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:	Fearna Manor Nursing Home
Name of provider:	Castlerea Nursing Home Limited
Address of centre:	Tarmon Road, Castlerea, Roscommon
Type of inspection:	Unannounced
Date of inspection:	02 November 2022
Centre ID:	OSV-0000339
Fieldwork ID:	MON-0038187

About the designated centre

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

The centre is a purpose-built facility single storey building that is registered to accommodate a maximum of 53 dependent persons aged 18 years and over. It is situated in a residential area a short drive from the town of Castlerea. Bedroom accommodation consists of 15 single and 19 double rooms all with en-suite facilities. There is a range of communal areas where residents can sit together and socialise. Other facilities include a dining area and spaces for visitors and people who smoke. There are toilets and bathrooms located near to communal areas. There are two outdoor areas that are easily accessible to residents. The centre caters for male and female residents who require long-term care and also provides care to people who have respite, convalescence, dementia or palliative care needs. In the statement of purpose, the provider states that they are committed to enhancing the quality of life of residents by providing a homely, safe and caring environment.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	36

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
Wednesday 2 November 2022	09:30hrs to 18:30hrs	Michael Dunne	Lead
Wednesday 2 November 2022	09:30hrs to 18:30hrs	Ann Wallace	Support

What residents told us and what inspectors observed

The inspectors found that residents living in the centre were mostly content with the care and support provided to them. Some residents told the inspector's that they would like more activities to be provided and that they would like more opportunities to visit the local community or to go on organised trips to local amenities. Residents said that staff were kind, caring and worked hard to support them in their daily routines.

On arrival to the centre, the inspectors were welcomed by the management team, however, there were no checks carried out or documentation completed regarding the medical wellness of the inspectors. This was pointed out to the person in charge, who then arranged for the appropriate documentation to be made available for visitors to the designated centre.

Residents were observed to be comfortable in the presence of staff. It was clear that staff were aware of residents individual needs and were able to respond to those needs in a person-centred manner. All interactions observed on the day between staff and residents indicated that staff were respectful of residents' rights and autonomy. Residents who required support with their personal care were observed to be in receipt of discrete care support, where their privacy and dignity was respected. All residents observed on the day of the inspection were dressed in appropriate clothing and footwear for their lived environment.

Residents who expressed a view, confirmed that staff arranged for them to receive their medication at various times during the day. They also confirmed that they could see their GP if they had concerns about their health care. A review of health care information reviewed on inspection found that some records required updating however, overall resident's health care requirements were well managed.

The designated centre is a low level construction with all rooms set out on the ground floor. The accommodation provided was in a mixture of single and twin bedded rooms. Residents were able to personalise their own living space with their individual mementos, ornaments and pictures. On the whole, residents were happy with their own private bed spaces, however, inspectors observed two twin-bedded rooms where the layout of these rooms did not allow residents to access their storage space without entering another residents private space. This was pointed out to the person in charge during the walk around of the centre.

There was a range of communal spaces available for residents to use which included a sun room, a day room, an activity room and a quiet room. The layout of the activity room did not promote inclusion or social engagement among residents due to the positioning of seating along the perimeter wall. A table located in the middle of this room facilitated activities, however, this also impeded resident movement. Residents were seen to use the sun room throughout the day and it was clear that they enjoyed this space. The activity room, however, was not observed to be used

by residents during the inspection, while the quiet room was being utilised as an mobility equipment store room. A prayer room was not available for residents use, as, at the time of the inspection, it was being used as a store room by the registered provider.

The upgrade of bedroom and communal fire doors in the centre had impacted on the quality of decoration throughout the centre. A number of walls required re plastering and repainting, as a result of these upgrades.

Residents were complementary about the quantity and quality of food provided in the centre. A meal service was observed by inspectors and was found to be well managed by the staff team present, with all residents receiving timely support to enjoy their meal. Residents who required additional support with their eating and drinking were able to enjoy their meal in an unhurried manner.

Residents spoken with told inspectors that they felt safe in the centre and that they could talk to any member of the staff team if they had concerns or if they were worried about their care. In particular, residents were happy that visiting was back to normal and that they could receive visits from their relatives and family members without restriction.

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

Capacity and capability

Overall, inspectors found that management systems and current oversight arrangements to be insufficient in order to provide a service that is safe, appropriate, consistent and effectively monitored.

Inspectors found that while the registered provider had carried out a number of actions to come into compliance with the regulations, there were a number of repeated non-compliance's found under Regulation 23: Governance and management, Regulation 27: Infection control, and Regulation 28: Fire precautions. This was the third unannounced risk inspection carried out in 2022 to monitor the provider's compliance with the Health Act 2007 (Care and Welfare of Residents in designated Centre's for Older People) Regulations 2013 (as amended). Compliance plan responses submitted by the registered provider with regard to the inspection carried out in August 2022 did not provide sufficient assurances that the provider would come into full compliance with the regulations. The registered provider failed to actively engage with the office of the Chief Inspector in relation to the delays in reaching compliance with Regulation 28, fire precautions or to submit an application to vary condition 5 on the current registration, which expired on 31 July 22 in relation to Regulations 23, Governance and Management and Regulation 27:

Infection Control.

The office of the Chief Inspector received two items of unsolicited information since the previous inspection in August 2022. The inspectors followed up on this information during the inspection and found that concerns in relation to checking visitors at the point of entry to the centre for signs and symptoms of infection to be substantiated and this concern was discussed directly with the provider. In addition, the provider confirmed that there had been a temporary change to the catering service and that this change had impacted on the quality of food provided to the residents. This issue had been addressed at the time of this inspection.

Castlerea Nursing home Limited is the registered provider for this designated centre of which there are two company directors. One of the director's is directly involved in the running of the centre and provides support to the person in charge. The person in charge was well-established in their role, however, while there were two clinical nurse managers (CNM) identified on the statement of purpose to support them in their role, inspectors found that only one (CNM) was in position and this reduced the capacity to provide nursing and clinical oversight. The remainder of the team consists of health care assistants, staff nurses, household staff, administration, maintenance and an activity co-ordinator.

The inspector's found that the person in charge had arrangements in place to provide training to staff however not all recently employed staff had completed their mandatory training prior to commencing employment. This had the potential for staff to be unaware of the appropriate procedures to follow in providing a safe and consistent service to the residents.

The inspectors found gaps on the roster regarding the number of household staff working in the centre at the time of the inspection. This was concerning due to repeated non-compliance's found in relation to infection prevention and control oversight. There was only one household staff on site to clean this centre when the roster indicated that there should have been two.

While the provider maintained a number of records in accordance with Regulation 21: Records, there were areas of the service where records were not well-maintained and had the potential to impact negatively on resident care and welfare. These issues are described in more details under Regulation 21. The maintenance of records is a repeated non-compliance found across the past two inspections.

The registered provider had management systems in place to identify risk and to promote health and safety within the centre. However, despite having these policies in place, the inspectors found that:

· Risk assessments did not identify risks regarding the fitting of new fire doors where these doors did not have door closures in situ or were linked into the fire safety system. This made the existing fire procedure obsolete as it did not take into account these changes.

· Audits did not identify areas of poor practice particularly in relation to high risk

areas in the centre such as the dirty utility.

The inspectors found that there was a complaints policy and procedure in place. A review of the complaints log found that, of the ten complaints logged since the last inspection, there were two complaints still unresolved and currently reviewed at stage two of the complaints procedure. Two other complaints received identified concerns around delays in communication with family members.

Regulation 15: Staffing

Inspectors found that there were insufficient numbers of staff available with an appropriate skill mix having regards for the assessed needs of the residents and the layout of the centre.

A review of the centre's rosters indicated that two household staff (cleaners) were scheduled to work on the day of the inspection however, there was only one household staff on site.
The numbers of clinical nurse managers available to support the person in charge was not in line with the centre's statement of purpose and this impacted on the quality of services been delivered.

Judgment: Substantially compliant

Regulation 16: Training and staff development

A review of training records confirmed that not all staff had completed their mandatory training prior to commencing in their respective roles. Four new staff had not completed fire safety training while three new staff had not completed training in safeguarding. The person in charge told the inspector that they were in the process of arranging this outstanding training.

Inspectors found that the household supervisor was not rostered to work on the day of the inspection. There were no alternative arrangements made to ensure that household staff were appropriately supervised, when the supervisor was not on site

Judgment: Not compliant

Regulation 19: Directory of residents

A review of the directory of residents found that it had not been updated for two residents in accordance with schedule 3 of the regulations. Documentation regarding

their transfer to hospital had not been updated.

Judgment: Substantially compliant

Regulation 21: Records

Not all Schedule 2 records were available in the designated centre. This was evidenced by:

- Two staff did not have most recent employment references in place.

Not all Schedule 3 records were available and up to date. This was evidenced by:

- The daily care records for two residents had not been completed in full for two days prior to the inspection.

Not all Schedule 4 records were available in the designated centre. This was evidenced by:

- The roster was not was not updated to reflect numbers of staff working in the centre on the day of the inspection.
- The records of dietary needs for some residents was not up to date in the catering staff records.

Judgment: Not compliant

Regulation 22: Insurance

The registered provider maintained an insurance policy which indemnified against injury to residents. The insurance policy was found to provide cover for the period 01 June 2022 until 31 May 2023.

Judgment: Compliant

Regulation 23: Governance and management

Resources were required to be allocated in relation to the outstanding fire safety works, to ensure that the provider had adequate precautions in place to protect residents in the event of fire.

Inspectors also found that resources were required with regard to staffing. This was

evidenced by:

- Only one clinical nurse manager position had been filled at the time of the inspection. This position was found to be vacant at the last inspection on 3 August 2022.
- There was insufficient numbers of household staff rostered on the day of the inspection.

The management structure was not clearly defined, this was evidenced by:

- The progress in relation to the fire safety upgrades. It was unclear as to who was taking the lead in arranging for these works to be completed. Neither the person in charge nor a senior manager were able to give information regarding the time-frames for these works to be completed. In addition the details of some of the contractors involved in carrying out these works was not widely known among the management team.

The management systems currently in place did not provide sufficient assurances that the service was safe, appropriate, consistent and effectively monitored. This was evidence by

- The management communication systems in place were not robust. For example, the structure of governance meetings required review to ensure that there was a clear agenda in place linked to key areas of service provision. Records reviewed on inspection did not provide assurances that there were clear action plans with defined timescales to address areas of poor compliance with the regulations.
- Inadequate monitoring systems. Infection prevention and control audits which did not identify risks that inspectors have found on repeated inspections. As a result, there was no clear action plans to address and mitigate against these risks going forward.
- Poor risk management.The identification of risks, with regard to fire safety and mitigation to reduce or eliminate these risks, were ineffective.
- Poor systems of oversight. Systems to ensure that staff were adequately trained in safeguarding prior to commencing in their role was not effective. In addition, inspectors found that while there had been resources allocated to improving fire safety in the centre, information regarding the completion of these works was not known.

The registered provider has still not implemented the required interventions to bring the designated centre into compliance with the regulations. The registered provider was in breach of Condition 5 of their current registration, with regard to Regulation 23: Governance and Management and Regulation 27: Infection Control and Condition 4, with regard to Regulation 28, Fire precautions.

Judgment: Not compliant

Regulation 3: Statement of purpose

The registered provider had maintained a statement of purpose which was updated in September 2022. A review of the facilities available for residents to use on inspection found that two facilities were not been used for their intended purpose as described in the statement of purpose. This is described in more detail under regulation 17, Premises.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The registered provider had an accessible complaints policy and procedure in place to facilitate residents and or family members lodge a complaint should they feel the need to do so. This policy was advertised in the designated centre and met the requirements as set out under regulation 34.

Judgment: Compliant

Quality and safety

Residents received a good standard of nursing care, in line with their assessed needs. Prior to admission, the person in charge ensured that residents had a comprehensive assessment which helped to ensure that the centre could meet the person's ongoing needs and that a good client home fit was achieved. Following admission, the resident and where appropriate their family worked with nursing staff to develop a care plan. Care plans reviewed by the inspectors were person-centred and reflected the resident's current needs, as well as their preferences for care and support. Care plans were reviewed regularly and the sample reviewed on this inspection were up to date and reflected the residents' current needs.

Care records showed that residents had access to a range of health and social care professionals to promote their health and well-being. However, some residents did not have access to medical review with their general practitioner (GP) in line with their needs. This is discussed under Regulation 6. There was no COVID-19 outbreak in the designated at the time of this inspection and as a result PRN medicines were being administered outside of the context of the prescriber's instructions.

Overall, care was person-centred and residents were supported to maintain their independence and to spend their days as they wished, however, a number of residents told the inspectors that they did not have enough to do and that they did

not have the opportunity to go on outings or visit the local town for coffee or shopping. Residents said that they enjoyed the bingo sessions each week, but there was little else to look forward to as activities were not on a planned schedule and they were not sure what was on offer to them each day. In addition, the inspectors noted that activities were carried out in the main lounge or in the activities room which was located just off the lounge area. These rooms were set out with large tables and chairs around the wall of the room and around the tables. The activities room itself was similarly laid out. This created quite an institutional feel to these areas.In addition, residents did not have access to a quiet area to sit other than the entrance lobby. There was a quiet room off the main lounge, but this was being used as an equipment store at the time of the inspection.

It was evident that staff knew the residents well and were familiar with their needs and their daily routines. Staff were prompt to attend residents who needed assistance with toileting or mobilising. Residents who congregated in the main lounge were supervised by a member of staff at all times. Staff and resident interactions were respectful and empathetic. Residents told the inspectors that staff were kind and that they felt able to ask staff for support when they needed t

The layout of resident's private space in most bedrooms was appropriate and met the resident's needs. However, the layout of two twin-bedrooms did not ensure that both residents had access to their possessions without encroaching on another resident's private space. This is addressed under Regulation 17.

Residents' privacy and dignity were respected by staff. Staff were seen to knock and wait for permission before entering a resident's bedroom or bathroom. Residents told the inspectors that they could get up and go to bed at a time that suited them and that they could vary their meal times, if they wished to do so. Inspectors observed that where a resident refused a care intervention, this was respected by staff and recorded in the resident's daily care record.

Care staff were diligent in reporting each resident's daily care progress to nursing staff and it was clear that they understood their role in reporting any changes from the resident's base line. However, more focus was required to ensure that the written records of each residents daily care were maintained so that each resident's health and well being could be effectively monitored. For example, two of the records reviewed by the inspectors did not record the resident's care and progress over several days, between the hours of 6pm and 2am the following morning.

Residents' meals were wholesome and nutritious and residents said that they enjoyed their food. Most residents said that they had plenty to eat, but a small group of residents said that the evening meal was not enough and that they sometimes felt hungry in the evenings. Inspectors reviewed the menus and found that there was a variety of evening meals on the menu and this was followed by supper at 9pm. The person in charge agreed to review the menus and times of evening meals in line with the feedback from residents. Staff were familiar with the residents' dietary needs, however, the dietary information held by catering staff was out of date in relation to key risks such as textured diets and thickened fluids. This created a risk that staff would follow out of date information and the resident would

be served with the wrong diet or fluids.

The inspectors observed the lunch time meal and saw that meals were nicely presented and that there were enough staff to provide support for those residents who needed help with their meals. Inspectors observed that a number of residents were wearing white plastic aprons to protect their clothes during meal times. It was not clear that residents had been consulted prior to these aprons being worn. This practice did not uphold the resident's dignity and was not an appropriate use of personal protective equipment. In addition, the dining room was quiet, with little in the way of interactions between residents.

There was a comprehensive policy in place in relation to protecting vulnerable adults from abuse, and safeguarding residents in the event of an allegation or incident of abuse. The majority of staff were facilitated to attend training in the protection of vulnerable adults as part of their mandatory training requirements. Staff who spoke with the inspectors were clear about their responsibility to safeguard residents and to report any incidents or allegations of abuse. The inspectors reviewed two potential safeguarding incidents and found that they had been investigated and followed up appropriately. This was a significant improvement from the previous inspection. Residents told the inspectors that they felt safe and that they could talk to a member of staff if they had any concerns.

There were a small number of residents accommodated in the designated centre who demonstrated responsive behaviours (How residents who are living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). Staff were familiar with the residents' behaviours and what may trigger responsive behaviours. Each resident had a care plan in place that identified what interventions were needed to support the resident if they became agitated or anxious. As a result, staff were able to recognise behaviours that would suggest the resident was becoming anxious and were able to provide support in an appropriate manner to distract the resident.

Although the inspectors found that improvements had been made in relation to infection prevention and control practices in the designated centre, more focus and effort is now required to ensure that the centre comes into full compliance with Regulation 27. These findings are set out under the regulation.

Inspectors found that the provider had failed to progress the actions required to bring the centre into compliance with Regulation 28, fire precautions, in a timely manner. As a result, residents were not adequately protected in the event of a fire emergency.

Deficiencies previously identified in relation to means of escape and fire door compartmentation were still in place at the time of this inspection. The fitting of internal compartment doors and the widening of two final fire exits was still outstanding and this had the potential to adversely impact on effective evacuation procedures.

The ability to safely evacuate residents from one compartment to another in the centre was compromised due to a lack of awareness among staff of the new fire

compartment that had been added.

Recent fire safety upgrades meant that many resident room doors did not have self closures fitted and were not linked into the centre's fire alarm system. This meant that in the event of a fire, these doors would not self close if left open. The current fire procedure had not been updated to mitigate against this risk and as a result this increased the risk of fire to spread in the centre.

The provider had a restrictive condition attached to their registration in June 2022 stating that they were not allowed to admit any new residents until the designated centre came into compliance with Regulation 28. This inspection found that the provider remained not compliant with the regulation.

Regulation 17: Premises

A tour of the designated centre found that the premises did not conform to Schedule 6 of the regulations. This was evidenced by;

- Corridor walls which were in need of painting upgrade due to damage as a result of the installation of fire rated doors in resident bedrooms.
- the resident communal area, known as the quiet room, was being used as a mobility equipment storage area.
- A room designated as a resident's prayer room was being used as a storage facility.
- The laundry facility was located outside of the footprint of the designated centre. Domestic washing machine equipment in use to launder resident's clothes was not suitable as it did not have a sluicing programme installed.
- The layout of two twin bedrooms did not ensure that each resident could store their clothes and personal items in their private space. Inspectors observed that one resident would have to enter the other resident's bed space to access their wardrobe and storage.
- The cluttered open plan environment in the communal areas created an institutional feel. This was validated by feedback from some residents who told the inspectors that they did not enjoy spending time in these areas as they could not sit in quiet and comfort especially if their were activities happening. Although residents could choose to sit in the front lobby some residents said that they would prefer to sit in a quiet lounge if it was available.

Judgment: Not compliant

Regulation 18: Food and nutrition

Residents had their nutritional needs met with wholesome meals that were safely prepared, cooked and served. There was choice at meal times and residents could request an alternative if they did not want anything on the menu.

There were adequate numbers of staff available to assist residents at meal times. Staff were familiar with the residents' nutritional needs and were respectful and discreet when supporting residents with their meals and drinks.

Although meals and snacks were available throughout the day some residents told the inspectors that the timing of the evening meal needed to be reviewed so that meal times were more evenly spaced throughout the day.

Judgment: Compliant

Regulation 26: Risk management

There was a risk management policy and procedure in place which met the requirements of Schedule 5 of the regulations. Identified risks in the centre were found to have been reviewed in February 2022. Risk assessments in relation to fire and infection prevention and control were not sufficient in identifying the potential hazards as a result of current practice. This is discussed in more detail under regulation 23.

Judgment: Compliant

Regulation 27: Infection control

The registered provider did not ensure that procedures,consistent with the National Standards for Infection Prevention and Control in Community Services (2018) published by HIQA, were implemented by staff. Evidence found on inspection confirmed that:

- A wash hand basin was required to be installed in the cleaning room to promote effective hand hygiene.
- Inappropriate storage of cleaning items found in the sluice room which was a repeated find from a previous inspection. Records to confirm the sluicing machine was serviced were not available.
- While inspectors noted that some improvements had been made and that the amount of storage of multiple use items had reduced in the main store room there were items stored on the floor which prevented effective cleaning.
- A number of pressure relieving cushions were torn and damaged and not suitable for use due to the risk of cross contamination.
- There was no evidence to confirm that communal slings were been cleaned

and stored in a safe manner.
- Inspectors were not checked for signs and symptoms of COVID-19 upon arrival. Documentation for visitors to sign confirming health status were not in place at the beginning of the inspection.
- There was a poor supply of paper hand towels available in the kitchen facility.

Judgment: Not compliant

Regulation 28: Fire precautions

A review of actions taken by the registered provider to achieve compliance with the regulations found that while some progress had been made, there were significant fire safety risks in this designated centre. Repeated non- compliance's were found on this inspection and meant that the registered provider was not in a position to assure the office of the Chief Inspector that all adequate measures were in place to protect residents against the risk of fire. This was evidenced by:

- Two external fire exit doors had not yet been fitted.
- Not all internal compartment fire doors had not been fitted.
- The provision of an appropriate oxygen storage facility was outstanding.
- Attic fire hatches were not fitted.
- Fire zone/compartment floor maps did not identify the new fire compartment.
- The installation of fire rated doors for two resident bedroom was outstanding.

Additional fire safety concerns identified on this inspection included:

- The kitchen serving hatch shutter was not connected to the fire alarm system.
- The new fire doors had not been connected into the L1 fire alarm system and did not have self closures fitted. As a result, these doors would not automatically close in the event of a fire.
- The current fire procedures had not been updated to take account of the additional risks associated with the fire doors not being linked into the fire alarm system.
- Four new staff had not had fire safety training and some staff did not demonstrate an awareness of the fire emergency procedure they would need to follow to ensure residents were safe in the event of a fire.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Overall, medication practices were found to be safe and medicines were

administered in line with best practice guidance. However, a review of controlled drug medications found that although the stock balance was correct, the daily records for one controlled medication were not correctly recorded over a number of days prior to this inspection. This had not been identified on the daily stock checks. which were signed as having been carried out by two nurses.

On the day of the inspection, the morning medication round was not completed until 11:10 am which meant that some residents did not receive their morning medications within the prescribed time frames.

Nursing staff were continuing to administer as needed intra-venous medications that had been prescribed for residents as part of their COVID-19 medication care plan. The care plan and prescription had not been reviewed for those residents who may require prn (as required) intra-venous fluids in other circumstances.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

The inspectors reviewed a sample of residents' assessments and care plans and found that each resident had a comprehensive assessment of their needs on admission to the designated centre. This information was used to develop a person centred care plan that identified the resident's needs,their self-care abilities, and their preferences for care and daily routines.

Judgment: Compliant

Regulation 6: Health care

The provider did not ensure that all residents in the designated centre had access to their general practitioner (GP) in line with their care needs. Records showed that several residents with high levels of physical needs including extreme frailty were expected to attend their GP surgery if they needed a medical review. For example, one resident who had had a significant deterioration in their health, had not been referred to their GP since February 2022.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

The number of restraints in the designated centre had increased since the previous

inspection with 19 bed rails in use at the time of this inspection. Each resident who was using a restraint had a risk assessment and a care plan in place for same. However, inspectors were not assured that residents were facilitated to trial other equipment, such as low low beds, prior to bed rails being implemented in line with national guidelines for the use of restrictive practice..

Judgment: Substantially compliant

Regulation 8: Protection

Staff were facilitated to attend training for protecting vulnerable adults from abuse however, three staff were not up to date with their mandatory training in relation to the protection of vulnerable adults.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The current activities schedule did not ensure that all residents had the opportunity to participate in activities in accordance with their interests and capacities. On the day of the inspection activities included arts and crafts, knitting group, daily newspapers and watching television. There was no planned schedule displayed throughout the centre and residents who spoke with the inspectors did not know what activities were on offer on the day.

The use of white plastic aprons as clothes protectors at meal times did not uphold the dignity and choice of individual residents. In addition there was no evidence that resident's chose to wear the aprons to protect their clothes.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 19: Directory of residents	Substantially compliant
Regulation 21: Records	Not compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Fearna Manor Nursing Home OSV-0000339

Inspection ID: MON-0038187

Date of inspection: 02/11/2022

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: 2 CNMs have been interviewed and offered posts. They are working through their notice periods. There are sufficient household staff but from time to time (as with other categories) illness does arise at the last minute and a shift cannot be covered. This happens in all businesses and especially in healthcare given the higher levels of exposure to the prevailing illnesses in the community. ***This compliance plan response from the registered provider did not adequately assure the office of the chief inspector that the actions would result in compliance with the regulations.***	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Staff training is carried out in line with the training matrix. Safeguarding training normally carried out prior to commencement of employment. In certain circumstances, where the person has had the appropriate training in a previous employment out training is done after employment commences. Each situation reviewed on its own merits. From now on training will be done prior to commencement. ***This compliance plan response from the registered provider did not adequately assure the office of the chief inspector that the actions would result in compliance with the regulations.***	

Regulation 19: Directory of residents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 19: Directory of residents:
Hospital admissions and transfer will be recorded.

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
Daily care records fully updated by end of shift. Dietary requirements updated for kitchen staff. Floor staff always aware and two now linked.
Rosters are updated at end of day. Updating too early in the morning does not allow for situations whereby someone has been delayed by a couple of hours.

This compliance plan response from the registered provider did not adequately assure the office of the chief inspector that the actions would result in compliance with the regulations.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
2 CNMs have been hired and are working out their notice periods with current employers. There are sufficient household staff and were rostered for the day in question. It just happened that one was out ill (suddenly) and no one was available to cover that particular shift.
The management structure is clearly defined and the registered provider representative is leading the fire element in conjunction with maintenance, who attended on site that day and informed the inspector of the works to date, the works to be done and the expected timeline. Given that most of the works were completed within 2 weeks of the visit shows that they had been organized. Because certain information is not known on site does not automatically mean there are no systems or organization in place, it just might indicate that certain information / matters are dealt with off site and filtered through as appropriate.
Infection control audits are now fully documented.

This compliance plan response from the registered provider did not adequately assure the office of the chief inspector that the actions would result in compliance with the regulations.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
The rooms in question are no longer used for storage so no amendment required.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Full repaint is commencing on 16 January now that all structural work is complete. This should be completed by 31 March at the latest. Laundry now ready for use within the registered footprint. Quiet room and prayer room no longer have items stored in them and are back in use. The 2 twin bedrooms are single occupancy for now and will be reconfigured prior to reverting to double occupancy. This means moving wardrobes and lockers.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
Items not stored on floor or in sluice rooms. Sling cleaning now fully documented. Cushions have been replaced and more ordered.
All visitors now checked before entry.

This compliance plan response from the registered provider did not adequately assure the office of the chief inspector that the actions would result in compliance with the regulations.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
External fire doors fitted, 2 bedroom doors fitted, closers fitted, kitchen hatch linked to alarm as are the relevant doors. All staff trained and drills carried out. Attic hatches on order and looking at possibility of reducing the number of hatches in place. Oxygen now stored in special purpose shed.

This compliance plan response from the registered provider did not adequately assure the office of the chief inspector that the actions would result in compliance with the regulations.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
Controlled drugs now checked twice daily.
Medicine rounds carried out withing the time frame required for the relevant medicines.

This compliance plan response from the registered provider did not adequately assure the office of the chief inspector that the actions would result in compliance with the regulations.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
One GP has refused to attend centre but has made the first slot after lunch in his practice available daily if required for a resident. This is not ideal but residents or families do not want to move from this GP despite this restriction so it is resident choice. Other practices in area are full. Westdoc reviews residents if necessary but in the main all residents reviewed 3 monthly by GPs.

This compliance plan response from the registered provider did not adequately assure the office of the chief inspector that the actions would result in compliance with the regulations

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:
We are looking at reducing the number of bed rails and have trialled other options in all cases. Some residents want them as a comfort and all trials and requests for comfort have been documented.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
All training up to date and new staff will not commence until they have our training (even if they have had it elsewhere recently)

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: Activity schedules now widely displayed and residents reminded regularly.

Use of plastic aprons discontinued. Where appropriate fabric clothes protectors offered.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Substantially Compliant	Yellow	30/11/2022
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	30/11/2022
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of	Not Compliant	Orange	30/11/2022

	purpose prepared under Regulation 3.			
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	30/11/2022
Regulation 19(3)	The directory shall include the information specified in paragraph (3) of Schedule 3.	Substantially Compliant	Yellow	30/11/2022
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	30/11/2022
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	Orange	30/11/2022
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure	Not Compliant	Orange	30/11/2022

	that the service provided is safe, appropriate, consistent and effectively monitored.			
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Not Compliant	Orange	30/11/2022
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Orange	30/11/2022
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	30/11/2022
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and	Not Compliant	Orange	30/11/2022

	building services.			
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	30/11/2022
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	30/11/2022
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	Orange	30/11/2022

	procedure to be followed in the case of fire.			
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	30/11/2022
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	Orange	30/11/2022
Regulation 29(4)	The person in charge shall ensure that all medicinal products dispensed or supplied to a resident are stored securely at the centre.	Not Compliant	Orange	30/11/2022
Regulation 29(5)	The person in charge shall ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.	Not Compliant	Orange	30/11/2022

Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose relating to the designated centre concerned and containing the information set out in Schedule 1.	Substantially Compliant	Yellow	30/11/2022
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	30/11/2022
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	30/11/2022
Regulation 8(2)	The measures referred to in paragraph (1) shall include staff training in relation	Substantially Compliant	Yellow	30/11/2022

	to the detection and prevention of and responses to abuse.			
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Not Compliant	Orange	30/11/2022
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Substantially Compliant	Yellow	30/11/2022