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:	An Teaghlach Uilinn Nursing Home
Name of provider:	Knegare Nursing Home Holdings Ltd
Address of centre:	Kilrainey, Moycullen, Galway
Type of inspection:	Unannounced
Date of inspection:	04 July 2024
Centre ID:	OSV-0000309
Fieldwork ID:	MON-0044023

About the designated centre

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

An Teaghlach Uilinn Nursing Home is a purpose-built designated centre for older people. Residents are accommodated in single and twin bedrooms. A variety of communal rooms are provided for residents' use, including sitting, dining and recreational facilities. The centre is located close to Moycullen village, Galway. Residents have access to a secure enclosed courtyard. The centre provides accommodation for a maximum of 75 male and female residents, over 18 years of age. The service provides care to residents with conditions that affect their physical and psychological function. Each resident's dependency needs are regularly assessed to ensure their care needs are met.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	37

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 4 July 2024	09:30hrs to 18:30hrs	Sean Ryan	Lead
Thursday 4 July 2024	09:30hrs to 18:30hrs	Catherine Sweeney	Support

What residents told us and what inspectors observed

Residents living in An Teaghlach Uilinn Nursing Home gave mixed feedback about their experience of living in the centre. While residents were complimentary of the staff who provided them with care and support in a caring and respectful manner, residents expressed discontent with the quality of social care they received, and the management of their feedback about the quality of the service. While residents spoke positively about staff as individuals who made them feel safe living in the centre, residents described the social care as being inconsistent. Residents attributed this to an increase in the number of residents living in the centre, and changes to the staff.

Inspectors were met by the person in charge and a person participating in the management on arrival at the centre. Following an introductory meeting, inspectors walked through the centre, reviewed the premises and external areas, and met with residents in the communal areas and in their bedrooms. Inspectors met with the majority of residents during the walk around the centre, and spoke to a number of residents in detail about their experience of living in the centre. Some residents were unable to articulate their views on the quality of the service they received. Inspectors observed that the comfort of those residents was checked by staff at periods during the day.

There was a busy atmosphere in the centre during the morning. Staff were busily attending to the residents requests for assistance in their bedrooms, while also supervising residents who were seated in the dayroom. Residents acknowledged how busy the staff were and described how this impacted on the care they received, particularly in recent weeks. One resident told the inspectors that there were 'new people' assisting them with their care needs, and this sometimes caused delays because they 'would have to tell them how to do things'. Another resident told the inspectors that they occasionally had to leave their room to find staff to assist a resident who called for help in the room next to them. Residents told the inspector that staff were very apologetic when this occurred.

The provider had made significant improvements to the premises such as renovation and redecoration of the communal areas, bathroom facilities and some bedrooms. Corridors had been redecorated and residents had contributed to the selection of colours to paint areas of the premises. The ground floor of the premises was warm, well-lit, clean and, and comfortable for residents.

Inspectors reviewed the unoccupied first floor of the premises. The dayroom was in the process of being painted. Bedrooms and en-suites were also being renovated. Wall tiles had been removed from a number of en-suite walls and building materials were observed in vacant bedrooms. While inspectors were informed that residents did not have access to the first floor, inspectors observed that this area was in use by residents for their hairdresser appointments.

Inspectors viewed the layout of shared bedroom accommodation in the centre. Three of the five twin bedrooms on the ground floor were occupied by one resident while the remaining two were unoccupied. Inspectors observed that the layout of these bedrooms would not facilitate two residents occupying the bedroom to have a chair, or storage facilities, in close proximity to their personal space. The allocation of private space was not equitable and works to address those issues had not commenced.

The quality of environmental hygiene on the ground floor had significantly improved and the centre was visibly clean throughout. Housekeeping staff were observed to clean the centre according to a schedule, and cleaning practices were observed to be consistent to ensure all areas of the centre were cleaned. Inspectors observed that the unoccupied first floor was not subject to frequent cleaning. Toilets in en-suites on the first floor were not cleaned, resulting in malodour.

Some fire safety risks were observed within the centre. Some ancillary areas such as the electrical rooms were observed to be locked, and keys to access this area were not readily available. Pieces of furniture were observed to partially obstruct an escape corridor on the first floor.

Throughout the inspection, the majority of residents were seen to spend their day in the day room. Inspectors observed that residents were engaged in a live music event in the morning. However, in the afternoon there was limited social activities taking place. Residents told the inspector that they found the day very long, and wished for more activities. Residents told the inspectors that in the absence of dedicated activities staff, they were not provided with consistent activities. Inspectors observed residents spending extended periods of time in the day room, and in their bedrooms with no social engagement. For example, while activities staff were assisting residents to and from the hairdresser in the afternoon, there were no further activities scheduled for residents who chose to remain in their bedroom or dayroom in the afternoon.

Residents were complimentary about the food served in the centre, and confirmed that they were always afforded choice. One resident told the inspector how they looked forward to the different meal choices. Staff were observed to engage with residents during meal times and provide discreet assistance and support to residents, if necessary. The food served was observed to be of a high quality and was attractively presented. Residents in all areas had access to snacks and drinks, outside of regular mealtimes.

Some staff were observed chatting with residents while passing through the dayroom to the dining room. However, these interactions were time limited as the staff were also required to attend to residents that were waiting for assistance.

Residents were provided with opportunities to express their feedback about the quality of the service during formal resident forum meetings. Residents told the inspector that they did not feel that their opinion was 'valued and listened to', and consequently, some residents had ceased to provide feedback at the meetings.

The following sections of this report detail the findings in relation to the capacity and capability of the centre, and how this impacts on the quality and safety of the service provided to residents.

Capacity and capability

This unannounced risk inspection was carried out by inspectors of social services to;

- monitor compliance with the Health Act 2007 (Care and welfare of residents in designated centre for older people) Regulation 2013 (as amended).
- follow up on the urgent actions taken by the provider to address significant issues of non-compliance identified on a risk inspection of the centre on 18 April 2024 with regard to resident's nutritional care, and the systems in place to plan and organise the staffing resources.
- review unsolicited information received by the Chief Inspector, pertaining to the organisation and management of the staffing resources, and the provision of social care to residents living in the centre.

On foot of serious concerns about the care and welfare of residents living in An Teaghlach Uilinn Nursing Home, this designated centre has been inspected ten times since June 2022. Over that period of time, the registered provider has responded to the findings of each inspection and at times achieved improved regulatory compliance but has not always managed to sustain those improvements.

Following the previous inspection on 18 April 2024, the registered provider was required to confirm the actions they would take to ensure the safety and well-being of residents, by dates specified by the Chief Inspector. The findings of this inspection were that while the provider had developed systems to manage the staffing rosters and to oversee the nutritional care needs of residents assessed as being at high risk of malnutrition, the provider had failed to ensure that these systems were consistently and effectively implemented. Consequently the registered provider failed to recognise and proactively address the issues identified by inspectors. This has been a repeated theme across the previous inspections of this designated centre.

Knegare Nursing Home Holdings Limited, a company consisting of five directors, is the registered provider of An Teaghlach Uilinn Nursing Home.

Following the previous inspection in April 2024, the registered provider outlined a revised organisational structure with the addition of a clinical services manager, who was also a person participating in the management of the centre. The clinical services director was responsible for monitoring clinical aspects of the service, in addition to providing governance and support to the person in charge. In addition, this inspection also found that a senior management team consisting of management personnel with delegated responsibility for key aspects of the service

including clinical and non-clinical operations, human resources, and facilities remained in place.

Similar to previous inspections, the roles and responsibilities among the management personnel were still not fully defined and the governance and management structures in place were not sufficiently robust to identify or address deficits in the quality and safety of the care of residents or to address the non-compliance with key regulations underpinning resident care.

Lines of accountability and responsibility in the centre were not clearly defined. An example of this was found in relation to the organisation and management of the staffing resource, where it was unclear who was responsible for ensuring appropriate staffing levels were maintained in the event of unplanned staff leave, or when additional staffing was required in recognition of increased resident occupancy and dependency. This was compounded by a lack of a clear procedure to escalate staffing risks to the provider or a pathway of action to manage unplanned staff leave.

The management systems in place did not ensure that the service provided was safe, appropriate, consistent or effectively monitored. The provider had completed a review of resident's nutritional risks. However, information of concern, relating to weight gain and weight loss, had not been identified or analysed and therefore, an effective quality improvement plan was not developed.

A review of the record management systems in the centre found persistent issues of non-compliance with the requirements of the regulations. While the provider had committed to improving the oversight and management of records and had implemented a revised roster management system, an accurate record of the duty roster worked by staff was not maintained, in line with regulatory requirements. For example, a number of staff were on unplanned leave on the day of inspection and the roster had not been updated to reflect this. In addition, the management personnel with responsibility for governance and oversight of the service who reviewed the available staff roster records could not confirm if absent staff had been replaced on a number of occasions.

Inspectors found that the organisation and management of the staffing resource was ineffective within the centre. A review of the staffing rosters evidenced that staffing resources were not available, or sought, to cover planned and unplanned leave, particularly in terms of administration staff, health-care staff, and staff to support the provision of social care to residents. A review of the rosters also found multiple occasions where health-care staff rosters were supplemented with nursing staff as a result of planned and unplanned leave, and inadequate health-care staff resources.

While staff were facilitated to attend training with regard to fire safety, inspectors found that staff were not appropriately trained with regard to fire safety procedures, revised following extensive fire safety works in the centre, to be followed in the event of a fire emergency.

The arrangements in place to supervise and support staff was not effective. For example, staff were not appropriately supervised to ensure residents received quality social care, in line with their assessed needs.

Regulation 15: Staffing

Staffing levels in the centre were not sufficient to meet the assessed needs of the residents, or for the size and layout of the centre. A review of the rosters found that there was inadequate staff available to meet the social care needs of the resident. This was evidenced by;

- A review of the activities staff roster for the previous two weeks showed that up to 52 hours allocated to the provision of social care to residents had not been filled. This impacted on the provision of consistent social care to the residents.
- Residents spoken with reported that the number of staff allocated to deliver meaningful activities was not adequate. For example, while staff allocated to provide social care supported residents to attend the hairdresser during the afternoon, residents in their bedrooms and in the communal dayroom were provided with no alternative activities.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Staff were not appropriately trained to deliver effective and safe care to residents. This was evidenced by;

- Staff had not been provided with appropriate training relevant to the revised fire safety procedures in the centre. This included training on the location of fire compartments to support the timely evacuation of residents to a place of safety in the event of a fire emergency.

Staff were not appropriately supervised. This was evidenced by;

- Inadequate supervision of staff allocated to the provision of social care to residents in the centre.
- Lack of oversight of the residents clinical documentation, including the assessment of residents needs and care planning, were accurate and up-to-date.

Judgment: Substantially compliant

Regulation 21: Records

A review of the records in the centre found that the management of records was not in line with the regulatory requirements. For example;

- Staff rosters did not reflect the staffing levels on the day of inspection and staff rosters for the two weeks prior to the inspection were not reflective of the roster that was actually worked by staff, as required by Schedule 4(9) of the regulations. For example, the roster showed that there were multiple incidence of staff unplanned leave among nursing and health care staff. However, the records did not reflect if vacant shifts had been filled.
- Some nursing records were not completed in line with the requirements of Schedule 3(4)(c). For example, a review of residents' nursing records found that some nursing notes were duplicated from previous entries over a four day period. This meant that the record was not person-centred, and did not provide assurance that the daily care needs of the residents had been met.
- A record of an incident in which residents may have suffered potential abuse was poorly documented and did not contain the detail required under Schedule 3(4)(j) of the regulations.
- Record of a complaint made by residents, and the action taken by the registered provider in respect of any such complaint were not always maintained in line with the requirements of Schedule 4(6).

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 23: Governance and management

A poorly defined organisational structure contributed to the provider failing to take appropriate action following previous inspections of the centre. This resulted in repeated non-compliance with a number of regulations assessed. The roles and responsibilities of the management team were not clear. For example, accountability, responsibility and oversight of key aspects of the service such as the management of risk, staffing resources, and the oversight of clinical care records were not clear and impacted on regulatory compliance.

The registered provider had failed to organise and manage the staffing resources to ensure the staffing levels could be maintained in the event of planned and unplanned leave, in line with the centre's statement of purpose. An inadequate availability of health-care staff meant that nursing staff were reallocated to perform health-care staff duties as a result of planned and un-planned staff leave.

The registered provider did not ensure that governance and management systems were effectively implemented to ensure the service provided to residents was safe, appropriate, consistent and effectively monitored. Inspectors found repeated failings in the governance arrangements that included;

- Poor oversight of record management systems to ensure compliance with the regulations. For example, there was poor oversight of records pertaining to staff rosters, nursing documentation, and records of incidents were found to be poorly documented.
- Poor oversight of nursing documentation. A review of the quality of resident's care plan found that care plans were not based on the assessment of residents needs or risks. Care plans, particularly those relating to residents with impaired skin integrity and complex behavioural support needs, were not based on assessment, and did not reflect the current care needs of the residents. Therefore, care plans lacked the required detail to ensure residents received safe and effective person-centred care.
- Inadequate systems of complaint management.
- Ineffective auditing systems. For example, a nutritional audit reviewed did not include an analysis of the findings, and areas for learning had not been identified. Therefore, there was no quality improvement plan developed to ensure residents' nutritional care needs, and nutritional risks were appropriately identified, monitored, and managed.

Judgment: Not compliant

Regulation 34: Complaints procedure

A review of the complaint management system found that complaints were not recorded and managed in line with the centres own policy and the requirements of the regulation. For example, not all complaints or expressions of dissatisfaction with the service had been investigated and therefore there was no plan in place to address the issues of concern. In addition, inspectors were informed by residents and their families that they had communicated complaints to the staff in the centre, however, there was no record of these complaints documented.

Judgment: Not compliant

Quality and safety

On the day of inspection, with the exception of residents social care needs, the residents' care needs were observed to be attended to appropriately and residents were observed to be content in their environment. Residents reported that the staff,

and their environment, made them feel safe living in the centre. Nonetheless, inspectors found that ineffective systems of governance and management impacted on aspects of the quality and safety of care provided to residents with regard to resident's rights, and individual assessment and care plans. While the provider had taken significant action to ensure residents received care in an environment that met their needs and protected them from the risk of fire, action was required to achieve full compliance with the regulations.

Inspectors found that the needs of residents were known to the nursing and care staff. A sample of residents' individual assessment and care plans were reviewed. While there was evidence that residents needs had been assessed using validated assessment tools, and all residents had a care plan, the assessment and care plans were not always developed within the time-frame specified in the regulations. In addition, assessment findings were not always reflective of the residents actual care needs. Consequently, the care plans did not identify the current care needs of the residents or reflect the centres own person-centred guidance on the current care needs of the residents.

Following the findings of the last inspection, a review of food and nutrition was completed. The provider had taken some action to ensure residents, who were at risk of malnutrition, were identified through appropriate clinical assessment. Arrangements had been made for residents to access the expertise of health care professionals such as dietetic services, and speech and language therapists for further expert assessment. However, inspectors were not assured that there were robust processes for monitoring in place to ensure the provision of consistent safe and quality nutritional care. This is actioned under Regulation 23; Governance and management.

A review of residents' records found that residents had access to a general practitioner (GP) of their choice, as requested or required. Arrangements were in place for residents to access the expertise of health and social care professionals for further assessment. The recommendations of health and social care professionals was observed to be implemented, and reviewed frequently to ensure care plans were effective.

A review of fire precautions in the centre found that the provider had taken significant action to ensure that fire containment measures protected residents from the risk of fire. The provider was awaiting assessment of the completed fire works by a competent person to ensure fireworks met essential safety requirements and standards. Records, with regard to the maintenance and testing of the fire alarm system, emergency lighting, and fire-fighting equipment were available for review and these were being serviced at the appropriate intervals. Nonetheless, some works were still outstanding including the replacement of some internal and external fire doors, and appropriate ventilation in an escape stairwell. In addition, staff had not received updated fire safety training in relation to emergency procedures, including evacuation procedures, building layout, and escape routes in the context of significant changes to the fire compartments in the centre.

Action had been taken with regard to the maintenance of the premises since the previous inspection. Significant redecoration works had been completed in many areas of the ground floor that included some bedrooms, communal areas such as the dining room, and corridors. The provider had also commenced a programme of redecoration on the first floor of the premises. This area remained unoccupied by residents. However, remedial works to address issues with the layout of shared bedrooms and ground and first floor of the premises had not yet progressed and there continued to be inadequate and inequitable space for two residents occupying the bedrooms to have a chair, or storage facilities, within close proximity to their personal place.

Regulation 17: Premises

Notwithstanding the work completed to date, and a project plan in place to ensure the premises met the individual and collective needs of the residents, the programme of premises redecoration and renovation was not yet completed. Therefore, there were areas of the premises did not comply with the requirements of Schedule 6 of the regulations. For example;

- The layout of bedrooms designated to accommodate two residents on the ground and first floor were not configured to ensure residents had adequate and equitable space. The layout of the rooms did not provide each resident with space for chair, or appropriate storage facilities. The position of privacy screens in shared bedrooms did not ensure resident had equitable private space to under activities in private.
- Refurbishment of the first floor of the centre was in progress, and therefore not available for use by residents.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider did not have adequate precautions against the risk of fire in place. For example;

- An escape corridor on the first floor was partially obstructed by furniture that had been removed from a dayroom during redecoration. This area was observed to be used by residents, and therefore presented a risk that residents means of escape would be partially obstructed in the event of a fire emergency.
- Storage rooms that contained electrical panels were locked. The keys for locked doors were not managed appropriately, creating a high risk that those areas were not accessible in the event of a fire emergency.

The systems in place for the adequate containment of fire were not completed. For example;

- An external fire door of the boiler house and internal corridor fire door on the first floor had not been replaced with the recommended fire rated door.
- The door to the laundry area required ironmongery to be replaced to ensure it was fully effective to contain fire in the event of an fire emergency.
- There was uncertainty if fire dampers had been incorporated into ventilation ducts passing through compartment walls. Consequently, the provider could not provide assurances that fire compartments were appropriately fire stopped to prevent the spread of fire.

The arrangements for evacuating, where necessary in the event of a fire, all persons in the designated centre and the safe placement of residents was not adequate. For example;

- Although staff were documented as having up-to-date fire safety training, staff had not been provided with training regarding the location of effective fire compartment boundaries in the centre to support the centre's fire evacuation strategy of progressive horizontal evacuation. This had the potential to impact on the evacuation of residents from the source of a fire to an adjoining perceived safe area.
- From a review of fire drill reports, inspectors were not assured that adequate arrangements had been made for evacuating residents from the centre in a timely manner with the staff and equipment resources available. For example, while staff had participated in a fire evacuation drill in January 2024, there had been no fire drill completed following completion of some fire safety works that resulted in the creation of additional compartment boundaries. Consequently, simulated fire evacuation drills did not provide assurance that residents could be evacuated from the centre, in a safe and timely manner.

The drawings displayed to support evacuation were not clear and did not include pertinent information such as the location of fire all compartment boundaries.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

A review of the residents' assessments and care plans found that they were not compliant with the regulatory requirements. For example;

- Residents with complex care and supervision needs did not have an appropriate assessment of their needs completed. Consequently, the care plan developed did not detail the interventions necessary to support residents who required close monitoring, supervision and support to manage their complex behavioural care needs.

- Care plans were not developed in a timely manner, in line with the known care needs of a resident. For example, a resident with a significant history of impaired skin integrity did not have an appropriate assessment of their care needs completed until 11 days following their admission to the centre. Consequently, a care plan to guide the appropriate care of the resident had not been developed within the time-frame specified under the regulations.
- Care plans were not reviewed or updated when a resident's condition changed. For example, a care plan to support a resident's increased monitoring, supervision and behavioural support needs had not been reviewed or updated following a number of incidents that had occurred in the centre. Consequently, staff did not have the required information to support the resident's assessed needs.

Judgment: Not compliant

Regulation 6: Health care

Residents had access to appropriate health and social care professional support to meet their needs. Residents had a choice of general practitioner (GP) who attended the centre as required or requested.

Services such as physiotherapy were available to residents weekly and services such as tissue viability nursing expertise, speech and language and dietetics were available through a system of referral.

Judgment: Compliant

Regulation 9: Residents' rights

The provider failed to provide the residents with facilities for occupation and recreation and for consistent opportunities to participate in activities in accordance with their interests and abilities.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for An Teaghlach Uilinn Nursing Home OSV-0000309

Inspection ID: MON-0044023

Date of inspection: 04/07/2024

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: An immediate review of current staffing levels was conducted, with a particular focus on the allocation of staff for social care and activities. The staffing roster has been adjusted to ensure adequate coverage, particularly during peak activity times, to meet the social care needs of all residents. Additional staff have been allocated or reassigned as necessary to ensure that no social care hours go unfilled. The Provider has confirmed that 52 hours per week are now consistently allocated to social care – Complete To further enhance the Social Program, a Social and Activities Survey was conducted, collecting valuable feedback from both residents and staff. Based on these insights, a more flexible and tailored activity schedule is being developed to accommodate the diverse interests, abilities, and cognitive functions of all residents, including those confined to their rooms, with full implementation expected by August 19th, 2024. Further details are provided under Regulation 9 – Residents' Rights.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: 1. All staff have now received comprehensive training on the revised fire safety procedures, including detailed instruction on the location and function of the newly created fire compartments. This training was conducted by the Group's Support Services Manager and completed on July 11th, 2024. Following this, four fire drills have been simulated since the inspection to ensure staff	

proficiency in the timely evacuation of residents to designated safety zones. These drills also reinforced staff awareness of the new compartment locations, effectively reducing the number of residents requiring evacuation at any one time.

Ongoing refresher training will be completed to ensure new hires receive fire safety training and compartment awareness as part of their induction.

To further enhance fire safety knowledge, the Maintenance Department will undergo Fire Warden Training on September 16th, 2024. This initiative will ensure consistent training and facilitate more frequent fire drills, reinforcing overall fire safety protocols within the facility.

2. The Activities Roster has been fully staffed to cover the complete 52-hour allocation per week. Supervision for staff involved in social care provision has been enhanced, and the Director of Nursing will ensure they receive the necessary support and guidance to deliver meaningful activities to residents - Monthly Activity Department Meetings will be held with the Director of Nursing and the Activities Team going forward, along with regular check-ins and observations, to ensure social care staff are effectively fulfilling their roles and to promptly address any performance gaps.

These meetings will also play a crucial role in overseeing the planning and execution of social care activities, ensuring that they align with the needs and preferences of all residents.

3. Regular audits of clinical records have been established to ensure that all documentation reflects the current needs of residents and complies with regulatory standards. In addition, training for nursing staff on best practices in documentation, emphasizing the importance of up-to-date and accurate record-keeping has been completed. A senior clinical staff member has been designated to monitor the consistency and quality of clinical documentation on an ongoing basis. Please refer to Regulation 5, Individual Assessment and Care Plan for our comprehensive action plan.

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
1. A daily roster verification process has been established, where staffing levels documented are cross-checked against recorded rosters that was actually worked by staff to ensure accuracy. The Director of Nursing is responsible for promptly documenting all changes to staff rosters, including unplanned leave and the filling of vacant shifts, each morning. This is further reviewed by the Administrator in the evening to ensure any additional changes throughout the day are accurately reflected – Ongoing daily

In addition, training sessions have been successfully conducted by the HR Director for

staff responsible for roster management, emphasizing the importance of accuracy and compliance with Schedule 4(9) of the regulations – Complete

Moving forward, staff rosters will be regularly audited by the Head Office Team to ensure ongoing compliance and to identify and correct any discrepancies – Ongoing

2. The Director of Nursing has emphasised through Group (August 08th, 2024) and Individual Meetings with the Nurses's, the critical importance of updating nursing records to accurately reflect the current status and care needs of each resident – Complete

This directive was reinforced by onsite training conducted by the Regional Manager, focusing on the importance of individualized and precise documentation in compliance with Schedule 3(4)(c) – Complete

An immediate review of all resident assessments and care plans has been undertaken with updates being made to incorporate best practices and ensure alignment with completed assessments to address the specific needs of each resident – Commenced and Ongoing

To ensure full compliance with regulatory standards, enhanced audits of assessments and care plans have been implemented within the Center. These audits will involve thorough reviews of relevant assessments and care plans to confirm that care is being delivered in accordance with each resident's documented needs and to eliminate any duplication of nursing notes – Ongoing

3. A Group standardized incident reporting template has been implemented that includes all mandatory fields as per Schedule 3(4)(j) – Complete

Training has been conducted for staff on the critical importance of detailed and accurate incident reporting, particularly in cases involving potential abuse - Complete

A monthly review process has been introduced where incident reports are assessed for completeness and adherence to regulatory standards before being finalized. This will be completed by the Director of Nursing and overseen by the Regional Manager. Learnings will be shared with all staff through daily handover and monthly staff meetings – Commenced and Ongoing

Monthly audits of incident records will be scheduled to ensure ongoing compliance and to identify areas for improvement – Commenced and Ongoing

4. A comprehensive complaint logging system has been developed utilising the Centres Resident Management System, that ensures all complaints and the corresponding actions are documented in accordance with Schedule 4(6) - Complete

Staff training has been provided on the importance of thorough documentation of complaints and the steps taken in response – Complete

A process has been introduced where the resolution of each complaint is reviewed and verified by the Director of Nursing for completeness before being closed – Commenced

and Ongoing

Monthly audits of complaint records will be conducted to ensure all requirements are being met and to identify any patterns or recurring issues – Commenced and Ongoing

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
1. Following the recruitment of a new Director of Nursing and Regional Manager for the Centre, a comprehensive review of the existing organisational structure was conducted. As a result, a clear organisational chart has been developed and implemented. The Statement of Purpose has also been updated to clearly define the roles and responsibilities of each team member. Additionally, all departments have been briefed in staff meetings on their specific duties to ensure that every team member fully understands their responsibilities and accountabilities - Complete

The revised Group Organisational Chart Structure was communicated by the Provider/CEO to all the Head Office Team, Directors of Nursing and Assistant Directors of Nursing on August 9th, 2024, further reinforcing the clarity of roles and responsibilities.

2. The Provider confirms that the roster is appropriately staffed to accommodate the 38 residents living in the Centre. In collaboration with the Director of Nursing, the HR Director has developed a staffing contingency plan that includes strategies for managing both planned and unplanned leave.

A system has been implemented to regularly assess and adjust staffing levels based on the Centre's needs, ensuring alignment with the Centre's Statement of Purpose. Additionally, since the inspection, healthcare staff have been recruited on a relief contract to provide additional support in the event of unexpected absences. The staffing roster system will be reviewed regularly to ensure adequate coverage at all times.

While the remedial works continue on the first floor and prior to offering any vacant shifts to relief staff, RGNs may choose to cover these HCA shifts to ensure their contracted hours are maintained. This will be supported by the Director of Nursing.

3. Subsequent to the Inspection a complete review of the Centres Record Management Systems has been completed to include:
Staff Records, Nursing Documentation and Complaint Management. Regular monitoring, training, and audits will be key to maintaining these improvements and ensuring a high standard of care for residents. We refer to you to Regulation 21 (Records), 34 (Complaints Procedure), 15 (Staffing), 16 (Training and Staff Development) & 5 (Individual Care Plan and Assessment) for further detailed responses of actions taken to

date to ensure that governance and management systems are effectively implemented to ensure the service provided to residents is safe, appropriate, consistent and effectively monitored.

4. The newly appointed Director of Nursing and Regional Manager have reviewed and revised current auditing procedures to ensure they include detailed analysis and identification of areas for improvement – Commenced and Ongoing
Staff involved in auditing have received training on best practices for conducting thorough audits and developing quality improvement plans – Commenced and Ongoing
A follow-up process has been implemented to ensure that findings from audits are addressed, and improvements are made. This will be overseen by the Director of Nursing – Commenced and Ongoing
A schedule for regular audits in key areas, including nutrition, care plans, and incident reporting has been developed. This will be monitored monthly in the Governance and Management Meetings – Commenced and Ongoing

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
Following the inspection, a comprehensive audit has been conducted on the current complaint management systems in the Centre to achieve the following:
• Identify any unrecorded or unresolved complaints.
• Review all existing complaint records to ensure they have been investigated and managed in accordance with the Centre's policy and regulatory standards.
• Identify any gaps in documentation and management processes.

All staff are undergoing re-education on the Centre's complaint management policy, with a strong emphasis on the importance of recording every complaint or expression of dissatisfaction, regardless of its nature. Clear guidelines have been provided on how to document complaints, including those communicated verbally or informally. This is completed.

We are now utilizing the Centre's Clinical Management Platform as the complaint tracking system, which will record all complaints, track the progress of investigations, and document outcomes and actions taken. This system ensures easy access and review by senior management and relevant staff, eliminating the previous reliance on paper documentation. Staff have received thorough training on the effective use of this new system.

All historical complaints identified during the audit that were not previously recorded or addressed are currently being investigated. An action plan is being developed and implemented to resolve any issues of concern identified through these investigations. All outcomes, along with any corrective actions, will be communicated to the residents and

families involved. All new complaints will be managed in accordance with the Centre's Policy.
This process is ongoing, with 13 of the initial 24 complaints already resolved since its initiation.

On July 11th, 2024, the Provider held a joint meeting with residents and their relatives to update them on improvements to the complaint management system, along with other enhancements at the Centre, including the appointment of the new Director of Nursing and Regional Manager. Additionally, we have established regular communication channels, such as resident and family meetings, where concerns can be raised and documented. These meetings have already begun and will continue on an ongoing basis.

We have further established regular reporting to senior management on the status of complaint management, including any trends or recurring issues, through weekly Clinical Review Meetings. Additionally, complaints are monitored through monthly KPIs and discussed in detail during monthly Governance and Management Meetings to ensure all actions are addressed appropriately.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Regulation 17: Premises
Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

The reconfiguration of five shared bedrooms on the ground floor has commenced to ensure each resident has adequate and equitable space. The updated layout now provides sufficient room for each resident to have a chair and appropriate storage facilities. Additionally, bespoke furniture, ordered on June 6th and delivered on July 9th, includes new wardrobes, ultra-low beds, lockers, resident armchairs, and a television for each resident. Each television is equipped with the capability to be listened to separately through Bluetooth headphones.

The positioning of privacy screens in shared bedrooms has been adjusted to ensure that each resident has equitable private space for personal activities. This includes the installation of privacy screens around the sink area.

To date, three rooms have been completed, with the remaining two expected to be finished by August 24th, 2024.

The refurbishment of the first floor is currently in progress. The Ground Floor was prioritized for upgrades, including painting and refurbishment of communal corridors, residents' bedrooms, en-suites, and dining room facilities to include flooring. The

Provider has committed to ensuring that no residents will be admitted to the first floor until all remedial work is fully completed. The Group's Support Services Manager regularly monitors the renovation and redecoration to ensure that progress aligns with the project plan and complies with all regulatory standards.

Updates are regularly provided to senior management and the Regulator to ensure transparency and accountability throughout the process.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: The furniture partially obstructing a fire escape corridor on the first floor has been removed. Although no residents currently reside on the first floor, one room was previously used for hairdressing on a weekly basis. This service has now been temporarily relocated to the ground floor while work on the first floor continues, therefore no evacuation of residents will need to occur from the first floor. The Maintenance Department will conduct regular monitoring to ensure all fire escapes remain clear.

The key to the Storage Room that contained an electrical panel is now safely located on a hook at the top of the door and therefore accessible in the event of a fire.

The internal corridor fire door will be replaced as part of the remedial works on the first floor and will be completed before any residents are admitted to this area. The replacement of the external fire door on the boiler house will be completed by September 30th, 2024.

The ironmongery on the laundry door was replaced on August 07th, 2024.

An assessment was completed on July 31st, 2024 by an external contractor on all fire dampers in the building. Fire damper tender will be issued upon the receipt of the Inspection Report with installation due for completion September 30th, 2024.

All staff received training on July 11th, 2024, led by the Support Services Manager, regarding the updated fire compartment boundaries within the Centre to support the fire evacuation strategy of progressive horizontal evacuation. This training will be further reinforced with onsite sessions scheduled for August 28th, 2024.

Since the inspection, four fire drills have been conducted to enhance staff proficiency in evacuating residents to designated safety zones. These drills have also reinforced staff familiarity with the new compartment locations, reducing the number of residents needing evacuation at once. The addition of these new compartments has therefore led to more efficient and timely evacuations, ensuring resident safety.

Current floor plans displayed clearly indicate the new compartments. Upgraded evacuation plans will be completed by the Centre's Fire Safety Consultant by August 27th, 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:
A review of all resident assessments and care plans has been completed, with priority given to those residents who have complex care and supervision needs. All care plans are being updated to reflect best practices and will align with the completed assessments to address the specific needs of each resident. The Director of Nursing will ensure that these care plans include detailed interventions and strategies tailored to each resident's requirements and will be updated promptly in response to any changes in a resident's condition. This task will be carried out by the assigned RGN for each resident, with oversight from the senior management team, and is scheduled for completion by August 31st, 2024.

Staff have been advised on the timely completion of resident assessments, emphasizing the importance of completing all assessments within the regulatory time frame (e.g., within 48 hours of admission). This process will be closely supervised by the CNM and will be subject to ongoing review.

Comprehensive training for all nursing and care staff has been completed, both individually and in group sessions, focusing on the development, implementation, and updating of care plans. This training included detailed guidance on identifying and documenting complex care needs, conducting timely assessments, and ensuring that care plans are updated whenever a resident's condition changes. To reinforce this training, case studies and practical examples are being utilized.

Additionally, three staff members have been appointed as Care Plan Champions for the Centre. The final phase of their training will be completed by August 28th. These Champions will play a crucial role in enhancing the care planning process, with daily responsibilities to monitor and support care planning within the home.

Enhanced audits of assessments and care plans have also been implemented within the Centre to ensure full compliance with regulatory standards. These audits will include thorough reviews of relevant assessments and care plans to confirm that care is being delivered according to each resident's documented needs. The Clinical Nurse Manager and Director of Nursing will lead these audits, with additional oversight provided by the Regional Manager.

Any findings or necessary quality improvements identified during these audits will be

communicated regularly to all staff during formal meetings and daily handovers, ensuring consistent and clear communication about the importance of accurate care planning and assessment.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: A comprehensive assessment of the current facilities for occupation and recreation was conducted by the Director of Nursing and the Activities Team. This included a thorough review of the existing activity schedule and participation records to identify gaps in meeting the residents' interests and abilities – Complete

To gain deeper insights into the needs and preferences of residents, the Activities Team introduced a Social and Activities Survey, gathering feedback from both Residents and Staff. Based on the survey results, as well as general suggestions and feedback from residents, the team will design and implement an enhanced activity program. This program will offer a diverse range of activities tailored to the varying interests, abilities, and cognitive functions of the Centre’s Residents. This will be completed by August 19th, 2024.

Staff training will be provided to ensure they are equipped to effectively engage residents in these activities and make full use of the available facilities. Additionally, residents will be kept informed of any changes and improvements through regular daily interactions - Ongoing

To ensure ongoing satisfaction and continuous improvement, a feedback mechanism has been established, allowing residents to express their views and suggest further enhancements. This mechanism includes a dedicated agenda item during the monthly Residents Meetings, with most recent Meeting held on August 08th, 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.	Substantially Compliant	Yellow	19/08/2024
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	30/08/2024
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/07/2024
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre,	Substantially Compliant	Yellow	30/11/2024

	provide premises which conform to the matters set out in Schedule 6.			
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Not Compliant	Orange	31/08/2024
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Substantially Compliant	Yellow	31/07/2024
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Substantially Compliant	Yellow	09/08/2024
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe,	Not Compliant	Orange	31/08/2024

	appropriate, consistent and effectively monitored.			
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	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	11/07/2024
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably	Substantially Compliant	Yellow	17/07/2024

	practicable, residents, are aware of the procedure to be followed in the case of fire.			
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	30/09/2024
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.	Substantially Compliant	Yellow	11/07/2024
Regulation 28(3)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place in the designated centre.	Substantially Compliant	Yellow	27/08/2024
Regulation 34(6)(a)	The registered provider shall ensure that all complaints received, the outcomes of any investigations into complaints, any actions taken on foot of a complaint, any reviews requested and the outcomes of any reviews are	Not Compliant	Orange	31/08/2024

	fully and properly recorded and that such records are in addition to and distinct from a resident's individual care plan.			
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.	Substantially Compliant	Yellow	31/08/2024
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	01/08/2024
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	Not Compliant	Orange	31/08/2024

	it, after consultation with the resident concerned and where appropriate that resident's family.			
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Substantially Compliant	Yellow	19/08/2024