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:	Claremount Nursing Home
Name of provider:	Claremount Nursing Home
Address of centre:	Claremount, Claremorris, Mayo
Type of inspection:	Unannounced
Date of inspection:	04 March 2024
Centre ID:	OSV-0000329
Fieldwork ID:	MON-0042617

About the designated centre

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

Claremont Nursing home is a purpose-built, two-storey centre which provides 24-hour nursing care for up to 60 residents requiring continuing care, convalescence, respite, dementia and palliative care. The centre is well laid out. Residents are accommodated on the ground floor. Bedroom accommodation comprises 50 spacious single and 10 twin bedrooms. All bedrooms have accessible en-suite toilet and showering facilities. There is a choice of different communal areas for residents to relax and a separate visitors' room, physiotherapy room and oratory are available. The centre is located approximately 1km outside the town of Claremorris in County Mayo. It has a large accessible internal garden for residents and is set in landscaped grounds.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	49

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
Monday 4 March 2024	08:30hrs to 17:30hrs	Yvonne O'Loughlin	Lead
Tuesday 12 March 2024	09:40hrs to 18:00hrs	Lorraine Wall	Support
Monday 4 March 2024	08:30hrs to 17:30hrs	Brid McGoldrick	Support
Tuesday 12 March 2024	09:40hrs to 18:00hrs	Gordon Ellis	Support

What residents told us and what inspectors observed

An unannounced inspection of Claremount Nursing Home was carried out over two days, with day one starting on the 4 March 2024 as a focused Regulation 27: Infection Prevention and Control inspection. Due to the findings on day one, a day two inspection was carried out on the 12 March 2024.

The centre had experienced a recent outbreak of respiratory syncytial virus that affected five residents.This outbreak was closed on the day of inspection. Prior to this outbreak the centre had an outbreak of COVID-19 which affected 27 residents and 10 staff. The community support team had visited the centre to give support during the outbreak but no report was available from this team on the day of the inspection.

On day one of the inspection the inspectors arrived to the centre, inspectors were greeted by the director of nursing and an introductory meeting was held in the visitors' room. Inspectors were guided on a tour of the premises by the director of nursing and the general manager, the provider of the nursing home joined the tour at a later stage.

On the tour of the nursing home the inspectors observed areas and equipment that were visibly dirty, this included the kitchen, the kitchen store room and the kitchen cold room. Findings in relation to cleanliness are discussed further in the report. The person in charge was responsive to issues identified during the inspection.

The centre had two floors, on the ground floor there were 50 en suite residents rooms.The centre is divided into sections, the north wing and the south Wing, it is linked by a large reception area with high glass windows which affords great sunlight. On the first floor there were store rooms, staff areas and rooms for visitors to stay overnight if they wished to do so to support in end of life care, however some of these rooms were not being used for their stated purpose and is further outlined under Regulation 23:Governance and Management.

There was a relaxed atmosphere within the centre as evidenced by residents moving freely and unrestricted throughout the day. Staff told inspectors that the majority of residents living in the centre had a known diagnosis of dementia. Those residents who could not communicate their needs appeared comfortable and content. Staff were observed to be kind and compassionate when providing care and support in a respectful and unhurried manner.

The design and layout of the building were observed to be suitable for the needs of the residents cared for within the centre, however a number of improvements were required in relation to premises and maintenance. Inappropriate storage was noted on the ground floor and the first floor, this is discussed further in the report.

The inspector observed that residents can only access the pleasant outdoor areas via emergency fire doors. As a result, residents are unable to enter the courtyards unaccompanied, as they require staff assistance to disarm the doors using key codes.

The inspectors observed two sittings of resident mealtimes. Residents and families said they were happy with quality of the food served. Residents enjoyed a cup of tea mid morning in the day area. Some residents had no side table to rest their cup and saucer so it was left by their feet.This meant that residents did not have easy access to more tea if inclined.

Inspectors observed a number of areas where fire stopping was required for example, in the electrical room behind the nurses station. In addition an number of fire safety concerns were identified which are detailed under Regulation 28: Fire precautions.

Closed circuit television was in use in the kitchen, drug store and corridors.

This centre is near Knock and residents were observed to enjoy the live streaming of daily mass from the Knock shrine. On the first day of the inspection, during the activities programme in the day room seven residents were observed to be in comfort chairs, some of these chairs were in poor repair and two of the chairs were missing the foot plates for residents to rest their feet comfortably. One resident in a comfort chair had a lap belt to restrict movement, inspectors spoke with staff who confirmed there were no records to show when the restraint is released.

One resident told inspectors that they had access to books from a small library as well as from one of the other residents. This gave them great joy as they loved to read.

On the second day of the inspection, residents told inspectors that they enjoyed the activities on offer and spoke about music entertainment which takes place regularly. The inspectors observed that the majority of activities were taking place in the main day room. The smaller day room was used by residents who were more dependent and had higher levels of cognitive impairment. The inspectors observed that there were hand massages being offered by staff but that there was a heavy reliance on television as entertainment.

The next two sections of the report will present the findings in relation to governance and management in the centre and how this impacts on the quality and safety of the service being delivered. The areas identified as requiring improvement are discussed under the relevant regulations.

Capacity and capability

Overall, the registered provider had failed to provide a safe and effective service for residents that was compliant with the regulations. Inspectors found that there were significant concerns in relation to fire safety and infection prevention and control.

The centre is registered to accommodate 70 residents, there were 49 residents accommodated on the day of inspection. Inspectors viewed a document dated January 2024 which identified that 49 per cent were assessed as maximum or high dependency. This meant that more than one staff member would be required to assist with personal hygiene and mobility needs for those residents that were assessed as maximum or high dependency.

This was an unannounced inspection to assess compliance with the regulations and was carried out over two days with four inspectors. Claremount Nursing Home Limited is the registered provider for this designated centre. The established governance structure in place includes a company director that represents the registered provider and to whom the person in charge reports to. The management team consists of the person in charge and a general manager. They oversee the work of a team of nurses, healthcare assistants, a physiotherapist, activity co-ordinators, housekeeping, catering and administrative staff.

Due to significant infection control and fire safety concerns on day one of the inspection, inspectors issued a number of immediate and urgent actions which included;

Immediate actions:

- Removal of a large number of storage boxes from the upstairs storage area and the area behind reception as they were a fire hazard.
- Removal of large number of boxes and lithium batteries located in a room with electrical panels.
- Securing oxygen cylinders and relocating surplus cylinders to a secure area. There was no signage to indicate that oxygen was been stored in this room.
- More frequent removal of lint from the dryer to prevent build up and decrease fire risk.

Urgent actions to be completed by 11 March 2024:

- Ensure sufficient resources in the housekeeping staff
- Ensure an effective deep clean of the centre including the kitchen
- Review the practice of topping up alcohol gels from a larger container
- Review the placement of hand sanitisers for effective hand hygiene practice
- Ensure staff have appropriate skills in relation to standard precautions
- Review by competent fire person to examine suitable storage areas

The second inspection was carried out to follow up on the issues identified above.The inspectors found that the kitchen had not been deep cleaned and that the cleaning store room beside the kitchen was visibly dirty.The registered provider

had increased housekeeping staff hours by one hour per day with a temporary additional member of staff to assist with the deep cleans.

On the second day of the inspection an urgent compliance plan in relation to fire concerns was issued for completion by the 19 March 2024. This included;

- Repair to the double fire doors from the kitchen to the dining room.
- Evidence of fire drills based on lowest levels staffing levels available, for example at night time.
- Submission of updated floor plans showing the location of the fire compartments for the safe evacuation of residents and staff in the event of a fire.
- Review of the fire door that would not close from the kitchen to the laundry

There was a statement of purpose available within the centre, however this did not reflect the premises and service as observed by the inspectors on the day.This is discussed further under Regulation 15:Staffing, Regulation 23:Governance and Management and Regulation 17:Premises.

Inspectors found that there were insufficient resources in housekeeping services to meet the needs of the centre. For example, on the first day of inspection, there were two housekeeping staff on duty from 8am until 2pm.The impact of this was evidenced by areas of the centre that were not cleaned to an acceptable standard.On the second day of the inspection there was an additional member of staff allocated for deep cleaning and the inspectors saw improvements in cleanliness in the main areas of the centre.

Inspectors found that there were gaps in fire safety training and training in the management of responsive behaviours. This was compounded by the observations on both days of the inspection in relation to restraint.

The supervision of staff within the centre was not adequate, as evidenced by the findings of Regulation 7: Management of behaviour that is challenging and the findings in relation to Regulation 27: Infection prevention and control within the centre.

The registered provider had audit and monitoring systems in place to oversee the service. However, the audit system was not sufficiently robust as it had failed to identify key areas for improvement such as assessments and care plans, the safe use of restrictive practices, poor infection prevention and control (IPC) practices and fire safety. This is discussed under Regulation 23:Governance and Management.

The person in charge had overall responsibility for infection prevention and control and antimicrobial stewardship. On the day of inspection the provider had not nominated an IPC link nurse to support the person in charge who had completed the national IPC link nurse programme.This is not in line with the national policy for IPC.

The volume of antibiotic use was monitored each month. However, the overall antimicrobial stewardship programme to improve the quality of antibiotic use,

needed to be further developed, strengthened and supported in order to progress and be effective.

The provider had not ensured that the Chief inspector was notified of all incidents which occurred within the centre, within the time frames outlined under Regulation 31: Notification of Incidents.

Complaints were managed appropriately and to the satisfaction of the complainant. However, the complaints policy and procedure document required updating to ensure that all residents have access to advocacy services, and are aware of the support available, should they require this assistance when making a complaint.

Registration Regulation 4: Application for registration or renewal of registration

The provider has submitted an application to renew the registration of Claremount Nursing Home, however the information set out in this application requires review to ensure that it is accurate and meets the requirements of Regulation 4.

Judgment: Substantially compliant

Regulation 15: Staffing

Inspectors were not assured that the provider had the required numbers of staff available with the required skill-mix having regard to the size and layout of the centre and the assessed needs of the residents. This was evidenced by:

- There was not enough staff employed to ensure effective cleaning of all areas of the centre.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The oversight of staff training was not robust and did not assure the inspector that staff had access to appropriate training in line with their roles.

- A review of the training records found gaps in fire safety training.

- Staff were not aware that there should be records kept for residents who had restraints to limit their movement.

This inspection found that staff were not appropriately supervised in their roles as evidenced in the findings outlined under Regulation 27 and Regulation 23. For example, areas of the centre were not clean including the main kitchen.

Judgment: Not compliant

Regulation 19: Directory of residents

The provider had a directory of residents in place which met the requirements of the regulations.

Judgment: Compliant

Regulation 21: Records

While many of the records reviewed during the inspection were in place and complete, the provider did not document the duration or release of the restraints used as required under Schedule 3 of the Regulations.

Judgment: Substantially compliant

Regulation 23: Governance and management

The registered provider did not ensure that all areas of the the premises of the designated centre was used in accordance with the statement of purpose and floor plans prepared under Regulation 3 as set out in Condition 1 of the centre's current registration.The inspectors found that;

A number of rooms on the second floor were not being used for their stated purpose as evidenced by:

- A room which is registered as a physiotherapy room was being used as a storage room for wheelchairs.
- Two rooms which were registered as visiting family suites were being used as a bedroom for staff and a storage room.
- One room which was registered as a bedroom was being used for storage.
- An en-suite toilet had been out of order since 2021.

The inspectors found that the management and quality assurance systems that would ensure that the service delivered to residents was safe and effectively monitored remained inadequate in a number of areas, and consequently, most of the inspectors' findings on this inspection had not been identified by the provider through their own oversight and auditing processes. This was evidenced by;

- A number of audits had not been completed in line with the centre's own audit schedule. For example, the three monthly falls audit and six monthly incidents audit had not been completed since 2022.The audit of residents' beds which is due for completion every six months had not been completed since April 2023. An environmental audit of the kitchen which was completed in January 2024 stated that the appliances and fixtures were clean but during both days of the inspection this was not the case.
- Poor oversight of cleaning practices relating to infection prevent and control meant that the standard of cleaning was not adequate.
- There was no evidence of antimicrobial stewardship quality improvement initiatives or guidelines.
- Improvement in systems in place to enable residents access their monies on weekends was required.
- Failure to submit all notifiable incidents to the Chief Inspector of Social Service as required by the regulations.
- Resident restraints were not monitored sufficiently in line with the national policy.
- Residents' care plans did not guide staff on how to care for the residents. Care planning audits did not identify these failures.
- The oversight of fire safety in the centre was not robust and did not adequately support effective fire safety arrangements and keep residents safe. Immediate and urgent compliance plans had to be issued on both days of the inspection to the provider due to the significant fire safety risks identified by the inspectors. These are outlined in detail under regulation 28: Fire Precautions.
- The keeping of fire safety records was not adequate to ensure effective fire safety management of the designated centre. For example, a comprehensive fire safety register was not available on the day of the inspection. A schedule of fire safety checks and maintenance in regards to; fire doors, emergency lighting and means of escape was not available. This resulted in a failure to identify fire risks, to manage the day-to-day fire precautions in the centre and to track items that required maintenance.

There were insufficient resources provided to ensure effective delivery of care in accordance with the statement of purpose, or to meet residents needs: This was evidenced by;

- There was not enough staff working in the kitchen or as household staff to provide a good service to the residents.There were two staff in the kitchen from 2.45pm and one staff after 6pm. This impacted on staff availability to clean the kitchen effectively. Two staff worked in housekeeping from 8am until 2pm which was not sufficient to respond to all areas that require cleaning and deep cleaning.

- The system for covering sick leave was not operating effectively, for example on the day of inspection there was no replacement for a member of staff who was off sick.
- There were not adequate assurances provided that there was enough night time staff to safely evacuate residents in the event of a fire.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

A small number of contracts of care were reviewed. The fees were not documented on two of the contracts viewed and one contract did not identify the occupancy of the room the resident was accommodated in.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The chief inspector was not notified in accordance with the regulation in relation to incidents that had occurred in the centre.For example;

- an unexpected death of any resident within three days of such occurrence, including the death of any resident following transfer to hospital from the designated centre.
- an outbreak of a notifiable disease

Judgment: Not compliant

Regulation 34: Complaints procedure

The complaints policy and procedure had not been updated in line with changes in legislation that came into effect in March 2023, in relation to how residents' could access independent advocacy services for the purpose of making a complaint.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

The complaints policy and the infection prevention and control policies were not in line with current best practice guidance. For example:

- The IPC policy did not reference the new national guidelines *National Clinical Guideline No. 30 – Infection Prevention and Control (IPC)* 2023 or include antimicrobial stewardship.
- The complaints procedure had not been updated in line with changes in legislation that came into effect in March 2023,

Judgment: Substantially compliant

Quality and safety

Ineffective systems of governance and management described in the capacity and capability section of this report impacted on the quality and safety of care provided to the residents in key areas such as the management of responsive behaviours, food and nutrition, residents rights, fire safety and infection prevention and control and did not ensure that the residents were adequately protected in the event of a fire emergency or in the event of an outbreak.

Inspectors found that the provider did not comply with Regulation 27 and the *National Standards for Infection prevention and control in community services* (2018). Weaknesses were identified in infection prevention and control governance, environment and equipment management. Details of issues identified are set out under Regulations 23:Governance and Management and Regulation 27: Infection Prevention and Control.

Barriers to effective hand hygiene practice were observed during the course of this inspection. Clinical hand washing sinks were not available within easy walking distance from all residents` rooms. Alcohol-based hand-rub was available in wall mounted dispensers along corridors. However, examples were seen where there were inadequate dispensers to ensure alcohol hand gel was readily available at point of care. Alcohol gel was being topped up by a larger container but the inspectors were assured this practice had been stopped as a result of the urgent action plan issued on day one of the inspection. There was no hand hygiene sink in the drug preparation room in the north wing for staff to clean their hands if visibly soiled. On the second day of the inspection, the inspectors observed that additional hand gel dispensers had been installed around the centre.

Examples were seen where the ancillary facilities such as sluice rooms did not support effective infection prevention and control measures. For example, the back splash behind the sink was stainless steel and rusty this is discussed further under Regulation 27: Infection prevention and control.

A range of issues were identified in the centre, in relation to infection prevention and control. For example policies and procedures for IPC were not up to date with

new national guidance to guide staff for example at the nurses station on the wall was a COVID-19 guidance document dated 2020. The centres own transfer document did not have sufficient detail to reflect a residents` infection status to enable safe transfer of residents to acute care if required.

Inspectors noted that some areas of the centre required maintenance attention, and these areas would impact on the residents safety, for example, the majority of the ensuite bathrooms had flooring that was stained and in poor repair, wooden furnishings and window sills were worn.These and other findings are outlined under Regulation 17: Premises.

The oversight of fire safety and the processes to identify, and manage fire safety risks were ineffective to ensure the safety of residents living in the centre. On the first day of the inspection, the provider was issued with immediate actions and an urgent compliance plan. These risks were in regards to; inappropriate storage practices of flammable items and oxygen cylinders, a number of closing mechanisms to fire doors were found have been interfered with, restricted access to the main fire panel for the centre, and the lack of available keys to access fire exits and garden gates on escape routes.

Following a day two inspection, it was noted that some of these risks had been addressed by the provider. However, the inspectors identified repeated and additional fire risks that warranted a second immediate action and an urgent compliance plan. These are outlined in detail under Regulation 28: Fire Precautions.

There were inappropriate containment arrangements. For example, inspectors found missing fire seals on some fire doors, damaged smoke seals and doors throughout the centre had gaps over the permissible tolerance. Door closing mechanisms to the majority of the bedroom fire doors were not functioning. In addition to this, fire rated ceilings and walls had gaps and holes that required fire sealing to maintain the fire rating. In the kitchen area, an urgent compliance plan was issued as the fire doors to this high risk room were in poor condition and a deep fat fryer was in use without the presence of a fire suppression system.

The records provided on the day of inspection showed that the fire detection and alarm systems, gas system, fire extinguishers were maintained and serviced. However, the annual and quarterly service and maintenance records were not available for the emergency lighting system. Furthermore, there were no records or schedules available of fire safety checks, a fire safety register and maintenance records in regards to items relating to fire safety.

Other concerns were identified with fire drills, staff fire training, evacuation floor plans and the evacuation of residents. These and other fire safety concerns are detailed further under Regulation 28: Fire Precautions.

There were some visiting restrictions in place, for example in the day room there was a sign to restrict visitors but overall, visits were encouraged and practical precautions were in place to manage any associated risks.

The inspectors reviewed a sample of residents' care plans and daily care records and found that some care plans were not consistently updated in line with residents' changing needs. Some residents did not have a social care plan in place and the inspectors were not assured that these residents were offered meaningful activities in line with their capacities.

The residents told inspectors that they enjoyed the activities on offer. A therapy dog visits weekly and an entertainer attend the centre weekly to provide a music session. There were two activities coordinators on duty on the second day of the inspection and the inspectors observed a number of activities taking place in one of the day rooms. However, action was required to ensure that all residents were provided with sufficient opportunities to participate in activities that were in line with their interests and capacities as outlined under Regulation 9:Residents rights.

The inspectors found that two residents did not have an occupational therapy assessment in place for the specialist chairs they were using. As a result, the inspectors were not assured that these residents were using equipment that met their needs.

The inspectors observed that residents did not have adequate space in their en-suite bathrooms to store their toiletries. This meant that residents were storing their toiletries on windowsills.

Restrictive practices required action as they were not managed in accordance with the national restraint policy and guidelines and the centre's policy. This is discussed in the report under Regulation 7: Managing behaviour that is challenging.

The inspectors observed residents socialising and having lunch together. Residents told the inspectors that they were happy with the food provided; however, residents were unaware what was on the menu on the second day of the inspection. In addition, the inspectors were not assured that residents who had cognitive impairments were offered adequate choice. This is discussed further under Regulation 18: Food and Nutrition.

Regulation 12: Personal possessions

Residents did not have adequate storage units in their en-suite bathrooms to store. Some residents' toiletries were being stored on windowsills, in baskets and others were stored on sinks which hindered the resident's access to their sink.

Judgment: Substantially compliant

Regulation 17: Premises

The registered provider did not, having regard to the needs of the residents at the centre, provide premises which conform to the matters set out in Schedule 6 of the regulations. For example:

- The premises were not well maintained throughout:
    - There were a number of items of furniture which required replacing. For example, a number of residents' chairs were damaged and stained and some residents' wardrobes were visibly scuffed and damaged.
    - Examples of damaged walls were in the nurses station and in residents rooms.
    - The flooring was damaged or stained in all residents' en-suite bathrooms, except for two floors which had recently been replaced.
    - The ceilings in some areas had holes and required sealing. For example, in an electrical store room, a boiler room and in a reception office.
    - Fire doors throughout the centre were found to not be maintained to ensure they functioned as intended and some were damaged.
    - A number of items of resident equipment such as commodes were rusty.
- Not all equipment for residents were in good working order:
    - Two mattresses that were in the room for a new admission were torn.
    - A number of items of resident equipment such as commodes were rusty.

Judgment: Not compliant

Regulation 18: Food and nutrition

While there were two choices of meals available for residents on the day of inspection, the menu board was not completed prior to the dinner being served and the inspector was not assured that all residents were informed about what choices were available. In addition, there were no picture menus available for residents with cognitive impairment who may not be able to understand the written menu options available. The inspector was not assured that these higher dependency residents were offered appropriate choice in relation to their meal. For example, the inspector spoke with staff who were unable to tell the inspector how they offered choice to these residents.

Judgment: Substantially compliant

Regulation 27: Infection control

Infection prevention and control and antimicrobial stewardship governance arrangements did not ensure the sustainable delivery of safe and effective infection prevention and control for example:

- The IPC policy was not up to date and in line with the new *National Clinical Guideline No.30* (IPC) May 2023.
- PPE was not not being used effectively, for example staff were wearing face masks below their noses and bringing dirty linen to the linen skip with no apron. Not adhering to standard precautions poses a risk to staff and residents of infection spread.

The environment was not managed in a way that minimised the risk of transmitting a healthcare-associated infection. This was evidenced by:

- Hand hygiene facilities were not sufficiently in place for clinical staff to wash their hands if visibly soiled.This could led to infection spread.
- The sluice room did not support effective prevention and control. For example,the bedpan washer in the sluice had an out of date detergent attached.This meant that bedpans and urinals may not be cleaned properly. There was a rusty jug and a toilet brush in the sink which staff said was used to clean urinals if stained.
- The centre had not been deep cleaned at the end of the outbreak and prior to opening to admissions.This increased the risk of infection spread from surfaces that have not been cleaned.
- Resident equipment was not cleaned after use to prevent infection spread to other residents. For example, a wheelchair in a store room was heavily stained, a commode in a communal toilet was visibly dirty.
- The kitchen including fridge, floor area were not clean. Some of the shelving in place was rusty and could not be effectively cleaned. The provider had arranged for an external cleaning service for the kitchen which was due for completion after the second day of inspection, however the provider had made no attempts to improve the cleanliness of the kitchen in the interim time period.
- The storage room adjoining the kitchen which was used to store cleaning products and also contained a sink, mops and buckets was unclean and was not listed on the centre's cleaning schedules.
- A number of vents were not clean and were not on a cleaning schedule.
- Disposable curtains were in use, however there was no date as to when the curtain had been erected.

Judgment: Not compliant

Regulation 28: Fire precautions

The registered provider was failing to meet the regulatory requirements on fire precautions in the centre and had not ensured that residents were protected from

the risk of fire. The provider was non-compliant with the regulations in the following areas:

Day-to-day arrangements in place in the centre did not provide adequate precautions against the risk of fire. For example:

- Inappropriate storage practices in relation to flammable items next to an electrical unit in a water storage room on the first floor were found. This created a fire risk and the storage of large amounts of flammable items in one area created a fire load should a fire occur.
- A fire panel was located in a locked room, access to this room is via key pad. This required an assessment, to provide assurance that there is no delay in the event of an evacuation. In a reception office, flammable items were found next to an electrical unit creating a fire risk. There was storage of large amounts of flammable items in this area which created a fire load.
- A number of oxygen cylinders were found to be stored internally, unsecured and warning signage was missing from where the cylinders were being stored. This created a fire risk.
- On both days of the inspection a number of closing mechanisms to fire doors were found to have been interfered with. This created a risk of fire and smoke to spread with ease in the event of a fire.
- On day two of the inspection flammable items were found to be stored in a boiler room. An immediate action was issued to the provider to remove all items from this area.

A number of bins were found to be stored up against the external wall of the centre. If a fire developed from this area, it could spread from the bins and onto the building.

In an internal smoking room used by residents, the inspectors found cigarettes and a box of matches unattended. This created a risk to residents with cognitive or dementia symptoms having access to a fire starting implement.

The provider failed to ensure that there was effective fire safety management systems and policies in place. For example, a comprehensive fire safety register was not available on the day of the inspection. Furthermore, a schedule of fire safety checks and maintenance in regards to; fire doors, emergency lighting and means of escape to mention a few were also not available. This resulted in a failure to identify fire risks, to manage the day-to-day fire precautions in the centre and to track items that required maintenance.

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

A number of fire exits were found to be operated with a key. The inspectors noted keys were not available at all fire exits and staff did not carry a key on their person. Furthermore, escape from an enclosed garden was through a gate. The gate was found locked with a rusty padlock. Staff when spoken with were not familiar with the evacuation procedures in regards to escape from the enclosed garden areas and

the locks that were fitted to the gate. This could cause a delay in an evacuation event. An urgent action was issued to the provider to promptly address this risk.

The majority of internal emergency directional signage was found to be functioning. However, some areas along a corridor and above a fire exit were found not to be illuminated. External emergency lighting was not provided to all evacuation routes. This was evident in the enclosed garden areas and at the front entrance to the centre.

The location of the fire assembly points required a review. The front assembly point was located in a parking space and could not be easily identified. The area for residents to gather was not large enough due to the impact of the car parking area. This would result in residents gathering at an area were emergency vehicles may be trying to access the centre in a fire emergency. A second fire assembly point at the rear of the centre was located on an access delivery road and the evacuation route was not easily accessible.

The provider did not adequately review the maintenance of the fire fighting equipment and of the building fabric. For example:

Annual and quarterly service and maintenance records were not available on the day of the inspection to ensure the emergency lighting system was being regularly serviced by a competent technician.

Some areas in the centre were noted to have utility pipes or ducting that penetrated through the fire-rated walls and ceilings (walls and ceilings built in a way to provide a certain amount of fire resistance time), and these required appropriate fire sealing measures. For example, the inspectors noted some holes in the ceiling of an electrical store room, a boiler room and in a reception office that required sealing. In addition to this, the inspectors was not assured the spray foam that had been used to seal around pipe work in some areas of the centre was an appropriate fire sealing product carried out be a competent person.

Fire doors throughout the centre were found to not be maintained to ensure they functioned as intended. Fire seals were found to have fallen off, were missing or were damaged. A number of doors failed to close fully when tested by the inspectors and some doors were damaged.

Arrangements for staff of the designated centre to receive suitable fire training were not adequate. From a review of fire training records, the inspectors noted that 12 staff were overdue fire training. The provider had informed the inspectors they had scheduled fire training later in the month of March. Furthermore, some staff when spoken with were not familiar with the evacuation procedures in the event of a fire. Additional training is required for staff to receive further aid and support in regards to this.

Personal emergency evacuation plans (PEEPS) were in place but required more detail. The records did not include a section for residents who may be taking

sleeping medication, had hearing or sight difficulty or who may have required supervision post an evacuation.

While fire evacuation drills were taking place,inspectors were not assured the provider had ensured an effective evacuation could take place with the least amount of staff available. Subsequent to the inspection, it was confirmed that larger compartments existed than previously stated by the provider on the day of the inspection. This created a significant risk to the safety of the residents as the existing fire evacuation strategy and staffing levels did not reflect compartments of up to 14 residents. Therefore the inspectors were not assured that adequate arrangements were in place to evacuate, where necessary all persons in the event of a fire. An urgent action was issued to the provider to promptly address this risk. Drills were subsequently submitted. However, further evacuation practices were required to ensure residents were evacuated in a timely manner, taking into consideration the existing fire safety risks. Furthermore, a review of staffing resources and evacuation procedures would be required if the occupancy of the centre is increased in line with the statement of purpose.

The registered provider did not make adequate arrangements for containing fires. For example:

The majority of bedroom doors throughout the centre had significant gaps and the door closing mechanisms were not functioning when tested by the inspectors. This would mean that a fire in a room with an open door, could spread to other areas of the centre, and smoke and fumes would not be contained for a period on the protected corridors. Some cross corridor double fire doors did not close when released and did not align. Some store room fire doors were noted to be fitted with non-fire-rated vents, which compromised the fire doors from containing the spread of smoke.

In addition to this, fire doors located in a kitchen required urgent action by the provider to ensure adequate containment of fire and smoke was in place. For example, a fire door adjacent to the laundry corridor was caught on the floor and would not close when tested by the inspectors. A second set of double fire doors from the kitchen that lead into the dining room were twisted, had a large gap underneath and at the top of the door. Smoke and intumescent seals were missing from sections of these doors. The inspectors also found these doors were held in an open position by a wall hook.

A physiotherapy room and a day room had been repurposed as store rooms without consultation from a fire specialist. This is required to ensure these rooms were suitable for this change of use and would meet the required fire resistance. Furthermore, the inspectors noted fire doors into a laundry appeared to not meet the criteria for a high risk room.

The displayed procedures to be followed in the event of a fire required a review by the provider. The fire evacuation plans were not up-to-date to reflect the current function of each room and required more detail. For example, there was no indication of the location of fire compartments, fire escape routes, fire extinguishers

or call points. A physiotherapy room and a day room had been repurposed and were in use as storage rooms. Furthermore, floor plans were not on display at the main fire panel.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

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

- Some care plans were not updated consistently to ensure that outdated information which was no longer relevant had been removed and that all aspects of the residents' care had been appropriately reviewed in order to provide clear information for staff caring for the residents.
- Social care plans were not in place for all residents. This meant that staff could not be aware of residents skills, abilities and interests.
- There was no care plan in place for a resident who had been admitted to the centre more than two weeks previously. This was a significant oversight as staff did not have the information they required to provide safe and appropriate care for this resident.
- The care plans for residents using restraints did not detail the periods of release and monitoring while in use to guide staff in the provision of safe care for these residents.
- Two residents who were assessed as requiring monthly nursing observations, did not have them consistently monitored.

Judgment: Not compliant

Regulation 6: Health care

Residents did not have adequate access to occupational therapy services in line with their needs.

A review of a sample of residents records showed that two residents who were using specialist comfort chairs did not have an appropriate occupational therapy assessment of their seating needs to ensure that the chairs they were using were appropriate for them. Nursing staff had made the decision to use these specialist chairs. A full review of all residents nursed in comfort chairs was required to ensure that their individual needs for specialist seating and positioning were met.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

Restraints in the centre were not managed in line with the centres own policy on restrictive practice and were not in line with the national restraint policy guidance on promoting a care environment that is free from restrictive practice.

For example, residents who required a form of restraint did not have a release chart in place to ensure that restraints were used in the least restrictive manner and for the minimum time required. In addition training records reviewed indicated that not all staff had up to date knowledge and skills in this area, appropriate to their role. As a result restraints were not managed safely. This was evidenced by;

- On the first day of the inspection, the inspectors observed a number of residents wearing lap belts that were not observed to be released.
- On the second day of the inspection, the inspectors observed that residents who required lap belts, as outlined in their care plans, were not wearing them.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The registered provider did not ensure that all residents had opportunities to participate in activities in accordance with their interests and capabilities.

- The inspectors carried out observations in residents' bedroom accommodation and in the communal areas. There were two activities co-ordinators on duty on the day of the inspection. There was no activity schedule on display in one of the communal rooms and the inspector was not assured that residents with higher levels of social and cognitive needs were offered activities to participate in meaningful social engagement, appropriate to their interests and abilities.
- A review of the daily activity notes found that for some residents with cognitive impairment, there was a high reliance on television and watching music on television most days.

While residents could access their monies during the week when either the receptionist or general manager were on duty, there were no arrangements in place

for residents to access their money at the weekend and on bank holidays. Therefore the inspectors were not assured that residents could access their money if required.
Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 4: Application for registration or renewal of registration	Substantially compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 12: Personal possessions	Substantially compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Substantially compliant

Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Claremount Nursing Home OSV-0000329

Inspection ID: MON-0042617

Date of inspection: 12/03/2024

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

This document is divided into two sections:

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

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

A finding of:

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

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the

non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Registration Regulation 4: Application for registration or renewal of registration	Substantially Compliant
Outline how you are going to come into compliance with Registration Regulation 4: Application for registration or renewal of registration: An Application to Vary the use of rooms on the second floor & an amended Statement of Purpose was submitted on 12th April 2024. Further changes were requested to the Statement of Purpose and these were submitted on 24th May 2024. Completed	
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Staffing hours have been increased in both the kitchen and housekeeping teams. The housekeeping shifts have been increased by 30 minutes per shift and the shift has also been split to ensure that a cleaner is on duty from 0730 until 1600. Kitchen shifts have	

been increased by 30 minutes for each shift, so that there is an increase of 1 hour for kitchen staff on duty each day.

This will be assessed every year in accordance with the Statement of Purpose and sooner if required, if resident numbers increase or if an outbreak occurs.

Completed

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
Fire Safety Training was completed on 6th March 2024 for any new staff requiring fire training and staff whose training had expired. Fire Training is ongoing and is scheduled for June and July 2024. A fire evacuation questionnaire has been completed by all staff in conjunction with fire training. This questionnaire will be completed monthly.

A CNM has been allocated to supervise kitchen cleaning on a daily basis since 15th March 2024. A housekeeper has been assigned as Team Leader to check all housekeeping on a daily basis and report to CNM or PIC. Spot checks will be conducted by CNM or PIC. Environmental Kitchen & housekeeping audits will be conducted on a monthly basis.

Kitchen & Housekeeping staff have undergone training on HSEland on "AMRIC Cleaning & Disinfecting the Healthcare Environment & Patient Equipment."

This was completed by 10th June 2024

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
A restraint release chart is now in place for all residents using lap-belts. This is also reflected in the individual residents care plans. The restraint release chart will be monitored by the Nurses, CNMs and PIC. Completed.

In line with the National Restraint Policy, our goal is to reduce the use of restraints, in order to achieve a restraint free environment.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
An Application to vary the use of the rooms on the second floor was submitted on 12th April 2024.

The toilet on the second floor is not part of the staff rooms. The toilet has been repaired and is working.
Three monthly falls audit & six monthly incidents audits are regularly updated. These were provided at the time of inspection & this was not discussed at the feedback meeting.

The Residents Bed Audit – a recent audit was completed on 15th February 2024 & was provided to the Inspector on the day of inspection.

Environmental Kitchen & housekeeping audits will be conducted on a weekly basis by CNMs and monitored by PIC. Kitchen & Housekeeping staff have undergone training on HSEland on "AMRIC Cleaning & Disinfecting the Healthcare Environment & Patient Equipment."

A housekeeper will be assigned as Team Leader to check all housekeeping on a daily basis and report to CNM or PIC. Spot checks will be conducted by CNM or PIC. Environmental Kitchen & housekeeping audits will be conducted on a monthly basis.

HSE posters regarding the safe use of Antimicrobial Stewardship & Skip The Dip have been displayed in the nurses' station. The antimicrobial stewardship audit and individual resident evaluation has been updated. The use of antibiotics is advised and prescribed by the resident's GP. All healthcare staff have completed or refreshed training on HSEland Infection, Prevention & Control. Hand sanitiser stations have been increased throughout the centre.

The PIC updated the Notifiable Incidents to the Chief Inspector on 11th April 2024.

A restraint release chart is now in place for all residents using lap-belts. This is also reflected in the individual residents care plans. The restraint release chart will be monitored by the Nurses, CNMs and PIC. In line with the National Restraint Policy, our goal is to reduce the use of restraints, in order to achieve a restraint free environment.

In conjunction with our Fire Safety Officer, the urgent compliance plans regarding Regulation 28 were submitted on 19th March 2024 and 3rd April 2024.

Staffing hours have been increased in both the kitchen and housekeeping teams. The housekeeping shifts have increased by 30 minutes and have also been split to ensure

that a cleaner is on duty from 0730 until 1600. Kitchen shifts have been increased by 30 minutes for each shift, so that there is an increase of 1 hour for both housekeeping kitchen staff on duty each day.

The staff sick leave was short notice on the day. Unfortunately, we could not arrange either staff cover or agency cover.

Night time simulated fire drills were submitted on 19th March 2024, reflecting the compartments. A review of staffing resources and procedures would take place if the occupancy of the centre increased in line with the statement of purpose.

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

Regulation 24: Contract for the provision of services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 24: Contract for the provision of services:
An audit was conducted on 25th March to review all Contracts of Care. All contracts were reviewed and are up to date. The PIC & Manager will monitor Contracts of Care as required by the Regulations.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
The PIC updated the Notifiable Incidents to the Chief Inspector on 11th April 2024.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:

The complaints policy has been updated in line with changes in legislation that came into effect in March 2023.

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures: The IPC Policy has been updated to reference the new national guidelines National Clinical Guideline No 30 – Infection, Prevention and Control (IPC) 2023 and also includes antimicrobial stewardship. The complaints policy has been updated in line with changes in legislation that came into effect in March 2023.

Regulation 12: Personal possessions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions: The current storage arrangement for residents' ensuite bathrooms is in baskets immediately outside the bathroom door. We will provide additional storage in the en-suite bathrooms. This will be completed by 31st August 2024.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises: A schedule of work has been put in place with a goal to have all works completed in 12 months' time – 30th June 2025. A carpenter is working full-time in the centre in order to bring all fire doors, including dining room, kitchen, bedroom & store room doors into compliance. This is due to be completed by 5th July 2024. Ceilings and walls gaps have been fire sealed in compliance with fire rating.

A review of all equipment is ongoing. The commodes have been removed from the floor.

Personal Emergency Evacuation Plans (PEEPS) have been revised to show the compartments. The PEEPS will be revised to show sleeping medication, hearing or sight impairment and supervision requirements by Friday 21st June 2025.

Night time simulated fire drills have been submitted, reflecting the compartments. A review of staffing resources and procedures would take place if the occupancy of the centre increased in line with the statement of purpose. Completed.

An application to vary the use of rooms has been submitted.

An independent fire risk assessment has commenced and floor plans are on display in the centre. The fire risk assessment will be completed by Thursday 27th June 2024.

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
Picture menus are in use by staff for the residents with cognitive impairments. The menu is displayed in the dining room and this is updated before each sitting. The choice of meals is offered to residents.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
The IPC Policy has been updated to reference the new national guidelines National Clinical Guideline No 30 – Infection, Prevention and Control (IPC) 2023 and also includes antimicrobial stewardship. Staff have completed refresher training on HSEland Infection, Prevention & Controlm module. Additional hand hygiene facilities have been installed throughout the centre. The sluice rooms have been reviewed and out of date detergent has been replaced and dirty equipment removed. The centre and all resident equipment was deep cleaned in March and additional staff were rostered to complete the cleaning. The kitchen was deep cleaned by an external cleaning company in March 2024. The storage room and equipment is included on cleaning schedules. Labels will be applied to all curtains to include date of use.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: In conjunction with our Fire Safety Officer, the urgent compliance plans regarding Regulation 28 were submitted on 19th March 2024 and 3rd April 2024.

Bins to the rear of the kitchen have been moved from the external wall of the centre.

The Smoking room is a purpose built room, with glass for easy observation in the event of an incident. Staff observe any resident every 15 minutes. Staff will assist the resident to light cigarettes and matches or lighters will not be left with the resident. Risk assessments have been completed for residents who smoke. These were completed by Friday 31st May 2024.

A carpenter remains in the centre full-time and has completed works to all dining room, kitchen, bedroom doors & store room doors. Corridor fire doors are currently being refurbished and will be completed by 5th July 2024.

Spray foam sealant has been replaced with fire retardant sealant. Completed.

Fire training was held in March and is ongoing with training scheduled for June & July in order for all staff to have up to date fire training. A fire evacuation questionnaire has been completed by all staff in conjunction with fire training. This questionnaire will be completed monthly.

Personal Emergency Evacuation Plans (PEEPS) have been revised to show the compartments. The PEEPS will be revised to show sleeping medication, hearing or sight difficulty and supervision requirements by Friday 21st June 2024.

Night time simulated fire drills have been submitted, reflecting the compartments. A review of staffing resources and procedures would take place if the occupancy of the centre increased in line with the statement of purpose.

An application to vary the use of rooms has been submitted.

An independent fire risk assessment has been completed and floor plans are on display in the centre.

The water tank room was emptied shortly after inspection and is now clear of all storage items. Completed.

The boiler room was emptied of all flammable materials on the day of inspection. Completed.

The door code is now displayed on the door to the back office with the fire panel. The room has been emptied of flammable items. Completed.

The oxygen cylinders are now stored outside the building. Completed.

The fire door closing mechanisms have been serviced and are working correctly. Completed.

There are now daily checks in place to monitor door closing mechanisms. Daily, weekly and monthly fire prevention checklists are in place to monitor compliance. Completed.

All fire exits are now fitted with keys & a green break glass mechanism. In addition, the nurses carry a key for each fire exit door. Completed.

Garden gate padlocks have been removed from the garden gates. Completed.

All emergency lighting and directional signage is working correctly. The emergency lighting is included on the weekly fire prevention checklist. Completed.

External emergency lighting is fitted above all fire exit doors, including the enclosed garden areas and the front entrance. Completed.

The fire assembly points have been reviewed and parking is restricted at the assembly point. The assembly point to the rear of the centre has been reviewed and the evacuation route has been made easily accessible. Completed.

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

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:
Care Plan audits will be carried out every 6 months and monthly care plan checks will be conducted by the CNMs. Spot checks will be conducted regularly by the PIC. The nurses will assess the residents care needs on a daily basis and a detailed handover will be reported to the care assistants on a daily basis. Completed.

Social assessments and care plans are in place for all residents. Each residents' needs and preferences will be informed to the carers in the daily handover. A copy of the social assessment, which includes their skills, interests and abilities will be given to the Activity Co-Ordinators. Life stories for all residents are accessible to all staff. Completed.

CNMs are responsible for all new admission assessments and care plans. PIC will oversee on the next day of admission. An admission assessment and care plan checklist is now in place to ensure that care plans and assessments are completed on admission. Completed.

The monthly observations for the two residents are now recorded. The nurses have a daily signing sheet in place and the CNM and PIC will complete monthly checks.

The resident admitted to the centre on 29th February 2024 had immediate assessments and care plans in place.

Occupational therapy have reviewed all residents when required. The two residents using specialist comfort chairs have now received occupational therapy assessments.

All residents will have a comprehensive assessment, including the need for an OT assessment. This will be completed every four months and will be checked by the CNMs and PIC as part of the regular care plan audit.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
A restraint release chart is now in place for all residents using lap-belts. This is also reflected in the individual residents care plans. The restraint release chart will be monitored by the Nurses, CNMs and PIC. Completed.

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
As per the HIQA Guidance for Designated Centres: Restraint Procedures (GDE3) page 4 "Interventions prescribed by healthcare professionals regarding the healthcare of residents are not notifiable restrictive practice. These may include, for example, the use of wheelchairs or standing frames or the immobilization of a body part to meet a medical or health need." As advised by the Occupational Therapist, the use of lap-belts is a positioning belt to align hips and decrease shearing. A repositioning chart has been introduced for all residents using recliner chairs. Repositioning takes place every two hours. This is reflected in the Use of Recliner Chair care plan.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: The Activity Co-Ordinators are overseen and audited by one of the CNMs and the activity timetable has been reviewed to provide meaningful social engagements for the residents, appropriate for their interests and abilities. Completed 15th March 2024.

The nurses have been provided with a key to the residents' safe in order to access the safe at weekends and the records book. Any monies dispensed to or taken in by nurses from residents will be recorded and witnessed by two members of staff.

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
Registration Regulation 4 (1)	A person seeking to register or renew the registration of a designated centre for older people, shall make an application for its registration to the chief inspector in the form determined by the chief inspector and shall include the information set out in Schedule 1.	Substantially Compliant	Yellow	27/05/2024
Regulation 12(c)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that he or she has adequate space to store and maintain his or her clothes	Substantially Compliant	Yellow	31/08/2024

	and other personal possessions.			
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	27/05/2024
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	16/06/2024
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Orange	27/05/2024
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.	Not Compliant	Orange	30/09/2024
Regulation 18(1)(b)	The person in charge shall ensure that each resident is offered choice at mealtimes.	Substantially Compliant	Yellow	27/05/2024
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and	Substantially Compliant	Yellow	27/05/2024

	4 are kept in a designated centre and are available for inspection by the Chief Inspector.			
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Red	11/03/2024
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.	Not Compliant	Orange	27/05/2024
Regulation 24(2)(a)	The agreement referred to in paragraph (1) shall relate to the care and welfare of the resident in the designated centre concerned and include details of the services to be provided, whether under the Nursing Homes Support Scheme or otherwise, to the resident concerned.	Substantially Compliant	Yellow	27/05/2024

Regulation 24(2)(b)	The agreement referred to in paragraph (1) shall relate to the care and welfare of the resident in the designated centre concerned and include details of the fees, if any, to be charged for such services.	Substantially Compliant	Yellow	27/05/2024
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Not Compliant	Red	11/03/2024
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Red	11/03/2024
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Red	11/03/2024
Regulation 28(1)(c)(i)	The registered provider shall	Not Compliant	Orange	27/05/2024

	make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.			
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	27/05/2024
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 practicable, residents, are aware of the	Not Compliant	Red	11/03/2024

	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	Red	19/03/2024
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.	Not Compliant	Red	19/03/2024
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	28/05/2024
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.	Not Compliant	Orange	27/05/2024
Regulation 31(2)	The person in charge shall ensure that, when the cause of an unexpected death	Not Compliant	Orange	27/05/2024

	has been established, the Chief Inspector is informed of that cause in writing.			
Regulation 34(5)(b)	The registered provider may, where appropriate assist a person making or seeking to make a complaint, subject to his or her agreement, to identify another person or independent advocacy service who could assist with the making of the complaint.	Substantially Compliant	Yellow	27/05/2024
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.	Substantially Compliant	Yellow	27/05/2024
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Substantially Compliant	Yellow	27/05/2024
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	Not Compliant	Orange	27/05/2024

	that resident's admission to the designated centre concerned.			
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Not Compliant	Orange	27/05/2024
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.	Substantially Compliant	Yellow	27/05/2024
Regulation 7(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to	Substantially Compliant	Yellow	27/05/2024

	respond to and manage behaviour that is challenging.			
Regulation 7(2)	Where a resident behaves in a manner that is challenging or poses a risk to the resident concerned or to other persons, the person in charge shall manage and respond to that behaviour, in so far as possible, in a manner that is not restrictive.	Substantially Compliant	Yellow	26/06/2024
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.	Substantially Compliant	Yellow	26/06/2024
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Not Compliant	Orange	27/05/2024
Regulation 9(3)(c)(i)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may communicate freely and in	Not Compliant	Orange	26/06/2024

	particular have access to information about current affairs and local matters.			
Regulation 9(3)(c)(ii)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may communicate freely and in particular have access to radio, television, newspapers and other media.	Substantially Compliant	Yellow	26/06/2024