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:	18 April 2024
Centre ID:	OSV-0000309
Fieldwork ID:	MON-0043430

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:	26

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 18 April 2024	09:00hrs to 17:45hrs	Sean Ryan	Lead
Thursday 18 April 2024	09:00hrs to 17:45hrs	Catherine Sweeney	Support

What residents told us and what inspectors observed

Residents living in An Teaghlach Uilinn Nursing Home told the inspectors that their quality of life in the centre had improved, and that staff treated them with respect. Inspectors found that residents received a satisfactory standard of care from a team of staff, under the supervision of a structured management team. Residents expressed satisfaction with the service, including their bedroom accommodation and the premises, the provision of meaningful and engaging activities, and the quality of the food.

Inspectors were met by the person in charge on arrival at the centre. Following an introductory meeting, inspectors walked through the centre, reviewed the premises, and met with residents and staff.

There was a friendly and homely atmosphere in the centre. Residents were observed chatting with one another and staff in the communal dayroom, and staff were seen to be attentive to their requests for assistance. While staff were busy attending to residents' requests for assistance, residents were observed to receive patient and person-centred care from the staff. Call bells were answered promptly by staff.

Inspector spoke with a number of residents in their bedrooms and in communal areas. Residents complimented the staff who they described as 'polite and caring'. Residents told the inspectors that staff supported them to get up from bed at a time of their choosing, and that they could have a shower when they wished. Residents described how they would not have to wait long for a member of staff to respond to their requests for assistance. They also spoke positively about the provision of daily activities and described how staff facilitated them to socialise with other residents. Residents spoke about changes that had occurred in the centre, including the redecoration of some bedrooms and communal areas.

The provider had progressed to carry out maintenance works to the premises, and redecoration of a number of areas throughout the centre. Three en-suites had been refurbished, corridors had been repainted, and ancillary areas had been upgraded to provide facilities to support their intended purpose. This included the housekeeping room and sluice room. A new floor covering had been installed in the dining room and the walls had been redecorated. Inspectors found that the premises was designed and well laid out to meet the needs of residents with the exception of five shared bedrooms. The layout of the bedrooms did not facilitate all residents occupying the bedroom to have a chair or storage facilities in close proximity to their personal space, and the allocation of private space was not equitable. Inspectors reviewed the unoccupied first floor of the premises. Inspectors observed that a number of bedrooms had restricted access while works were underway to repair and redecorate en-suites and bedrooms. Residents told the inspectors that they were

kept informed about planned works to the premises, and complimented the works completed.

The quality of environmental hygiene had improved in many areas such as bedrooms, dining room, kitchen and communal dayroom. Equipment used by residents was observed to be visibly clean. Staff detailed how each piece of equipment was cleaned after use, and also cleaned at night time. 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.

Residents expressed a high level of satisfaction with regard to the quality and quantity of food they received, and confirmed the availability of snacks and drinks at their request. The residents dining experience was observed to be a pleasant, sociable and relaxed occasion for residents. Residents had a choice of meals from a menu that was updated daily. The dining room was appropriately laid out, and was comfortable and homely for residents. Staff were observed to provide assistance and support to residents in a person-centred manner. Staff were also observed attending to residents in their bedrooms to provide support during mealtimes.

Residents were engaged in activities throughout the day. There was a detailed weekly activity schedule on display to support residents to choose what activities they would like to participate in. Inspectors observed the interactions between residents and staff during activities and found that staff supported residents to enjoy the social aspect of activities. Staff were observed spending time with residents in their bedrooms chatting.

Residents were kept informed about changes occurring in the centre through scheduled resident meetings. Residents told the inspector that they were provided with the opportunity to meet the management team, and to provide feedback on the quality of the service they received. Residents stated that they felt included in decisions made about the service they received, and that their feedback and requests were acted upon.

The following sections of this report details the findings with regard to the capacity and capability of the centre and how this supports the quality and safety of the service being 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 17

January 2024 with regard to the management of fire, including the emergency lighting system.
- review the actions taken by the provider to address significant issues of non-compliance identified during a series of poor inspection, with particular regard to the governance and management of the centre.

On previous inspections of the centre, significant risk and regulatory non-compliance were found in relation to Regulation 28, Fire precautions. The provider had repeatedly failed to identify serious deficits in the management of fire safety, and actions to mitigate the risk associated with deficits in the emergency lighting system had not been identified. The registered provider was required to confirm the actions required to ensure the safety and well-being of residents, by dates specified by the Chief Inspector. The findings of this inspection were that the provider had taken the necessary action to ensure there was an effective and functioning internal emergency lighting system in place to support the safe and timely evacuation of residents from the centre, in the event of a fire emergency.

Following an inspection in January 2024, the registered provider outlined a revised organisational structure, to ensure compliance with Regulation 23; Governance and management. The findings of this inspection were the provider had made further changes to the organisational structure to support their governance and oversight of the quality and safety of the service provided to residents. This was evidenced through progress towards regulatory compliance identified in key aspects of the service such as the management of risk, complaints, and resident's rights. However, while the provider had systems in place to monitor the quality of the service provided, these systems were not fully effective, particularly in relation to the management of nutritional risk and the management of staff rosters. This issue posed a significant risk to both resident well-being, and the management of staffing resources. As a consequence of these concerns related to clinical oversight, an urgent compliance plan was issued to the provider following this inspection. The submitted plans were accepted by the Chief Inspector.

The provider of this centre is Knegare Nursing Home Holdings Limited, a company comprised of five directors. The organisational structure had changed since the last inspection through the appointment of an operations director who was also a person participating in the management of the centre. The operations director was responsible for monitoring non-clinical and operational aspects of the service, in addition to providing oversight and governance support to the person in charge through an increased presence in the centre. On the day of the inspection, the operations director and facilities manager attended the centre to support the inspection process. A clinical director was also available to provide oversight to the service. Within the centre, the person in charge was supported clinically and administratively by an assistant director of nursing, and a clinical nurse manager.

The provider had repeatedly failed to implement effective systems to monitor, organise and manage the staffing resources within the centre, despite the risk being identified on previous inspections of the centre. Inspectors reviewed the system of recording the attendance of staff in the centre and found that accurate records of staff working in the centre were still not maintained. While the provider had a

system in place for agency support staff to sign-in on arrival to the centre, a review of the staff attendance log found that there was no record of agency support staff attending the centre on a number of days. This meant that the attendance of all staff in the centre could not be verified.

The provider had systems in place to ensure clear communication between staff. Records evidenced that meetings between the person in charge and staff from different departments in the centre were held regularly. These meetings were used to discuss day-to-day issues relating to resident safety, quality of care and on going risk. Regular meetings were also held with the management team and the provider allowing for discussion in relation to the progression of fire safety and premises improvement works, staffing, and adverse event. These meetings facilitated escalation of risk to the provider.

The provider had implemented management systems to monitor aspects of the quality of the service. Key clinical indicators with regard to the quality of care provided to residents were collated on a weekly basis. This included the incidence of wounds, restrictive practices, falls, and other significant events. The provider had introduced an electronic system of clinical and environmental audit. There was an audit schedule in place which identified risk and areas of quality improvement. Audits had been completed in line with this schedule. However, inspectors found that the monitoring of some aspects of clinical care was poor. For example, a review of residents care records found that residents who were assessed as being at risk of malnutrition did not have appropriate care plans developed to address this risk. The system of clinical oversight, including the clinical audits, failed to identify this significant risk to residents.

The provider had reviewed the risk management systems in place to identify and manage risks in the centre. A risk registered contained both operational and clinical risks that may impact on the safety and welfare of residents living in the centre. However, risks that had been assessed by the provider were not always managed in line with the centre's own risk management policy. While potential fire risks were identified, assessed, and controls were developed to mitigate the risk to residents, the provider had not reviewed the effectiveness of existing risk mitigating controls. For example, while remedial works had been carried out to some fire doors, the assessment of risk in relation to the fire doors and the controls in place to manage the risk had not been reviewed or updated to reflect works completed, and works outstanding.

A review of the record management systems in the centre found persistent issues of non-compliance with the requirements of Regulation 21; Records. There were two systems in operation to record the attendance of staff in the centre. However, accurate records of the duty roster and a record of the roster that was actually worked by staff could not be provided for review. In addition, some records in relation to the care provided to residents were not appropriately maintained.

There was an effective complaints policy and procedure which met the requirements of Regulation 34: Complaints procedure. Inspectors reviewed the records of

complaints received by the centre and found that they were appropriately managed, in line with the requirements of the regulations.

A review of staffing rosters found that staffing levels were adequate to meet the needs of the current 26 residents in the centre, and for the size and layout of the building. The team providing direct care to residents consisted of registered nurses, and a team of health care assistants. There were sufficient numbers of housekeeping, activities, catering and maintenance staff in place. However, health-care staff and housekeeping staff levels were not always maintained with the centres own staffing resources. Consequently, agency staff were required to support the rosters, as the centre continued to have multiple vacancies, and inadequate staffing resources to respond to planned and unplanned leave.

A review of the staff training records evidenced that staff had completed training relevant to the provision of safe quality care to residents. Training completed included safeguarding, managing behaviour that is challenging, fire safety, cleaning and decontamination training and manual handling training.

While the provider had made changes to the arrangements in place to supervise and support staff, some parts of the service, such as the documentation of clinical care records were not effectively supervised to ensure that they were accurately maintained.

Regulation 15: Staffing

On the day of the inspection, the staffing levels and skill-mix were appropriate to meet the assessed needs of the residents.

However, there was insufficient health-care and housekeeping staff to sustain planned rosters, and respond to planned and unplanned leave. For example, agency support staff were required cover up to seven vacant housekeeping shifts. In addition, nursing staff were required to cover shifts in the health care assistant roster. This resource issue is actioned under Regulation 23: Governance and management.

Judgment: Compliant

Regulation 16: Training and staff development

Staff supervision arrangements were not always sufficient to protect and promote the care and welfare of all residents. This was evidenced by a lack of oversight of the residents clinical documentation to ensure that residents assessments and care

plan were accurate and up-to-date to reflect the current care needs of the residents. This resulted in poor management of residents at risk of malnutrition.

Judgment: Substantially compliant

Regulation 21: Records

The management of records was not in line with the regulatory requirements. For example;

- A record of the duty roster of all persons working at the designated centre, and a record of whether the roster was actually worked by staff, was not maintained in line with the requirements of Schedule 4(9).
- Records of specialist treatment, nutritional care and nursing care provided to residents were not accurately or appropriately maintained in line with the requirements of Schedule 3(4)(b). For example, records of repositioning charts for residents of high risk of impaired skin integrity were not maintained in line with the residents care plan. Records of nutritional care and residents dietary intake were not appropriately maintained for residents assessed as being at risk of malnutrition.
- A record of a residents refusal of treatment was not maintained in line with the requirements of Schedule 3(4)(h). For example, there was no records maintained for residents who refused nutritional monitoring, or weight monitoring.

Judgment: Not compliant

Regulation 23: Governance and management

While inspectors found improvements in many areas of the management systems in the centre, some areas remained ineffective and posed a significant risk to residents. Following this inspection, the provider was required to submit an urgent compliance plan to address the following risks;

- There were ineffective systems of oversight in place to ensure accurate and consistent recording of resident's weights to identify unintentional weight loss, and subsequent risk of malnutrition. This was compounded by ineffective systems of escalation to ensure an appropriate pathway of care was implemented in response to a resident's risk of malnutrition. The providers response provided assurance that the risk was adequately addressed.
- There were ineffective management system in place to record the attendance of staff in the centre and to ensure that accurate records of persons working

in the designated centre were maintained. This meant that the attendance of all staff in the centre could not be verified. The providers response provided assurance that the risk was adequately addressed.

In addition to the above, the following management systems were not effective. This was evidenced by;

- poor oversight of record management systems to ensure compliance with the regulations.
- risk management systems were not effectively implemented to manage risks in the centre. Risks that had been assessed by the provider were not managed in line with the centre's own risk management policy. For example, fire safety risks were not subject to review to assess the effectiveness of controls in place to manage fire risks as risks were resolved, or new risks identified.

The registered provider did not fully ensure that resources in the centre were planned and managed to ensure person-centred, effective and safe services. The number of full-time health-care staff and housekeeping staff employed by the provider did not reflect the number of staff outlined in the centre's statement of purpose. While there was active recruitment processes in place, the service was dependent on the use of agency staff to support staffing rosters in the event of planned and unplanned leave.

Judgment: Not compliant

Regulation 34: Complaints procedure

A review of the complaint management system found that complaints were recorded, promptly responded to, and managed in line with regulatory requirements. Staff demonstrated knowledge of the complaints procedure, including how to identify a complaint.

The provider had identified, and facilitated access to, independent advocacy services who could assist the resident with making a complaint. There was a complaints policy in place and the complaints procedure was displayed prominently within the centre.

Judgment: Compliant

Quality and safety

Inspectors found improvements in the quality and safety of the service as a consequence of the provider's actions to improve the management and oversight systems described in the capacity and capability section of this report. The impact of such actions were evident in the positive feedback from residents with regard to the quality of care they received and that residents felt safe living in the centre. Resident's health and social care needs were met to a satisfactory standard of care and support from a team of staff who knew their individual needs and preferences. Residents were satisfied with their access to health care. While the registered provider had taken some action to ensure residents safety in relation to fire safety, the actions taken were not sufficient to bring the service into full compliance with the regulations. Additionally, residents individual assessments and care plans were not updated in line with the requirements of Regulation 5. The layout of a number of shared bedrooms was not appropriate to accommodate two residents.

Residents were provided with food choices for their meals and snacks, and refreshments were made available at the residents request. Menus were developed in consideration with residents individual likes, preferences and, where necessary, their specific dietary or therapeutic diet requirements as directed by dietitians and speech and language therapists. Daily menus were displayed in suitable formats, and in appropriate locations so that residents knew what was available at meal-times. There was adequate numbers of staff available to assist residents with their meals. However, there were poor arrangements in place to monitor residents at risk of malnutrition.

Residents' care plans and daily nursing notes were recorded on an electronic documentation system. While there was evidence that resident's needs had been assessed using validated assessment tools, the provider had not sustained compliance with regard to ensuring residents care plans were updated following a change in their assessed care needs. Consequently, the care plans did not identify the current care needs of some residents or reflect person-centred guidance on the current care needs of the residents.

Residents were reviewed by a medical practitioner, as required or requested. Referral systems were in place to ensure residents had timely access to health and social care professionals for additional professional expertise. There was evidence that recommendations made by professionals had been implemented to ensure best outcome for residents.

A safeguarding policy provided guidance to staff with regard to protecting residents from the risk of abuse. Staff demonstrated an appropriate awareness of the centres' safeguarding policy and procedures, and demonstrated awareness of their responsibility in recognising and responding to allegations of abuse. Residents reported that they felt safe living in the centre.

A review of the care environment found that the provider had taken action to improve and sustain an appropriate standard of environmental, and equipment hygiene. Facilities necessary to support effective infection prevention and control had been improved through the provision of a dedicated housekeeping room for the storage and preparation of cleaning agents and equipment. The facilities to support

effective decontamination of toileting aids had been upgraded, and equipment such as a bedpan washer was appropriately serviced and maintained. There was a cleaning schedule in place to support the systematic cleaning of all areas of the centre. This included both occupied and vacant bedrooms, storage area, communal dayrooms and toilets, and the kitchen.

Action was being taken with regard to the maintenance of the premises since the previous inspection. Corridors and a number of bedrooms had been redecorated and new floor coverings had been installed in the sluice facilities. Inspectors found that the layout and design of the premises met the individual and collective needs of residents with the exception of five shared bedrooms on the ground floor. The layout of the bedrooms would not facilitate two residents occupying the bedroom to have a chair, or storage facilities, in close proximity to their personal space, and the allocation of private space was not equitable. These bedrooms were occupied on a single occupancy basis only during the inspection. In addition, there was inadequate storage facilities within the bedrooms.

The fire safety action plan submitted by the provider following the previous inspection was in progress at the time of this inspection. Inspectors found that while the provider had taken action to address the deficits in the emergency lighting system, and to ensure all areas of the premises had adequate fire detection, significant action continued to be required to support effective containment of fire in the centre. The provider had committed to completing the required fire safety works, and come into full compliance with Regulation 28; Fire precautions by the 31 May 2024, in line with the compliance plan submitted following the previous inspection of the centre in January 2024. In the interim, the provider had measures in place to mitigate the risks to residents until the fire works were completed. This included accommodating residents on the ground floor only, increased fire evacuation drills, and daily monitoring of potential fire risks. Notwithstanding this, fire safety risks will continue to impact on the safety of residents, until such time has the provider had completed all requisite fire safety works to achieve full compliance with the regulations.

Residents told the inspectors that they felt at home in the centre and that their privacy and dignity was protected. Residents were free to exercise choice about how to spend their day and were encouraged to enjoy and participate in activities.

Residents were consulted about their care needs and the overall quality of the service, through schedule resident meetings and surveys. Residents confirmed that they were kept informed about planned premises and fire safety works that occurred in the centre.

Visiting was found to be unrestricted and residents could receive visitors in either their private accommodation or designated area if they wished.

Regulation 11: Visits

The registered provider had arrangements in place for residents to receive visitors. Those arrangements were found not to be restrictive, and there was adequate private space for residents to meet their visitors.

Judgment: Compliant

Regulation 17: Premises

Inspectors found that the premises did not fully comply with the requirements of Schedule 6. For example;

- The layout of five twin-bedrooms designated to accommodate two residents were not configured to ensure residents had adequate and equitable space. For example, the layout of the rooms would not afford one resident in each bedroom adequate usable and private space to include their bed, a chair, and personal storage within their private bed space. In addition, one bed-space was positioned against the window. This had the potential to restrict the flow of natural light to the other resident when privacy screens were drawn.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

There were inadequate arrangements in place to monitor residents nutritional needs, and residents at risk of malnutrition or dehydration. This included weekly weights, maintaining a food intake monitoring chart, and timely referral to dietetic, and speech and language services.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Notwithstanding the work completed to date, and a project plan in place, the programme of fire safety works was not yet complete, and therefore full compliance had not been achieved. Consequently, the following aspects of fire safety were not in compliance as a result of;

- Inadequate means of escape, including emergency lighting.
- Inadequate arrangements for the containment of fire.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

A sample of resident's assessments and care plans found that they were not in line with the requirements of the regulations.

Care plans were not guided by a comprehensive assessment of the residents care needs. Some resident's care plans did not accurately reflect the needs of the residents and did not identify interventions in place to support residents when identified as being at high risk of malnutrition or impaired skin integrity. Consequently, staff did not have accurate information to guide the care to be provided to the residents.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had timely access to General Practitioners (GP) of their choice and the person in charge confirmed that GPs attended the centre as required. Residents also had access to a range of health and social care professionals such as physiotherapy, occupational therapy and tissue viability nursing.

Judgment: Compliant

Regulation 8: Protection

There were systems in place to safeguard residents and protect them from the risk of abuse. Safeguarding training was up-to-date for all staff and a safeguarding policy provided staff with support and guidance in recognising and responding to allegations of abuse. Residents reported that they felt safe living in the centre.

The provider had a plan in place to ensure residents pensions and social welfare payments were managed in line with best practice guidance.

Judgment: Compliant

Regulation 9: Residents' rights

Staff demonstrated an understanding of residents' rights and supported residents to exercise their rights and choice. Residents' choice was respected and facilitated in the centre. Residents could retire to bed and get up when they choose.

There were facilities for residents to participate in a variety of activities such as art and crafts, live music events, gardening, and exercise classes. Residents complimented the improved provision of activities in the centre and the social aspect of the activities on offer.

Residents attended regular meetings and contributed to the organisation of the service. Residents confirmed that their feedback was used to improve the quality of the service they received.

Residents were provided with information about services available to support them. This included independent advocacy services.

A variety of daily national and local newspapers were available to residents. Religious services were facilitated regularly.

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	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	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for An Teaghlach Uilinn Nursing Home OSV-0000309

Inspection ID: MON-0043430

Date of inspection: 18/04/2024

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 16: Training and staff development	Substantially Compliant

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

In continued efforts to enhance oversight and supervision of resident's clinical documentation, the DoN and ADON have taken significant steps to improve the Centre's practices:

a. The DoN and ADoN have conducted a thorough review of all residents' nutritional assessments and care plans on April 19th.

b. Any gaps were identified, and an action plan implemented immediately.

c. Based on the findings, toolbox talks were developed to address specific areas of concern and completed April 19th.

d. In addition, refresher Assessments and Care Plan Training has commenced for the Nursing Team and will be completed by June 19th.

e. Roles and responsibilities related to Assessments and Care Planning have been clearly defined for the nursing team.

f. A clear reporting protocol has been established for reporting any instances of poor documentation/ non-compliance.

g. As of the 26th of May, comprehensive competence checks were implemented across all departments to provide additional oversight of staff. Staff members who exhibit inconsistencies or gaps in their practice will receive targeted additional supervision which will involve one-on-one coaching. Ongoing monitoring of their performance will be completed to ensure sustained improvement and adherence to standards.

h. The ADoN also has full time supernumerary hours dedicated to supervising the Nursing Team, providing hands-on training and support and addressing any issues promptly and effectively.

i. Additionally, and to determine compliance and progress, audits will be conducted frequently by the DoN and or Clinical Services Director. Findings of these audits will be discussed with the relevant department and appropriate actions taken.

j. Further, residents at risk of malnutrition, will be detailed and discussed at Governance and Management meetings to ensure transparency and accountability.

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
1. Effective from May 1st, 2024, the Centre transitioned to a paper-based roster system, demonstrating each employee by department, record any annual leave/other absences taken, and log the use of agency staff (where used) by name. All changes to the roster will be recorded on the paper roster in real-time.
This will ensure that the roster accurately reflects the staff on-site on any given day, providing a clear and up-to-date record of staffing. Regular audits will be conducted to ensure that the roster is maintained in line with regulatory requirements.

2. Following the inspection, all residents' repositioning charts and records have been updated. A full review also included record improvements for nutritional care and dietary intake information. (This is detailed further under Regulation 18). These records will be maintained as required. The DoN and the ADoN will monitor these records to ensure consistency and accuracy. Frequent audits will be conducted to ensure compliance in this area.

3. On April 19th, toolbox sessions were conducted by the Director of Nursing for all nursing and care staff on the importance of maintaining records of treatment refusals, to include nutritional and weight monitoring.
Documentation of treatment refusals will be tracked by the Nursing Team and recorded on the homes clinical management system.
Regular audits shall be undertaken by the Management Team to determine compliance to this procedure.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
1. The center has reviewed and updated the Policy for Meeting the Nutrition and Hydration needs of Residents and refresher training on the policy has been completed with staff. This includes a clear pathway on assessment of resident nutritional risk and outlines procedures to be followed.
Specific measures implemented to enhance oversight and improve nutritional documentation since the inspection are detailed under Regulation 18.
2. Following recent inspection findings, the Centre has decided to switch back to a paper roster system for managing staff attendance and scheduling, effective May 01st. The

paper roster now provides a clear and accurate record of all staff members' working hours on any given day and further reflects an amended record of whether the roster was actually worked by staff. This change has been implemented to ensure precision and compliance in line with the requirements of Schedule 4(9).
3. Subsequent to the Inspection, a full review of the Centre's records management system was completed. The improvement steps implemented are documented in detail under Regulation 21 & 18.
4. The risk register will be updated to reflect the completed fire remedial works and any outstanding works. This update will be completed by June 15th. The Director of Nursing and the Support Services Manager will closely monitor this process.
5. The Statement of Purpose has been updated to reflect the numbers of whole time equivalent staff working in the centre.
6. During times of short notice absences, it is the intention of the Director of Nursing to cover these shifts initially with the Centre's internal team. In the event these cannot be covered, agency staff will be utilized as a last resort.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
A detailed assessment of the current layout of the five twin-bedrooms was conducted by the Support Services Manager on May 17th. As a result, bespoke fitted furniture has been ordered to ensure that each resident in these bedrooms will have adequate usable and private space, including their bed, a chair, and personal storage within their private bed space.
In the interim and until these upgrades are completed, only one resident will be accommodated in each of these shared rooms to ensure comfort and privacy.

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
Subsequent to the inspection a full review of all 26 residents' records has been completed by the Director of Nursing with oversight by the Clinical Operations Director and the Independent Nurse Consultant, reviewing weights from December 2023 to date. On April 19th a food and fluid diary commenced for a 3-day period to provide an additional baseline of food intake and monitoring. Further, all residents were weighed again and a full analysis of their weight record history, together with their current weight, MUST score, BMI and medical/ allied health referrals was completed.

In addition, the following procedures and measures were implemented to improve the management and monitoring of residents' weights:

• Monthly weights for all residents will be conducted by the assigned staff nurse on the first Monday of each month. Residents with a MUST of 2 or more will be weighed weekly whereas residents with a MUST of 1 will be weighed every fortnight. Nutritional care plans for each resident will outline the required frequency of weights required and these will be updated where there are any changes in the residents' status or MUST score.
• In the event that any resident declines to be weighed this will now be recorded in their notes and follow-up attempts will be made taking into consideration the resident's preference with a view to ensuring all weights are completed by the end of the first week of the month.
• Where a weight entry is significantly different from the previous weight record, staff will repeat the process at that time and recheck the weight is accurate, getting a second opinion or using a different weight measurement device if required.
• The Director of Nursing will review the residents' weight and MUST report weekly and going forward this review will form part of the weekly Clinical meeting with the Clinical Services Director. This will be implemented by running a report off the electronic system to identify current weights and those residents with a MUST of 2 or more. This information will also be used to populate the monthly KPI template.
• Where a resident receives a MUST score of 2 or more, the calculation will be cross examined by the DoN/ ADoN to ensure it has been calculated correctly, using a timeframe of 3-6 months to calculate significant weight loss. Additional spot checks will be undertaken on other MUST scores to identify if these have been calculated correctly.
• A monthly audit based on residents "identified weight loss" has been added to the electronic audit system, released on 22/04/24 and will be completed by DoN going forward. The results will form part of the monthly G&M meeting.
• Where concerns over a Residents weight may be identified, a food diary will commence for 3 days to provide an additional baseline of food intake and monitoring. All staff have been reminded to report any changes in residents' Food and Fluid intake habits at handover.
• All nurses have completed refresher training on weight measurements and the calculation of MUST assessments.
• Timely referrals will be placed with dietetic, and speech and language services where required.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: As part of the Centre's ongoing efforts to ensure the safety and compliance of the building, the Register Provider has engaged the services of a contractor to complete all outstanding fire safety works.

With the exception of the compartment in the Laundry (completion date slightly delayed

until June 15th), all outstanding areas are completed, including:
1. Upgrade of Emergency Lighting:
o Internal and external signage and lighting have been upgraded.
o Completion Date: 31/05/2024
2. Fire Doors Repairs:
o Repairs have been completed on the ground and first floors.
o 8 Corridor FD60 doors have been replaced.
o Completion Date: 07/06/2024
3. Additional Fire Stopping to Services Penetrating Fire Rated Construction:
o First floor ceiling
o Compartment walls
o Protected corridor walls
o Fire rated rooms – walls and ceilings
o Completion Date: 31/05/2024

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:
A thorough review and update of all care plans has commenced by the DoN and ADoN to ensure that every assessed need is accurately reflected and that appropriate care plans are in place to meet these needs. A completion date of June 19th is set.

In conjunction with this review, training and support is being provided to all RGN's. This training emphasizes the importance of ongoing assessment and care planning, particularly in areas such as malnutrition and impaired skin integrity, as well as for emerging and changing care needs. The training sessions have already begun and will be completed by June 19th.

To ensure the Nursing Team will remain well-informed and compliant with current care plan requirements and guidelines, periodic refresher courses will be conducted by the Director of Nursing.

Additionally, Care Plan Audits will be conducted monthly, and any findings requiring action addressed and implemented immediately. The Director of Nursing (DoN) will oversee this process locally, and the Clinical Director will review it monthly at the Governance and Management Meetings.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	19/06/2024
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	19/07/2024
Regulation 18(1)(c)(iii)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional	Substantially Compliant	Yellow	19/04/2024

	assessment in accordance with the individual care plan of the resident concerned.			
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	01/05/2024
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	31/05/2024
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Red	24/04/2024
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Substantially Compliant	Yellow	31/05/2024

Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	15/06/2024
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	19/06/2024