Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	Glendonagh Residential Home
Name of provider:	Glendonagh Residential Home Limited
Address of centre:	Dungourney, Midleton, Cork
Type of inspection:	Unannounced
Date of inspection:	25 April 2024
Centre ID:	OSV-0000229
Fieldwork ID:	MON-0039098

About the designated centre

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

Glendonagh Residential Home is located near the village of Dungourney in East Cork. It is set on well maintained, extensive grounds. The centre is registered as a designated centre under the Health Act 2007 for the care of 42 residents with 24-hour nursing care available. The centre is registered to provide accommodation for 42 residents over two floors. There is a specific nine bedded dementia care unit for residents who required additional support called the Orchard unit. Care is provided by a team of nursing staff who are supported by care, catering, household and activity staff. Medical and allied healthcare professionals provide ongoing healthcare for residents.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	40

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
Thursday 25 April 2024	08:20hrs to 18:15hrs	Siobhan Bourke	Lead
Thursday 25 April 2024	08:20hrs to 18:15hrs	Breeda Desmond	Support

What residents told us and what inspectors observed

This was an unannounced inspection carried out over one day. The inspectors met a number of residents in the centre to gain an insight into their experiences of living in Glendonagh Residential Care Home and spoke in more detail with eight residents. Overall, the feedback from residents was positive and residents told inspectors that staff were kind and caring to them. A small number of residents outlined that when they called for staff, they sometimes knew that they may have to wait for assistance, but that they would always come to them. The inspectors met with four visitors who were happy with the care provided to their loved ones.

The inspectors observed that action was required to ensure residents' safety was promoted at all times, in particular in relation to nursing staffing levels at night, infection control practices and fire precautions. These findings will be outlined further in the report.

The person in charge accompanied the inspectors on a walk around the premises, where inspectors met with residents and staff. Glendonagh Residential Care Home is located on spacious, well maintained grounds, near the rural village of Dungourney. The centre has three floors, with 31 residents living on the ground floor and 11 residents living on the first floor, in the Manor Wing. The laundry and storage areas are in the basement of the building. Resident accommodation is in three distinct units, namely the Orchard Unit, which is a secure unit for residents living with dementia, or other specific needs. This unit has seven single rooms and one twin room for residents. The Courtyard unit is on the ground floor and accommodates 14 residents in two twin rooms and 10 single rooms. The Manor unit is over two floors with one triple room on the ground floor, four twin rooms and eight single bedrooms. The inspectors saw that bedrooms were clean and in general, well maintained. Many of the residents' bedrooms were personalised with residents' family photographs and personal possessions. Residents had plenty room for storage of their clothes in wardrobes and lockers. Each resident had access to a lockable storage box in their rooms.

The centre had a number of well-maintained communal rooms and private spaces for residents' use, including a large day room and oratory, a large dining room, the Gold room, used as a visiting room and the Green room or family room. The Green room had a TV and a bookshelf with a large selection of books. There was a large sofa and table and chairs in the room where residents could spend time with their families. The Gold room had a fireplace, plenty chairs and a table and was very homely room. There was window seating along the corridors in the courtyard where residents could sit and look out at the well maintained Courtyard garden. The inspectors noted that the multipurpose room was cluttered with equipment such as hoists, stacks of chairs and a weighing scale which took from the peaceful space.

The Orchard Unit had a small kitchenette/dining room and cosy day room. The corridors in the Orchard unit had scenic murals to brighten up the corridors and

activity boards, which residents could use as they walked up and down during the day. Residents, living in the Orchard Unit, could also access a small internal garden from the conservatory off the day room, when weather permitted. Bedroom doors in the Orchard Unit were personalised with pictures and residents' names to help them with way finding.

During the morning, the inspectors saw that access to an emergency exit was impeded by a domestic waste bin and boxes on the ground floor and a second exit was impeded by a table and chair. The person in charge ensured staff addressed this during the day.

Conveniently located hand sanitiser dispensers were installed along corridors near most bedrooms, however, there was none in close location to the triple room on the ground floor, to ensure staff had access to hand hygiene facilities. Clinical hand wash sinks were limited in the centre to the nurses' office and the sluice rooms. None of these sinks met recommended guidance. The hand wash sink in one of the sluice rooms did not have any water when the taps were turned on by an inspector. This was addressed during the inspection. The inspectors noted a commode frame that was in a resident's room was not clean. The centre had two sluice rooms on the ground floor, both were fitted with a bedpan washer. The inspectors saw that equipment such as commode inserts, urinals and bedpans that were stored on racks ready to be used were visibly unclean. These and other infection control findings are outlined in the quality and safety section of the report.

The inspectors observed the lunch time meal, in both the Orchard dining room and the main dining room. The menu was located outside the main dining room and displayed the choices available for the meal. The dining room was decorated in a homely style with lovely table coverings and flower arrangements. The inspectors saw that staff provided assistance to residents who required it in a respectful and unhurried manner. There were two sittings for lunch to ensure everyone, who chose to, could eat in the dining room. The inspectors saw that residents were offered a choice of main course and meals appeared wholesome and appetising. A choice of sauces such as white sauce and gravy were offered with the main course. Residents who required modified textured meals were also offered a choice of main course. Residents told the inspectors that the food was "lovely" and "tasty."

The inspectors observed residents and staff interactions throughout the inspection which were seen to be respectful, unhurried and friendly. Nursing and care staff appeared to know residents well. During the morning walkaround, the inspectors saw that staff consistently knocked before entering residents' rooms to ensure their privacy and dignity were respected. The inspectors saw that residents living in the dementia unit were gently directed by staff. Residents appeared to be well dressed, according to their preference.

The inspectors observed that the activities programme available for residents had improved since the previous inspection. An activity co-ordinator, who was also one of the clinical nurse managers was responsible for ensuring that varied and stimulating activities were available every day. A health care assistant was assigned to the day room every day from 11.00hrs to assist with activities. Residents told the

inspectors that they loved the external musicians who attended the centre, and they enjoyed a lively exercise class that was also available once a week. The inspectors saw posters on display for an upcoming tea party in aid of Alzheimer's awareness week. During the morning, inspectors saw that a care assistant engaged residents in small group activities and ball games. Residents appeared delighted with a visit from a therapy dog in the day room and the dog and their companion also went to visit residents in their bedrooms. In the afternoon, an external provider led a Zumba class in the day room.

Residents were consulted regarding the running of the centre through residents' meetings and surveys. In general feedback from residents was positive.

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

Capacity and capability

This was an unannounced inspection to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). Findings of this inspection were that significant action was required by the registered provider, to improve the governance and management of the service. There were inadequate resources in relation to availability of nursing staff in the centre and the provider was operating the centre without the agreed nursing complement as outlined in the centre's statement of purpose. Action was also required in relation to Regulations 16 training and staff development, 23 governance and management, 27 infection control and 28 fire precautions to achieve regulatory compliance. These will be detailed under the relevant regulations.

The registered provider for Glendonagh Residential Home is Glendonagh Residential Home Ltd. The registered provider company has two directors, one of whom is actively involved in the management of the centre and is the nominated person representing the provider. The designated centre also had a full time administration manager.

The person in charge, who was the director of nursing, had the required experience and qualifications for the role. The person in charge was supported in their role by one full time clinical nurse manager and a second clinical nurse manager who also had the role of activity coordinator. A person who was previously the director of nursing for the centre, was employed two days a week, to assist the person in charge with completion of audits and other administrative duties, pertinent to their role. There was a team of nursing, health care, catering, house hold, administrative and maintenance staff working in the centre. The findings of the inspection were that the nursing staff complement were not adequate to meet the assessed needs of

the 40 residents living in the centre, as outlined under Regulation 15 Staffing.

A suite of both online and face-to-face mandatory training was available to all staff in the centre and staff were up-to-date with training including, fire safety, manual handling, managing behaviour that is challenging and safeguarding. One of the clinical nurse managers undertook small group face-to-face training with staff on issues such as dysphagia, wound care, personal care and care planning training. The inspectors were satisfied that there was appropriate supervision of care staff during daytime hours, however, this could not be assured during night time hours, as there was only one registered nurse on duty each night, to supervise care staff working over two floors, with one care staff member assigned to the secure dementia unit. This is outlined under Regulation 16;Training and staff development.

The provider had a schedule of meetings to ensure effective communication between management and the team providing care. From a review of minutes of these meetings, it was evident that key issues such as training, care of residents, activities and infection control were discussed at these meetings. There was a schedule of audits in place to monitor the quality and safety of the service provided. The person in charge also collated and monitored key clinical risks to residents such as falls, pressure ulcers and use of restraint. There was a good system of three monthly multidisciplinary review of residents' medicines by the person in charge, a GP and the pharmacist. There was good oversight of residents' nutritional care through audit. Infection control practices such as hand hygiene, use of PPE and equipment and environmental audits were also undertaken. However, the good compliance found in provider audits were not reflected with the findings of the inspection in relation to infection control. Furthermore, oversight of fire precautions and care planning was also required as detailed under Regulation 23; Governance and management.

Residents who spoke with the inspectors were aware how to make a complaint. Complaints were recorded and investigated by the management team. The provider had a complaints procedure displayed in the centre and in each bedroom. The inspectors saw that this procedure was not in line with the updated requirements of the regulation. This and other findings are outlined under regulation 34 Complaints procedure.

From a review of recorded incidents in the centre, an inspector saw that required notifications were reported to the office of the Chief Inspector in line with regulations.

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 had been prepared for 2023.

Regulation 15: Staffing

Inspectors were not assured that night time nursing staffing levels were appropriate

to meet the assessed needs of the 40 residents living in the centre at the time of inspection, given the size and layout of the centre. At the time of inspection, there were 15 residents who had been assessed as having maximum needs and 11 residents with high care needs, which meant that the majority of residents living in the centre require a high or very high level of care.

The nursing staffing levels in the centre's statement of purpose outlined that seven whole time equivalent (WTE) nurses were available. At the time of inspection, there were only six nurses available to the roster.

From a review of rosters and from speaking with nursing staff and management, the provider had only one registered nurse rostered from 7.30pm to 7.30 am each night. There were two health care assistants rostered each night from 7.30pm to 7.30 am and a third health care assistant rostered for a twilight shift from 7:30pm to 11.30pm. A resident was actively dying, in the nights preceding the inspection, and required close nursing observation, medical input and palliative symptom management. This meant that the only nurse available would have limited time to support other residents or administer night time medications uninterrupted. This nurse was also responsible for supervision of care staff working over two floors, furthermore, one of the two care staff was assigned to the secure dementia unit that could accommodate nine residents, leaving just one care staff and one nurse to support the remaining residents from 11.30pm each night.

The provider had previously committed to having two nurses and two care staff rostered at night but this was not in place at the time of this inspection and had not been in place for a long period of time.

Judgment: Not compliant

Regulation 16: Training and staff development

While staff were provided with training appropriate to their roles, care staff were not appropriately supervised at night.

At night, there was only one nurse on duty who was responsible for the supervision of care staff working over two floors, as well as ensuring supervision of staff working in the secure dementia unit, where one care staff worked alone during the night.

Judgment: Substantially compliant

Regulation 23: Governance and management

The inspectors found that the designated centre was not adequately resourced, as

evidenced by nursing staff shortages outlined under Regulation 15 staffing.

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. This was evidenced by the following:

- There were insufficient assurance mechanisms in place to ensure compliance with the National Standards for infection prevention and control in community services as reflected in the findings related to ineffective oversight of decontamination processes as outlined under Regulation 27;Infection control.
- Oversight of fire precautions required review to ensure that simulations of evacuation of the largest compartment reflected the availability of three staff working in the centre at night after 11.30pm and monitoring of escape routes.
- the oversight of care provided to residents at night required action as there was only one staff nurse on duty to supervise staff working over two floors and in the secure dementia unit, therefore the provision of care to all residents could not be assured, taking into account the dependency needs of the residents and the size and layout of the centre.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

Residents had a signed a contract. The contract detailed the services provided to each resident whether under the Nursing Home Support Scheme or privately. The type of accommodation was stated along with fees and the room number.

Judgment: Compliant

Regulation 31: Notification of incidents

Incidents occurring in the centre were recorded and monitored by the person in charge. From a review of records of incidents, it was evident that notifications were reported to the office of the Chief Inspector as required in the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

The complaints procedure was displayed in the centre and in residents' bedrooms,

however, it required updating to reflect the current complaints officer and review officer for the service.

Written responses provided to complainants did not include whether the complaint was upheld, and details of the review process required in the regulations.

Judgment: Substantially compliant

Quality and safety

Overall, this inspection found residents had good access to medical care and reported they felt safe in the centre. However, action was required in relation to infection control, fire precautions and individual assessment and care planning to ensure residents' safety at all times. Findings will be detailed under the relevant regulations.

The inspectors reviewed a sample of residents' files and found evidence that residents' care plans were completed within 48 hours of admission to the centre in line with regulatory requirements. Each resident had a care plan in place. Residents' assessments were completed using validated tools and the inspectors saw that care plans were person centred. However, some residents' individual clinical assessments and care planning required action in relation to ensuring residents' medical histories formed part of their assessment and other findings as outlined under Regulation: 5 Individualised assessment and care plan.

From a review of records, it was evident that residents had good access to GP services and a GP was onsite on the day of inspection. Arrangements were in place for residents to access the expertise of health and social care professionals such as speech and language, dietitian and palliative care through a system of referral.

The person in charge was the lead for infection control for the centre. The inspectors saw that there was an adequate number of housekeeping staff rostered to ensure the centre was clean. There was a schedule of daily and deep cleaning of rooms. The inspectors saw that residents' bedrooms and communal areas were visibly clean and residents who spoke with inspectors reported that their rooms were cleaned on a daily basis. A number of practices were identified which had the potential to impact the effectiveness of infection prevention and control within the centre. These included inconsistencies in the implementation of standard infection control precautions including equipment decontamination, management of waste and hand hygiene practices. Findings in relation to these are outlined under Regulation 27 Infection control.

An inspector reviewed the fire folder and saw the provider had systems in place to monitor fire safety precautions and procedures within the centre. The inspector saw records available, indicated that quarterly and annual testing of the fire alarm and emergency lighting was in place. Fire-fighting equipment was serviced annually.

However, the inspectors saw that an escape route was not clear and partially obstructed. This and other findings are detailed under regulation 28 fire precautions.

Residents had access to an independent advocacy services. Residents were consulted in the running of the service through residents’ meetings and surveys. The provider also held family meetings and consulted with families through surveys to ascertain their views on the service. Residents had access to daily and weekly newspapers and television. There was a schedule of activities available for residents which was seen to have improved since the previous inspection.

Regulation 10: Communication difficulties

From a review of a sample of care plans, it was evident that residents who experienced communication difficulties were supported by the care team to communicate freely and specialist communication requirements were recorded in their care plans.

Judgment: Compliant

Regulation 11: Visits

There was an open visiting policy in the centre, and visitors were seen coming and going during the day to visit residents. Visitors could meet residents in their bedrooms or in one of the two visiting rooms in the centre.

Judgment: Compliant

Regulation 12: Personal possessions

The provider ensured residents' laundry was managed onsite and clothes were labelled to ensure they were returned to residents after laundering.The inspectors saw that residents had lockable storage in their rooms to keep their valuables.

Judgment: Compliant

Regulation 17: Premises

While overall, the premises met the requirements of Schedule 6 of the regulations,

the inspectors saw that storage throughout the centre required action. The multipurpose room, which is registered as a communal space for residents, was used to store hoists, a weighing scales, wheelchairs and stacks of seats.

The hairdressing room had storage of clinical supplies which in not in line with its function.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Residents were complimentary about the food provided and the dining experience, however, a number of residents sitting together at dining room tables, in the main dining room, were not always served their meals at the same time, to enable them to have a sociable dining experience. While some care staff ensured that consent was sought from residents prior to putting on clothes protectors, a few did not. The person in charge agreed to monitor this.

Judgment: Compliant

Regulation 25: Temporary absence or discharge of residents

Copies of transfer letters were kept in residents' files. When residents were transferred to or returned from hospital, inspectors saw evidence that relevant information was communicated between services.

Judgment: Compliant

Regulation 27: Infection control

The inspectors found that the registered provider had not ensured that some procedures were consistent with the National Standards for infection prevention and control in community services (2018). The following findings required action:

Equipment was not managed in a way that minimised the risk of transmitting a health care-associated infection. This was evidenced by:

- a number of commode inserts and urinals on a storage rack within a sluice room were visibly unclean. Ineffective decontamination increased the risk of cross infection
- a commode was visibly unclean in a resident's ensuite

- the inspectors saw a staff member empty a urinal into the equipment sink in one of the sluice rooms. Jugs used for emptying urinary catheter bags were not decontaminated in the bedpan washer and were being manually decanted into toilets and then washed by staff. This increased the risk of environmental contamination and the spread of MDRO colonisation,
- a dust pan and brush were very unclean and were stored in one of the centre's sluice rooms, this risks cross contamination
- some surfaces such as ends of bed frames and lockers were worn and could not be effectively cleaned
- a number of bed bumpers, used to protect bedrails on residents beds were worn and cracked and could not be effectively cleaned.

Staff access to hand hygiene facilities required review as evidenced by the following:

- there was no immediate access to alcohol hand gel in or near the triple room on the ground floor
- there was no water in the hand hygiene sink in one of the sluice rooms
- there was a limited number of hand wash sinks dedicated for staff use in the centre. The available hand hygiene sinks did not comply with current recommended specifications for clinical hand hygiene sinks.

There was no signage over hand hygiene sinks in one of the sluice rooms to prompt staff to use correct hand washing techniques.

There was no access to gloves and other PPE in the sluice rooms for staff.

Two staff were observed wearing wrist watches and other hand jewellery and therefore were not bare below the elbow in line with best hand hygiene practices.

Judgment: Not compliant

Regulation 28: Fire precautions

The provider was not taking adequate precautions against the risk of fire as evidenced by the following findings:

- an emergency exit with two doors had a latch lock on the inside of one of the doors, which may impede a safe exit in an emergency, the provider agreed to remove this lock immediately on the day of inspection,
- floor plans displayed throughout the centre did not contain enough information, such as primary or secondary evacuation routes in the event of a fire
- an escape route on the ground floor was cluttered with a domestic waste bin, and boxes and bags and therefore was not clear in the event of an emergency
- in the basement, an escape route was also obstructed with boxes of clinical supplies

- while the provider conducted drills, records did not indicate that simulations of evacuations of the largest compartment in the centre were conducted with minimum staffing levels available as there were three staff on duty after 11.30pm every night
- residents' personal emergency evacuation plans did not record the residents' night time requirements which may differ to those required during the day
- an emergency light on an exit route near the laundry was noted to be broken.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Actions were required in relation to the documentation of discarded controlled drugs. An inspector saw that where a portion of an ampule of a controlled medication was administered as prescribed, records maintained in the centre did not record that the remaining solution was discarded in line with best practice professional guidelines.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Based on the sample of care plans viewed, action was required in individual assessment and care plans to ensure the needs of each resident are assessed and an appropriate care plan is prepared to meet these needs. As evidenced by:

- while administration of prescribed subcutaneous fluids was recorded on the daily progress notes, total intake of prescribed subcutaneous fluids were not recorded on the care plan system nor on a paper record as required to enable assessment and monitoring of residents hydration levels.
- residents medical history was not consistently used to inform assessments and care plans
- personal emergency evacuation plans required review to ensure they included assessment of residents mobility at night time as well as day.

Judgment: Substantially compliant

Regulation 6: Health care

From a review of a sample of residents' files, there was evidence that residents had

good access to medical services from local GP practices who attended the centre regularly.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

The provider ensured staff were provided with appropriate training on managing responsive behaviour. There was evidence that alternatives to bedrails were trialled in the centre. Staff were seen to interact with residents in a dignified and respectful manner. The inspectors saw that a number of bedrails that were restrictive were recorded as enablers, the person in charge agreed to review this during the inspection.

Judgment: Compliant

Regulation 9: Residents' rights

Residents had access to advocacy services when required. The provider held residents' meetings and surveys to ensure residents were involved in the running of the centre. A member of the nursing team was assigned as activity co-ordinator and was responsible for ensuring care staff were assigned to activities along with external facilitators such as musicians, exercise and dance facilitators and arts and crafts. Residents had close links with the community and were encouraged to go on outings with their relatives and also enjoyed a recent visit from a local school to the centre. Residents also had access to the local mobile library service.

Judgment: 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	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Glendonagh Residential Home OSV-0000229

Inspection ID: MON-0039098

Date of inspection: 25/04/2024

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 compliance plan response from the registered provider does not adequately assure the chief inspector that the action will result in compliance with the regulations.

The assessment of residents using the Barthel Index demonstrates Glendonagh's commitment to continuously review the ever evolving requirements of our residents. This ensures staff are able to meet residents needs at any point in time, both day and night.

Glendonagh has never at any point in its history fallen short of the Health Act 2007 (S.I. 415/2013 15/2) in ensuring there is a qualified staff nurse on duty 24/7. Glendonagh in line with HIQAs core function strives to ensure continuous improvement.

However note the following actions:

Our on call system has been further formalized on the roster and a written report put in place should it be required. The report is completed by the nurse on duty and documents the reasons for additional resource and the support provided. The report is submitted to management for review and discussion. We have also implemented a 3-monthly audit of the on-call system, the first of which will be due in August 2024 . The review will be carried out by the DON and CNM. Please see sample documents attached.

Glendonagh is ready to implement the MADOS (Medication Administration Observation Sheet) to support a quantifiable review of the protected time for the nurse to carry out their medication round. Please see document attached. Once in place this will be reviewed monthly. The first review is expected in Aug.

On completion of the above audits we will carry out a full review of staffing focusing predominantly on nursing care provision during twilight hours to assess actual or potential negative outcomes for residents. To be completed by September 2024. We will

also ensure outcomes are communicated to our regulator.

Currently we can support a twilight shift within our nursing roster however this does impact our level of flexibility on the general roster.

As 7 day consistency is imperative when making any change Glendonagh has started the recruitment process in order to ensure we maintain flexibility across the nursing team. Given our experience with recruitment we would suggest a 3 month time frame to have this additional resource in place. We welcome discussions at any point in regards, the above.

Glendonagh is committed to ensuring a high quality of service at all times and gives a commitment of September for the completion of audits with a further target of October 2024 for additional nurse to be in place. This additional resource is to support a twilight shift ensuring a protected medication round and also ensure our current level of flexibility within the roster is maintained.

Regulation 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:

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.

We place enormous emphasis on training across all teams in particular our HealthCare team – Nurses and HCAs. All staff whom are recruited are qualified to the highest level within their field. Glendonagh provides a thorough induction program over a minimum 3 day period or until staff member is competent. Mandatory training is provided as well as supplementary training from both external sources and a sharp inhouse training program which is carried out weekly. Our inhouse training is overseen by our CNM and includes group education sessions alongside one to one training, to ensure everyone is trained to the highest standard. Furthermore staff are continually encouraged to complete various relevant education on HSELand. Night Team members, Nurses and HCA, have all completed a minimum 6 months training on day before going on nights, this ensures they are familiar with our residents, building and the high standards which we expect.

The night shift commences with a full detailed handover from Day to Night Team followed by a Night Team huddle to discuss specific individual needs in each area for the night ahead. Huddles are carried out again after the medication round and when all

residents are settled to discuss any issues that have arisen and any extra care needs of the residents. A third and final huddle is held before handover in the morning. Furthermore, throughout the night the nurse is updated after each hourly check is completed by the HCA in each area.

In regards protected medication round time, a nurse is continuously supervising the care being provided by the HCA's to residents as they complete their round – this is no different on day or night. A MADOS will be implemented to capture disturbances over the next 2 months – July and Aug – to ensure they have sufficient quality time to carry out their task. If it is felt this is not possible a twilight shift will be introduced.

Throughout the night the nurse, in between completing their own tasks, continues supervision of staff throughout the whole building by conducting walk-abouts and liaising with HCA's- again similar to that of the duties as a day nurse. During morning personal care, the nurse is actively involved in same and continues to supervise the care being provided and resident's needs.

Given the difference in care levels on night and the increased ratio of nurses to carers - 1:2/2.5 NIGHT as opposed 1:3/3.5 DAY Glendonagh does not have any concern in regards protected time or supervision however we give our commitment to continue to monitor and audit in a quantitative manor.

Please note in addition to the above HCAs have clearly defined allocations so as the nurse is aware at all stages what they their responsibilities are throughout the night. Our nurse when in med rounds will always wear their apron to indicate their protected time and all staff members are aware unless urgent they are not to be disrupted. Glendonagh also has 32 cameras around the facility with a overview main screen in the nurses station. Phones are located in every room as well as all corridors. Nurse call systems are also located at each bedside and all communal spaces. A full fire alarm system is also in place which is audited quarterly by a professional external company, it is tested weekly and reviewed daily in house to ensure it is fully operational.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Governance by definition corresponds to the processes and structures that provide autonomy, control and authority to staff regarding practices within an organization. High standards of governance are maintained by a clear framework through sharp up to date audits, regular and thorough governance meetings and daily oversight.

HIQA have deemed a non-compliance based on "not adequately resourced" specifically at

night which Glendonagh refute. After exceptionally challenging years we have stabilised our team and place a huge emphasis on staffing both recruitment and training to ensure we have adequate resource at all times. It is not financially viable or justifiable to allocate a full time second nurse on nights 7 days a week. As HIQA is aware we have trialed a second nurse at their request, however whilst you can argue increasing staffing numbers will always support better care, on review with staff and review of care and needs, a night allocation was seen to not be clinically indicated. Glendonagh review staff requirements on a daily basis and a support team is in place at all times. Glendonagh are currently going through a review with the NTPF and will request specific additional funding to meet HIQAs request in regards a second nurse.

Also noted under governance is oversight of fire – All staff are trained annually which includes fire drills. In addition, on site evacuations are regularly carried out to cover varied scenarios ie minimal staff in the largest compartments, drills from ground floor/ upper manor and varied team sizes. Glendonagh feels strongly that ensuring mixed and varied simulated evacuations rather than just minimal is important.

The process of putting the jugs in the washer as opposed hand sterilizing has been implemented. All other minor points were rectified within 24 hours.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
Complaints procedure has been reviewed and required addition made.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The oratory is a multifunctional space that is used for purposes such as events, training, quiet space for residents or small group-focused activities. It is an invaluable space however its function evolves throughout each day, hence a certain number of additional tables and chairs are kept in there to meet these needs. It also houses all our hoists for charge at night and potentially at points throughout the day.

At present we are reviewing our current salon and wheelchair storage room with the view to swopping them round to provide a larger dedicated store area for the additional hoists we recently purchased. This is likely to take circa 12 months before completion - should it go ahead. We are always reviewing our premise and pride ourselves on

ensuring it is fit for purpose and homely at all times from the moment you enter our gates.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
Hand wash sinks has been under review and discussed with HIQA on previous inspections. Glendonagh carried out a detailed risk assessment in regards the requirement for additional sinks to communal areas however it was felt the risk associated to residents superseded any benefit. Current sinks will be reviewed in regards national infection control guidelines.

Wear and tear is continually assessed within Glendonagh and items routinely replaced or upgraded. All major and minor updates are documented in the annual review as well as our regular Governance meetings. Staff are routinely reminded about the importance of reporting all maintenance and ensuring equipment is fully cleaned after use.

All other points were minor and updated within 24 hours

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Floor plans are currently being reviewed to ensure they include clear primary and secondary evacuation routes.

Simulated evacuation drills are conducted in various areas of our building with varying numbers of staff, however Glendonagh will ensure that simulated evacuations are conducted with minimum staffing levels to replicate potential for evacuation on a night shift where 1 nurse and 2 healthcare assistants are on-duty after 23:30hrs.

PEEP sheets are reviewed 3 monthly and updated as necessary. All are on display in residents wardrobes and currently are all individualized and fit for purpose should an evacuation be required. All PEEP Sheets take into consideration both day and night evacuations.

Escape routes which were seen to be obstructed on the day were cleared on the day of the inspection and staff are reminded regularly to keep all escape routes free from clutter/obstruction.

A latch lock on an emergency door was removed on the day of the inspection also

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
A discussion has been held with our pharmacy whom provide the Controlled Drugs Book. It has been decided to document discarded volume of morphine beside administrated volume going forward.

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
We have a dedicated training resource whom is rolling out supplementary training to ensure consistency across all Individual assessments and Care Plans. In addition quarterly Care Plans are reviewed quarterly by allocated nurses as well as overseen and sample checks done by management.

Full medical history is clearly documented and incorporated into each residents activities of daily living care plan under the appropriate sub section.

All resident PEEP plans contain both day and night information and are resident specific.

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	30/09/2024
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	30/09/2024
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	01/06/2025
Regulation 23(a)	The registered provider shall	Not Compliant	Orange	26/04/2024

	ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.			
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	30/09/2024
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Not Compliant	Orange	30/06/2024
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	26/04/2024
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire	Not Compliant	Orange	30/04/2024

	precautions.			
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Orange	27/05/2024
Regulation 29(6)	The person in charge shall ensure that a medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident shall be stored in a secure manner, segregated from other medicinal products and disposed of in accordance with national legislation or guidance in a manner that will not cause danger to public health or risk to the environment and will ensure that the product concerned can no longer be used as a medicinal product.	Substantially Compliant	Yellow	30/05/2024
Regulation	The registered	Substantially	Yellow	17/05/2024

34(1)(a)	provider shall provide an accessible and effective procedure for dealing with complaints, which includes a review process, and shall make each resident aware of the complaints procedure as soon as is practicable after the admission of the resident to the designated centre concerned.	Compliant		
Regulation 34(2)(c)	The registered provider shall ensure that the complaints procedure provides for the provision of a written response informing the complainant whether or not their complaint has been upheld, the reasons for that decision, any improvements recommended and details of the review process.	Substantially Compliant	Yellow	17/05/2024
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and	Substantially Compliant	Yellow	14/07/2024

	where appropriate that resident’s family.			