Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	Kilcolgan Nursing Home
Name of provider:	Mowlam Healthcare Services Unlimited Company
Address of centre:	Killeely More, Kilcolgan, Galway
Type of inspection:	Unannounced
Date of inspection:	24 June 2024
Centre ID:	OSV-0000351
Fieldwork ID:	MON-0040693

About the designated centre

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

Kilcolgan Nursing Home is a purpose built facility located near Kilcolgan, Co Galway. The centre admits and provides care for residents of varying degrees of dependency from low to maximum. The nursing home is constructed on ground level. The centre is divided into two units. One unit has capacity for up to 30 residents. The dementia specific unit can accommodate up to 18 residents. All resident bedrooms are single occupancy and have ensuite, handwash basin, toilet and wheelchair accessible showering facilities. The provider employs a staff team consisting of registered nurses, social care workers, care assistants, housekeeping and catering staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	46

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Monday 24 June 2024	19:45hrs to 22:45hrs	Rachel Seoighthe	Lead
Tuesday 25 June 2024	09:00hrs to 18:00hrs	Rachel Seoighthe	Lead
Friday 12 July 2024	09:00hrs to 12:00hrs	Rachel Seoighthe	Lead
Tuesday 25 June 2024	09:00hrs to 18:00hrs	Kathryn Hanly	Support

What residents told us and what inspectors observed

This unannounced inspection was completed over an evening and two days. There were 46 residents accommodated in the centre on the days of inspection and there were two vacancies.

Inspectors observed that residents were supported to enjoy a satisfactory quality of life, supported by a team of staff who were kind and caring. Inspectors heard positive comments about staff who were described as 'very nice' and 'very kind'. A small number of residents expressed concern about accessing equipment to meet their care needs. However, the majority of residents were very complimentary in their feedback and expressed satisfaction about the standard of environmental hygiene, and how well staff had cared for them.

On the first evening of the inspection, the inspector was welcomed to the centre by the nurse in charge. The person in charge returned to the centre when staff notified them that the inspection was in progress. The inspector spent time chatting with, and observing residents in the various areas of the centre. Several residents were seen relaxing in the spacious reception area in the main centre where music was playing. Other residents were observed in their bedrooms, relaxing and watching television. The inspector noted there was a relaxed atmosphere in the memory care unit. Residents were seen resting in bed, or spending time in the communal sitting room, where a staff member played music and encouraged a sing-along, which residents appeared to enjoy. Visitors were welcomed to the centre without restriction, and refreshments such as tea and cold drinks were provided for residents throughout the evening.

On the morning of the second day of inspection, inspectors completed a tour of the designated centre accompanied by the person in charge, giving an opportunity to observe the lived experience of residents in their home environment and to observe staff practices and interactions.

Kilcolgan Nursing Home provides long term and respite care for both male and female adults with a range of dependencies and needs. The designated centre was a purpose built, single-storey building, registered to accommodate to a maximum of 48 residents. The centre was divided into two distinct units. Eighteen residents were accommodated in the memory care centre and 28 residents were living in the main centre.

Inspectors spent time walking through the centre and they noted that, again, the atmosphere was friendly and relaxed. Some residents were observed having breakfast, while other residents were relaxing in the main reception, which contained several seating areas. A number of residents were in their bedrooms, receiving support with personal care. There were a variety of communal spaces in the main centre which included a large dining room, an activity room and an oratory. A nurses station was located in the centre of the reception and inspectors

noted there was a constant staff presence there. Inspectors observed residents engaging with staff, while others were relaxed, reading and watching television.

Inspectors noted that residents were encouraged to personalise their bedrooms, with items of significance such as photographs and artwork, to help them feel comfortable and at ease in their home. Inspectors observed that residents had televisions and call bell facilities in their bedrooms. While the centre generally provided a homely environment for residents, inspectors observed deficits in respect of the premises and infection prevention and control, which are interdependent. For example, inspectors observed surfaces and finishes including paintwork, wood finishes and flooring in a large number of resident rooms were worn and poorly maintained, and as such, did not facilitate effective cleaning.

The main centre had a secure outdoor courtyard with ample seating and decor. Residents living in the main centre could access this area without restriction and inspectors observed several residents relaxing in this area during the inspection. Residents were also seen socialising and enjoying a programme of activities. Inspectors noted that a pictorial activities schedule was displayed for resident information and staff assigned to the provision of resident activities, were seen supporting residents with art and exercises.

Inspectors noted that entry to the memory care unit was secured with key code access. Corridors were wide and had handrails on both sides to support residents safe mobility. Inspectors observed that the memory care unit was decorated with features that were intended to be stimulating for residents with dementia. Residents bedroom doors were seen to be painted in a variety of bright colours which replicated front doors, and feature wall paper which depicted images of interest was visible along corridor walls. There was a communal sitting room which was decorated with resident artwork and a quiet room was also available for resident use. Inspectors noted that residents spent their time relaxing in the communal sitting room, or in their bedrooms.

The second day of the inspection was warm and sunny day and inspectors observed that residents living in the memory care unit had views of a secure garden from the communal sitting room and dining room. However, inspectors noted that the doors to the enclosed garden, which also served as final fire exit doors, were locked with a key. Inspectors observed that residents living in the memory care unit could not access a safe outdoor space without the assistance of staff to open the doors. A third final fire exit door in the memory care unit was also manually locked. Inspectors observed that there were no keys held in close proximity to the fire exit doors and keys were held by nursing staff. Inspectors noted that when nursing staff attempted to unlock the fire exit doors, the correct keys were not easily distinguishable and fire exit doors could not be unlocked immediately. This posed a significant risk of delay in the event of an emergency evacuation being required. The person in charge was required to take immediate action to address this risk on the day of inspection.

Inspectors observed a resident meal service in the memory care unit. Inspectors noted that action was taken since the previous inspection to ensure all residents

were offered a choice of meal. Inspectors noted that tables were neatly set and traditional irish music was played to enhance the atmosphere. Inspectors noted that care staff worked hard to ensure the dining experience was a pleasant occasion. Food was freshly prepared and specific to each resident's individual nutritional requirements. Staff were observed interacting with residents in a caring manner. There were a number of residents who were living with a diagnosis of dementia or cognitive impairment who could not communicate their needs and they appeared to be relaxed and enjoyed being in the company of staff.

Inspectors observed that the ancillary facilities including the housekeeping room, the laundry, kitchen and sluice rooms did not support effective infection prevention and control. Staff had access to a dedicated housekeeping room for storage and preparation of cleaning trolleys and equipment. This room contained a toilet cubicle and inspectors observed it was visibly unclean. The main kitchen was of adequate size to cater for resident's needs. Residents were generally complimentary of the food choices and homemade meals made on site by the kitchen staff. Toilets for catering staff were in addition to and separate from toilets for other staff. However, inspectors observed that some areas of the the main kitchen were unclean.

Inspectors noted that the majority of laundry, and resident clothing was sent to an external laundry for washing. A small amount of laundry including cleaning textiles and blankets were washed in the on-site laundry. Inspectors observed the infrastructure of the on-site laundry did not supported the functional separation of the clean and dirty phases of the laundering process. This area was cluttered and access to the hand wash sink was obstructed.

Barriers to effective hand hygiene practice were also identified. Inspectors noted that the available hand hygiene sinks in the sluice rooms and treatment room did not comply with current recommended specifications for clinical hand hygiene sinks. Inspectors observed that alcohol-based hand-rub was available in wall mounted dispensers along corridors. However, additional dispensers or individual bottles of alcohol hand gel were not readily available at point of care (directly outside or inside every bedroom).

Visitors were observed attending the centre on the days of the inspection. Visitors spoken with were very complimentary of the staff and the care that their family members received.

The following sections of the report detail the findings with regard to the capacity and management of the centre and how this supports the quality and safety of the service provided to residents. The areas identified as requiring improvement are discussed in the report under the relevant regulations.

Capacity and capability

This was an unannounced inspection to monitor compliance with the Health Act

2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 (as amended). Inspectors followed up on the provider's compliance plan response to the previous inspection in November 2023, which had identified non-compliance in relation to governance and management, staffing, premises, infection control, fire precautions and residents' rights. Inspectors found that the provider had not fully implemented their own compliance plan submitted following the previous inspection of the centre in November 2023. This inspection found significant non-compliance in relation to Regulation 27: Infection control. The provider was required to submit an urgent compliance plan to the office of the Chief Inspector following this inspection, to give assurance of local oversight, supervision and the mechanisms in place to ensure that the environment was effectively cleaned and decontaminated. The urgent action plan was accepted. A third day of inspection was scheduled to review the actions committed to by the provider and inspectors found that significant improvements were made.

The designated centre is operated by Mowlam Healthcare Services Unlimited Company who are the registered provider of Kilcolgan Nursing Home. The person in charge worked full-time in the centre and they were supported in their role by a full-time clinical nurse manager. Senior clinical support was provided by a director of care services and regional healthcare manager. A team of nurses, health care assistants, social care practitioners, household, activity, catering, administration and maintenance staff made up the staffing compliment.

Inspectors found that the clinical management support for the person in charge was not in place as described in the centre’s statement of purpose, which detailed the management structure to include an assistant director of nursing and a clinical nurse manager. Inspectors found that the clinical nurse manager was on a period of extended leave and the position of assistant director of nursing was vacant. There was no evidence available that recruitment was in progress to fill this role. This directly impacted on the supervision of staff and the monitoring of infection prevention control practices in the centre. Furthermore, although the provider had recently outsourced the housekeeping duties to an external company, inspectors observed that there were insufficient numbers of housekeeping staff to meet the infection prevention and control needs of the centre, particularly at weekends.

The registered provider had ensured that staff had access to a varied training programme and education, appropriate to their role. Nonetheless, training records viewed by inspectors demonstrated that there were gaps in the provision of fire safety, infection control and safe-guarding training. Staff did not demonstrate apppropriate knowledge and competence in the management of residents colonised with Carbapenemase-Producing Enterobacterales (CPE) and standard infection control precautions. Inspectors also found that staff supervision systems were not robust. For example, inspectors were informed that a tagging system was used to identify commodes that had been cleaned. However, this system had not been implemented in practice. There were no guidelines in the use of this system and staff reported that they had not received any training prior to its implementation. This is detailed further under Regulation 16: Training and staff development.

There were management systems in place to oversee the service and the quality of

care, however the systems in place did not ensure that the service provided was safe, appropriate, consistent or effectively monitored. A schedule of audits was completed in areas such as falls, restrictive practices and medication management. Infection prevention and control audits were undertaken by nursing management and covered a range of topics including hand hygiene procedures, sharps management, equipment and environment hygiene. High levels of compliance were consistently achieved in recent audits. However, the findings of recent audits were not reflected in observations on the day of the inspection. An accurate record of residents with previously identified multi-drug resistant organism (MDRO) colonization (surveillance) was not maintained. This meant that the provider was unable to monitor the trends in development of antimicrobial resistance within the centre.There was no evidence of ongoing targeted multidisciplinary antimicrobial stewardship quality improvement initiatives, audit or training. For example, the use of prophylactic antibiotics was not routinely audited. High levels of compliance were also achieved in restrictive practice audits, which did not reflect the inspectors findings.

There was a system to manage risks in the centre, and clinical and environmental risks were recorded on a risk register. However, inspectors found that some risk management controls were not implemented in a consistent manner. For example, the management of sharps was rated as a moderate risk in the centre, however risk controls were not implemented effectively, as evidenced by inspectors findings detailed under Regulation 27: Infection control.

An electronic record of all accidents, incidents and complaints involving residents that occurred in the centre was maintained. A review of the complaints records found that complaints were not managed in line with the requirements of Regulation 34. For example, where residents had provided feedback at resident meetings in relation to their dissatisfaction with parts of the service, there was no record to demonstrate that these issues were investigated and resolved to the residents satisfaction.

The policies required by Schedule 5 of the regulations were in place and updated in line with regulatory requirements.

An annual report on the quality of the service had been completed for 2023 which had been done in consultation with residents and set out the service's level of compliance as assessed by the management team.

Regulation 15: Staffing

The number and skill mix of staff was not adequate to meet the needs of the residents taking into account the size and layout of the designated centre. This was evidenced as follows;

- There were insufficient numbers of housekeeping staff to meet the infection

prevention and control needs of the centre.

Judgment: Not compliant

Regulation 16: Training and staff development

Not all staff had completed up-to-date training appropriate to their role. For example,

- Records showed there were gaps in training including fire precautions, infection prevention and control and safeguarding.
- Additional education was required to ensure staff are knowledgeable and competent in the management of residents colonised with MDROs including Carbapenemase-Producing Enterobacterales (CPE).

Staff were not appropriately supervised to ensure that they carried out their work to the required standards. This was evidenced by the following findings:

- Inappropriate use of personal protective equipment.
- There was a lack of antimicrobial stewardship and poor implementation of standard infection control precautions including sharps management.
- There was a poor standard of equipment and environmental hygiene.

Judgment: Not compliant

Regulation 23: Governance and management

A review of staffing in the centre found that the management resources available were not in line with the the centres' statement of purpose.

Management systems were insufficiently robust to ensure the service provided was safe, appropriate and effectively monitored. For example;

- The monitoring and oversight systems of key areas of the service, such as fire safety and the premises was not effective, and did not ensure the safety and well-being of the residents.
- Inadequate oversight of staffing resources and staff supervision.
- Inadequate oversight of resident's rights.

Infection prevention and control and antimicrobial stewardship governance arrangements did not ensure the sustainable delivery of safe and effective infection prevention and control and antimicrobial stewardship. This was evidenced by:

- Ineffective management systems to monitor the quality of infection

prevention and control measures including equipment and environmental hygiene, compounded by inadequate resources allocated to cleaning the centre impacted on the quality of equipment and environmental hygiene. Gaps were observed in cleaning records for the treatment room and housekeeping room. A kitchenette that had been consistently signed off as cleaned was visibly unclean. There was no staff member allocated to oversee the management of the onsite laundry.

- There were insufficient assurance mechanisms in place to ensure compliance with the National Standards for infection prevention and control in community services. Disparities between the finding of local audits and the observations on the day of the inspection indicated that there were insufficient assurance mechanisms in place to monitor quality and safety of the service.
- The provider had not nominated a staff member to the role of infection prevention and control link practitioner to support staff to implement effective infection prevention and control and antimicrobial stewardship practices within the centre.
- An antimicrobial stewardship programme had not been implemented to promote the appropriate use of antimicrobial medications, to reduce the risk of antimicrobial resistance and *Clostridioides* difficile infection.
- Accurate surveillance of MDRO colonisation was not undertaken. There was some ambiguity among staff and management regarding which residents were colonised with MDROs. Lack of awareness meant that appropriate precautions may not have been in place to prevent the spread of the MDROs within the centre.

In addition, there was ineffective oversight for resident's assessments and development of associated care plans. This is further detailed under Regulation 5: Individual assessment and care plan.

Judgment: Not compliant

Regulation 34: Complaints procedure

Inspectors found that the management of complaints was not in line with the requirements of the regulations. For example, a review of a sample of complaints records demonstrated that complaints and expressions of dissatisfaction with the service provided were not recorded and responded to. For example, residents issues with food and equipment had not been appropriately responded to.

Judgment: Substantially compliant

Quality and safety

Residents living in the centre were generally satisfied with the quality of the service they received. Inspectors observed staff engaging with residents in a kind and gentle manner. Inspectors found that assessment and care planning, healthcare and resident rights, did not meet the requirements of the regulations. In addition, the provider had not ensured that the care environment was safe for residents, particularly in relation to fire safety, and immediate action was required during this inspection to address high risk issues of concern. Issues in relation to the premises and the management of infection prevention and control required the provider to submit an urgent compliance plan to ensure the safety of residents.

The designated centre had a fire safety system in place, including fire-fighting equipment and a fire detection and alarm system. Fire drills were completed and the staff had access to a fire safety training programme. However, the arrangements in place to ensure that the timely evacuation of residents in the event of a fire emergency in the centre were not adequate. The provider took immediate action to address this risk on the day of inspection. Inspectors also observed several fire doors that had a significant gap between the under surface of the door and the floor. This gap could compromise the doors ability to contain smoke in the event of a fire. These findings are detailed further under Regulation 28: Fire precautions.

Inspectors were informed that a deep clean had not been undertaken following the closure of the most recent infection outbreak in May 2024 and the overall the standard of environmental and equipment hygiene observed in the centre fell well below an acceptable level. This was a repeated finding from the previous inspection. Inspectors also observed inconsistent application of standard infection control precautions including safe use of sharps, use of personal protective equipment (PPE) environmental and equipment cleaning. Barriers to effective hand hygiene practice were observed during the course of this inspection. There was no specimen fridge for the storage of clinical samples awaiting transport to the laboratory. Staff informed inspectors that if samples required refrigeration they would be stored within the medication fridge in the treatment room. This posed a risk of cross infection. The provider was required to submit an urgent compliance plan to the office of the Chief Inspector following this inspection, to ensure that equipment and the environment, was effectively cleaned and decontaminated. Assurances were also required regarding the safe use of sharps devices. The urgent compliance plan was accepted.

The premises was designed and laid out to meet the individual and collective needs of the residents. However, there were areas where floor surfaces were in a poor state of repair and wall surfaces and skirting board were visibly damaged. This finding is detailed further under Regulation 17: Premises.

Records demonstrated that there were referral systems in place and resident had access to health and social care professionals, such as dietitian services, physiotherapy and speech and language therapy as needed. Residents had access to medical assessments and treatment by their General Practitioners (GP). Notwithstanding this positive finding, inspectors found that the provider had no antimicrobial stewardship programme in place.

Inspectors viewed a sample of residents electronic nursing notes and care plans. There was evidence that residents' were comprehensively assessed prior to admission and resident's care needs were assessed through a suite of validated assessment tools to identify areas of risk specific to residents. This included the risk of impaired skin integrity, falls, malnutrition and safe mobility needs. Care plans were informed through the assessment process and care plans viewed by inspectors were generally person-centred. However, accurate information was not recorded in resident care plans to effectively guide and direct the care of residents with short term urinary catheters and residents with a history of MDRO colonisation. There was an over reliance on the use of dipstick urinalysis for assessing evidence of urinary tract infection. This was contrary to national guidelines which advise that inappropriate use of dipstick testing can lead to unnecessary antibiotic prescribing which does not benefit the resident and may cause harm including antibiotic resistance. Elimination care plans for use of short-term urinary catheters did not provide sufficient detail to guide and direct staff in the safe and effective management of two residents with short term indwelling urinary catheters. Furthermore, a care plan for a resident with a recent history of antibiotic associated Clostridioides difficile infection did not contain any advice regarding antibiotic usage. Inspectors also found that several care plans contained historical information that did not accurately reflect the care to be given to some residents at the time of inspection.

The provider had measures in place to safeguard residents from abuse. The provider acted as pension agent for four residents and pensions were paid into a separate resident bank account. Vetting disclosures in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 were in place for all staff. A safeguarding policy provided guidance to staff with regard to protecting residents from the risk of abuse. Staff who spoke with inspectors demonstrated an appropriate awareness of their safeguarding training and detailed their responsibility in recognising and responding to allegations of abuse. However, records demonstrated that training was not up-to-date for all staff.

Residents had access to television, radio, newspapers and books. Religious services and resources were also available. A programme of activities was available to residents which included arts and crafts, ball games and outings. There was an independent advocacy service available and details regarding this service were advertised on the resident information board, displayed in the reception area of the centre. Residents' meetings were convened regularly to ensure residents had an opportunity to express their concerns or wishes. However, concerns raised at residents meetings were not responded to, to ensure a satisfactory resolution for the residents. Furthermore, residents' right to choice was not fully supported and upheld in all aspects of their care and daily life. For example, records demonstrated restricted choice around some personal care routines and several residents told inspectors their daily choices were restricted due to the absence of appropriate equipment. Findings in this regard are detailed under Regulation 9; residents' rights.

There were no visiting restrictions in place. Inspectors found that the registered provider had ensured that visiting arrangements were in place for residents to meet with their visitors as they wished. Visitors were observed attending the centre during

the inspection.

Regulation 17: Premises

The registered provider failed to ensure that the premises conformed to the matters set out in Schedule 6 of the regulations. For example:

- The infrastructure of the on-site laundry did not support the functional separation of the clean and dirty phases of the laundering process. This area was cluttered and unclean.
- Surfaces and flooring in the main kitchen were unclean.
- The toilet cubicle (which did not contain a hand wash sink) within the housekeeping room posed a risk of cross infection. Furthermore, the housekeeping room was poorly-ventilated, unclean and cluttered.
- The décor in some parts of the centre was showing signs of wear and tear. Surfaces and finishes including wall paintwork, floor covering and wood finishes in some resident rooms and communal areas were worn and as such did not facilitate effective cleaning.
- The design of the shower trays within the majority of en-suite bathrooms did not facilitate effective cleaning and encouraged the accumulation of dirt and biofilms. There was ambiguity regarding cleaning responsibility for these shower trays and they were visibly unclean.
- Clinical equipment including commodes, toilet seats and shower chairs was inappropriately stored within an assisted shower room.

Judgment: Not compliant

Regulation 27: Infection control

The registered provider had not ensured that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff. For example;

- A full range of safety engineered needles were not available. The use of devices with safety engineered protective features (for example Safety or retractable devices) has been mandated in all European Union member countries. Inspectors saw evidence (used needles recapped in the sharps disposal bin) that needles were recapped after use. Sharps were not disposed of immediately after use. A used insulin needle was observed on the medication trolley. These practices increased the risk of needle stick injury.
- Several items of frequently used equipment such as bed-tables, wheelchairs, a urinal, commodes and nebulisers were observed to be unclean.
- Cleaning chemicals were stored and prepared within a sluice room (adjacent

to the sluice hopper). This significantly increased the risk of environmental contamination and cross infection.

- Both cleaning trolleys were visibly unclean. Effective cleaning and decontamination is compromised if cleaning equipment is unclean.
- A dedicated specimen fridge was not available for the storage of laboratory samples awaiting collection. Microbiology specimens for refrigeration should be stored in a fridge dedicated for this purpose to reduce the risk of cross contamination.
- Hand hygiene facilities were not in line with best practice and national guidelines in all areas of the centre. Dispensers or individual bottles of alcohol hand gel were not readily available at point of care.
- Inspectors observed inconsistent use of PPE. For example, on one occasion gloves were not removed prior to leaving residents bedroom. Hand hygiene was not performed after removing gloves and gloves were inappropriately discarded on two occasions.
- A number of slings were being stored together in a storeroom along with resident equipment and were found to be overlapping, which increased the risk of cross-contamination.

Judgment: Not compliant

Regulation 28: Fire precautions

Three final fire exit doors located in the memory care unit were locked with key. There was no spare keys located in close proximity to the doors. This may pose a delay in evacuating residents in the event of a fire emergency in the centre. The person in charge was required to take immediate action to address this risk during the inspection.

Additional concerns were identified in relation to fire safety as follows:

- There were visible gaps under several bedroom doors in the memory care unit, which could impact the effectiveness of the door to contain fire and smoke in the event of a fire emergency.
- Emergency lighting was not available in some parts of the centre. This may delay the direction of residents and staff to the emergency exit in the event of a fire.
- Person evacuations plans (peeps) displayed in resident bedroom were not up-to-date, which may delay the direction of residents and staff in the event of a fire.
- A fire exit in the residents activity room was partially blocked during the inspection and paint was stored in this room.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Inspectors were not assured that medications were managed in accordance with best practice guidelines. For example:

- Medicinal products such as out-of-date eye-drops, unlabelled loose tablets and ointments, were not segregated from other medicinal products which were in use.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Inspectors reviewed a sample of resident files and found that individual assessment and care planning was not in line with the requirements of Regulation 5. For example;

- A resident communication care plan was not reviewed to ensure that it contained the most up-to-date information in relation to residents' care needs and that out-dated information which was no longer relevant had been removed. This posed a risk that this information would not be communicated to all staff.
- A residents assessed at being at high risk of skin damage due to pressure, did not have an appropriate care plan developed to address the risk which contained the most up-to-date information in relation to the residents preferences.
- The majority of residents had generic infection prevention and control care plans which were not not reviewed to ensure that out-dated information which was no longer relevant was removed and where when there was no indication for their use.

Judgment: Not compliant

Regulation 6: Health care

Residents had timely access to general practitioners (GP), specialist services and health and social care professionals such as physiotherapy, dietitian and speech and language therapy, as required.

Judgment: Compliant

Regulation 9: Residents' rights

Residents were not supported to exercise choice in their daily routines. This was evidenced by:

- Inspectors observed that doors to the secure garden in the memory care unit were locked with a key. This arrangement placed restrictions on residents' freedom of movement and their choice to access the outside space without the support of staff to open the door for them.
- Several told inspectors that they had restricted choices in relation to some aspects of their daily routines, such as frequency of personal care and access to equipment. This was validated by a review of records and discussions with staff.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Kilcolgan Nursing Home OSV-0000351

Inspection ID: MON-0040693

Date of inspection: 12/07/2024

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • We have reviewed the housekeeping service and increased the number of staff and hours to facilitate the provision of two housekeeping staff on duty every day. • The housekeeping supervisor will ensure that all members of the housekeeping team adhere to their designated work schedules and complete their work to expected standards. • The Person in Charge (PIC) and housekeeping supervisor will monitor compliance with cleaning standards as part of their daily rounds. Any areas that have not been cleaned to a satisfactory standard will be highlighted to the housekeeping team by the PIC and these will be addressed by the team.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • The Person in Charge (PIC) has completed a review of all staff training records. Since the inspection, additional training sessions have been provided and all staff are now up to date with mandatory training requirements. Refresher updates have been scheduled for staff in advance of their due dates. • Additional education has been scheduled to ensure that staff have a thorough understanding of how to apply theoretical learning to practice in relation to the management of residents colonised with MDROs. • The PIC will ensure that daily cleaning schedules are maintained, including the cleaning of all sluice rooms in line with Infection Prevention & Control (IPC) recommendations and guidelines.	

• The IPC lead, with the support of the PIC /CNM, will complete daily walkabouts of the building to monitor and ensure compliance with cleaning/decontamination of equipment.
• The IPC lead, with the support of the PIC, will ensure that Infection Control issues are discussed at daily handover/safety pause meetings.
• The IPC lead will monitor appropriate IPC practices, including the appropriate use of Personal Protective Equipment.
• The PIC will ensure that antimicrobial stewardship is monitored to provide guidance for the safe use of antimicrobial agents.
• The appropriate management of sharps has been incorporated into the infection control training programme and the IPC lead will monitor staff compliance with the appropriate and safe management of sharps in the centre.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• The PIC will be supported by the Healthcare Manager and the Director of Care Services in the achievement of all required objectives and in ensuring that there are safe, high-quality systems of governance and management in place. The PIC reports on all Key Performance Indicators and operational issues in the home on a weekly basis and these reports are reviewed by this senior management team to ensure sustainability of progress, to identify areas in need of improvement and take corrective actions as required.
• There is a robust recruitment plan in place to address identified staffing deficits, including the current CNM vacancy.
• Fire safety precautions have been addressed: gaps under fire doors have been repaired, emergency lighting has been replaced/repaired as required and the personal emergency evacuation plans have been reviewed, updated and communicated to all staff. The final exit doors now have keycode access and are connected to the fire alarm system.
• Since the inspection, the centre has been deep cleaned to a high standard. We have increased the number of housekeeping staff and working hours to ensure that there are always sufficient staff available to maintain high standards of cleaning and the PIC, in conjunction with the housekeeping supervisor, will oversee compliance with this. The housekeeping supervisor will be responsible for ensuring that there are no gaps in cleaning records and will regularly check that staff are accurately signing off work that has been completed to a satisfactory standard. The PIC will conduct weekly walkabouts with the cleaning contractor area supervisor to monitor cleaning standards and address any areas identified to maintain compliance with expected standards and protocols within the centre.
• The PIC will ensure that there are sufficient staff supervision arrangements in place in all departments in the centre.
• The laundry service has been outsourced to an external company for linen and

residents’ personal clothing. All clothing is labelled appropriately. The Healthcare Assistants will manage the laundry when it is delivered back to the centre, ensuring that it is neatly folded, and they will deliver residents’ clothing back to their rooms and put it into the wardrobes/drawers.
• The nursing home now has an identified IPC lead nurse who will act as the link practitioner to support staff to implement effective infection prevention and control and antimicrobial stewardship practices within the centre. The IPC lead nurse will be responsible for monitoring and maintenance of the MDRO register and associated infections within the home.
• The IPC lead will hold monthly IPC Committee meetings in the home. These meetings will serve as an opportunity for the IPC lead to share education, IPC audit results, agree actions and implement quality improvements.
• The PIC will ensure that the management team and the IPC lead nurse will actively monitor IPC standards and adherence to IPC protocols in the centre.
• The PIC will ensure that there is an effective system of IPC and environmental audits in the centre. Audit findings will be accurately reflected and will lead to appropriate quality improvement plans to address any deficits identified. Quality improvement plans will be reviewed at monthly management meetings to ensure that they are being adhered to.
• There is a monthly management team meeting in the home which reviews all operational aspects of the home, including key performance indicators, risk management, audits and progress on identified actions, and updates on quality improvement initiatives. This meeting is well attended and includes at least one representative from each department.
• The PIC will ensure the right to choose is exercised and promoted within the nursing home. Residents will have a choice on personal needs care and will be encouraged to exercise individual choice.
• The PIC will ensure that all fire doors are connected to a coded access system that will activate to be released at certain times during the day; this will ensure all residents have unrestricted access to and from the enclosed garden.
• The PIC will ensure that all staff have completed training in restrictive practice within the home.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
Inspectors found that the management of complaints was not in line with the requirements of the regulations. For example, a review of a sample of complaints records demonstrated that complaints and expressions of dissatisfaction with the service provided were not recorded and responded to. For example, residents issues with food and equipment had not been appropriately responded to.

• The PIC, supported by the HCM, will review incidents, communication records and progress reports weekly to ensure that any issues, concerns or expressions of

dissatisfaction are recorded as complaints, addressed and responded to in line with the centre’s Complaints Procedure.
• Complaints management and awareness training has been scheduled for all staff in the centre, including the management team.
• Records of resident meetings will be reviewed, and any issues or concerns will be recorded as complaints and investigated in accordance with the Complaints Procedure.
• The PIC will provide information about complaints received in the centre, including, source, learning outcomes and recommendations at the monthly KPI meetings.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• The laundry service has been fully outsourced to an external company, including linen and residents’ personal clothing.
• Since the inspection the laundry room has been decluttered and deep cleaned.
• A deep clean has taken place in the kitchen. The PIC will ensure that a thorough cleaning of the kitchen department will be completed weekly as per schedule and the Catering Manager will be responsible for implementing this.
• The PIC will ensure that IPC audits results are shared with the Catering Manager and any areas requiring further attention will form the basis of a Quality Impropvement Plan.
• The PIC with support of the Facilities team will ensure that decorative works identified will be completed to facilitate effective cleaning.
• Since the inspection the toilet cubilcle has been removed from the housekeeping room. Shelving has been installed for storage. A lockable metal cabinet has been provided in this room for the storage of chemicals. The flooring has been repaired/replaced as required. The housekeeping supervisor will ensure that this room is maintained in a clean and organised manner and the PIC will oversee compliance with this.
• The PIC will check all equipment and furniture to ensure that they are maintained in a good state of repair; damaged or obsolete items will be disposed of and replaced with new items as required.
• A tagging system has been introduced so that equip,ent can be labelled to identify when it has been cleaned or to confirm that it requires cleaning. The IPC Lead monitors the appropriate use of the tagging system as part of the daily walkabout and discusses its effectiveness at the daily safety pause.
• It has been agreed that the housekeeping staff will be respnsble for cleaning the shower trays. This will be included in the cleaning schedules. The Maintenance Person will remove the shower trays periodically to enable housekeeping staff to ensure that they can be thoroughly cleaned.
• Since the inspection, the wheelchairs, commodes and shower chairs are safely and appropriately stored.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:

The registered provider had not ensured that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff. For example;

• Infection Prevention & Control training has been provided to all staff in the centre. This will include a special focus for nursing staff on sharps safety management. This will raise the awareness of the risks of needlestick and sharps injuries and outline how staff working in situations exposed to risk can adopt safe working practices and minimize injury.
• The PIC will ensure that the appropriate safety engineered needles will be readily available for nursing staff.
• The PIC has increased the number of staff and working hours for housekeeping to facilitate the provision of two staff on duty every day. The PIC has collaborated with the regional are manager of the contract cleaning company to review cleaning schedules and practices.
• The PIC and the housekeeping supervisor will conduct weekly walkabouts of the home to monitor standards and confirm that the cleaning practices are effective and in line with the centre’s protocols. They will inspect the cleanliness of frequently used items such as bed tables, wheelchairs, urinals and commodes.
• There is now a dedicated specimen fridge available for the storage of laboratory samples waiting for collection.
• The IPC lead will ensure that nursing and care staff adhere to the centre’s policy on replacement of nebulizer equipment and maintaining it in a clean condition.
• The pump cleaning system has been relocated from the sluice room to the housekeeping room. Housekeeping staff prepare the cleaning solutions from this area, which has eradicated the risk of cross-contamination from the sluice hopper to the cleaning bottles.
• Cleaning trolleys have been deep cleaned and the cleaning of trolleys has been incorporated into the regular cleaning schedule. The PIC and cleaning supervisor will monitor the trolleys to ensure compliance with standard cleaning practices.
• The PIC supported by the Facilities team has carried out a review of the alcohol gel dispensers. Additional dispensers have been installed and staff have been provided with pocket sized gels to ensure availability at point of care. The IPC lead will continue to monitor the availability of the alcohol gel and ensure that all staff have access to same.
• The PIC with the support of the IPC lead will monitor compliance with hand hygiene standards. All staff have received up to date training in IPC.
• The IPC lead with the support of the PIC is completing in-service education sessions with staff to incorporate the importance of effective hand hygiene, the donning and doffing of PPE and MDRO awareness.
• The PIC has completed a review of the storage of slings to ensure items are stored effectively and to reduce the risk of cross contamination.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• The final fire exit doors in the Memory Care Centre have been fitted with a door release mechanism which was serviced by the elctrician on the day of the inspection. All three doors can be released by activation of a code in the event of an emergency evacuation .
• The visible gaps under the fire doors in the Memory Care Centre have been repaired. The PIC has designated the maintenance person as the responsible person for monitoring for gaps under the fire doors as part of the weekly fire safety checks. The maintnenance person will escalate any concerns with any of the fire doors to the PIC.
• A review of the emergency lightening has been completed by Facilities and any emergency lighting requring to be repaired or replaced has been completed. The maintenance person will check all emergency lighting as part of the weekly fire safety checks.
• The PIC has completed a review of all the personal emergency evacuation plans (PEEPs) and they include the appropriate details pertaining to each resident, and their required method of evacuation in the event of an emergency is clearly idenitified. The PIC will ensure that this information is communicated to all members of the team at handovers and daily safety pauses.
• The PIC will ensure that all emergency exit doors are kept free from obstacles and will ensure that all flammable items are safely and appropriately stored.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
Inspectors were not assured that medications were managed in accordance with best practice guidelines. For example:
• Medicinal products such as out-of-date eye-drops, unlabelled loose tablets and ointments, were not segregated from other medicinal products which were in use.
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• The PIC will ensure that all medicinal products will be managed in accordance with the centre’s medicines management policy and best practice.
• The PIC will communicate with all nurses the importance and requirements to ensure that all medications have a date of opening, appropriate labelling and are stored appropriately to their requirements.

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:
• The PIC will complete a weekly audit of clinical documentation to ensure that each resident’s required care needs are being addressed, that the care plan guides the delivery of care and that the care delivered is reviewed and evaluated appropriately and is in accordance with the resident’s expressed preferences. Findings and recommended improvements will be discussed at nursing staff meetings, daily handover/safety pause and at monthly management team meetings. Any changes or developments in the resident’s condition or plan of care will be updated as they occur.
• The PIC with the support of the CNM will ensure that all residents identified at risk of skin damage will have an appropriate wound management assessment completed and the care plan will be updated to reflect this.
• The PIC will ensure that care plans are person-centred and individualised to the specific resident to which they relate.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• The PIC and all staff will be responsible for ensuring that the right to choice is exercised and promoted within the nursing home. Residents will be offered a choice on personal needs care and will be encouraged to exercise their preferences.
• All fire doors are connected to a coded access system that will be released for certain times of the day to enable all residents to have unrestricted access to the enclosed garden.

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	31/08/2024
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	30/09/2024
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/09/2024
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre,	Not Compliant	Orange	31/10/2024

	provide premises which conform to the matters set out in Schedule 6.			
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	30/09/2024
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Red	02/07/2024
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Not Compliant	Red	02/07/2024
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency	Not Compliant	Orange	30/09/2024

	lighting.			
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	31/08/2024
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.	Substantially Compliant	Yellow	31/08/2024
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	31/08/2024
Regulation 29(6)	The person in charge shall ensure that a medicinal product which is out of date or has been dispensed to a resident but is no	Substantially Compliant	Yellow	31/08/2024

	longer required by that resident shall be stored in a secure manner, segregated from other medicinal products and disposed of in accordance with national legislation or guidance in a manner that will not cause danger to public health or risk to the environment and will ensure that the product concerned can no longer be used as a medicinal product.			
Regulation 34(2)(b)	The registered provider shall ensure that the complaints procedure provides that complaints are investigated and concluded, as soon as possible and in any case no later than 30 working days after the receipt of the complaint.	Substantially Compliant	Yellow	30/09/2024
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and	Not Compliant	Orange	30/09/2024

	where appropriate that resident's family.			
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	31/08/2024