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:	16 July 2024
Centre ID:	OSV-0000183
Fieldwork ID:	MON-0043971

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 136 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:	99

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 16 July 2024	06:55hrs to 15:00hrs	Lisa Walsh	Lead
Wednesday 17 July 2024	09:00hrs to 15:45hrs	Lisa Walsh	Lead
Tuesday 16 July 2024	06:55hrs to 15:00hrs	Brid McGoldrick	Support
Tuesday 16 July 2024	06:55hrs to 15:00hrs	Sheila McKevitt	Support
Wednesday 17 July 2024	09:00hrs to 15:45hrs	Sheila McKevitt	Support

What residents told us and what inspectors observed

This unannounced risk inspection was carried out over two days. The overall feedback from residents and visitors was more positive than on previous inspections. Both parties expressed an increased level of satisfaction with the quality of care, staffing levels and activities available in the centre. They said that the standard of care across the board had improved in the last three months. On both days of inspection, inspectors spent time talking with residents, visitors and staff to gain an insight into what it was like living in the centre. Inspectors also spent time observing the environment and interactions between residents and staff.

On the first day of inspection, inspectors met with a nurse on duty who was in charge of the centre that night. Inspectors then went to different units to observe the morning routine and attend that handover. Following this, inspectors had an opening meeting with a CNM and two assistant directors of nursing (ADON) in the absence of the person in charge (PIC). Both of the ADON's were new to the role, one started on the first day of inspection and the other started just over two weeks previous. Inspectors were informed that the CNM was the senior nurse on duty in the absence of the person in charge (who was on scheduled leave) and that she was being supported by the chief executive officer (CEO) and group lead for quality, compliance and patient safety. The CEO joined part of the opening meeting and later on the first day of inspection the PIC attended the centre.

The centre is divided into five units which are set out across two floors. They are referred to as the Lambay unit, Shenick unit, Erris unit, Columba unit and Iona Unit. The Lambay unit, Shenick 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, on the first floor, 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.

Inspectors observed a communication board at reception in the main entrance with information on changes in management personnel and information in respect of HIQA guidance on a human rights based approach to care. Each unit also had an information board for residents which displayed posters for independent advocacy services, the activity schedule, staff one duty that day with their pictures and the complaints process.

Staff were observed providing care to residents in a person-centred, calm, unrushed manner on both inspection days. Staff were aware of residents' needs, and the inspectors observed warm, kind, dignified and respectful interactions with residents and their visitors throughout the two days of inspection by staff and management. However, on the first morning of inspection a high number of residents on the first floor did not have access to their call bell. Inspectors observed many of these residents were in bed asleep, while their call bell was out of reach, most were hanging on the wall behind their bed.

Inspectors spoke with many residents and met with fifteen of the residents' close family members and friends visiting their loved one during the inspection. Residents spoken with said there was "huge improvements" in relation to staffing and that the ceasing of admissions allowed staff to carry out their duties in an unhurried manner. They said they felt there were more staff who were beginning to settle with less of a turnover of staff. They also said they observed that very little agency staff had been used in the centre in recent weeks which meant that staff knew their needs. Staff spoken with also said that they had more time to provide personal care and take time with residents. Other residents spoken with said there had been improvements in the quality of care provided to them. Residents said the impact of improved staffing arrangements meant that staff had more time for them now and that their care was no longer being rushed. Residents were observed to be up and ready to go out to their day services in plenty of time. Residents also reported that recently they had no issues being ready in the mornings when they had to go out early. One resident was delighted to tell inspectors that they were able to shower daily before leaving for their day service. However, one resident said they felt staff did not listen to them when providing care. Staff were aware of this residents needs and had scheduled to complete a care plan review with them. Residents also reported improvements in activities provided. Some residents said they were now offered more one-to-one activities and activities that were aligned to their interests like horse racing and events based on current affairs like the recent football Euros.

Visitors spoken with expressed a high level of satisfaction with the quality of the care provided to their relatives and friends and stated that their interactions with the new person in-charge was positive. They knew them by name. Those spoken with had great praise for the staff. They said that staff were more attentive and that they appeared to have more time to provide person-centred care. One relative explained how staff appeared to have more time to attend to the resident's hygiene needs, such as, the manner in which they were shaved. Another relative stated that their loved ones hair was now always styled the way they liked it styled. Relatives also said that they were kept up-to-date with the residents condition. Most knew the in-house medical officer and were happy with the service provided. Other relatives spoken with said they felt very welcome in the centre and that the unit their relative was in was like a family.

Overall, inspectors observed a better variety of group and one-to-one activities occurring over the course of the two days. On the first day of inspection three residents were in the Lambay activity room playing games while two other residents watched television. Other residents in the unit had gone out for the day to attend other services. In Columba/Iona residents took part in a therapy session with head/hand massage and personal nail care with sensory lights and soft music playing. In the afternoon in Columba/Iona residents watched a movie, while other residents were doing a reminiscence session in another room. However, on day one of the inspection, in the Shenick unit there was limited activities available for residents. The activity planner had a sing song scheduled, however, this was not happening. Instead, two residents were colouring a picture. Staff spoken with on the unit said there was no activity staff on that day in Shenick and confirmed no scheduled activities had taken place that day.

On the second day of inspection, activities were available across all units. Residents in Columba/Iona and residents in the Erris unit were having a sensory experience with music, aromotherapy, soft lighting and hand massage or nail care in the morning. Other residents in Erris were at the hairdressers, playing cards or at pet therapy. In the afternoon, Erris residents enjoyed an ice-cream in the garden. A group of residents were playing card games in the morning and eating ice-cream in Lambay. In the afternoon a group of residents were participating in bingo in Lambay. They appeared to be having good fun, with one resident saying it was worth it for the prize they got if they won. In Shenick residents were playing ball games in the morning and were out in the garden having tea and ice-cream while playing tennis in afternoon.

All relatives spoken with stated that the standard of activities provided had improved greatly. They said that their was a greater variety and that staff were ensuring maximum dependant residents who could not leave their room without assistance were taken out of their room to attend activities of their choosing. One relative explained how they came in every day and there has been a number of days recently where the resident was not in their room or the nearby living room, they were attending an activity in another area of the home. Residents were observed enjoying the massage therapy sessions on both inspection days. Relatives gave very positive feedback about these sessions, as they said the environment was well prepared to ensure it facilitated a relaxed feeling.

Three of the relatives spoken with said that the resident they were visiting had been moved from the Shenick unit to the unit they were now in. Relatives said that the new environment was better and one stated it was much calmer. All three relatives stated the standard of care received had improved greatly since they had been moved, with one saying 'now they are never alone', staff are so much more attentive and 'the standard of personal care has improved'.

Residents and relatives expressed satisfaction with the laundry service. One relative said that they noted that the residents 'bed linen was changed daily' and they were impressed with this level of service.

Inspectors observed that there were no restrictions on visitors. They signed the visitors book on entry into the centre.

In the Lambay unit renovation work had commenced in an area where hoists were stored. Previously this was an open space facing out onto a fire exit corridor, this had been sealed up and a wall was now in place. A new opening had been created out into the day space with double doors that could be held open with a magnet release. This was due to be completed over a three week period.

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

The findings of this inspection were that the registered provider had made improvements in some areas, for example, staffing, activities and efforts to eliminate institutional practices. However, the provider needed more robust management systems in place to ensure that they were fully effective; that the service provided was safe and the care and welfare needs of the residents were met. Although the provider had made efforts to improve the governance and management arrangements and care practices in place, some similar poor practices were observed which had been identified on previous inspections on 19 June 2023, 7 and 8 November 2023 and 7 and 15 March 2024. These are outlined under regulations; training and staff development, governance and management, records, individual assessment and care planning, managing behaviour that is challenging, residents rights, infection control and fire precautions. Feedback received by inspectors from residents and relatives was very positive. Residents and relatives said that they were no longer dissatisfied and had observed huge improvements with the staffing levels in the centre, the quality of care being delivered and activities they had access to.

This unannounced inspection was conducted over two days in Tara Winthrop Private Clinic, the first day of inspection was 16 July 2024 from 6:55am to 3pm, the second day of inspection was 17 July 2024 from 9am to 3.45pm. This was a risk-based inspection to assess compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and follow up on the actions taken by the provider to address significant issues of non-compliance identified during the previous three inspections in November 2023, June 2023 and March 2024. The registered provider had been issued a notice of decision to stop admissions from 10 June 2024.

The Chief Inspector had attached a condition that no new residents may be admitted to the designated centre until the registered provider had:

1. Implemented a revised governance and management structure which will ensure that the registered provider can demonstrate that it has effective oversight of the care of residents.

2. Implemented a revised staffing model to ensure residents needs are met.

3. Ensured that the management team had the knowledge, competence and skills required to supervise the delivery of care to residents as evidenced by improved regulatory compliance.

The findings of this inspection were that the provider had ceased admissions with the last admission 29th May 2024.

The registered provider is Tara Winthrop Private Clinic Limited. Since the last inspection on 6 and 15 March 2024, there have been several changes in the governance and management of the centre, including another change to the person

in charge. They were in their role since March 2024 and reported to the chief executive officer. There had also been a recent change made to the management structure, whereby the general manager role has been replaced with an assistant director of nursing (ADON), who had began their role just over two weeks previous to the inspection. The person in charge was supported by two additional ADON's who were also new to the role and seven clinical nurse managers (CNM). One ADON started their role on the first day of the inspection and the other ADON started a few weeks previous to the inspection. Night cover was provided by a CNM or senior nurse, however, on the first morning of the inspection, inspectors found that the most senior nurse, while on duty, was not in charge. In addition, staff nurses, healthcare assistants, housekeeping, activities co-ordinations, catering, administration, laundry and maintenance staff supported the person in charge.

There was documentary evidence of communication between the person in charge and the chief executive officer (CEO), who was also a director of the registered provider company. Records of monthly senior management meetings were reviewed since the last inspection in March 2024. These had been attended by the person in charge, other heads of department in the centre and the group lead for quality, compliance and patient safety. The CEO had also attended for three of the four meetings. Areas such as, individual resident updates, occupancy and admissions, staffing and training, audits, health and safety, infection prevention control, catering, risk management, incidents and complaints and activities were discussed. It was evident from these records that the provider had clearly communicated that admissions to the centre were to stop from 8 June 2024 until further notice.

The provider had committed to establishing an infection prevention and control (IPC) committee to support learning and sharing of any quality improvements in the centre. Only one record of IPC meeting minutes were provided to inspectors to review, therefore, it was unclear what level of oversight this committee had regarding these key quality and safety areas such as, multi-drug resistant organism MDROs. A falls committee had also been established by the provider since the last inspection with one meeting having occurred on 22 March 2024 and another meeting scheduled in July 2024. The record of this meeting was limited, with the details of the discussion section blank and actions not time-bound. Within the centre, at unit level, communication occurred at weekly staff meetings which were attended by the person in charge, assistant directors of nursing, clinical nurse managers, physiotherapist, maintenance, catering, housekeeping and activity staff. Aspects of quality service delivery, including clinical and non clinical areas were discussed such as, staffing, training, kitchen/housekeeping/maintenance updates, activities, wounds and falls. A weekly quality care indicator report had also been introduced since the last inspection which reported on all clinical aspects of care for residents on each unit. Records of these quality care indicators were limited, it was not clear what unit some of the records related to and the information gathered did not allow for trending or analysis of the data to identify areas of quality and safety of care delivered to residents that required improvement.

A new computerised auditing system had been established to audit and monitor practices in the centre, however, it was not fully implemented in practice. Some audits were completed using a paper based audit system and some were completed

using the computerised based system. The new system had a schedule of audits, which indicated that most areas of practice were being audited on a monthly basis. However in practice this was not happening.

For some audits completed, the audit tool used required review to ensure the questions asked were aligned with their own policies and procedures. For example, the audits completed to date in relation to the use of monitoring and use of restraint, had not identified that those with bed rails did not always have two hourly checks completed when in use as the audit tool did not ask that question. Some audits completed were detailed, and had action plans that had been implemented in practice. However, others had action plans that had not been implemented in practice. The person in charge was aware of the issues and had plans to review current practices.

On the days of inspection, there were adequate numbers of staff on duty with appropriate skill-mix to meet the needs of the 99 residents, taking into account the size and layout of the designated centre. However, some gaps were identified on review of the rosters for the previous two weeks. While the provider had worked hard to recruit and fill the vacancies, some operational positions were yet to be filled. For example, the regional manager post and the practice development facilitator. Inspectors were informed that the regional manager post was filled and due to start, the practice development facilitator post was still being recruited for. The person in charge had been in post for four months and the ADON posts had recently been filled, with that in mind, there was a need for enhanced focus on the support and development of a new management team.

All staff had up-to-date mandatory training completed in protection of vulnerable residents. Three staff did not have up-to-date manual handling training in place, however, they were scheduled to attend the next training session in July. Eight staff did not have up-to-date fire safety training in place, however, they were scheduled to attend the next training session scheduled for July. While staff had their mandatory training completed, inspectors observations of staff practice found that additional training and supervision were required. For example, training records reviewed showed that 100% of staff had completed training in relation to infection prevention and control and fifteen nurses had completed training in relation to anti-microbial stewardship. However, inspectors identified through a review of care plans, observing staff practice and talking with staff, that further supervision and training was required to ensure staff are knowledgeable and competent in the management of residents colonised with multi-drug resistant organism (MDROs).

While residents contracts were updated to detail what additional service they were funded for, the records for seven residents reviewed did not give assurances that they were receiving all the services they were funded for.

Regulation 15: Staffing

There was enough staff on the two days of inspection to meet the needs of the 99 residents. There was at least one registered nurse on duty at all times.

Judgment: Compliant

Regulation 16: Training and staff development

Notwithstanding the fact that mandatory training was provided and up-to-date for all staff or scheduled to occur in the coming weeks, this inspection found that further training and supervision was required in infection control, fire safety, assessment and care planning, use of restrictive practice, and auditing. This was evidenced by:

- Approximately a third of staff had received training in restrictive practice. However, from speaking with staff and reviewing care plans inspectors found that staff did not have a comprehensive understanding of restrictive practices and restraint was not always used in accordance with national policy.
- There were a number of residents identified with multi-drug resistant organism (MDRO) colonisation. However, some staff were unaware of residents that had an MDRO. In addition, some staff practice observed during the inspection increased the risk of environmental contamination and the spread of MDRO colonisation. For example, staff reported and inspectors observed that they manually decanted the contents of urinals into toilets prior to being placed in the bedpan washer for decontamination.
- While fire safety training was provided, inspectors found that staff on the Lambay unit did not follow the centres procedures when a drill took place on the first day of the inspection.
- Gaps remained in assessment and care planning that had the potential to negatively impact the care provided. This is evidenced further under Regulation 5: Assessment and care plans.
- Improvements were required on the Shenick unit to ensure that care and supports for those who are cognitively impaired are provided by staff with appropriate experience, skills and training.
- Staff completing audits had not had training in this area. Some audits completed were detailed had action plans that had been implemented in practice, however, others had action plans that had not been implemented in practice.

Judgment: Not compliant

Regulation 19: Directory of residents

The directory of residents was available in electronic form, however, it did not include all of the information specified in paragraph (3) of Schedule 3.

Judgment: Substantially compliant

Regulation 21: Records

Following on from the previous inspection on 6 and 15 March 2024, the registered provider had failed to ensure that some of the records set out in Schedule 3 were kept in the designated centre and available for review on inspection. This is a repeat finding.

Seven residents who were in receipt of additional funding contributions had updated contracts in place which detailed specialist additional health care services or nutrition to be provided to each resident. However, some of the care plans for these residents had not been updated to outline the allocation of the funding for each resident as was detailed in the providers compliance plan.

In addition, for those residents improvements were required in the recording of the details of their plan in respect of nursing care, specialist health care services or nutrition. For example, several residents who were receiving additional funding for specialist health care five days a week for two hours had this recorded in both their contract and care plan. However, there were gaps in records reviewed and inspectors were not assured that residents were receiving these services. In addition, there was no plan in place for client liaison visits which were identified as a specialist additional health care service in the residents contracts. Four residents who were to be provided additional menu options above the standard daily meal options within the centre had care plans in place. However, the residents were not afforded menu options for breakfast or dinner other than those in place for all residents. A review of records did not show any alternative dinner orders recorded for the previous two weeks for these residents.

There were medical reviews carried out, however, for those residents who were identified as needing additional medical assessment and treatment, records were not available to demonstrate that these were provided.

Judgment: Not compliant

Regulation 23: Governance and management

The management systems in place did not ensure that the service provided to residents was safe, appropriate, consistent and effectively monitored. For example:

- The system to monitor the clinical and environmental areas of the service were not effective. A schedule of audits indicated that most areas of practice were being audited on a monthly basis. However in practice this was not happening. Audits and monitoring systems in place did not identify and address inspection findings in respect of care planning and assessment, restrictive practice, fire safety and infection control. The clinical team confirmed that they had not received training in auditing and would benefit from accessing same. In addition, some audits had action plans that had not been implemented in practice.
- The oversight, training and 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, which is a repeat finding from the previous inspection. This is further detailed under Regulation 16: Training and staff development.
- The system of assessment of infection control risk did not recognise the risks of transmission of infection on one unit due to the large number of residents on one unit who were colonised with multidrug resistant organisms (MDRO'S). The registered provider did not ensure that staff had access to appropriate infection control expertise.
- Repeated non-compliance were found with:
    - Regulation 5: Assessment and care plan
    - Regulation 7: Managing behaviour that is challenging
    - Regulation 16: Training and staff development
    - Regulation 21: Records
    - Regulation 23: Governance and management

Judgment: Not compliant

Regulation 4: Written policies and procedures

Policies and procedures in accordance with Schedule 5 of the regulations were in place and were reviewed regularly. However, the infection Control, restraint, assessment and care planning and fire safety policies were not implemented in practice.

Judgment: Substantially compliant

Quality and safety

Inspectors observed that efforts were being made to improve the systems in place for overseeing the quality and safety aspects of residents' care to ensure that all residents living in the centre were protected by safe practices, which would promote a good quality of life. However, inspectors identified that the provider had failed to

fully oversee aspects of care. Further sustained action was required by the provider to ensure that residents received care to meet their assessed needs, particularly in relation to assessment and care planning and managing behaviour that is challenging. Improvements were also required in relation to residents rights, healthcare, infection control, fire safety, medication management and premises.

Comprehensive assessments, risk assessments and care plans had improved since the last inspection. However, gaps remained that had the potential to negatively impact the care provided. For example, a review of care plans on the Lambay unit found that accurate infection prevention and control information was not recorded in a small number of resident care plans to effectively guide and direct the care residents that were colonised with a multidrug resistant organisms MDRO. This increased the risk of environmental contamination and the spread of MDRO colonisation. This is evidenced further under Regulation 5: Assessment and care plans.

As in previous inspections, residents did not have access to the expertise of a health and social care professional for seating assessment. Inspectors were informed that private assessments (which would have to be paid by the resident), however, these were declined. Referrals have been made for residents to community services.

Residents had independent access to the enclosed gardens. The doors leading into all gardens were open and/or unlocked. However, the front door continued to be locked from 12.30pm to 1.30pm daily. The registered provider gave a verbal commitment to review this practice. Approximately a third of staff had received training in restrictive practice and some improvements were observed. However, from speaking with staff and reviewing care plans inspectors found that staff did not have a comprehensive understanding of restrictive practices and that restraint was not always used in accordance with national policy. Additional action was required in the Shenick unit to support residents with responsive behaviours (how residents living with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment) and ensure that the staff working in this unit had the knowledge and experience to support their assessed needs.

In general, residents rights were being upheld in a more personalised manner since the last inspection. There was now a movement towards a rights based approach to care. This was echoed by residents, relatives and observed by inspectors. Institutional practices that had been identified on previous inspections were not in use. Residents reported being able to shower when they wanted too. Bedroom doors in Shenick unit were no longer being locked by staff. The bedroom doors that were locked had been locked by residents.

Residents religious needs were met, Mass was celebrated in the home each week and those who had requested the sacrament of the sick received it. Residents also had access to daily newspapers. Their voice was heard at resident meetings and they had access to the complaints policy. Residents also has access to independent

advocacy service, with contact details for two advocacy services posted throughout the centre.

Overall, there was also an improvement in the activities provided across the centre. Residents and relatives also reported that the activities available were aligned with residents interests and abilities and that some one-to-one activities were also being provided which they thoroughly enjoyed. Residents had access to a timetable of meaningful activities, however, some improvements were still required to ensure residents rights were fully upheld. This is detailed under Regulation 9: Residents rights.

In general, the premises of the designated centre were appropriate for the number and needs of residents. However, on the day of inspection on the Shenick unit, there was a high volume of residents with cognitive impairment and responsive behaviours (how residents living with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment), which impacted those residents living with dementia on the unit. The provider gave a verbal commitment to review the skill-mix and resident-mix of this unit.

From a fire safety perspective, inspectors found that the registered provider was progressing their plan to come into compliance with Regulation 28: Fire precautions. This plan, when complete, will address the red and orange rated risks identified in the centres own fire risk assessment completed in June 2021. The works completed included, upgrade of ironmongomery of fire doors, creation of a safe external route to the rear of the Erris unit, provision of additional fire detection in electric room in chefs office, hoist charging area renovated, and in outdoor shed area. In addition, the timber ceiling had been treated, the fire exit in communal space 1 and 2 has had an emergency directional signage installed and all electrical fuse boards were maintained within a fire rated box. While progress was being made on the providers compliance plan, improvements were required in the oversight and implementation of fire procedures. Inspectors observed a fire drill where staff on the Lambay unit did not adhere to their own procedures when the fire alarm sounded.

Inspectors observed there were sufficient numbers of housekeeping staff to ensure the centre was clean. The provider had a number of assurance processes in place in relation to the standard of environmental hygiene. These included cleaning specifications and checklists, and color coded cloths to reduce the chance of cross infection. Cleaning records viewed confirmed that all areas were cleaned each day. Inspectors found that the provider needed to make further improvements to comply with regulation and standards. Weaknesses were identified in infection prevention and control governance, antimicrobial stewardship and the implementation of infection prevention and control standard precautions.

Unsafe medication storage practices were not recognised or responded to. For example, medicines were not stored in a safe and secure manner on one unit. This was addressed immediately once identified by inspectors.

Regulation 10: Communication difficulties

A sample of care plans were reviewed and found that where a resident had specialist communication difficulties, specific requirements were recorded in their care plan. Inspectors saw that picture aids and communication boards were in use as required.

Judgment: Compliant

Regulation 11: Visits

There were no visiting restrictions in place. Staff and residents confirmed that visits were encouraged and facilitated in the centre. The front doors of the centre were locked during lunchtime. If visitors wanted to access the centre during this time they had to phone a number posted on the front door to gain entry. The registered provider gave a verbal commitment to ensure the front doors remained open at lunchtime.

Judgment: Compliant

Regulation 17: Premises

The Shenick unit is not designed to deliver and meet the specific needs of residents with cognitive impairment. The environment does not aid orientation or promote the independence of those who are cognitively impaired. Three relatives spoken with said that the resident they were visiting had been moved from the Shenick unit to the unit they were now in. They said that the new environment was better and one stated it was much calmer. All three relatives recognised the impact that the environment had on the care received stating that the standard of care received had improved greatly since they had been moved.

Judgment: Substantially compliant

Regulation 27: Infection control

The provider generally met the requirements of Regulation 27: Infection control and the National Standards for infection prevention and control in community services (2018). However, further action was required to be fully compliant. For example:

- Staff reported and inspectors observed that they manually decanted the contents of urinals into toilets prior to being placed in the bedpan washer for decontamination. This increased the risk of environmental contamination and the spread of multidrug resistant organisms (MDRO) colonisation.
- Products for use such as dressings, alcohol wipes in the first aid box on Shenick were not in date.
- Some hand wash sinks in the treatment rooms and dirty utility rooms did not comply with HBN-10 specifications, however, inspectors acknowledge that this was due to be addressed by 30 September 2024.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Notwithstanding the fire safety works completed, some fire actions were not fully completed to comply with the regulations. The proposed actions were within the timeframes as set out in the previous compliance Plan. These included:

- Completion of works external to the Lambay unit. These works had commenced and are due to be completed by the date provided in previous compliance plan that is 31 August 2024.
- The upgrade of the hoist store to provide compartmentation was in progress.
- Smoke ventilation certification, this certification was not yet available.
- The smoke kiosk for residents was ordered and to be installed in the coming weeks.
- While there was an upgrade to some fire doors completed, the replacement of a small number of doors had yet to be carried out. Certification was required following completion of works to all fire doors.
- Confirmation that the front fire exit sliding door was connected to the fire alarm.
- The providers competent fire person was due to complete a fire risk assessment on 26 July 2024.
- The provider was to provide confirmation and sign-off by their fire competent person when all the outstanding works were completed.

While fire safety training was provided, inspectors found that staff on the Lambay unit did not follow the centres procedures when a drill took place on the first day of the inspection. Staff were observed to permit visitors to enter the unit and a staff member continued to attend to distributing a food tray. Furthermore, there was no system of recording any learning from routine drills, this was a lost opportunity to educate staff on procedures.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

Improvement were required in the medication management systems in the centre to ensure that they are safe and effectively monitored. For example, medicines were not stored in a safe and secure manner on one unit. This was addressed immediately once identified by inspectors.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Improvements in both resident assessments and care plans were required to ensure the assessed needs of each resident were comprehensively met. For example:

- Care plans reviewed were not always detailed enough to guide practice, for example, six resident were identified as requiring 'close monitoring' on the Shenick unit.
- A review of care plans also found that information recorded in several resident care plans on the Lambay unit did not effectively guide and direct the care for residents colonised with MDROs.
- A resident who had a witnessed fall did not have neurological observations recorded in line with the registered provider's falls policy.
- A resident on the first floor was receiving subcutaneous fluids however, this was not reflected in her care plan.
- A number of residents had COVID-19 care plans in place, although they did not have COVID-19.
- Several residents in Iona and Columbia Unit did not have access to their call bell while in bed asleep on the first morning of the inspection.
- A residents' risk of falls assessment had been completed, however, the relevant care plan had not been updated to reflect the residents' current risk.
- A resident who had low mood and suicidal thoughts had a care plan for the management of anxiety, however, it did not guide staff practice to support the residents needs.
- Residents end of life care needs were assessed, however, some end of life care plans did not reflect the residents assessed needs.

Judgment: Not compliant

Regulation 7: Managing behaviour that is challenging

Where restraint was used, it was not always evident that alternatives had been trialled, tested and failed prior to the restraint being used. From speaking with staff

and from reviewing the care plans inspectors found that they did not have a comprehensive understanding of restrictive practices.

The front door continued to be locked for an one hour at lunch time on a daily basis. Inspectors acknowledge that the provider gave verbal agreement to review the arrangements in place on day one of the inspection. On day two inspectors were told that a process had begun, where by a member of the management team would stay at the reception desk while the receptionist took their lunch break.

Sixty two per cent of residents accommodated on the Shenick unit exhibited responsive behaviours (how residents living with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment). The unit was noisy, with a number of residents wandering about displaying challenging behaviours. This was not conducive of a quite calm environment required for residents living with dementia. A review of the environment, knowledge and experience of staff working in this unit together with the number of residents living there was required to support their health and wellbeing and to ensure the environment was appropriate to meet their needs and as least restrictive as possible.

A number of residents had bed rails, bed bumpers and two crash mats in use while in bed. Just one resident was found to have a bed rail risk assessment in place, however it did not reflect the rationale for the use of the restraints or alternatives trialled prior to their use. In addition, two hourly checks were not always carried out when bed rails were in use. A number of records reviewed had gaps of 4-5 hours between safety checks.

Judgment: Not compliant

Regulation 8: Protection

Inspectors reviewed a sample of residents safeguarding care plans and found that these had improved since the last inspection. Residents who were identified as having a safeguarding concern had a safeguarding care plan in place as required and they were reviewed following any changes to the residents needs. They were person-centred and contained sufficient information to guide staff practice.

Judgment: Compliant

Regulation 9: Residents' rights

While a lot of work had been completed in ensuring that residents rights were respected some further improvements were required. On the second day of

inspection, activities were observed across all units. However, on the first day of inspection there was limited meaningful activities available for residents on the Shenick unit commensurate with their individual interests and abilities. In addition, it was noted that the activities on display on the time table were not always the ones being delivered in the units.
Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 19: Directory of residents	Substantially compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 11: Visits	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Tara Winthrop Private Clinic OSV-0000183

Inspection ID: MON-0043971

Date of inspection: 17/07/2024

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • There is an onsite training in progress on restrictive practice for all staff. This will be completed by 31st October 2024. • All nurses will be completing an online training on Amric Antimicrobial Stewardship and Amric Antimicrobial Resistance and MDRO. This will be completed by 30th September 2024. • An update on residents that had an MDRO will be discussed daily in the mid day handover. This is completed on 31st August 2024. • Frequent fire drills will be completed in Lambay unit. The response of staff will be recorded and an action plan will be discussed with staff to ensure all staff follows the centres procedure whenever a drill takes place. This will be completed by 30th September 2024. • All residents assessment and care plan will be reviewed again by 31st of October 2024. • A review of staffing in Shenick completed to make sure there are staff with appropriate experience and skill mix. All staff in Shenick completed training on Therapeutic Management of Violence and aggression and this training is ongoing for all new staff. Completed and ongoing. • All staff who do audits will be completing a training on Clinical audits in hseland. This will be completed by 30th September 2024.	
Regulation 19: Directory of residents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 19: Directory of residents:	

The electronic healthcare record provider has now rectified glitch in the system and the directory is showing all entries with no gaps. Completed

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
• The care plans of residents who receive additional funding will be updated with the frequency of weekly visits from medical officer and Client Liaison officer. This will be completed by 30th September 2024.
• There is a calendar now in place for the residents who receive additional funding to evidence the visits of medical officer, client liaison officer, companionship and physio. Completed on 31st July 2024.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• The audit schedule has been reviewed and the audits will be completed as per the schedule. The process of auditing and completion of action plan is reviewed and updated. All staff who do audits will receive the training on clinical audit in hseland. This will be completed by 30th of September 2024.
• In relation to the effective management of resident's finance on the day of inspection there was;
1. a policy and procedure in place for management of resident finances,
2. there is a contract with the HSE for the additional services in place a
3. the contracts of care clearly outline the services provided.
Since the inspection a is a calendar now in place for the residents who receive additional funding to evidence the visits of medical officer, client liaison officer, companionship and physio.
• There is a process in place now that the ADON/PIC and the HR will be having an oversight of training and the system of supervision to support staff to carry out their duties to protect and promote care and welfare of all residents. This will be completed by 30th September 2024
• We have an IPC link practitioner, who is one of the ADON, to ensure an effective system in place for the recognizing the infection control risk and preventing the transmission of infection in all units. This will be evidenced by IPC audits and and IPC committee meeting. Completed and ongoing.
• In relation to Regulation 5 please see regulation 5 response

• In relation to Regulation 7 please see regulation 7 response • In relation to Regulation 8 please see regulation 8 response • In relation to Regulation16 please see regulation 16 response • In relation to Regulation 21 please see regulation 21 response • All actions from the inspection will have oversight by the Registered Provider Representative and the PIC, timelines and responsibilities, should there be a delay in completion of actions the regulator will be updated.

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 PIC will make sure all staff have access to the updated policies and procedures to enhance better understanding and implement it in the practice within the centre. There will be ongoing training to all staff members on infection control, restrictive practices, assessment and care planning and fire safety in line with updated policies and procedure. Completed and ongoing.	

Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: • A review completed on the residents in Shenick unit and the plan to relocate the residents between the units to promote a safe environment. This will be completed by 1st of November 2024.	

Regulation 27: Infection control	Substantially Compliant
Outline how you are going to come into compliance with Regulation 27: Infection control: • A toolbox talk will be provided to all staff on the process of disposing the contents of urinals following the infection control techniques. This will be completed by 30th September 2024. • All first aid boxes checked and replaced the contents which were not in date. A	

checklist is in place now for monthly check of all first aid box. Completed and ongoing.
• HBN-10 sinks are in all clinical rooms - a review will be completed of the sluice rooms and an action plan will be implemented- Completed by 1st of November 2024

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• The works external to the Lambay unit had commenced but there was a delay in completion due to the delivery of handrails. This will be completed by 11th October 2024.
• The upgrade of the hoist store is completed.
• Most recent service of smoke ventilation was completed on 20/05/2024. The certification is available.
• The smoke kiosk of residents is installed, and this work is completed.
• The Fire door certification is commenced and Fire door replacement program completion by 1st of November 2024
• The front fire exit sliding door is connected to the fire alarm. Completed.
• The fire risk assessment by the providers competent fire person was delayed due to illness the assessment has been rescheduled and will be completed by 31st of October. Confirmation and sign off by Fire Competent person by 1st of November 2024.
• Frequent fire drills will be completed in Lambay unit. The response of staff will be recorded, and an action plan will be discussed with staff to ensure all staff follows the centres procedure whenever a drill takes place. This will be completed by 30th September 2024.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
• All nurses educated the importance of storing medicinal products in a safe and secured manner. Completed

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:

• The care plans of residents in Shenick unit will be reviewed and updated. This will be completed by 30th September 2024.

• The care plan of residents in Lambay who had MDRO will be reviewed and updated to guide and direct the care of residents. This will be completed by 30th September 2024.

• All witnessed and unwitnessed falls will be reviewed to ensure the neurological observations ae recorded in line with the policy. Completed and ongoing.

• The care plan of residents who receive subcutaneous fluids will be reviewed and will reflect the same. Completed and ongoing.

• The care plan of all residents will be reviewed and the Covid 19 care plans will be removed and will be only in place if resident have Covid 19. This will be completed by 30th of September 2024.

• The call bell safety check will be recorded in Epic touch care to ensure resident have the access to their call bell while in bed. This will be completed by 30th September 2024 and ongoing.

• The assessment and care plan of residents who have risk of falls will be reviewed and updated by 31st of October 2024.

• The care plan of resident who had low mood and suicidal thoughts, have been updated to guide staff practice to support the residents needs. Completed.

• The end of life care plan of residents will be reviewed and will update to reflect the residents assessed needs. This will be completed by 30th September 2024.

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:

• There is an onsite training in progress on restrictive practice for all staff. This will be completed by 31st October 2024.

• An audit has been completed on restrictive practices and the action plans include evidence of alternatives trialed, tested and failed prior to the restraint being used. This will be completed by 31st October 2024.

• A review completed in Shenick unit of the environment, knowledge and experience of staff to support their health and well being and to ensure the environment was appropriate to meet the needs of residents. The roster is reviewed and ensured the staff in Shenick unit has experience and skill mix. Completed and ongoing.

• The residents will be relocated between the units according to their needs to promote a safe environment. This will be completed by 30th September 2024.

• The restrictive practices in the centre is under review and the action plan will be completed by 31st October 2024. This included the types of restrictive practices in use

for each residents, rationale for the use of restrictive practice and alternatives trail prior to use.
• The two hourly check has been added to the restrictive practice audit and also staff were educated to enter this in epic touch care. Completed and ongoing.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• The activity team leader reviewed and updated the weekly activity list to ensure there are meaningful activities available for residents in Shenick unit. Also the staff allocated for activities will ensure the activities on display on the timetable is followed, but activities are subject to change if residents request. Completed and ongoing.

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 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	31/10/2024
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	31/10/2024
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	30/11/2024
Regulation 19(3)	The directory shall include the information specified in paragraph (3) of Schedule 3.	Substantially Compliant	Yellow	31/07/2024
Regulation 21(1)	The registered provider shall ensure that the records set out in	Not Compliant	Orange	30/09/2024

	Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.			
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	30/09/2024
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Substantially Compliant	Yellow	01/11/2024
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	01/11/2024
Regulation 28(1)(b)	The registered provider shall	Substantially Compliant	Yellow	01/11/2024

	provide adequate means of escape, including emergency lighting.			
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	01/11/2024
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.	Substantially Compliant	Yellow	01/11/2024
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	01/11/2024
Regulation 29(4)	The person in charge shall ensure that all medicinal products	Substantially Compliant	Yellow	31/07/2024

	dispensed or supplied to a resident are stored securely at the centre.			
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	31/07/2024
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	31/10/2024
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Not Compliant	Orange	31/10/2024
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	Not Compliant	Orange	01/11/2024

	manage behaviour that is challenging.			
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	01/11/2024
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 the website of the Department of Health from time to time.	Not Compliant	Orange	01/11/2024
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Substantially Compliant	Yellow	31/07/2024