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:	06 March 2024
Centre ID:	OSV-0000183
Fieldwork ID:	MON-0043020

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:	120

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
Friday 15 March 2024	10:00hrs to 18:10hrs	Lisa Walsh	Lead
Wednesday 6 March 2024	07:55hrs to 16:00hrs	Lisa Walsh	Lead
Friday 15 March 2024	10:00hrs to 18:10hrs	Gordon Ellis	Support
Wednesday 6 March 2024	07:45hrs to 16:00hrs	Brid McGoldrick	Support
Wednesday 6 March 2024	07:45hrs to 16:00hrs	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 was one of dissatisfaction with the quality of care, staffing levels and activities available in the centre. On both days of the inspection, inspectors walked around the centre speaking with residents, staff and visitors 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.

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, 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.

As with previous inspections, residents who spoke with inspectors voiced their concerns with the care provided and activities available. Residents told inspectors that they would like to be able to shower more frequently and would like more things to do on a day to day basis. Residents expressed frustration with the ongoing limited access to showers, with residents describing how their access to showers was not informed by personal choice but by staffing routines and numbers. Furthermore, some residents spoken with said that 'not much had changed' since the last inspection and the centre was 'still short staffed'. Other residents told inspectors that staff were a bit rushed especially in the morning and although they would like a shower every 2-3 days this was not always possible. A resident told inspectors that they believed staff did not have time to shower them some mornings. The records of another resident whose care plan stated "likes a shower every 3-4 days" had two recorded showers in the month of February.

A residents meeting which took place in February identified that residents expressed wish was for outdoor trips and activities such as afternoon tea and cupcakes with their loved ones. Residents spoken with said that the 'days are repetitive', they spend 'a lot of time watching TV' and that there 'isn't much to do'. The observations of inspectors over the two days of the inspection confirmed what residents were saying. Inspectors observed an undue reliance on television and background music in lieu of interesting and meaningful activities for residents. In the absence of staff, either due to vacant posts or staff leave, there was no system in place to ensure residents had access to activities. The exception was the Lambay unit on day two of the inspection where residents had choir practice and word games in the morning and were making green cookies in the afternoon for St. Patrick's Day.

While residents were complimentary of individual staff members, they described having to wait for prolonged periods of time before they received the care they required. One resident told inspectors they had been left "sitting in wet continence wear for two hours" as staff had more urgent people to see too. Some residents

expressed dissatisfaction with aspects of the service, such as not having their feedback listened to or taken on board by management. Residents reported that staff are kind and caring in their interactions, however there are communication difficulties due to a language barrier. Residents also reported that staff sometimes communicate in their first language while providing care, excluding residents from the conversation.

Inspectors observed that the supervision and allocation of staff was inadequate especially for residents in the Shenick unit. Inspectors were informed and residents care plans detailed that staff should be allocated to supervise the corridors and day space in this unit. However, inspectors observed on both days of the inspection that there were periods of time when no staff were allocated to supervise the corridors and day space. Inspectors also reviewed a debriefing report following an incident that took place prior to day two of the inspection in the Shenick unit which identified a deficiency in supervision which had significantly contributed to the incident.

The main entrance door to the designated centre is locked daily from 12:30-13:30, and 21:00 to 08:00. Inspectors observed family members waiting to access the centre during the lunch time period. Visitors spoken with also reported that the day space in Iona is used for family meetings which impacts the availability of this room for residents to use.

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 failed to put effective management systems in place to ensure that the service provided was safe and the care and welfare needs of the residents were met. Inspectors identified similar examples of poor governance and management and poor care practices as identified on previous inspections on 19 June 2023 and 7 and 8 November 2023, which are outlined under regulations; staffing, training and staff development, governance and management, records, individual assessment and care planning, healthcare, managing behaviour that is challenging, protection, residents rights, infection control and fire precautions. Feedback received by inspectors from residents and relatives was that they remained dissatisfied with the staffing levels in the centre, the quality of care being delivered and lack of activities they had access to.

Following day two of the inspection in light of significant concerns about the oversight of fire precautions and governance and management, inspectors issued an urgent compliance plan. The response to the urgent compliance plan did not provide

the required level of assurances and was not accepted.

This unannounced inspection was conducted over two days in Tara Winthrop Private Clinic, the first day of inspection was 6 March 2024 from 7:45am to 4pm, the second day of inspection was 15 March 2024 from 10am to 6pm. 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 two inspections in November 2023 and June 2023. The inspection was also to review representation submitted by the registered provider following the issuing of a notice of proposed decision to stop admissions.

The Chief Inspector had proposed to add 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 registered provider is Tara Winthrop Private Clinic Limited. A general manager had been in position since November 2023 and was responsible for non-clinical oversight of the centre. The person in charge reported to the chief operating officer who then reported to the chief executive office. The person in charge was in their role since August 2023 and is responsible for clinical oversight of the care of residents. The person in charge was supported by an assistant director of nursing (ADON), four clinical nurse managers (CNM) during the day and one full time and one part time CNM's during the night. In addition, staff nurses, healthcare assistants, housekeeping, activities co-ordinations, catering, administration, laundry and maintenance staff supported the person in charge.

Similar to the findings of the last two inspections, inspectors found that there continued to be insufficient resources available to meet the assessed needs of the 120 residents living in the centre on the day of inspection. 66% of the residents living in the designated centre were assessed as having maximum or high dependency needs. Of these residents 46%, assessed as maximum dependency required help from one or two staff to provide personal hygiene and mobility.

On inspection in June 2023 there were two assistant directors of nursing (ADON) to support the person in charge but this had been reduced to one ADON due to staff vacancies on the November 2023 inspection and there continued to be one ADON for this inspection.

Contrary to a commitment from the provider to have:

Two assistant directors of nursing.
Six full time clinical nurse managers who work in the centre and are also supernumery on a daily basis, including during night duties.
33 staff nurses employed for full capacity of 136 residents.
73 healthcare assistants for full capacity of 136 residents.
Inspectors found that there was:

One assistant director of Nursing.
5.5 clinical nurse managers.
27 staff nurses
62 healthcare assistants.

In addition, although the registered provider had committed to enhancing supervision on night duty, on the first day of inspection there was no clinical nurse manager on night duty and the staff nurse who was in the supervisory role was allocated to the Lambay unit, meaning there was little or no time available to supervise the delivery of care.

There was an ongoing schedule of training in the centre and staff had received their mandatory training, which included fire safety and safeguarding training. The findings of the inspection in November 2023 were that staff would benefit from additional training in 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 with infections and recognising and implementing resident rights, which the provider had committed to in their compliance plan. Some additional toolbox talks had been provided in some areas, such as restrictive practice and fire precautions, however, inspectors identified that there had been insufficient progress in addressing deficits in staff knowledge and competence. Furthermore, there continued to be a lack of staff supervision which impacted the care and welfare of residents.

Concerns about inadequate staffing were also detailed in a number of logged complaints in relation to personal care provided to residents. For example, complaints about residents only being showered once a week or residents not being washed properly. A residents survey completed in February 2024 by both residents and relatives also identified concerns about staffing levels, care being rushed and items missing from the laundry, these are repeat concerns residents raised with inspectors on the November 2023 inspection.

Inspectors also found that the registered provider failed to implement their own risk management processes. For example, an investigation into an incident whereby a resident exited the centre at night-time did not take account of all of the factors that could have contributed to the incident and as a result measures to mitigate a repeat of the incident were not implemented.

In addition, following day two of the inspection as a result of concerns as to the efficacy of the fire alarm and security system an urgent compliance plan was issued to the registered provider. While the provider engaged with this process, the

responses did not assure the Chief Inspector that appropriate action was taken. This is further detailed under Regulation 23: Governance and Management and Regulation 28: Fire Precautions.

Regulation 15: Staffing

Residents informed inspectors that sometimes they had to wait for a prolonged period of time before they received the care requested. Notwithstanding the registered providers recruitment drive, the findings of this inspection were that:

- There were not enough staff with the required skill-mix to meet the assessed needs of residents. For example, some residents were not receiving a shower as frequently, as outlined in their care plan. One resident had not received a shower since 22 February 2024.
- Where residents were assessed as requiring nursing care, this care was not always being provided. For example, one resident who was assessed as being continent was wearing incontinence wear.
- Where a resident was assessed as needing one-to-one supervision, this care was not being provided. For example, one resident as requiring one to one supervision (as evidenced in a request for additional funding) did not have the supervision arrangements in place.
- In the absence of rostered activities staff residents spent long periods of time with no social engagement or access to interesting and stimulating activities.
- Staff were slow to respond to residents at different times during the day and night. Residents informed inspectors that sometimes they had to wait for a prolonged period of time before they received the care they required.
- There was only one assistant director of nursing when the provider had committed to having two in post, which is a repeat finding from the inspection in November 2023.
- Clinical nurse managers (CNM) who provided oversight to the designated centre nightly, continued to provide nursing cover for breaks which limited the time available to them to oversee the delivery of care. Furthermore, on the day of inspection there continued to be a vacancy of a part-time CNM.
- On day one inspectors found that the nurse in charge on night duty was responsible for supervising all five units, as well as being the sole nurse on the Lambay unit.
- From a review of the incident and accident log for a period from 1 February 2024 to 6 March 2024, a total of 23 falls had occurred in the centre with nearly 70% occurring between 8pm and 8am. Of the total number of falls, 89% were recorded as being unwitnesssed, meaning that residents were unsupervised at the time of the fall.
- In the Shenick unit there was only one staff nurse working on the first day of inspection with no CNM, when the provider had committed to two staff nurses and a CNM for each unit.
- staff vacancies included the following:
    - two activity coordinator staff

- one kitchen assistant
- one practice development facilitator
- for a full complement of staff for a capacity of 136 beds there were 11 healthcare assistant vacancies and six staff nurse vacancies, based on the registered providers staffing commitment.

- In addition multiple residents informed inspectors that sometimes they had to wait for a prolonged period of time before they received the care requested.

This is a repeated non compliance.

Judgment: Not compliant

Regulation 16: Training and staff development

Notwithstanding the fact that the majority of staff had their mandatory training in place. Further training and supervision was required. For example:

- Staff had not been provided with the specific training to ensure they could meet the specific nursing care needs of the residents admitted to the centre. Inspectors found that residents who had been admitted for respite care following limb fractures were not having their fractured limb checked for colour, warmth and sensation on a routine basis. This is a repeat finding from the previous inspection.
- Although approximately half the staff had completed training on a rights based approach to care and other staff had also received training on restrictive practices inspectors observed staff locking residents' bedroom doors, when they left their bedrooms, without their consent, which reflected a lack of knowledge with respect to residents rights or what constituted a restrictive practice.
- Staff had poor knowledge of fire safety, as detailed under Regulation 28.

There was a lack of appropriate supervision of staff on each unit on the days of inspection, which is a repeat finding from the previous inspection. For example:

- There continued to be a poor adherence to infection prevention and control standards that included the inappropriate use of cleaning products which was identified on the previous inspection.
- On the first day of inspection, there was no clinical nurse manager on night duty to supervise staff.

This is a repeated non compliance.

Judgment: Not compliant

Regulation 21: Records

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 non-compliance.

The records setting out residents additional funding contributions, and how it was being spent were not clear. The inspection in November 2023 identified eight residents who received additional funding. The compliance plan for the November 2023 inspection gave assurances that the additional services residents received, for example, a resident may receive physiotherapy twice a week were detailed in the contract of care, and the residents care plan. Additional information received by the Chief Inspector from the provider demonstrated that the funded additional services included nutrition and physiotherapy for seven of the residents. Inspectors reviewed the residents contracts, however, it was not clear the purpose for which the additional funding was used. For example, the contract had a total figure for both and did not set out actual additional nutrition or physiotherapy which was to be provided. Records viewed recorded the total amount paid and the residents initials. Furthermore, the residents care plans did not detail the additional nutrition services.

The registered provider informed the Chief Inspector that there was a contractual agreement in respect of the additional monies paid for the residents care, however, this was not available on the day of inspection for inspectors to review.

Judgment: Not compliant

Regulation 23: Governance and management

The registered provider had failed to ensure the designated centre was operated at all times in line with its statement of purpose and its conditions of the registration. For example, the management structure in place was not reflective of that outlined in the statement of purpose. The designated centre did not have sufficient resources to ensure the effective delivery of care in line with the statement of purpose and the number and skill-mix of staff was having a negative impact on the care and welfare of residents. For example:

- Residents were not receiving care in line with their care plans due to reduced staffing levels. This is detailed in Regulation 15: Staffing.
- There was inadequate supervision of residents in some units. For example, following a number of incidents prior to the inspection, a resident was assessed as needing one to one support and additional staff supervision in January 2024. The same resident was involved in an incident where they exited a fire exit door at 4:51am. The findings from the inspection were that

additional staff supervision was not consistently in place to protect the resident and other residents on this unit. An urgent compliance plan addressing this matter was issued following the inspection.
- Some residents did not have access to a schedule of activities due to the absence of activities staff, one resident spoken with on Erris said "there were not enough activities and they got bored".

Management systems to ensure that the service provided was safe, appropriate, consistent and effectively monitored, as required under Regulation 23(c), were not sufficiently robust. The provider failed to implement effective systems to monitor, evaluate, and improve the quality and safety of the service. For example:

- Some audits, for example call bell audits, were not robust enough and the action plans for the audit were not time-bound. For example, two action plans stated "review indicated".
- The provider failed to implement effective systems to manage residents' finances, this is detailed under Regulation 8: Protection.
- Examples were observed where residents' rights were not upheld. Practices observed on the days of inspection infringed on the rights of residents.
- Overall, ineffective systems to manage and respond to risk, for example, while the investigation report into an incident where a resident left the centre unaccompanied, stated the door alarm had been left in isolation mode due to human error which resulted in the alarm not sounding when the fire exit door was opened by the resident, the investigation did not conclude how the fire exit door was able to be opened in the first place by the resident. An urgent compliance plan addressing this matter was requested following the 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, which is a repeat finding from the previous inspection. This is further detailed under Regulation 16: Training and staff development.
- The oversight of fire safety and the processes to identify, and manage fire safety risks were ineffective to ensure the safety of residents living in the centre. An urgent compliance plan addressing this matter was requested following the inspection. Furthermore, a number of repeated fire safety risks were found that had been identified in November 2023. This is detail under Regulation 28: Fire precautions.
- Repeated non-compliance were found with:
    - Regulation 5: Staffing
    - Regulation 7: Managing behaviour that is challenging
    - Regulation 8: Protection
    - Regulation 9: Residents rights
    - Regulation 15: Staffing
    - Regulation 16: Training and staff development
    - Regulation 21: Records
    - Regulation 23: Governance and management
    - Regulation 27: Inspection control
    - Regulation 28: Fire precautions

An annual review of the quality and safety of care delivered to residents in 2023 had not been completed and therefore was not available for review.

This is a repeated non compliance.

Judgment: Not compliant

Quality and safety

Overall, inspectors were not assured that the systems in place for overseeing the quality and safety of aspects of resident's care, ensured that all residents living in the centre were protected by safe practices, which promoted a good quality of life. The lack of effective governance and management in the centre was impacting on the quality and safety of care in key areas such as residents' rights, managing behaviours that challenge, individual assessment and care planning, healthcare, infection control and fire precautions. Significant and sustained action was required to ensure that residents received care to meet their assessed needs.

Inspectors reviewed assessments and care plans for residents and found similar findings to the previous inspection in November 2023. For example, some residents did not have pain assessments following a fracture and as a result, appropriate interventions were not always carried out. Some care plans were not detailed enough to guide staff practice and some residents did not have a care plan in place when required. For example, a safeguarding care plan had not been completed for a resident who was subject to verbal abuse. Action was required to ensure that care was delivered in line with each resident's assessed care needs as outlined further under Regulation 5: Individual assessment and care plan.

Residents had access to a General Practitioner, however, as in previous inspections residents did not have access to the expertise of a health and social care professional for seating assessment.

The centre had a policy to guide the use of restraint and restrictive practices and maintained a register of restrictive practices in use in the centre. From a review of the risk registers, inspectors found that there was a low use of restraint on two of the five units. However, as found on the previous inspection, thirteen residents were nursed in tilted comfort chairs which staff did not recognise as a restrictive practice in the absence of an appropriate assessment of their needs. Staff also did not recognise that preventing residents from accessing their bedrooms, as doors were locked, placed a restriction on the movement of residents that was not in line with a rights-based approach to care. Improvements were required to ensure that any restrictive practices are used in accordance with national policy. This will be discussed further under regulation 7: Managing behaviour that is challenging.

Inspectors were not assured that all reasonable measures were in place to protect and safeguard residents from abuse as some of the systems in place and

safeguarding care plans to direct staff were found to be inadequate. Residents finances were also not managed in line with best practice. This is further detailed under Regulation 8: Protection.

Inspectors were informed that a review of the activity schedule, care plans and environment was taking place on the first day of inspection. Furthermore, staff training around activities was planned for care staff and activity coordinators. Residents in the Lambay unit reported that activities had improved since the last inspection. However, due to a shortage of staff, there was inadequate provision of meaningful activities for residents in the other units.

From a fire safety perspective, inspectors found that the registered provider had not taken adequate precautions against the risk of fire. While the Provider had completed a fire risk assessment in June 2021 and an action plan to address the assessment findings was in progress, the registered provider had not addressed three red rated risks and one orange rated risk in regards to; fire door issues, an unsafe external evacuation route, floor plans and fire action notices and confirmation that the front fire exit sliding door was connected to the fire alarm.

While some action had been taken since the previous inspection in November 2023, the inspectors noted a lack of progress by the provider in fulfilling all the commitments to carryout and complete significant fire safety works by the 31 March 2024. These works were in regards to; fire doors to address containment deficiencies in the Shenick and Erris unit, fire detection and to address the uneven external evacuation route. The above issues remained unresolved on this current inspection.

The oversight of fire safety and the processes to identify, and manage fire safety risks were ineffective to ensure the safety of residents living in the centre. A number of repeated fire safety risks were found that had been identified in November 2023, these are discussed further under Regulation28: Fire precautions.

Regulation 27: Infection control

Inspectors found that the laundry area had improved from the previous inspection, however, further improvement in other areas was required to come into compliance with the regulations and the National Standards for infection prevention and control in community services (2018).

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.

This is a repeated non compliance.

- Chlorine tablets were used to clean urinals, this did not ensure effective cleaning and disinfection. Staff removed chlorine tablets on the day of the inspection. This is a repeat finding.

The environment was not always managed in a way that minimised the risk of transmitting a healthcare-associated infection. For example, inappropriate storage of bins in communal shower and bathrooms.

Notwithstanding, the new sinks the provider had installed, clinical hand wash sinks in the treatment rooms and dirty utility rooms did not comply with HBN-10 specifications.

This is a repeated non compliance

Judgment: Not compliant

Regulation 28: Fire precautions

The provider did not take adequate precautions against the risk of fire. For example:

- Storage of flammable items alongside items such as alcohol, cleaning products and documentation were found stored directly under an electrical panel in an office.
- A residents smoking area located in a garden did not have a fire extinguisher, a fire blanket or a call bell available and paper was found in a cigarette bin. This could result in delays to alert staff and to retrieve a fire extinguisher in the event of a residents clothes catching fire. This was a repeated finding from a previous inspection in November 2023. An immediate action was issued to the provider to remove the paper from the cigarette bin.
- The inspectors observed hoists being charged in a nurse station and in an open store room creating a potential fire risk that could compromise the protected means of escape.
- A set of cross corridor doors along a corridor in the Shenick unit were found to be tied open by a chain.

The provider did not provide adequate means of escape including emergency lighting. For example:

- A disabled refuge space in a protected stairwell on the first floor was being used as a storage area on the first day of the inspection. An immediate action was issued to the provider and items were removed. However, later on the same day further items were again being stored in this area.
- An external escape route to the rear of the Erris unit was very uneven. This was a repeated finding from a November 2023 inspection. The provider had committed to resolving this issue by the 31 March 2024. However, the inspectors did not see signs of progress.

- A second external escape route to the side of the Lambay unit had an excessive sloped embankment but no measures were put in place to ensure residents were protected from falls. Additionally, a set of fire exit doors that served both the Lambay unit and escape from the first floor protected staircase narrowed this escape route when in the open position. This obstructed the evacuation to the front assembly point in a fire emergency. This risk had been previously identified in the providers own fire safety risk assessment dated June 2021, yet it remained unresolved.
- It was not clear that a means of escape via a bi-fold wall and door and through an oratory in the Lambay unit to reach a final fire exit was suitable as a means of escape.
- A fire exit from a communal space 1 and 2 did not have an emergency directional signage above the fire exit door and a green break glass unit was not available to release the magnetic lock fitted to the fire exit door in the event that it failed to release the door. Furthermore, the inspectors was not assured the timber ceiling in this area would meet the required fire rating criteria as it was on a means of escape.
- On the first day of the inspection staff were unaware that a fire exit door was thumb locked and did not demonstrate a knowledge of the evacuation procedure when the thumb turn lock was engaged.

The registered provider had failed to adequately review fire precautions throughout the centre. For example:

- The inspectors noted repeated findings from the providers own fire safety risk assessment dated 2021 had not been resolved which included three red risks and one medium rated risk. For example, fire door issues, an external evacuation route, floor plans and fire action notices and confirmation that the front fire exit sliding door was connected to the fire alarm.
- Repeated findings from the inspection carried out on 07 November 2023 were identified again on the current inspection.
- Following an incident where a resident exited a fire exit door when an alarm failed to sound, the provider failed to ensure that a fulsome investigation by a competent person to ensure the overall fire alarm system was functioning properly was carried out. An investigation was carried out in response to the urgent compliance plan requested following this inspection.

The registered provider did not ensure that all staff of the designated centre received suitable training in fire prevention. For example, from a review of the staff training records, 13 staff members were overdue fire training and a new staff member working in the centre a week prior to this inspection had not received any fire training.

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 nor did the provider have a clear robust fire procedure in place to ensure that in the absence of automatic door closures; fire doors

are latched, generally closed and doors are closed after an evacuation of an occupant to ensure containment of smoke and fire.
- On a previous inspection in November 2023, it was found that the 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 provider had committed to resolving these issues by 31 March 2024, however, this work had yet to commence.

The provider had taken measures to provide appropriate fire detection in most cases. However, the inspectors noted a lack of detection available in a sluice room, an electrical store in an office, and a number of out buildings. This was a repeated finding from a November 2023 inspection. The provider had committed to resolving this issue by the 31 March 2024. However, the inspectors did not see any signs of progress. This is a repeated non compliance.

The displayed procedures to be followed in the event of a fire lacked detail and clarity for people working in the centre to be able to easily follow in the event of a fire. For example:

- Layout plans posted on walls in the centre were not accurate and lacked detail.
- Fire action instructions on display did not provide clear instructions for staff as to the actions to be taken in the event of a fire. This risk was previously identified in the providers own fire safety risk assessment dated June 2021 remained unresolved.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

A review of residents' assessments and care plans found that they were not always reviewed and updated in line with the assessed needs of residents. For example:

- A safeguarding care plan had not been completed for a resident who was subject to verbal abuse.
- Residents admitted with fractures were not routinely assessed for pain and there were no care plans in place, consequently it was unclear if the medication prescribed was effective.
- A resident who had sustained a fall and bruising to the head did not have a care plan to monitor the bruising.
- A residents care plan was not sufficiently revised and did not detail the assessed one-to-one staff supervision arrangements to meet their care needs. The residents care plan detailed that staff were to be allocated specifically for supervision, however, on the first day of inspection no staff were allocated for supervision from 8am to 1:30pm. On the second day of inspection no staff were allocated for supervision from 8am to 12pm.

- A resident with Carbapenemase-producing Enterobacteriaceae (CPE) had a care plan in place. The resident was required to use to a distant shower room that was to be reserved for this resident's use to reduce the risk of spreading infections to others, however, this was not detailed in the care plan.
- A resident who had broken skin had a care plan in place which detailed that the resident needed to be repositioned every two hours. However, records reviewed did not always evidence that the resident received this level of care. Inspectors were informed that records of repositioning were only maintained when the resident was in bed, not when they are sitting out in their chair.
- Inspectors were informed that a resident was assessed as needing a comfort chair by occupational therapy (OT) following recent surgery, however, there was no record of the OT assessment available to review.
- A residents responsive behaviour that was observed by inspectors was not reflected in their care plan.
- Two residents' care plans stated "likes a shower every 3-4 days" however, on review of the care records for these residents they had not received a shower in accordance to their care plan.

This is a repeated non compliance.

Judgment: Not compliant

Regulation 6: Health care

Evidence based nursing practice was not carried out in respect of pain management, as the effectiveness of pain management was not being monitored.

During the November 2023 inspection several residents were identified as requiring additional professional expertise, for example, occupational therapy assessment for the use of tilted chairs. On the day of inspection none of the residents in tilted chairs had been assessed by occupational therapy.

Following an incident where a resident had been outside from 4.51am to 5.10am in their night clothes, they were not appropriately assessed on their return to the centre to ensure they were in good health and didn't require medical treatment. For example, the residents temperature was not taken.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

Although additional training had been provided to staff in relation to restrictive practices since the last inspection, inspectors observed examples that evidenced that

staff 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). Responsive behaviours were not appropriately managed within the centre. Residents care plans in relation to responsive behaviours did not always have a description of triggers and de-escalation techniques to guide the staff in safe care delivery.

Aspects of the use of restraint in the designated centre were not in accordance with national policy published by the Department of health, or the centre's own restraint policy. Both require that any assessment for the use of restraint should include the least restrictive alternatives that have been tried, including length of time and outcomes and the least restrictive form of restraint must be used for the shortest time possible. As found on the previous inspection, thirteen residents were nursed in tilted comfort chairs which staff did not recognise as a restrictive practice in the absence of an appropriate assessment of their needs.

Inspectors also observed how doors to multiple bedrooms and bathrooms were locked throughout the designated centre. This restriction on the movement of residents and the rationale for its use were not appropriately risk assessed or recorded. In seeking to manage the behaviours of some residents staff failed to recognise the impact such restrictions had on the rest of the residents. This is a repeat finding from the inspection carried out in June 2023.

This is a repeated non compliance.

Judgment: Not compliant

Regulation 8: Protection

The oversight and management of residents finances required review. Inspectors were informed that additional funding was in place to support specific assessed care needs of eight residents. Seven residents had additional funding in place to provide additional menu options above the standard daily meal options within the centre. However, the residents were not afforded menu options for breakfast or dinner other than those in place for all residents. Inspectors were informed that the residents could order a bespoke meal at tea time, however, kitchen orders were taken for tea time from all residents in the unit. Inspectors could not find evidence that residents in receipt of additional funding for the provision of additional menu options above the standard daily meal options did receive meals that were in any way different to what the rest of the residents could order. For example, residents with additional funding ordered omelette's; sandwiches; sausages and chips, which was also ordered by other residents in the unit. Furthermore, a resident who was in receipt of additional funding for menu options was not aware that there were any such arrangements in place for them.

Some elements of the systems in place did not ensure that residents were protected from risk. For example, the care plan in place for a resident identified as a risk for exit-seeking was inadequate and did not detail the steps to take to ensure the residents safety.

The registered provider had failed to take all reasonable measures to protect residents from abuse. For example,inspectors observed a resident repeatedly opening other residents bedroom doors, when residents were in their bedrooms. At times, the resident followed other residents when they entered their bedroom. Furthermore, when staff observed the resident walking into another residents bedroom they did not intervene.

Safeguarding care plans to direct staff were found to be inadequate. For example, two safeguarding plans did not detail the steps for staff to take to keep the resident and other residents who may be impacted safe. For another resident inspectors found that there was no safeguarding plan in place, despite a safeguarding concern having being raised. The management and staff also failed to recognise and manage peer to peer incidents between two residents.

This is a repeated non compliance.

Judgment: Not compliant

Regulation 9: Residents' rights

Some institutional practices aligned to staffing levels undermined some residents choice and a rights based approach to care. For example, residents told inspectors that they could not always have a shower when they wished to owing to staffing levels.This feedback was supported by records of care reviewed by inspectors. Furthermore, some residents were prevented from accessing their bedrooms during the day as they were locked by staff when the resident left, impacting their ability to undertake activities in private.

Other institutional practices were also observed, such as, the transfer of a resident who was not properly covered from a communal shower to their bedroom. The staff who were transferring the resident failed to recognise that this impacted the privacy and dignity of the resident.

Residents did not always receive a service in line with their assessed care needs and funding arrangements. This is detailed under Regulation 8: Protection.

The registered provider failed to ensure that the centre was resourced so that all residents had access to meaningful activities commensurate with their individual interests and abilities. Residents identified this as a significant concern for them and they had given this feedback directly to the registered provider through a survey. Inspectors observed that there was an undue reliance on television and background music as resident activities and only a small number of residents were able to

benefit from the limited activities that were available such as the visiting cat. The exception was the Lambay unit where residents reported an improvement in some activities provided to them. Inspectors also observed activities like choir practice, word games and making cookies for St. Patrick's Day on day two of the inspection.

Residents reported that there are communication difficulties due to a language barrier. Residents also reported that staff sometimes communicate in their first language while providing care, excluding residents from the conversation.

This is a repeated non compliance of Regulation 9.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Substantially 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-0043020

Date of inspection: 06/03/2024

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 15: Staffing	Not Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
The Registered Provider assures the Chief Inspector that:

• The Centre has sufficient staff and resources to deliver care to all its residents and to deliver the 24-hour one-to-one supervision to the Resident. As of the date of this action plan, there are 106 residents in our Centre. There is a sufficient number of Health Care Assistant and a sufficient complement of professionally qualified nurses. All residents had their care plan reviewed and updated with the resident preferences on their shower frequency. Residents are receiving shower as per the care plan and being discussed in the handover if there is a refusal/omission. This is monitored on a daily basis by the clinical nurse manaagers. Completed on 31st May 2024.
• All residents continence assessments have been updated and their care plans have been updated to reflect their assessed care needs. Completed by 30th June 2024.
• Currently we do not have any residents who require 1:1 supervision. If there is a requirement for 1:1 supervision, an assessment of care and care plan of needs will be completed. The roster will reflect the 1:1 Supervision and the daily allocations to that resident Furthermore, if a resident required 1:1, a review of the resident and their care needs required would be completed internally. Following this review the staffing allocations would be adjusted within the centre to support the allocation of increased supervision for the Resident on the specified unit. The increased supervision is allocated within the staff allocations book which remains on the unit. This is completed by the CNM on duty a daily basis, with additional review and oversight by the ADON on duty.
- In addition, a risk assessment would be completed for the protection of residents on the unit. This would be reviewed on a regular basis in line with the changing needs of all residents on the unit. Completed on 18th of March.

• A seven day a week activities plan is developed by the acitvity staff. This is overseen by the clinical nurse managers. This will identify activities on each unit and communal activites 7 days a week. The usual pattern for activities is 4 activities on each unit a day- depending on the requirements and preference of the residents on the units. With both

internal and external providers. The activitiy co-ordinators ensure the activity schedule is delivered to each unit with the assistance of HCA's.
At each resident meeting the residents can give feedback on activitiy schedules and any issues or preferences will be addressed. Each resident has an acitivity care plan to reflect their preferences. Completed on 31st May 2024.
• Call bell audits have been increased to weekly from May 2024. This will identify the response times to call bells, an action plan will be created if required and all feedback discussed at handover on each unit. Completed 31st of May 2024.
• Senior management reviewed the management roster and currently there is 2 CNMs and 1 ADON on duty on a daily basis, 7 days a week. This promotes improved supervision and support in all units. The CNMs and ADON are supernumerary. There is a CNM/Senior Nurse supernumery cover on every night shift. Completed 31st of May 2024.

The staffing as agreed with the Regulator will be adjusted accroding to occupancy. :
Currently the staffing levels in the centre are as follows:
0.2 WTE PPIM
1 WTE PIC
2 WTE ADON (1 maternity cover commencing 17.06.24)
1 GM/ ADON (commencing 15.07.24)
6.5 WTE CNM's
27.3 WTE Nurses (7 incoming nurses by End of July)
65.74 WTE HCA's (3 incoming by end of July)
1 WTE Medical officer
2 WTE Physio
6.5 WTE Activities co-ordinators
5.0 WTE Admin
1 WTE Head of HR
11 WTE Hygiene
1.0 WTE Mainteance
1.0 WTE Hairdresser
3.25 WTE Chefs
9 WTE Kitchen assistants

• A review and analysis of falls will be completed on a regular basis to ensure that trends in falls will be identified, and shift pattern changes will be implemented to ensure the centre is meeting the needs of the residents. An analysis of falls was completed and an action plan developed based on the findings, this will be completed by June 30th 2024.

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
• Protocol developed on the management of any resident post fracture. This is

communicated to all staff and there is additional oversight of this through incident review and clinical handover. This is in place with ongoing review and will be completed by June 15th 2024.
• A preadmission assessment is completed by ADON or PIC to ensure that the assessed needs can be met within the centre. This pre admission details will be discussed with all staff on the unit before admission. If we identify any specific training needs, this will be completed before admission. Completed on 31st of April 2024.
• A review of all pre-assessments is completed by the ADON/ PIC to ensure that all equipment required for rehabilitation during convalescence is available prior to admission in the centre. This will be completed in conjunction with the MDT. 30th of June 2024.
• There is an ongoing program of training around rights based approach and restrictive practice. This will be completed for all staff by July 31st 2024.
• Additional oversight and supervision on the floor, as well as the introduction of a clinical handover in the morning and an afternoon handover means there is increased oversight of practices such as the locking of doors. The RPR will attend the daily handover on a regular basis. When the RPR cannot attend any risks identified in the handover will be escalated by PIC/ ADON to the RPR. Completed on 30th of April 2024.
• All residents who request their doors to be locked as it their preference have an updated care plan to reflect this. Spot checks on locked doors are completed by 15th of June by PIC/ ADON/CNM's.
• All staff who require fire training or refresher fire training will be completed by the 16.07.24 (please note this will an ongoing process as new staff arrive and current staff will require refresher). 5 dates booked; 13.06.2024; 17/06/2024; 21/06/2024; 05/07/2024; 16/07/2024.
• Fire drills have been increased to monthly on each unit. All staff receive training on how to reset access control on each unit. Completed by 30th of June 2024.
• There is a management roster developed to identify the 2 CNM's and 1 ADON daily and the individual identified on nights who is in charge. Each CNM will oversee 2 units and the ADON will support the oversight of all units. Completed on May 6th.
• The introduction of the daily clinical handover support increased oversight and understanding of key clinical items such as infection control and the discontinuation of the use of chlorine tablets. Additionally a weekly management meeting with managements including the hygiene manager ensures these practices do not continue. Spot checks are completed by the management team to ensure adherence, and additional IPC audits are being completed on each unit by the CNMs on a weekly basis. Completed by May 31st 2024.

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
A review was undertaken of all records pertaining to additional funding received for those residents;
• All contracts outlining additional funding and the breakdown of such have been reviewed and updated. The new contracts will clearly outline the services provided for

the additional funding. The process of signing the new contracts is underway This will be completed by July 31st 2024.
• The care plans for all residents receiving additional funding have been updated to outline the allocation of funding for each individual. These have been reviewed by the Person in Charge. This was completed by May 5th 2024.
• The Service Level Agreement for these residents is under review by the community services at present and will be closed out by 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 Registered Provider assures the Chief Inspector that:

• The Centre has sufficient staff and resources to deliver care to all its residents and to deliver the 24-hour one-to-one supervision to the Resident. As of the date of this Action plan, there are 106 residents in our Centre. There is a sufficient number of Health Care Assistant and a sufficient complement of professionally qualified nurses. All residents care plan reviewed and updated with the resident preferences on their shower frequency. Residents are receiving shower as per the care plan and being discussed in the handover if there is a refusal/omission. This is monitored on a daily basis by the clinical nurse manaagers. Completed on 31st May 2024.
• Currently we do not have any residents who require 1:1 supervision. If there is a requirement for 1:1 supervision, an assessment of care and care plan of needs will be completed. The roster will reflect the 1:1 Supervision and the daily allocations to that resident Completed on 18th of March. resident Furthermore, if a resident required 1:1, a review of the resident and their care needs required would be completed internally. Following this review the staffing allocations would be adjusted within the centre to support the allocation of increased supervision for the Resident on the specified unit. The increased supervision is allocated within the staff allocations book which remains on the unit. This is completed by the CNM on duty a daily basis, with additional review and oversight by the ADON on duty.
- In addition, a risk assessment would be completed for the protection of residents on the unit. This would be reviewed on a regular basis in line with the changing needs of all residents on the unit. Completed on 18th of March.

• A review of the activities has been completed with the residents input at resident meetings and familiy meetings. These meetings were held in April 2024. Following the feedback from the residents and family a plan was delveloped as follows:
• A seven day a week activities plan is developed by the acitvity staff. This is overseen by the clinical nurse managers. This will identify activities on each unit and communal activites 7 days a week. The usual pattern for activities is 4 activities on each unit a day, depending on the requirements and preference of the residents on the units. With both

internal and external providers. The activitiy co-ordinators ensure the activity schedule is delivered to each unit with the assistance of HCA's.
• At each residents meeting the residents can give feedback on activitiy schedules and any issues or preferences will be addressed. Each resident has an acitivy care plan to reflect their preferences. Completed 31st May 2024.
• The managment structure will updated and outlined all roles and responsibitlites in the Statement of Purpose. The updated Statement of purpose will be available to all staff and residents. A copy of the organisational chart will be distributed to each unit to display for residents and staff. This will be completed by 31st of July. (please note the Regional Manager for the Group and responsible for the centre will commence in the role in the 2nd week in September 2024. In the meantime the group supports from RPR/ PPIM will remain in place). The resources of the centre are in place and reflect the current occupancy of the centre to ensure the effective delivery of care. This will be monitored on a regular basis with the PIC/ RPR/ Group Head of HR. Completed by 15th of September 2024.
• An electronic auditing system has been implemented in the centre. This includes a specific call bell audit which can be completed by members of the centres management team. This allows the management team to identify where call bells are not been answered in a timely manner. All learnings or actions required are identified and completed within a timeframe. Completed on 31st of May 2024.
• The centre has an updated policy and procedure in place in order to manage residents finances. Each resident's contract of care will be updated to reflect the additonal funded and care plans will be updated to reflect the same. This will be compelted by 31st of July.
• Any resident admitted to the home with additional funding will have an updated contract of care to reflect the additional funding and services provided. This will be overseen by the PIC. All care plans will be updated to reflect the same and residents and families will be informed of the same 31st May 2024.
• There has been a full review of the residents assessments and care plans to ensure their preferences are updated. This includes the idenfication of what their preferences are around personal care, activities and if any forms of restrictive practice are in place. All updated care plans and assessments will be discussed with residents or family members by the 30th of June.
• All residents who are in chairs which are tiltled, have had referrals to the OT services in the community, which has a delayed national waiting list. Private services have been offered to families and residents in the meantime. In the interim individual risk assessments are in place for every resident utilizing a comfort chair, with a program of restraint release in place. This is regularly checked by Senior Management. It is expected this will be completed by community service by 31st of December 2024. If there are further delays the regulator will be updated.

• All residents and families have been made aware of the compaints procedure and have access to the complaints procedure which is displayed throughtout the centre. Completed on 31st May 2024.
• A review and update of the Fire Safety Management Proograme has been completed and implemented at the centre. This was completed in conjunction with a fire competendent person and the management of the centre. This will come into effect on the 1st of July, this is to facilitate staff education around staff education around new policy and protocols.

This new programme includes:
• An Updated Fire Safety Management Policy and strategy
• An Updated Emergency Response Plan
• A Building Saftey Engangement Strategy- Which outlines the communication process between TWPC and GHC

• The Incident in relation to absconsion did not involve the Centre's fire detection and alarm system which complies with I.S. 3218. The Centre's management systems ensure that the Centre's fire detection and alarm systems are fully functional, serviced and certified. The Registered Provider is advised by a professional and competent fire safety advisor and is assured that these systems ensure the effectiveness of the fire safety systems and procedures for the Centre's residents and staff. The Incident was the result of human error on the part of a staff member. As a precautionary measure to address the risk in (c) above, all of the Centre's security access codes have been changed - to fortify security and to ensure that the Centre's security protocols are robust and effective. Additionally, the Registered Provider has ensured the delivery of focussed additional education and training by a competent person to all staff to ensure the effective communication of the lessons learnt from the Incident. Competed by 31st March 2024.
• The annual review which was completed in February 2024 has now been distributed to all units. Completed by 31st March 2024.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
• The resident with CPE has a dedicated bathroom. This bathroom is reserved for the resident with a colour coding system and all staff is aware of this colour codes. Completed on 30th March 2024.
• The chlorine tablets are no longer kept in sluice rooms and the sluice machine has been fixed. The CNMs and house keeping staff are checking this on a regular basis to ensure the chlorine tablets are not in use. 30th March 2024.
• The IPC spot checks are done by the CNMs during their walkaround in each units and a recorded spot checks done by CNMs weekly in the electronic auditing system. Completed on 31st May 2024.
• An IPC committee has been established in the centre to support learning and sharing of any quality improvements required in the home in relation to IPC. This is overseen by the Person in Charge and is held on a monthly basis, with key staff from all departments including Clinical and Hygiene staff. Completed on 31st May 2024.
• Daily spot checks have been commenced in all units to ensure that there is oversight of the environment on a daily basis and that inappropriate storage of items etc is addressed

in a timely manner by the CNMs of the unit. Completed on 31st May 2024.
• An additional 14 handwash sinks were installed in May 2022. Since then an additional 4 clinical sinks have been installed in September 2023. A full review of the handwash sinks in treatment rooms and dirty utility rooms will be completed by the Registered Provider again, and any sinks that require replacement will be completed by 30th September 2024.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: The compliance plan response from the registered provider does not adequately assure the Chief Inspector that the action will result in compliance with the regulations.

• Any flammable items were removed on the day of inspection completed by 15th of March 2024.
• All distribution doors are enclosed in 60 minute fire rated resistance doors
• Upgrade works were also completed to the doors accessing any electrical fuse board, which ensured increased fire protection and was completed by 28.03.2024.
• Smoking areas in the Erris unit will be reviewed, and a plan will be developed to complete this in line with resident requirements. This will be completed by 30.09.2024. In the interim, a risk assessment will be implemented for each resident utilising the smoking area.
• Hoist battery charging points have been removed from the nurse's station, and an electrician has reviewed the charging area in the Lambay unit to ensure appropriate power loads on individual power sockets. This was completed by 10.03.2024. Additional fire detection/smoke heads have also been installed in this area. This was completed by 28.03.2024.
• A review has been undertaken of the cross corridor doors in Shenick, they are not intended to function as a fire door, they were installed as an infection control measure, however they will be linked to the fire alarm. This will be completed by 31st May 2024.
Means of Escape:
• Immediate action was taken to address the storage of inappropriate items in any disabled refuge area. The Senior Management Team monitors this, and staff completes checks on these areas. Completed by 31st of March 2024
• All work to the rear of the Erris unit was completed by 31.03.2024, which was the agreed date for completion of works as per the previous action plan.
• The external escape area to the side of Lambay will require work to be completed. A risk assessment is in place while we await contractors' availability to complete this project. Dates for completion are TBC and are dependent on their availability. We are currently in the process of appointing a contractor to complete this work. It is expected that the appointment of a contractor will within 4 weeks and a further 4 weeks for completion. We expect this to be completed by 31st of August. If there are any delays in this process which are out of our control the Regulator will be updated.
• A fire safety engineer will review the issues identified within the report, and a plan will

be implemented to address them accordingly. This will be completed by July 31st 2024. The fire exit in communal spaces 1 and 2 has had an emergency directional sign installed. Access controls at this door with a break glass unit have been installed by Altech access control and security company. This was completed by 28th of March 2024.
• A fire safety engineer will review the timber ceiling in the area identified if issues remain with this area, as the fire cert has been issued on the basis that this ceiling was in place at the time of issue. This will be completed by July 31st 2024.
Fire Precautions:
Following the incident where a resident exited a fire exit door, the Registered Provider, following this review confirmed that;
• To addres the concerns in relation to the oversight of fire safety in the centre. A review and update of the Fire Safety Management Proograme has been completed and implemented at the centre. This was completed in conjunction with a fire competent person and the management of the centre. This will come into effect on the 1st of July, this is to facilitate staff education around staff education around new policy and protocols.

This new programme includes:
• An Updated Fire Safety Management Policy and strategy – including how to manage fire risk.
• An Updated Emergency Response Plan
• A Building Saftey Engangement Strategy- Which outlines the communication process between TWPC and GHC
• This will be compelted by 1st of July 2024.

The program will achieve the oversight of fire risk by using the following steps in line with best practive and guidance:
1. Identify Potential Fire Hazards
2. Determining who might be at risk
3. Evaluating the level of risk and implmenting control measures
4. Recording findings
5. Providing informaiton and training to those at risk
6. Implementing fire risk control measures ie, Fire Detection and warning, Means of escape, Fire Fighting equipment, Fire Emeregency plan, Fire safety training, and Fire prevention.
This will be completed 1st of July 2024.

• The Incident did not involve the Centre's fire detection and alarm system, which complies with I.S. 3218 2013+A12019. The Centre's fire detection and alarm systems are fully functional, serviced and certified. The Incident was isolated to the access control system and did not engage the functionality of the Centre's fire detection system.
• The Centre's Management Team has delivered all toolbox talks. An external provider delivered training on the emergency exit access control and how to ensure it is reset correctly to all centre staff. In addition, the Registered Provider has arranged for a competent external provider to deliver fire safety training to its staff, and the training is CPD-certified 31st of July.
• Management confirms that training videos on resetting access control alarms on all doors within the Centre have been developed for each unit and circulated to all staff using Altra services, the training platform. Regular spot checks are in place and

completed by the management team. There is a sign in sheet on every unit to demonstrate that the staff have completed the training. This will be added to the induction program for new starters. Completed by July 15th 2024.
• Management confirms that resetting keys are available for all fire exit doors in the Centre. The keys for resetting the panels and green boxes are in each nurse's station.All checks on exit doors and access controls are now recorded, and a record of these checks are kept on each unit. Completed by 30th April 2024.
• Since the inspection, 3 fire training sessions have been held, with 6 additional sessions scheduled. All staff will have completed this by 30.06.2024. A system has been implemented to ensure all staff are scheduled for training per best practice. The PIC will oversee this monthly. Completed by 31st of July 2024.
• The fire certificate granted to the building is granted on the basis that not all bedrooms in some parts of the building do not require automatic door closures. Through fire training, staff are all educated on the importance of ensuring doors are closed after any evacuation; this is also monitored and fed back to all staff during fire drills completed in the centre. As part of the training program staff are advised to close doors on successful completion of an evacuation of a room, staff also actively monitor rooms to ensure doors remain in line with best practice and current guidelines. This has been updated in line with the new fire safety program. This will be completed by 1st of July 2024.
• The fire doors along the escape route in Erris and Shennick have had all ironmongery upgraded, and this was completed by 31.03.2024. We are awaiting a sign-off report on this work by SVS, a contractor specialising in compartmentation who was on site the week of 15.05.2024. We acknowledge the published report received introduces confusion regarding ironmongery on certain doors including self-closing devices. We have requested the company who carried out the survey to provide clarification on this matter. Once clarification is sought any actions required will be reviewed and a timeline for completion will be updated to the Regulator. Competed by 31st of August 2024.
• In regards, to the Door replacement We are currently in the process of appointing a contractor to compelte this work. It is expected that the appointment of a contractor will within 4 weeks and it is estimated that once the contractor is appointed the procurement date for the doors will be updated to the regulator. We expect this to be completed by 31st of August. If there are any delays in this process which are out of our control the Regulator will be updated.
• Additional detection outlined in the report was all installed by 28.03.2024.
• A fire safety engineer has completed a review in collaboration with the Management team, and new fire evacuation plans will be updated and displayed in the home Fire action instructions on display have been updated. Completed by 30.06.2024.

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:
• Oversight of residents' assessment and care plan is supported by the oversight afforded

at the Clinical handover daily with the Person in Charge to ensure the changing needs of all residents are responded to appropriately and all assessments and care plans are updated accordingly. An assessment and care plan review will be undertaken every 4 months in line with regulation, and with the involvement of the resident and their family, if they so wish. This is being achieved by meetings held with all residents and family by the RGN/CNMs. This meeting is documented on Epic with additional oversight by the Person in Charge, this will be completed by June 30th 2024, with ongoing review.
• A safeguarding care plan has been completed for residents who were subject to verbal abuse. 31st May 2024.
• The residents admitted with fractures will have a pain assessment completed and will be routinely assessed for pain which will be recorded in their daily notes. Nurses have been educated to record the effectiveness of medication prescribed for pain. 30th June 2024.
• A care plan is updated for the residents who had a fall and bruising. This process of updating care plan following an incident will be continued. 31st May 2024.
• There are no residents in the centre who require one to one care. This resident has been safely discharged from the centre. . If there is a requirement for 1:1 supervision, an assessment of care and care plan of needs will be completed by the PIC. The roster will reflect the 1:1 Supervision and the daily allocations to that resident. If there was a resident who required 1:1. A review of the resident and the care needs required would be completed internally. Following this review the staffing allocations would be adjusted within the centre to support the allocation of increased supervision for Resident on the specified unit. The increased supervision is allocated within the staff allocations book which remains on the unit. This is completed by the CNM on duty a daily basis, with additional review and oversight by the ADON on duty.In addition, a risk assessment would be completed for the protection of residents on the unit. This will be reviewed on a regular basis in line with the changing needs of all residents on the unit. Completed by 31st of March 2024.
• The resident with CPE have a dedicated bathroom. This bathroom is reserved for the resident with a colour coding system and all staff is aware of this colour codes. Completed on 30th March 2024. This will be updated in the care plan by 15th of June 2024.
• The care plan of residents who had broken skin was reviewed and updated. The resident is being repositioned as per the care plan. 31st May 2024.
• In line with the review of pre admissions all reports completed by OT will be requested from the referring hospital. Completed by 31st March 2024.
• The care plan of residents who have responsive behaviors are reviewed and updated. Completed by 30th June 2024
• All residents care plan reviewed and updated with the resident preferences on their shower frequency. Residents are receiving shower as per the care plan and being discussed in the handover if there is a refusal/omission. This is monitored on a daily basis by the clinical nurse manaagers. Completed on 31st May 2024.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care: • A pain assessment (Abbey Pain Scale) has been completed for all residents in the centre and a care plan is updated as required. The residents who have a care plan for pain management will be routinely assessed for pain which will be recorded in their daily notes. Also the staff nurses have been educated to record the effectiveness of medication prescribed for pain in their daily notes. 30th June 2024. • All residents who are in chairs which are tiltled, have had referrals to the OT services in the community, which has a delayed national waiting list. Private services have been offered to families and residents in the meantime. Further information received from community services on the 4th of June stating that referrals will go live on 24th of June and referrals will be accepted in the interim All referrals have been sent to the adult primary care services for the residents who need OT assessment. Completed by 31st Dec 2024. • A full review of incident reporting process has been undertaken by PIC and implemented a new incident review process. All open incidents will be reviewed daily by CNMs/ADON. This oversight ensures that all relevant information is accurately recorded and completed, including any updates or learning following any incident. This will be reviewed by PIC/ADON and will close it when it is complete. This will assure the PIC that all assessments have been carried out post incident. This is completed by May 15th 2024, with ongoing review by the PIC.	
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: • Refresher training on Responsive Behaviour in person is underway. This training covers how to respond, manage and report responsive behaviour. RPR/PIC will ensure this has been managed in the centre by monitoring the incident reports. 97 staff completed responsive behaviour training. The staff who are yet to complete this training will be completed by 31st August 2024. • PIC will complete a full review of restrictive practices within the centre by 30/06/2024. This review include care plan update regarding the least alternatives that have been tried, including the length of time and outcomes. The lesson learned and action plan will be completed by 31st August 2024. • All residents who request their doors to be locked have an updated care plan to reflect this. Spot checks on locked doors are completed by 15th of June by PIC/ ADON/CNM's. • A care plan audit on residents with responsive behaviour and the use of restraint have been completed and the action plan will be completed by 30/06/2024. • The PIC reviews all incidents on a daily basis to ensure that any behaviour that is possibly escalating or requiring safeguarding input is managed in a timely manner. Any incident requiring notification is submitted in the timeframe. Completed by 30th April 2024.	

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• All contracts outlining additional funding and the breakdown of such have been reviewed and updated.
• A detailed care plan audit on residents who have exit seeking behaviours will be completed on 30th of June 2024 followed by the completion of action plan which will ensure the RPR that the care plans in place are adequate.
• The allocation in each unit clearly shows the staff who is allocated for lounge and corridor supervision which will protect the residents in their room. Completed by 31st May 2024. There will be an hourly safety check on residents who stays in their room. Completed by 31st June 2024.
• PIC continues to have an ongoing communication with RPR by email, meetings and report. Safeguarding audits in the electronic system is accessible to RPR. All staff and management staff have completed the safeguarding training.
• The care plans for all residents receiving additional funding have been updated to outline the allocation of funding for each individual. These have been reviewed by the Person in Charge. The centre has an updated policy and procedure in place in order to manage residents finances. Each resident's contract of care will be updated to reflect the additonal funded and care plans will be updated to reflect the same. This will be compelted by 31st of July.
• Any resident admitted to the home with additional funding will have an updated contract of care to reflect the additional funding and services provided. This will be overseen by the PIC. All care plans will be updated to reflect the same and residents and families will be informed of the same 31st May 2024.
• The assessment and care plan review will be undertaken every 4 months in line with regulation, and with the involvement of the resident and their family, if they so wish. This will ensure that any resident in receipt of additional funding clearly understands the options available to them. This is being achieved by meetings held with all residents and family by the RGN/CNMs. This meeting is documented on Epic with additional oversight by the Person in Charge, this will be completed by June 30th 2024, with ongoing review.
• Staff complete Safeguarding training as part of their mandatory training before commencing in the centre. As of May 21st 2024, ALL staff have completed safeguarding training on HSELand. This is also being supported with in person training delivered in the centre. Completed on 31st May 2024.
• Any complaints, incidents or omissions of care which may be a safeguarding issue are discussed in the daily report/handover to PIC. The safeguarding plan will be communicated with the team through addition of same to the resident's care plan and discussed verbally at handover to ensure staff are aware of measures put in place to ensure the safety of residents and staff. Completed by 31st May 2024.
• A safeguarding audit and this will be completed on a monthly basis going forward. The findings of this audit will be shared at staff meeting, with safeguarding a set agenda item at CNM and staff meetings to support staff understanding. Completed by 31st May 2024.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• We have a safe staffing level in all units as per the occupancy. Staff has been educated through handover and reports daily regarding the improtance of residents choice and rights based approach. All staff to complete training on Human Rights-Based Approach by 31st July 2024.
• All staff are aware that old institutional practices cannot be continued and the residents privacy and dignity has to be maintained at all times especially covering them properly when they are transferred from communal shower to their bedroom. Completed on 31st March 2024.
• The care plans for all residents receiving additional funding have been updated to outline the allocation of funding for each individual. These have been reviewed by the Person in Charge. The centre has an updated policy and procedure in place in order to manage residents finances. Each resident's contract of care will be updated to reflect the additonal funded and care plans will be updated to reflect the same. This will be compelted by 31st of July.
• Any resident admitted to the home with additional funding will have an updated contract of care to reflect the additional funding and services provided. This will be overseen by the PIC. All care plans will be updated to reflect the same and residents and families will be informed of the same 31st May 2024.
• A review of the activities has been completed with the residents input at resident meetings and familiy meetings. These meetings were held in April 2024. Following the feedback from the residents and family a plan was delveloped as follows:
• A seven day a week activities plan is developed by the acitvity staff. This is overseen by the clinical nurse managers. This will identify activities on each unit and communal activites 7 days a week. The usual pattern for activities is 4 activities on each unit a day- depending on the requirements and preference of the residents on the units. With both internal and external providers. The activitiy co-ordinators ensure the activity schedule is delivered to each unit with the assistance of HCA's. At each resident meeting the residents can give feedback on activitiy schedules and any issues or preferences will be addressed. Each resident has an acitivy care plan to reflect their preferences. Completed 31st May 2024.
• An 'English Language Only' message from senior management went to all staff and also this has been discussed in staff meetings to ensure all staff will follow it. Completed on 31st May 2024.

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	31/07/2024
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	31/07/2024
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	31/07/2024
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	Not Compliant	Orange	31/07/2024

	and are available for inspection by the Chief Inspector.			
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 the statement of purpose.	Not Compliant	Red	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	Red	31/07/2024
Regulation 23(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.	Not Compliant	Orange	15/09/2024
Regulation 23(e)	The registered	Not Compliant	Orange	15/09/2023

	provider shall ensure that the review referred to in subparagraph (d) is prepared in consultation with residents and their families.			
Regulation 23(f)	The registered provider shall ensure that a copy of the review referred to in subparagraph (d) is made available to residents and, if requested, to the Chief Inspector.	Not Compliant	Orange	15/09/2023
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	30/09/2024
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.	Not Compliant	Orange	31/08/2024
Regulation 28(1)(b)	The registered provider shall provide adequate	Not Compliant	Orange	31/08/2024

	means of escape, including emergency lighting.			
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Red	31/07/2024
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.	Not Compliant	Orange	31/08/2024
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	31/08/2024
Regulation 28(3)	The person in charge shall ensure that the procedures to be followed in the	Not Compliant	Orange	31/08/2024

	event of fire are displayed in a prominent place in the designated centre.			
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	31/07/2024
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	31/07/2024
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Substantially Compliant	Yellow	31/07/2024
Regulation 5(4)	The person in charge shall	Not Compliant	Orange	31/07/2024

	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 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.	Substantially Compliant	Yellow	31/12/2024
Regulation 6(2)(c)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the care referred to in paragraph (1) or other health care service requires additional professional expertise, access	Substantially Compliant	Yellow	31/12/2024

	to such treatment.			
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	31/08/2024
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	31/08/2024
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	31/08/2024
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Orange	31/07/2024
Regulation 9(1)	The registered provider shall carry on the business of the designated	Substantially Compliant	Yellow	31/07/2024

	centre concerned so as to have regard for the sex, religious persuasion, racial origin, cultural and linguistic background and ability of each resident.			
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Not Compliant	Orange	31/07/2024
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	31/07/2024
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	31/07/2024
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Not Compliant	Orange	31/07/2024