Compliance Plan.
2. Fire extinguisher- The Registered Provider has engaged with its external professional fire safety consultant for professional advice to ensure that all fire extinguishers are fire safety compliant and are situated in locations within the Centre in compliance with the IS 291 and all applicable rules as advised by the Centre's external professionally qualified fire safety consultant.
3. Issues with storage in the disabled refuge areas were rectified on the day of inspection.
4. The Registered Provider assures the Chief Inspector that the uneven surface at the rear of the Centre's Erris unit is on a schedule of maintenance works in the centre. The Registered Provider confirms that it arranged to carry out/complete a risk assessment completed on this area and the assessment identified that this area is not high risk requiring immediate action. Notwithstanding, the extensive nature of the work required to address the uneven surface, the Registered Provider will commence a project to address the matter with a view to having works completed by 31 March 2024.

5. The Registered Provider, since the Inspection, has arranged a review of all bedroom doors. They do not have automatic door closers attached to them. However, all compartments have fire doors and the Centre's door are compliant with the fire certification for the Centre. Notwithstanding, the Registered Provider obtained external expert opinion in relation to the fire rating of the doors in the Erris and Shennick units, which recognises the need for upgrades to the brass look iron mongery. The Registered Provider has, accordingly, committed to a replacement programme to be implemented across 2024.
6. Frequent fire drills will be completed on each unit. Fire drills will be completed on night time staffing levels, in the largest compartment and will include vertical evacuation procedures. This will be overseen on a frequent basis by the Senior Management Team to ensure completion of drills. This oversight will also address the issue of doors not being closed as a recurring issue.
7. Education to be provided to all staff working in the laundry to ensure that the doors to the laundry need to be closed at all times. Supervision and oversight of this process will be supported by the Hygiene Manager and the General manager.

Finally, the Registered Provider has arranged for a review of the Centre's layout plans which have been updated to accurately reflect the layout of the Centre, and safe has been completed in February 2024.

The Registered Provider assures that following the inspection, additional gas shut off valves were installed in the Centre after the inspection in three areas within the laundry room. All shut off valves are clearly visible with additional signage having been put in place. Staff have all been informed of how to use the shut off valves and, as an additional precaution, same has also been included in the Centre's staff induction booklet with on-going communication with all laundry staff by the General Manager and Hygiene manager to support understanding.

The Registered Provider assures that on-going education is being provided to all staff working in the laundry service to ensure that the laundry doors remain closed at all times. Supervision and oversight of this process will be supported by the Hygiene Manager and the General manager.

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
1. A full review of all resident's dependency levels will be completed within the Centre. This was completed by 31 December 2023.
2. Education and training will be provided to all staff members focussed on assessment and care planning to ensure understanding. Training will be supported by the Senior Management team on a formal and informal basis, with support from Group

management. Oversight of training will be reviewed on a weekly basis at Senior Management team meetings.
3. Increased audit and analysis of audits will be completed on care planning and assessment to ensure compliance and adherence to the policies in place in the centre. Any findings or required Quality Improvements will be communicated on an ongoing basis with all staff at formal staff meetings, and at daily handover to ensure consistent communication of the importance of accurate care planning and assessment.

The Registered Provider assures the Chief Inspector that it shall ensure the putting in place of improvements in care planning and assessment processes within the Centre, by putting in place specified measures to include a thorough review of the format of all care plans within the Centre to ensure that a more accurate and accessible format is in use for all residents.

Care plan training is being delivered to all staff nurses in the Centre on an ongoing basis, with training completed for all staff by 14 February 2024.

Increased audits are being completed on assessments and care plans within the Centre to ensure compliance with the applicable rules, this includes audits on relevant care reports as well as the care plans themselves to ensure care is being delivered in line with the residents' care plans. The audits are completed by the Clinical Nurse Managers in each unit with additional oversight from the ADON and the Director of Nursing within the Centre. This approach supports understanding and analysis of findings to ensure that all learnings from such audits are clearly communicated with the team to ensure care is being delivered in line with the residents' care plans.

The Registered Provider assures that all residents' care plans:

- Will record where interventions were completed to prevent skin breakdown; and
- Will record where interventions occurred following any fall by a resident, once brought to the attention of clinical staff;
- Are implemented within the Centre to avoid any situation where any resident is viewed as being required to book time for a shower a week in advance or anything of the like; and
- Detail with clarity the additional services supported by additional funding to which individual residents are entitled pursuant to their contractual arrangements.

For the avoidance of doubt, the Registered Provider assures that care to all residents will be delivered in the Centre in compliance with the residents' individual care plans.

Regulation 7: Managing behaviour that is challenging	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
1. Face to face training for all staff members in relation to dementia care is being delivered by the Centre's Senior Management Team.
2. All staff have been asked to complete Safeguarding training on HSELand by 5 January 2024. Additional face to face training is due to commence for all staff in January 2024.
3. Training for all staff in relation to Restrictive Practice will be delivered to ensure understanding of use of any restraint within the centre.
4. Occupational therapist referrals have been submitted for all residents that currently use comfort chairs. Occupational therapy is currently provided within the community. The Registered Provider has taken steps to facilitate individual residents/families with an opportunity to avail of a private service OT, at their discretion. Risk assessments will be completed on all residents using a comfort chair to ensure that appropriate risk mitigation is in place for these residents.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
1. All staff have been asked to complete Safeguarding training on HSELand by 5 January 2024. Additional face to face training is due to commence for all staff in January 2024.
2. The Group Financial Controller is now the designated pension agent for the Centre. All residents who require pension agent documentation now have this in place and this has been confirmed.
3. The Registered Provider will arrange for focused education and training to ensure the effective statutory notification, statutory investigation, and investigation reporting to the Chief Inspector of all allegations/incidents of abuse.

All staff within the Centre have completed online safeguarding training, and this is being supported by on site, in person training that is being delivered in the Centre by an external provider to support understanding and engagement with staff. This will be completed for all staff by 1 June 2024. Safeguarding Designated Officer training is also scheduled for the Director of Nursing and the ADON in the first week of February 2024 to ensure they can also support safeguarding processes effectively and safely in the Centre.

The Registered Provider has reviewed the Centre's safeguarding policy and the enhaced policy will be communicated and shared with all staff to support understanding alongside on-going training in the Centre to promote the prevention, detection and management of any safeguarding concern. This is underway and will be completed by 31 January 2024.

Incident and complaint training is being delivered to all staff to support their understanding of the escalation of any issues within the Centre. The Director of Nursing reviews the incidents and complaints within the Centre on a daily basis, to ensure that any incident or issue that may be a potential safeguarding concern is identified promptly and managed appropriately, as well as ensuring that the appropriate submission of any

required notification to the HSE's Safeguarding team and the Chief Inspector are done within the appropriate timeframes. The Director of Nursing reviews incidents and ensures that learning from all incidents are shared with all staff on an ongoing basis. This is in place with ongoing review.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
1. The Registered Provider refers the Chief Inspector to the Compliance Plan for Regulation 15 (staffing) to ensure that there is an appropriate skill mix based on the dependency and needs of all residents in the Centre at material times, to include in relation to Activities under the Centre's Social Programme.
2. Pre-admission assessments shall be completed by the Person in Charge in accordance with the Compliance Plan submitted under Regulation 5 above.
3. A review will be undertaken of the processes supporting the management of personal possessions in the home. Communication will be issued to families and residents to support these processes. Training will be provided to all staff in the management and maintenance of personal belongings within the home, with audits conducted by the Centre's General Manager to assess adherence to the process. Any quality improvements will be identified and shared with the team to support the process.
4. Training for all staff in relation to Restrictive Practice will be delivered to ensure understanding of use of any restraint within the Centre in line with the Compliance Plan under Regulation 7 above.
5. Occupational therapist referrals have been submitted for all residents that currently use comfort chairs. Occupational therapy is currently provided within the community but there are significant delays in accessing these appointments. To address same, the Registered Provider has taken steps to facilitate individual residents/families with an opportunity to avail of a private service OT, at their discretion. Risk assessments will be completed on all residents using a comfort chair to ensure that appropriate risk mitigation is in place for these residents

The Registered Provider assures that all residents will be included in discussions about their contracts for care within the Centre. The Registered Provider has put in place a process whereby the Clinical Nurse Managers of each unit, overseen by the ADON and Director of Nursing, will ensure the residents participation in discussions about their contracts for care within the Centre. Engagement will be clearly documented and an on-going review will be undertaken by the Registered Provider to ensure compliance. This will be completed by 31 March 2024 ,with on-going review.

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.	Not Compliant	Orange	04/03/2024
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	01/06/2024
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	31/01/2024
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre	Substantially Compliant	Yellow	31/01/2024

	are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.			
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	31/01/2024
Regulation 21(1)	The registered provider shall 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.	Not Compliant	Orange	28/02/2024
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Not Compliant	Orange	28/02/2024
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with	Not Compliant	Orange	31/03/2024

	the statement of purpose.			
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Not Compliant	Orange	31/03/2024
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	31/03/2024
Regulation 24(1)	The registered provider shall agree in writing with each resident, on the admission of that resident to the designated centre concerned, the terms, including terms relating to the bedroom to be provided to the resident and the number of other occupants (if any) of that bedroom, on which that resident shall reside in that centre.	Substantially Compliant	Yellow	31/01/2024

Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Not Compliant	Orange	31/03/2024
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Substantially Compliant	Yellow	31/03/2024
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	31/03/2024
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are	Not Compliant	Orange	31/03/2024

	aware of the procedure to be followed in the case of fire.			
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	31/03/2024
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.	Not Compliant	Orange	28/02/2024
Regulation 34(1)(b)	The registered provider shall provide an accessible and effective procedure for dealing with complaints, which includes a review process, and shall display a copy of the complaints procedure in a prominent position in the designated centre, and where the provider has a website, on that website.	Substantially Compliant	Yellow	28/02/2024
Regulation 34(2)(c)	The registered provider shall ensure that the complaints procedure provides for the provision of a written response informing the	Substantially Compliant	Yellow	28/02/2024

	complainant whether or not their complaint has been upheld, the reasons for that decision, any improvements recommended and details of the review process.			
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.	Substantially Compliant	Yellow	31/01/2024
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Not Compliant	Orange	31/12/2023
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.	Not Compliant	Orange	31/12/2023
Regulation 5(4)	The person in charge shall	Not Compliant	Orange	31/12/2023

	formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.			
Regulation 7(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.	Not Compliant	Orange	29/02/2024
Regulation 7(2)	Where a resident behaves in a manner that is challenging or poses a risk to the resident concerned or to other persons, the person in charge shall manage and respond to that behaviour, in so far as possible, in a manner that is not restrictive.	Not Compliant	Orange	29/02/2024
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on	Not Compliant	Orange	29/02/2024

	the website of the Department of Health from time to time.			
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Orange	01/06/2024
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Not Compliant	Orange	31/03/2024
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Not Compliant	Orange	31/03/2024
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	Orange	31/03/2024