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:	Flannery's Nursing Home
Name of provider:	Flannery's Nursing Home Limited
Address of centre:	Chapel Road, Abbeyknockmoy, Tuam, Galway
Type of inspection:	Unannounced
Date of inspection:	20 October 2021
Centre ID:	OSV-0000341
Fieldwork ID:	MON-0034333

About the designated centre

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

This registered centre is a modern purpose-built single-storey premises, which provides residential care for 61 residents. The building has many features that contribute positively to residents' quality of life. These include large bedrooms with en-suite facilities, windows that provide a view of the outside when sitting down, a range of sitting areas where residents can spend time during the day and wide hallways that enable residents to walk around freely. The centre cares for both female and male residents aged 18 years and over with the following care needs: respite care to residents following hospital stay, post surgery or from home, respite care, post-operative care for those after orthopaedic surgery, and cardio-thoracic surgery. Long term care is provided to residents requiring full time care, including those with dementia and who are no longer able to look after their own physical and mental well-being. The registered centre provides palliative care, dementia care, and convalescence care.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	34

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 20 October 2021	07:30hrs to 16:45hrs	Fiona Cawley	Lead
Wednesday 20 October 2021	07:30hrs to 16:45hrs	Sean Ryan	Support

What residents told us and what inspectors observed

The feedback from the residents was that this was a good place to live where they were supported by caring staff who knew them well. The atmosphere in the centre was generally relaxed and most of the residents were observed to be very content in their surroundings. The staff were observed to be kind, caring and attentive in their interactions with the residents. However, whilst some improvements were found during this inspection, the inspectors observed that the provider had not addressed all issues identified on the last inspection. .

The inspectors spoke with a number of residents during the inspection who said that they were happy in the centre and that the staff were always kind and helpful to them. A number of residents were living with dementia and therefore conversations with some residents were limited. Those residents who were unable to communicate verbally were observed by the inspectors to be content. One resident asked to meet with the inspectors and told them that they were more than happy living in the centre and that they received '110% care', adding that they could not praise the centre enough. Another resident who was in the centre for respite told the inspectors that the centre was a very nice place, the staff were very kind and could not do enough for them. That resident also told the inspectors that this was their first experience of living in a nursing home. and that the person in charge was very attentive and visited them on a daily basis. One resident who was resting in their bedroom explained to the inspectors that they preferred to spend their time in their room reading and that they always got help when they needed it..

Inspectors observed that the centre had a pleasant homely envirnment, was bright, airy and welcoming and the communal areas were decorated with comfortable furnishings. The corridors were wide and well lit and the walls were decorated with colourful artwork. Grab rails were available along the corridors to assist residents to mobilise safely. The building was warm and well ventilated throughout. The bedroom accommodation provided the residents with sufficient space to adequately store their personal belongings. Many residents had decorated their rooms with personal items to enhance their surroundings and create a homely atmosphere.

The dining room was also a bright, spacious area. However, on the day of the inspection the inspectors observed that this area was crowded during the lunchtime period.

Overall, the premises was laid out to meet the needs of the residents and to encourage and aid independence. However, insectors observed that the standard of cleaning in the centre was found to be unacceptable on the day of the inspection. For example, a number of areas including resident bathrooms were unclean and items of resident equipment were found to be visibly soiled. This will be discussed further under Regulation 27 Infection prevention and control. The inspectors spoke with housekeeping staff about their roles and responsibilities to ensure the centre was kept clean.The inspectors were not assured that the staff had the required

knowledge and skills regarding the cleaning processes in place ot ensure they were in line with national guidance on infection prevention and control in residential care settings.

An outdoor garden area provided unrestricted access to a pleasant outdoor space for the residents. There were landscaped lawns, a water feature, a variety of beds with lovely colourful flowers and plants. There was also a polytunnel which provided the residents with opportunities for gardening. However, some improvements were required to ensure unrestricted, safe access to the area.

Throughout the day, the inspectors observed residents socialising with each other and with the staff in the various areas of the centre. Other residents were observed to be content in their own company reading, watching television or enjoying some quiet time. Staff were attentive to the residents and the inspectors saw that they knew the residents well and treated them with kindness.

Call bells were available in all areas and answered in a timely manner.

The daily schedule of activities was displayed in a prominent place. The inspectors observed staff engage with the residents in a positive manner during the inspection and friendly conversations were heard throughout the day. Residents were observed enjoying a lively sing a long and a quiz on the day of the inspection. Residents could move around freely and the inspector observed a number of residents mobilising around the centre independently or with the help of staff.

Residents had access to television, radio, newspapers and books. Internet and telephones for private usage were also readily available. There were arrangements in place to support residents to maintain contact with their loved ones including video calls. Visiting was facilitated in line with current guidance (Health Protection and Surveillance Centre, COVID-19 Guidance on visits to Long Term Residential Care Facilities).

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impacted on the quality and safety of the service being delivered. The levels of compliance are detailed under the individual regulations.

Capacity and capability

The findings of this inspection were that the registered provider had failed to ensure that an effective and safe service was provided for residents living in Flannery's Nursing Home. The registered provider had not ensured that the service provided met the needs of the residents living there, particularly in terms of the arrangements for fire-safety, infection control, staffing, complaints and assessment and care planning.

Similar to findings of the previous inspection the governance and management of the centre needed to be significantly strengthened and improved to ensure that there was sufficient monitoring and oversight. Increased supervision was required to ensure the service delivered to residents was safe and of high quality.

This was an unannounced risk inspection. The purpose of the inspection was to determine if the centre had come into compliance following the inspection of 21 June 2021. Overall, inspectors found that Flannery's Nursing Home continued to have significant levels of non-compliance in relation to the overall governance and management, as evidenced by continuing non compliance in the areas of:

- Regulation 15 Staffing
- Regulation 16 Training and staff supervision
- Regulation 23 Governance and management
- Regulation 31 Notification of Incidents
- Regulation 34 Complaints
- Regulation 28 Fire precautions
- Regulation 27 Infection prevention and control.

In addition newly identified areas of non compliance were found in relation to:

- Regulation 07: Managing behaviour that is challenging
- Regulation 05: Individual Assessment and Care Plan
- Regulation 17: Premises
- Regulation 19: Directory of Residents
- Regulation 21: Records
- Regulation 04: Written policies and procedures

In response to the regulatory non-compliances found on the inspection in June 2021, the office of the Chief Inspector had engaged with the registered provider in relation to the governance and management of the centre and a cautionary meeting was held on 2 July 2021. The provider gave a commitment to address the identified regulatory non-compliances to ensure a safe and quality service was provided to residents.

Inspectors found that the systems to monitor, evaluate and improve the quality of the service were not robust and this meant that the oversight by senior management was not effective to ensure that the service provided was safe, appropriate, consistent or effectively monitored.

For example:

• Failure to ensure that staff had sufficient knowledge of the procedures to be followed in the event of a fire

• Failure to ensure that all staff had attended up-to-date training in mandatory areas, such as fire safety, safe moving and handling, safeguarding vulnerable persons and management of responsive behaviours

• Failure to ensure that cleaning staff were appropriately supervised to ensure that

the centre was clean.

· The risk register in place which identified risks in the centre and the controls required to mitigate those risks was not current and up to date.

Flannery's Nursing Home Limited is the registered provider. There are two company directors, one of whom was the person in charge. This dual role was supported by a director of nursing who was supernumerary and two administration staff. The person in charge informed inspectors that the senior management team had been expanded to include a clinical nurse manager and senior staff nurse. However, these roles were not identified in the rosters viewed by inspectors. The person in charge worked in the centre in a supernumerary capacity Monday through to Friday. The director of nursing worked Monday to Thursday. Clinical supervision arrangements were not clear on weekends but both the person in charge and director of nursing confirmed that they were available to provide support and guidance to staff outside of normal working hours. As found on the previous inspection, roles and responsibilities were not clearly defined and it was not clear who held clinical responsibility and oversight of the governance and management systems in the centre.

On the day of inspection, there were 34 residents living in the centre including two residents who were in hospital. The staffing levels on the day of inspection were appropriate to meet the health and social care needs of the residents. The person in charge informed inspectors that each shift had one registered nurse on duty supported by four healthcare staff during the day and two healthcare staff at night. The catering staff consisted of one chef and a kitchen assistant. However, there continued to be a deficit in the staffing resources allocated to housekeeping as evidence by the poor standard of environmental cleanliness found on the day of inspection. There was one housekeeping staff on duty each day and this was not adequate for the size and layout of the premises. The addition of a kitchen assistant to the catering department meant that direct care hours for residents were not impacted on. However, a review of the rosters found that staffing was not consistent with the information about staffing levels provided to inspectors by the person in charge. For example, worked rosters showed discrepancies in the staffing levels in the catering department.

The inspectors acknowledged improvement in the training records. Staff were supported and facilitated to attend training relevant to their role and all staff had completed mandatory training in fire safety and safeguarding of vulnerable adults. All nursing staff had up-to-date cardio-pulmonary resuscitation training. Infection, prevention and control training had been provided to all staff with emphasis on standard and transmission based precautions, the use of personal protective equipment (PPE) and hand hygiene in line with national guidelines.
However, there continued to be gaps in the training records of the senior management and further analysis of staff training needs was required. As found on the previous inspection, staff were not appropriately supervised to ensure their training was implemented in practice to ensure safe manual handling and transfers of residents.

The policies and procedures, as required by the regulation, had been reviewed and updated in April 2021 with the exception of one policy that was not available for review. Policies were made available to staff. However, some staff to whom the inspector spoke with were not aware of the schedule 5 policies.

A complaints log was maintained in the centre and a complaints procedure was prominently displayed at the reception area. However, inspectors found that complaints were not managed or documented in line with the centres own policy and procedure or the requirements of the regulations. Some complaints remained open since the previous inspection.

Inspectors concluded that significant improvement was required to ensure that those in charge are monitoring the service and have the necessary oversight to ensure that residents are receiving a safe and appropriate service.

Regulation 15: Staffing

Overall a review of the rosters found that staffing was not consistent with the information about staffing levels provided to inspectors by the person in charge. As a result, inspectors could not be assured that rosters reviewed accurately reflected actual staffing levels on duty at all times. In addition, rosters reviewed by the inspectors evidenced significant challenges in maintaining the appropriate number and skill mix of staff to meet the assessed health and social care needs of the residents. For example:

On the worked rosters from 1 October to 17 October there was:

· two occasions on the healthcare assistant roster where planned staffing levels were not maintained due to unplanned leave.

· four occasions where there was no kitchen assistant rostered for duty.

· There were inconsistiencies in the nursing rosters that were not reflected in the changing needs of residents.

· There were multiple deficits in the housekeeping roster that resulted in healthcare staff carrying out housekeeping duties, which in turn reduced the numbers providing direct care to residents.

· While the centre employed two activities co-ordinators, neither were rostered for duty at weekends.

On the planned rosters from 18 October to 31 October 2021

· There was no kitchen assistant rostered for 23 and 24 October 2021.

· There was no chef scheduled for duty from 23 October to 31 October 2021.

· One occasion where there was a planned shortage in healthcare staff.

· There was only one housekeeping staff rostered which was not sufficient taking the layout of the centre into account.

In addition, inspectors were not assurred that there were robust contingency plans to ensure adequate staffing levels in the event of a COVID-19 outbreak which was also found on the previous inspection.

Judgment: Not compliant

Regulation 16: Training and staff development

The current staffing arrangement did not support adequate supervision of staff to ensure that training was implemented in practice. Inspectors noted that staff did not have appropriate knowledge in relation to manual handling, fire safety and responsive behaviours, and supervision of cleaning practices in the centre required strengthening. For example,

Inspectors observed incorrect and unsafe manual handling practices on a number of occasions that placed both the resident and staff at risk of injury. This was also identified on the previous inspection.

- There was inadequate supervision of staff to ensure the centre was appropriately cleaned.
- Healthcare staff were observed entering the kitchen to prepare breakfast prior to performing hand hygiene and without protective clothing.
- Some staff did not have adequate fluency in English to communicate effectively with residents. This also impacted on the residents and staff safety as staff were unable to detail the arrangements in place for the safe evacuation of residents.

Further analysis of staff training needs was required to ensure staff were appropriately trained and supported to carry out the role and responsibilities safe and effectively. For example:

- There were gaps in the training records for a member of the senior management team.
- There were also gaps in the training records for healthcare staff in manual handling. This was also brought to the attention of the provider on the previous inspection.
- Not all staff working on night duty had completed a fire drill evacuation simulating night time staffing levels.

Judgment: Not compliant

Regulation 19: Directory of residents

The directory of residents did not include all the information specified in paragraph 3 of schedule 3 of the regulations. For example, the marital status of each resident was not recorded in some of the records.

Judgment: Substantially compliant

Regulation 21: Records

The inspectors reviewed a sample of staff files and observed that there were gaps in the employment history in a small number of files.

In addition, the inspector observed filing cabinets containing residents records that were not securely maintained in accordance with the Regulations.

Judgment: Substantially compliant

Regulation 23: Governance and management

The governance and management of the centre was not robust and did not ensure that the care and services provided for the residents was safe and appropriate and in line with the centre's statement of purpose.

In particular inspectors were concerned that:

· The members of the management team were not clear about their roles and responsibilities and it was not clear to the inspectors or to staff and residents who was responsible for clinically supervising the delivery of care.

· The systems in place to assess, evaluate and improve the quality and safety of the service provided to residents was not effective. For example, a number of audits on the the audit schedule contained in the governance plan for 2021 were not completed. As a result the inspectors found that the oversight of a number of key areas was not robust and a number of areas of non-compliance found on this inspection were not identified by the management team.

· Although there was a risk register in place, the registered provider had failed to identify risks observed on the day of the inspection. For example; risks associated

with ongoing staff recruitment and staffing issues; unsecured and unsafe external areas accessible to residents; cleaning equipment and cleaning chemicals not secured on cleaning trolleys.

As set out above the registered provider had failed to improve compliance with key regulations which underpin safe care of residents.

Judgment: Not compliant

Regulation 31: Notification of incidents

The person in charge was aware of the requirement to submit statutory notifications to the office of the Chief Inspector in line with the requirements of regulation 31.

However, the Chief Inspector had not been notified of the occurrence of two incidents where residents required hospital treatment.

Judgment: Not compliant

Regulation 34: Complaints procedure

Inspectors reviewed the complaints log and found that the record did not always contain adequate details of the investigation and there was not always a satisfactory resolution to the complaint. For example, complaints made by residents about noise created by other residents, particularly at night, were not addressed. The actions taken had not adequately addressed the complaint or the impact the noise was having on other residents and therefore the complaint was unresolved.

Inspectors reviewed another complaint where the actions taken on foot of the complaint were not documented in response to the complaint. There was no further detail to suggest that the complaint has been resolved to the satisfaction of the complainant.

Complaints made at residents' meetings were still not investigated or documented in the complaints log. One such complaint was regarding the lack cleanliness of an area following visiting. This complaint was substantiated by the inspectors on the day of the inspection.

The centres policy on complaints management was not aligned with the complaints procedure on display. The policy required updating to be centre specific and outline the personnel involved in the management of a complaint.

The procedure on display referred to the centres own personnel as the independent

appeals personnel to review and respond to a complaint.

Judgment: Not compliant

Regulation 4: Written policies and procedures

A policy for the access to, retention of and destruction of records in compliance with the regulatory requirement was not available for review.

Some staff whom the inspector spoke with were aware of the schedule 5 policies but had not read them while others confirmed that they were neither aware nor had read the policies.

Each policy had a staff signature sheet attached that required the staff member to sign as acknowledgement that they had read and understood the policy. However, in some cases, only six signatures were present.

Judgment: Substantially compliant

Quality and safety

Residents in the centre were generally satisfied with the quality of the service they received. Nonetheless, improvements were required in relation to residents' assessments and care plans, managing responsive behaviour, fire safety, infection control practices, and and premises.

In general, the inspectors found the care and support provided to the residents of this centre to be satisfactory. On the day of the inspection the residents were well-groomed, nicely dressed and most were observed to be content and happy. There was a person-centred approach to care and the residents' well-being and independence were promoted. Staff were respectful and courteous with the residents.

The inspectors reviewed a sample of resident files and found evidence that residents had an assessment of their needs prior to admission to ensure the service could meet the assessed needs of the residents. Following admission, a range of validated assessment tools were used to assess falls risk, skin integrity, nutritional status and level of dependency. Care plans were informed and developed by these assessments. Overall, individual care plans contained person-centred detail to provide guidance to staff. However, on the day of the inspection, the inspectors did not see evidence that care plans were regularly reviewed and updated when resident's condition changed in order to ensure they remained relevant and continued to appropriately guide staff in respect of residents' care needs. Additional

details are provided under Regulation 5 Individual assessment and care plan.

Residents had access to medical care with the residents' general practitioners providing on-site reviews when required. Residents were also provided with access to other healthcare professionals in line with their assessed need.

Overall, residents' rights and choices were respected. Residents had the opportunity to meet together and discuss management issues in the centre. Minutes of recent meetings showed that relevant topics were discussed including COVID-19, visiting arrangements, and activities. Residents had access to an independent advocacy service. However, some improvements were still required in responding to complaints raised by residents in relation to managing responsive behaviours of fellow residents.

Closed circuit television cameras (CCTV) were in use throughout the centre including communal spaces. The inspectors observed documentary evidence that residents and staff were aware of the presence of such cameras.

The inspectors found that there were opportunities for residents to participate in meaningful social engagement, appropriate to their interests and abilities. There were staff available to support residents in their recreation of choice and there were regular activities including music, quizzes, bingo and exercise.

Some improvement had been made in the management of fire safety risk in the centre. Residents personal evacuation plans were updated to contain information to support residents safe evacuation, action had been taken to ensure lint was cleaned from the dryer daily and floorplans were displayed throughout the centre detailing the nearest escape route. A fire risk assessment had been completed as requested following the previous inspection of the centre. However, the risk assessment did not adequately assess aspects on the centre in regard to fire safety. A further review of the fire safety management system was required to provide assurance that residents, staff and visitors were protected in the event of a fire. This will be discussed further under Regulation 28 Fire Precautions.

Infection Prevention and Control (IPC) measures were in place and some improvements were found since the previous inspection. An environmental audit had been completed by an external company in September 2021 and a number of recommendations were made as a result. However, improvements were still required and will be discussed in detail under Regulation 27. The centre had a COVID-19 contingency plan in place which included guidance from Health Protection and Surveillance Centre (Health Protection and Surveillance Centre Interim Public Health, Infection Prevention and Control Guidelines for the Prevention and Management of COVID-19 Cases and Outbreaks in Long Term Residential Care Facilities). However, this plan did not include contingency planning to ensure adequate governance of the centre and staffing levels in the event of a COVID-19 outbreak.

Regulation 11: Visits

Visits were facilitated in line with the current guidance *(Health Protection and Surveillance Centre, COVID-19 Guidance on visits to Long Term Residential Care Facilities).*

Judgment: Compliant

Regulation 17: Premises

Although there was storage facilities available in the centre, on the day of the inspection better organisation of equipment was required to ensure the residents could move freely around the building. For example, a number of hoists were stored in resident bedrooms.

One vacant resident bedroom located in the identified isolation area was in use by staff as overnight accommodation.

A kitchen store room contained clinical equipment, such as infusion stands, weighing scales, catering consumables and personal protective equipment. This area was not clean.

Judgment: Substantially compliant

Regulation 26: Risk management

The centre had an up to date risk management policy in place which included the all of required elements as set out in Regulation 26.

Judgment: Compliant

Regulation 27: Infection control

Inspectors found that the registered provider did not ensure that care was provided in a clean and safe environment as evidenced

· Multiple en-suites required deep cleaning to remove a build up of organic matter from the grout and tiles.

· Gaps between the radiator pipes and floor were heavily soiled with dust and debris.

· Some steel sinks were rusted and not amenable to cleaning. For example the laundry sink.

· Some drains, in the kitchen store room, were heavily soiled with dirt and debris.

· PPE was not disposed of in accordance with best practice. For example, used gloves and face mask were observed on the floor in the laundry room. Used gloves were found disposed of in a residents room, on the ground behind the bin.

· Skirting boards and behind fire doors were not clean.

· Residents mobility aids and bathroom aids were not clean as evident by the build up of organic material.

· There was a lack of appropriate bins in a number of areas.

· The management of sharps required improvement as the disposal of a sharps box was not in line with best practice.

· Healthcare staff entering the kitchen to prepare breakfast without performing hand hygiene and without wearing protective outer clothing such as an apron or hairnet.

Judgment: Not compliant

Regulation 28: Fire precautions

The systems in place to protect the residents from the risk of fire were not sufficiently robust

For example

· There were gaps records did not provide assurance that escape routes that checked daily. In addition some records that were available for the period between January and October 2021 had been completed by a staff member who wasn't rostered on duty on the day the record refferred to. across corridor fire door did not close correctly resulting in a gap between the seals.

· The smoking room fire door, which was wedged open with a chair, did not close correctly. This compromised the purpose of the door in containing smoke in the event of a fire.

· The weekly check completed on the 15 October 2021 had not identified the faults found with the fire doors on the day of inspection.

· Further assurance was required to ensure that the supporting timber beams in the roof of the boiler room are fire resistant.

· Two staff were unable to detail their role and responsibility in regard to the centre fire safety procedure.

· Inspectors were not assured that the fire panel could be accessed by staff in a timely manner from the furthest points in the centre which may result in a delayed response to a fire.

· A fire risk assessment completed following the previous inspection of the centre did not adequately assess all aspects of the centre with regard to fire safety.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

While staff were knowledgeable regarding residents individual care needs, a number of care plans did not consistently capture this person-centred information. For example;

- A review of a resident's nutritional care plan did not contain information regarding their poor nutritional intake or their relevant medical history. Recommendations from the dietician had not been updated into the resident's care plan.
- There was no care plan in place for a resident who required subcutaneous fluids.
- There was no care plan in place for a resident with a wound.

In addition, the inspectors did not see evidence of regular assessments being carried out.

Judgment: Not compliant

Regulation 6: Health care

The inspectors found that the residents had access to medical assessments and treatment by their General Practitioners (GP) and the person in charge confirmed that GPs were visiting the centre as required.

Residents also had access to a range of allied healthcare professionals such as physiotherapist, occupational therapist, dietitian, speech and language therapy, psychiatry of old age and palliative care.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

The use of restrictive practice was very low on the day of the inspection and a record of restraints used was maintained. However, records did not evidence the least restrictive interventions used prior to commencing the use of bedrails.

A review of a resident's care plans in relation to 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) contained guidance for staff on resident's preferences, triggers for certain behaviours and de-escalation techniques to manage responsive behaviours. However, staff and residents informed the inspectors that the behaviour was not managed in accordance with the care plan. Residents and staff reported that poorly managed responsive behaviours of some residents were impacting on their quality of life.

Judgment: Not compliant

Regulation 9: Residents' rights

Staff were observed engaging positively with the residents throughout the day. There were opportunities for the residents to participate in social activities of their choice. Residents who wished to remain in their bedrooms were supported in their choice and staff checked on them frequently.

There were regular resident meetings where a wide range of topics were discussed.

There was an independent advocacy service available to all the residents. There was appropriate supports in place for those residents aged under 65 years.

Closed circuit television cameras (CCTV) were in use throughout the centre including communal spaces. The inspectors observed documentary evidence that residents and staff were aware of the presence of such cameras.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 19: Directory of residents	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Not compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management	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	Compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Flannery's Nursing Home OSV-0000341

Inspection ID: MON-0034333

Date of inspection: 20/10/2021

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Staffing levels are kept under review constantly. Consideration is given to the size, and layout of the building. Contingency plans are in place in the event of a shortfall in staffing levels due to the Pandemic. Recruitment Agency is actively sourcing staff - ongoing. The following staff have been appointed and have taken up positions: Clinical Nurse Manager appointed Appointment of Staff Nurse 24hrs week. Housekeeper Cleaner appointed 5 days week Staff Nurse on Maternity leave returning in January 2022 Kitchen Assistant appointed 5 days week Additional Activities Coordinators 24hrs week. Healthcare Assistants X 4 appointed full time hours. Additional 1 HCA`s awaiting Garda Clearance. Recruitment practices are in line with legislation. We have resolved the severe difficulties we had experienced with the Garda Vetting process as processing times are now better. 09/12/2021 training was provided in Infection Prevention and Control and Safeguarding the Older Person Training is provided to improve outcomes for all residents Policies have been updated and are there to guide staff Greater supervision and support is provided to allow staff carry out their duties to protect and promote the care and welfare of all residents. Staff understand their roles and responsibilities, have accountability and reporting lines, and are aware of policies and procedures to be followed. Performance Appraisals are done Annually by the PIC Training is provided to ensure staff have the required competencies to manage and deliver person-centred, effective and safe care. Specialist training is provided to ensure staff maintain competence appropriate to their role. We aim to provide staff with the required skills, and competencies to fulfil their role.	

Education and training is available on line and in house.
We have reviewed and updated our Policies and Procedures which provide staff with guidance about how to deliver safe care to the residents.
Policies are available to all staff. Staff have signed off as read and understood.
All schedule 5 Policies which are required by regulations are up to date.

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 have access to mandatory training and they have completed all necessary training. All newly recruited staff have had induction as per Flannery's Induction policy. We have developed a staff training matrix that is consistently updated highlighting when training is due.
Staff have availed of training on HSE land as well as our specialised trainer who has provided in house training on the 09.12.2021 in Infection Control and Safe Guarding, with further training scheduled as the need arises.
Staff Nurses had further education day in Peg Insertion on 04.01.2022 thus reducing the need for resident being admitted to hospital. Performance Appraisals will be carried out annually. Staff are made aware of their roles and responsibilities and policies and procedures to be followed to ensure safe and effective care. This will be monitored through greater presence of management at floor level. Staffing levels are kept under review constantly.
There is a comprehensive training matrix in place..
Contingency plans are in place in the event of a shortfall in staffing levels due to the Pandemic.
Clinical supervision and support to all staff is provided by the DON and CNM.

Regulation 19: Directory of residents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 19: Directory of residents:
All details as outlined in Schedule 3 Regulation 19 are updated in the Directory of Residents.
Audit are actioned as appropriate.

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
Filing cabinet containing records is lockable and key is located within reach.
Door to treatment room is key pad locked for extra security.
Care plans are reviewed 4 monthly based on individual assessments.
Care plans are given to those prescribed sub cut hydration.
Wound care plans are now computer based.
Staff files have been audited and required documentation in place.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The registered provider shall ensure that Flannery's Nursing Home will have sufficient resources to ensure the safe and effective delivery of care accordance with our Statement of Purpose. The registered provider shall ensure that there are clearly defined management structures that identifies clear lines of reporting authority and accountability specifies roles and details responsibilities for all areas of care provision. The registered provider will ensure that the services provided is safe, appropriate, consistent and effectively monitored with greater presence and supervision of the management teams on the floor observing safe manual handling techniques, hand hygiene and quality of care given. Audit findings will be consistently analysed to identify areas needing improvements and action plans will be developed to inform and track improvements. Audit findings will be discussed at staff meetings.

Feedback from audits and surveys is used to identify areas for improvement and the findings are communicated to the relevant staff so that any changes can be implemented in a timely manner.
Governance structure is paramount to the success of Flannery`s Nursing Home.
We have strengthened our management structure with the appointment of a new Person in Charge (01/03/2022) and a Clinical Nurse Manager (01/11/2021). This will allow for a more team based approach and better communication going forward.

We have developed an Annual Plan for audits which will monitor and evaluate the quality and safety of the care provided. Improvements will be made based on the findings of the audit.
Information is gathered through surveys and managed in line with policy.
Incidents are reported and risk assessed. Risks identified are actioned as a priority.

They are discussed at staff meetings and control measures put in place. Trends in practice and care is monitored through audits and is used to improve care provided. All residents are provided with access to other healthcare professionals in line with their assessed needs. A gate will be installed near the polytunnel which will restrict access to this area thus ensuring resident safety. Two new cleaning trolleys have been purchased and cleaning chemicals are now secure and trolleys are locked.

Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: All notifications will be notified in a timely manner as per regulations. All Incidents and Accidents are recorded and are discussed at team meetings. A Falls audit is conducted 3 monthly and key findings identified. A Falls management plan is implemented.	

Regulation 34: Complaints procedure	Not Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: Flannery`s Nursing Home Complaints Policy is updated in line with regulatory requirements and the complaints procedure is on display prominently in the residents lounge and in the reception area. Recommendations from the Office of the Ombudsman are included. The person involved in the management of complaints is added in. We take all complaints seriously. Where there is a need for change, we learn from our mistakes and will develop an action plan setting out what we will do and the timeframe. Satisfaction level is recorded and actions taken to prevent reoccurrence of issues.	

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 policy "the creation of, access to, retention of and destruction of records" has been returned to the Schedule 5 Policy folder. All Policies are readily available to all staff. Staff sign to indicate they have read and understand the policy.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: There will be better use made of our store room facilities. All clinical equipment such as drip stands, weighing scales are stored in same now. Residents hoists will be no longer stored in residents bedrooms. Vacant resident bedrooms are no longer to be used by staff. Kitchen store room is now returned for the storage of kitchen consumables only. Furniture and fittings have been assessed and some have been removed. Regular steam cleaning of chairs has commenced.	
Regulation 27: Infection control	Not Compliant
Outline how you are going to come into compliance with Regulation 27: Infection control: Management have provided all necessary equipment, supplies and products to comply with infection prevention and control best practice. PIC has the role of lead for Infection Control and has completed required training. Her role is to drive and co-ordinate all aspects of IPC. A further deep clean of the Centre was carried out following the inspection report. Greater attention was given to radiator pipes, skirting boards and Laundry sink. All staff are made aware of correct and safe disposal of gloves and masks. Residents mobility aids are now part of our cleaning schedule. More suitable bins with closed top have been purchased with more on order. The sharps bin is dated and signed when opened and sealed as per our policy. All our health care staff are aware of performing hand hygiene prior to entering the kitchen and the use of protective clothing is now positioned outside the kitchen door. Further footfall is now reduced into the kitchen with the placement of a Kitchen Assistant. We are in the process of tiling our ensuite bathrooms and have completed two to date. Careful consideration is given that noise levels does not effect or disrupt residents quality of life. Advisory assessment on Infection prevention and control was carried out by HSE infection control team on 03 /12/2021.	

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Works have been carried out to smoking room door and a new door release system is now in place. Gaps found in fire doors have new seals replaced, going forward fire doors will be checked by two staff members to allow for more robust checking (weekly).
The fire panel is checked daily.
The boiler room is a stand alone zone and in the event of a fire there are 3 automatic sprinkler systems in place, last checked by our fire officer on the 10/12/2021.
All fire extinguishers were checked and updated on this date also.
During our recent fire drill staff responded in a timely manner to our assembly point. The purpose of this drill was to check staff response times.
Our action plan by our fire officer for upgrade works was submitted on 30//11/2021

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:
All care plans have been reviewed and updated. Residents healthcare needs are assessed using a validated tool, which reflects each residents needs.
Care plans are developed using these assessments. They are person-centred and resident rights and choices are upheld. They are developed and initiated within 48hrs of admission to the centre. Independence is promoted.
We are currently transferring all documentation onto computerized system.

Regulation 7: Managing behaviour that is challenging	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
Residents who exhibited responsive behaviours are assisted and supported sensitively. Staff are aware of the individual behaviour patterns and residents have timely access to psychiatry of later life. Care plans are in place to guide staff and ensure interventions are

effective.
Care plans have been updated for residents with Behavior that challenge. Triggers and de-escalation techniques are recorded. Assessment and re-assessment is completed on a regular basis.
Staff have had further training. Behaviour that is challenging is managed and responded to effectively to promote well-being and has the least restrictions.
Policy has been reviewed and updated.
Episodes of aggressive behaviour is highlighted in handover meetings. All efforts are made to
prevent escalation of the behaviour. Episodes of behaviour are risk assessed individually and control measures put in place taking into consideration the safety and welfare of other residents.
Where Triggers are identified, the safety and welfare of other residents is risk assessed.
Staff are trained to utilize a positive approach to the management of the behaviour. Staff promote the resident`s dignity and ensure they are comfortable and respected.

Staff will record the event that occurred immediately before,, during and after the behaviour that is challenging, and observations on why the incident occurred on an Antecedent Behaviour Consequences (ABC) chart.
Staff members and other residents are provided with all necessary support including psychological support.
Staff will monitor residents with behaviour that is challenging to identify changes in their manner or mood.

All residents are encouraged to participate in meaningful social engagement, appropriate to their interests and abilities.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	01/12/2021
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	31/01/2022
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	01/12/2021
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre,	Substantially Compliant	Yellow	31/12/2021

	provide premises which conform to the matters set out in Schedule 6.			
Regulation 19(3)	The directory shall include the information specified in paragraph (3) of Schedule 3.	Substantially Compliant	Yellow	01/12/2021
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.	Substantially Compliant	Yellow	01/12/2021
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Substantially Compliant	Yellow	01/12/2021
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	01/12/2021
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	Not Compliant	Orange	01/12/2021

	details responsibilities for all areas of care provision.			
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	01/12/2021
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	31/01/2022
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	10/12/2021
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	10/12/2021
Regulation 28(1)(d)	The registered provider shall make	Not Compliant	Orange	31/01/2022

	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.			
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	10/12/2021
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	Yellow	31/10/2021
Regulation 34(1)(d)	The registered provider shall provide an accessible and effective complaints	Not Compliant	Orange	31/10/2021

	procedure which includes an appeals procedure, and shall investigate all complaints promptly.			
Regulation 34(1)(f)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.	Not Compliant	Orange	31/10/2021
Regulation 34(1)(g)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall inform the complainant promptly of the outcome of their complaint and details of the appeals process.	Not Compliant	Orange	31/10/2021
Regulation 34(1)(h)	The registered provider shall provide an accessible and	Not Compliant	Orange	31/10/2021

	effective complaints procedure which includes an appeals procedure, and shall put in place any measures required for improvement in response to a complaint.			
Regulation 34(2)	The registered provider shall ensure that all complaints and the results of any investigations into the matters complained of and any actions taken on foot of a complaint are fully and properly recorded and that such records shall be in addition to and distinct from a resident's individual care plan.	Not Compliant	Orange	31/10/2021
Regulation 34(3)(a)	The registered provider shall nominate a person, other than the person nominated in paragraph (1)(c), to be available in a designated centre to ensure that all complaints are appropriately responded to.	Not Compliant	Orange	31/10/2021
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on	Substantially Compliant	Yellow	31/10/2021

	the matters set out in Schedule 5.			
Regulation 04(2)	The registered provider shall make the written policies and procedures referred to in paragraph (1) available to staff.	Substantially Compliant	Yellow	31/10/2021
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	01/12/2021
Regulation 7(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.	Not Compliant	Orange	31/01/2022