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:	Anovocare Nursing Home
Name of provider:	Costern Unlimited Company
Address of centre:	Stockhole Lane, Cloghran, Swords, Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	22 August 2022
Centre ID:	OSV-0005191
Fieldwork ID:	MON-0037697

About the designated centre

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

AnovoCare Nursing Home is a purpose-built facility located in a countryside setting while remaining in close proximity within the local metropolitan community. The centre is registered to provide residential care to 89 residents, both male and female, over the age of 18 years. It provides care on an extended/long-term basis as well as transitional, step down, respite and convalescent care basis. Residents with health and social care needs at all dependency levels are considered for admission. Care is provided to residents with varying facets of cognitive impairment and dementia; residents with features of physical, neurological and sensory impairments and residents with end-of-life and mental health needs. Residents are accommodated on two floors. There are 71 single and nine twin bedrooms all with their own en-suite bathroom facility. This modern building has its own inner courtyard and secure landscaped gardens designed to meet the needs of a variety of residents who may wish to live in the nursing home. AnovoCare Nursing Home is situated in the North Dublin region close to the vibrant villages of Malahide and Swords. There is close access to hotels, restaurants, pubs, local park lands and shopping centres. There is an established bus service to and from Stockhole Lane.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	77

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 22 August 2022	08:20hrs to 19:00hrs	Niamh Moore	Lead
Monday 22 August 2022	08:20hrs to 19:00hrs	Siobhan Nunn	Support
Monday 22 August 2022	09:30hrs to 19:00hrs	Niall Whelton	Support

What residents told us and what inspectors observed

The general feedback inspectors received from residents was that overall they were content with their bedrooms and the premises in Anovocare Nursing Home. Some residents said that staff were good but very busy and at times could be rushed in assisting with their care. In addition, two visitors reported that that there were staffing issues and temporary staff did not always know their loved ones preferences.

When inspectors arrived at the centre, they were met by the receptionist who conducted a signing-in process, including hand hygiene and the wearing of a face mask upon entering the designated centre. There was a delay in inspectors being requested to have their temperatures taken and to confirm that they had no symptoms of COVID-19 or of any other infection.

Following an introductory meeting with two members of management, inspectors went on a walk around of the designated centre. The designated centre is located in Swords, County Dublin. The centre is registered for two storeys with bedrooms set out across the ground and first floors, which are accessible by stairs and lifts. The centre provides accommodation for 89 residents in 71 single and nine twin bedrooms. Residents have access to en-suite bathrooms. There is a second floor within the building which the registered provider plans to register as part of the designated centre in the future.

Inspectors viewed a number of residents' bedrooms and found that they were of a sufficient size. Residents had personalised their spaces with family photographs, ornaments and art work. Residents spoken with told inspectors that they were happy with their bedrooms and the environment.

The premises was bright and seen to be clean. There were a number of communal areas available for residents use, such as a large day, dining and activity room available on each floor. In addition, the ground floor had a number of additional communal areas such as a quiet room, a hairdressing room and a large coffee dock available. There was also outdoor space available such as an internal courtyard and a balcony available on the first floor. Outdoor areas were not seen to be well-maintained.

While staff were observed to follow infection control guidelines in relation to washing hands during the medicines round and at meal time, overall the use of PPE (personal protective equipment) was not appropriate as many staff were seen to wear facemasks incorrectly. In addition, not all staff were bare below the elbow, and some staff were seen to wear wrist watches and stoned rings.

Inspectors spoke directly with residents and visitors, reviewed feedback from residents' meetings, and also spent time observing staff and resident engagement. The general feedback from residents was that staff were kind but as there was not

enough staff, at times the response times were slow. Some residents and visitors spoke about the impact of temporary staff not being aware of their needs which they reported was difficult. Inspectors observed that some staff were moved to work from different units and therefore during conversations were not aware of residents' care needs. Inspectors were told that the registered provider was working hard to recruit additional staff with new starters due to commence in the weeks following the inspection.

Inspectors observed the main dining room during the lunch-time meal. Residents reported mixed reviews regarding their experience and the choice available at mealtimes. Most residents reported satisfaction with breakfast, however some reported that there were delays in receiving their meals throughout the day due to staffing levels. On the day of the inspection, there was sufficient staff within the dining room. Some residents were unhappy with the choices available. One resident told inspectors that at the tea-time meal usually there is only one choice available and reported that overall the experience at tea-time is "poor". Another resident reported that the meat all tastes the same.

Activities on offer were displayed in communal areas and lifts within the centre. Activities on offer included mass, Zumba, crafts and aromatherapy. Residents were observed partaking in group activities such as listening to classical music and playing bingo on the day of the inspection. Residents spoken with reported to enjoy the group activities, however for those who did not partake in groups, there was insufficient opportunity to be supported on a one-to-one basis.

The provider had arrangements in place to support residents to receive their visitors. Many visitors were seen to meet and spend time with their loved ones in the coffee dock within the centre. Residents who spoke with the inspectors said they were happy with the visiting arrangements within the centre. In addition, a visitor reported to be happy that there was no restrictions on their visits.

The next two sections of this 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 the quality and safety of the service being delivered.

Capacity and capability

While there were established management structures in the designated centre, inspectors found that there was poor governance systems and that the current systems were impacting on the safety of the service provided to residents. Systems had failed to monitor and mitigate risks relating to staffing and auditing. In particular, inspectors found:

- there was inadequate monitoring and oversight of resident care to ensure the safety and protection of residents at all times
- Inspectors were not assured that there was sufficient staff with the

appropriate skills to meet the assessed care needs of residents
- the system of risk identification was not adequate, for example, inspectors identified a number of risks during the inspection that had not been identified and as a result to mitigate the risk were not in place.
- residents assessed needs and associated risks did not always have an appropriate care plan in place to support them.

This purpose of this unannounced inspection was to review compliance plan assurances submitted by the registered provider following an inspection carried out in March 2021. The inspection also reviewed an application submitted by the registered provider to vary conditions 1 and 3 of the current registration to increase the numbers of residents in the designated centre through the provision of an additional 23 bed spaces, additional communal spaces and store rooms on the second floor. However, on the day of the inspection inspectors found that the provider was not adequately ready to progress this application and it was subsequently withdrawn by the provider following the inspection. In addition, during the inspection, inspectors followed up on concerns raised through the receipt of unsolicited information which was focused on staffing levels and care provision.

Costern Unlimited Company is the registered provider for Anovocare Nursing Home. The management team comprises the Chief Executive Officer, a HR Director, a Clinical Operations Manager and the person in charge. There is a governance structure in place which identified clear lines of accountability and responsibility.

The person in charge worked full-time in the centre and was supported in their management role by an assistant director of nursing and two clinical nurse managers. Other staff members included nurses, healthcare assistants, activity staff members, catering and domestic staff, maintenance and administration staff. From an examination of the staff duty roster and observations on the day of the inspection, inspectors were not assured there was a sufficient number and skill mix of staff to meet the assessed needs of residents. Clinical nurse managers were not supernumerary as they were seen to be covering staffing vacancies. In addition, feedback from staff and residents was that there was insufficient staffing levels. One resident told inspectors that on occasions they were asked to retire to bed earlier than preferred.

A review of management meeting minutes outlined that the management team were meeting regularly and were discussing key performance indicators and topics relevant to service delivery. This included a weekly report and bi-weekly meetings and a quarterly infection control and health and safety meeting. Topics discussed at these meetings included occupancy, residents' clinical care, staffing levels and training, complaints, incidents and accidents, fire safety, COVID-19 and audits. However, despite these regular management meetings and key topics being discussed, inspectors were not assured that the service was being effectively monitored. Inspectors were told that the provider was aware there were gaps within their current care planning systems, however, there was no time bound plan to respond and inspectors were told it was a work in progress. In addition, while regularly reviewing staffing levels and response times to call bells, this information did not collate with inspectors findings and feedback from residents, staff and

visitors who reported there was not enough staff.

The annual review of the quality and safety of the service delivered to residents in 2021 had been done in consultation with residents. There was an action plan developed for 2022 which included using the feedback from the residents to improve the service, such as providing a greater choice and quality of meals. In addition, improvements were planned for the garden and courtyard to be landscaped.

Regulation 15: Staffing

On the day of the inspection, inspectors found that there was an insufficient number and skill mix of staff for the assessed needs of residents and the size and layout of the designated centre. For example:

- the inspectors were told that the day time staff nurse vacancies were being covered by clinical nurse managers, this resulted in insufficient management oversight within the designated centre.
- there were delays to the morning medicine round due to the insufficient number of staff nurses working on the day of the inspection. For example, the 08:00 medicine round did not finish until 10:45 and the 10:00 medicine round only commenced following this.
- the inspectors observed that the care provision for residents was delayed, for example gaps were seen in meeting residents personal care needs of showers and continence wear. On one unit, inspectors observed a handover sheet which recorded that eight out of 15 residents had not had a shower within the last three days. Inspectors were told this number remained the same at 5pm on the day of the inspection. Staff informed inspectors that there was not enough time to complete all duties and tasks, particularly relating to providing any one-to-one social activities for residents.
- some residents spoken with told inspectors that at times staff were slow to respond to their needs and due to the provision of temporary staff working, they were not familiar with their needs. Inspectors saw on worked rosters that for some nights, temporary staff made up 50% of the staff team.
- the person in charge told inspectors that vacancies within staffing were being covered by temporary staff but at times of short notice leave, there was an in-availability of temporary staff.

Judgment: Not compliant

Regulation 23: Governance and management

Inspectors were not assured that management systems in place ensured that the service provided was safe, appropriate, consistent and effectively monitored. For

example:

- staffing resources in place were insufficient to ensure the effective delivery of care and were not in accordance with the provider's statement of purpose. The inability to effectively manage resources hindered management oversight of the designated centre.
- audits were not driving quality improvements and did not identify issues found on the day of the inspection. For example, a care plan audit in June 2022 found 97% compliance and had not registered errors in care records seen for some residents on the day of the inspection. A medicine audit in July 2022 had not identified improvements required relating to storage of medicines.
- the inspectors did not see evidence that the analysis of information was leading to quality improvement plans being developed and put into action. For example, while the provider had responded to requests for assurance from the Chief Inspector of Social Services, these reports were not seen to drive learning for the centre. For example, staffing levels and residents' preferences for retiring to bed had not been adequately addressed.
- the inspectors were not assured that temporary staff and staff moving across different units were sufficiently inducted and supervised to ensure they had sufficient information to guide them on residents' care.
- systems of oversight of the service were not satisfactory. For example, regular review of staffing levels and response times to call bells, did not collate with inspectors findings and feedback from residents, staff and visitors who reported there was not enough staff.

Judgment: Not compliant

Quality and safety

Residents spoken with reported to feel safe within the centre and could receive their visitors. However, inspectors found that improvements were required to ensure that the quality and safety of care delivered to residents was consistently managed. In particular, care planning, healthcare, residents' rights, premises, food and nutrition, infection control, fire precautions and medicines all required action to ensure the best possible outcomes for residents.

Inspectors reviewed a sample of residents' records and found that overall these were not sufficiently detailed to guide staff in providing care to residents. The provider told inspectors that they were aware that their care planning and records required review, however a plan had not been put in place to address this matter. In addition, gaps were seen where residents' assessed needs were not met. For example, inspectors were told that residents' preferences for the time they went to bed was recorded within care plans but this was not in place on the day of the inspection. A resident told inspectors that they are encouraged to go to bed early

when this was not their preference. Further gaps are discussed under Regulation 5 below.

Inspectors were told that a general practitioner (GP) visited the centre twice a week. Records showed that residents had access to other services such as gerontology, dietitians, speech and language therapy, opticians and chiropody. However, inspectors found that the registered provider had not ensured timely access to all medical and health care services.

The registered provider had a policy on the protection of vulnerable adults dated in April 2021. Staff spoken with had good knowledge of appropriate measures to take if any safeguarding risks were identified. The registered provider was a pension agent for one resident with good systems in place for the management of this resident's money.

Residents have access to an advocacy service which was displayed within the centre. Televisions, magazines and radios were available for residents' use. The provider employed two activity staff who worked Monday to Sunday within the centre. Inspectors were told there was a sufficient budget for group activities including outings with a recent trip to a seaside town. Inspectors were told that the activity workers hoped to facilitate outings twice a month where they hired a minibus for these trips, however the last outing occurred six weeks prior to the inspection. Inspectors were not assured that residents who preferred one-to-one activities were able to avail of these.

Inspectors reviewed evidence where residents were consulted with and participated in the organisation of the centre through monthly resident meetings. Feedback was provided on catering, ongoing building works, premises, visiting and activities. However, inspectors saw evidence where minutes from meetings held in February, March, April and July 2022 included dissatisfaction with meal choices and temperature, no access to the garden due to building works and lack of garden furniture, request for more external and one-to-one activities and the impact of temporary and low staffing levels. An action plan has been developed to respond to the feedback raised however, despite items being recorded as complete, this information reflected the same feedback inspectors were provided with of residents' dissatisfaction on the day of the inspection.

Overall, the building was spacious and welcoming. However the maintenance of the external areas of the building required action. This is further discussed within this report under Regulation 17: Premises.

There was a menu available in paper format on the tables within the dining rooms. A pictorial menu was also on display. However, this did not reflect the menu on offer on the day of the inspection. Inspectors found that there was a choice of food on offer for the main meal at lunch-time, however the choice at tea-time was limited. Overall, mealtimes were observed to be a relaxing and social experience for residents. However, the feedback on the food on offer was mixed. Inspectors saw that this feedback was also recorded within the provider's 2021 annual review with an action for better choice and quality of food. Inspectors also reviewed records

relating to nutritional risks and found that action was required in ensure that information within nutritional care plans was accurate to provide sufficient information to guide staff.

Overall, resident bedrooms were seen to be clean, however one bedroom had a bad odour. Some areas and items throughout the day of the inspection were seen to be unclean. In addition, there was inappropriate storage of sangenic bins (for storage of used incontinence wear) on corridors. Inspectors were told these would be removed following morning care but they remained at 4pm and many were seen to be visibly unclean. The oversight of visitors for symptom checking and staff use of PPE and hand hygiene required more sufficient oversight.

Inspectors noted a good awareness of fire safety in this centre. Staff spoken with were mostly knowledgeable on the evacuation procedures in place and confirmed they had participated in fire safety training and fire drills. Good examples of fire safety within the centre included:

- the configuration of the centre meant that there was an adequate number of escape routes and exits and it was sub-divided into reasonably sized fire compartments to support the phased evacuation strategy adopted in the centre.
- there was a fully addressable fire detection and alarm system, which would display the location of a fire if one started.
- emergency lighting was provided internally and along external escape routes. These were serviced at the appropriate intervals.
- the inspectors reviewed evacuation drill records; they were carried out frequently and where appropriate included residents. Inspectors noted the records highlighted what went wrong to inform areas for improvement.
- the inspectors saw that each fire door was individually labelled with a unique annotation and were told these informed fire door audits

While good practices including those listed above were observed, there were a number of areas identified that required action to ensure compliance with fire precautions, as detailed under regulation 28. Some examples included that the fire doors provided throughout were robust and of a good quality, however maintenance deficits were noted. There was ongoing work to improve fire containment, including the sealing up of gaps in fire rated construction, but this was not yet complete. The fire safety policy viewed was not centre specific, nor was the implementation date evident.

Inspectors reviewed medicines management within the designated centre. While inspectors observed the nurse actively engaged well with residents during the morning medicine round, inspectors observed numerous occasions where the registered provider's policy on medication management dated March 2022 was not adhered to throughout the day of the inspection. For example the following gaps were observed:

- medicines were not seen to be administered in a timely manner
- the transcription of medicine prescriptions were not accurate from the

prescription to the centre's electronic kardex
- the disposal of medicines required review as medicines which were no longer in use or had expired were observed to still be stored within the designated centre
- inspectors were told that medicines were returned to the pharmacy on a weekly basis, however there was no documented assurances that this was occurring since 05 May 2022
- despite the medicine fridge temperature being checked daily, there were occasions where the recorded temperature was out of the recommended temperature range with no action taken.

Regulation 17: Premises

Action was required by the provider to improve the external grounds of the centre to ensure it promoted a safe, comfortable and homely living environment for all residents. For example, bins at the smoking shelter were seen to be full, there was no seating available for residents' use, and weeds were seen in the grass and raised flower beds. In addition, the garden was not seen to be secure due to recent building works on the second floor.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Three residents expressed dissatisfaction with the choice of meals available.

One resident who was at risk of under nutrition did not have their care plan reviewed following the advice of the dietitian. While this care plan dated May 2022 did reflect that weight monitoring was required weekly, this was not seen to be in place. For example, the resident was weighed twice in June, once in July and three times in August.

A resident with a requirement to have weight monitoring in place, did not have a care plan to reflect how often the monitoring should take place. As a result, weights were seen to be irregular.

Judgment: Substantially compliant

Regulation 27: Infection control

All visitors were not checked to see if they had any symptoms of COVID-19

infection. In addition, the correct use of PPE and hand hygiene were not followed by all staff in relation to infection control guidelines.

Inappropriate storage was observed which posed a risk including of cross contamination to residents. For example:

- cleaning chemicals were stored in an unlocked press.
- a hand hygiene sink in a sluice room was inaccessible due to three empty laundry trolleys being stored in front of it.

There was insufficient oversight of cleaning in a number of areas. For example:

- areas within the nurses' station on the first floor such as the splashback at the sink was unclean.
- tables on the first floor balcony were dirty with crumbs and dried-in stains. In addition, cigarette butts were littered on the ground in this area.
- sangenic bins were seen to be unclean with brown residue, including in corridors on the ground floor and within a sluice room on the first floor.
- some items in poor repair impacted on the provision of cleaning. For example, a nurses station had holes in the table top and a handwash sink and wooden enclosure surrounding it on the first floor was worn.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Adequate precautions were not in place to protect residents against the risk of fire. For example:

- the designated smoking area was out of commission while builders were on site and the temporary smoking areas for residents were not adequate. Call bells were not provided. The ground floor smoking area was not provided with fire fighting equipment and the timber bench used was broken
- fire doors were being held open by means other than appropriate hold open devices activated by the fire detection and alarm system
- combustible storage was noted within higher risk rooms, the electrical room and the boiler room. While these were in a separate building it was poor practice. The risk of a fire escalating is increased as a result of the combustible storage.

Arrangements for maintaining fire equipment, means of escape and building fabric was not effective:

- fire doors were not being maintained to ensure they performed as required; this included gaps around doors, smoke and heat seals missing or damaged and some doors didn't close. The door protecting an escape stairs was getting caught on the floor covering. The in house fire safety checks included

weekly inspections of fire doors, however they were not identifying issued noted by inspectors
- the service records for the emergency lighting included deficits to a number of units and there was no records of these being repaired
- storage was noted within escape stairs, including a cleaners trolley and furniture. This meant that the escape route along the stairway was not free of obstruction and combustible storage.

The means of escape was not adequate, for example:

- a final exit from an escape stairs was obstructed by a bin. This had been identified by a staff member and recorded in a maintenance book four days before the inspection and had not been actioned.
- the inspectors noted areas where escape signage was not visible to direct occupants on escape.
- curtains were positioned across exits, causing potential obstruction and delay in the event of a fire

Notwithstanding the ongoing work to improve fire containment, the containment measures in place were not adequate;

- it was noted that a number of fire doors did not have appropriate sealing between the frame and the wall it was located in
- the inspector was not assured that appropriate fire containment was provided between a recessed nook in a protected corridor and an adjacent store room
- gaps to fire doors located in fire compartment boundaries meant that the compartment boundaries may not be effective to contain fire and smoke

Action was required to ensure early warning of, and adequate detection of fire:

- the laundry store appeared to be fitted with a heat detector and not a smoke detector to ensure early detection of fire.

Action was required to ensure adequate arrangements were in place to evacuate residents in the event of a fire:

- A fire drill record highlighted delays in evacuation where an agency staff member was not familiar with the use of the evacuation aid.

The floor plans displayed for the purpose of evacuation were small and difficult ro read.

There was a fire safety policy and strategy document, which had no effective date of implementation. This was at an organisational level and was not centre specific.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The provider needed to improve the storage of medicines within the designated centre. On three occasions within the two weeks previous to the inspection, a medicine fridge was outside the recommended temperature range with no action taken. In addition, one staff member spoken with did not know the correct range.

Medicinal products were not seen to be administered in accordance with the directions of the prescriber. For example:

- the 08:00 morning medicine time was delayed and as a result the time of completion was 10:45, which delayed the start time for the 10:00 medicines.
- a prescription for crushed and covert medicines had not been signed by the GP.
- some medicines which were seen to be opened did not have a date of opening recorded on the medicine. This created a risk that medicines would be dispensed for longer than the recommended timeframe.

Medicines which had expired or were for residents no longer residing in the centre were stored within the controlled medicine press and had not been disposed of within the required timeframes.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

The registered provider had failed to meet the needs of some residents as per their care plans. For example, one resident who had a care plan which stated they like to ensure they have an outing every second day. This was not seen to be occurring and there was no alternative one-to-one activities occurring within the nursing home. There were gaps in a resident's personal hygiene records relating to continence and showering.

Inspectors found for one resident had not had a comprehensive assessment prior to or on their admission to the designated centre. This resulted in gaps in meeting this resident's assessed needs which are further discussed under Regulation 6: Healthcare.

Inspectors found that for one out of two residents reviewed, their care plans were not prepared within 48 hours or on their admission to the designated centre.

Action was required to ensure that care plans were reviewed at intervals not exceeding four months or as necessary. Inspectors observed that the evaluations were overdue for a number of residents' records.

Judgment: Not compliant

Regulation 6: Health care

Inspectors found that for one resident their assessed medical care needs had not been met. For example, the resident's pre-admission assessment recorded a psychiatric need which had not yet been met. Inspectors were told the provider had referred the resident to a service in June 2022 and were awaiting an appointment. In addition, this resident was delayed receiving a medicine for a number of months. This medicine was administered at the end of the inspection.

Residents did not have access to physiotherapy services for three weeks prior to the inspection. Inspectors were told that the provider's physiotherapist was currently on planned leave and they were trying to recruit another physiotherapist to cover this vacancy.

Judgment: Not compliant

Regulation 8: Protection

Inspectors were assured that there was reasonable measures in place to protect residents from abuse. Staff had received training in safeguarding and a sample of safeguarding allegations reviewed were seen to be thoroughly investigated.

Judgment: Compliant

Regulation 9: Residents' rights

From inspector's observations and feedback from the day of the inspection, inspectors were not assured that all residents were provided with sufficient opportunities to participate in activities in line with their interests and capacities. Records demonstrating residents' engagement with one-to-one activities were unavailable on the day of the inspection.

Resident feedback was not responded to appropriately. Inspectors found that despite items being brought to the attention of the registered provider during monthly residents' meetings from February to July 2022. This information reflected the same issues inspectors were provided with of residents' dissatisfaction on the day of the inspection.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Anovocare Nursing Home OSV-0005191

Inspection ID: MON-0037697

Date of inspection: 22/08/2022

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The person in charge with the support of the clinical operations manager will undertake a full review of the rosters to ensure each shift is worked in accordance with the statement of purpose and function in line with the resident care needs. The Director of Nursing and the Assistant Director of Nursing and the clinical nurse managers will continue to provide clinical oversight of the resident's care needs. Rosters are compiled fortnightly and are monitored in relation to dependency using a validated dependency tool (Barthel) and occupancy levels within the center to ensure safe staffing levels and required skill mix is addressed. In the event of rostered staff vacancies due to short notice sickness every effort is made to realign the rosters with staff that is known to the resident either from the existing inhouse staff or agency. In the event of vacant staff posts, agency staff will be arranged and prebooked to ensure every effort is made to hire staff that is known to the nursing home and the residents to facilitate continuity of care. An oversees recruitment drive has taken place in September whereby a large number of registered nurses were selected and are planned for the service as soon as reasonably practicable. Trinity care has employed 9 healthcare personnel since the time of the inspection all have commenced employment in AnovoCare with a further 5 to commence as soon as Garda Vetting is completed. This will identify the issues identified at the time of inspection in delay with delivery of care. There is a weekly reporting system of staff vacancies submitted to group HR dept and this is actively reviewed by Senior Management and the HR Department from both a national and oversees recruitment campaign. Since the inspection, one CNM has been working supernumerary in a supervisory capacity, as nursing posts are filled the second CNM will also be working supernumerary. As newly appointed staff are appointed and are in place, residents' needs will be attended to in a timelier fashion. A review of the audits at the nursing home will be	

undertaken to ensure findings are actioned and implemented.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
There is a defined management structure within the nursing home which consists of DON/ADON and two clinical nurse managers.
The Clinical Operations manager also visits the nursing home on a regular basis to support the managers onsite at the nursing home. Healthcare staff from outside the EU who have recently been appointed will be inducted into the vacant positions.

Since the inspection, one CNM has been working supernumerary in a supervisory capacity, as nursing posts are filled the second CNM will also be working supernumerary. As newly appointed staff are appointed and are in place, residents' needs will be attended to in a timelier fashion. A review of the audits at the nursing home will be undertaken to ensure findings are actioned and implemented. There will be a review of the audit process whereby peer to peer audits will be carried, which in turn will provide more transparent oversight

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Works have now been undertaken in the garden, the rear garden which was not open to residents during the time of the inspection due to building works, has been completed and repair works and securing of the boundary are now completed and are made available to residents. The resident's smoking area was fitted with a nurse call bell system and a fire extinguisher. The outside area has now been cleaned and all bins are monitored for emptying and new garden furniture has been ordered.

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and

nutrition:
The Director of Nursing has undertaken a full review of nutritional care plans to include the frequency and rationale for weight monitoring to ensure the needs of the resident is documented in the care plan.
There has been engagement with the dietitian to ensure reviews of at-risk residents.

A System of work has been implemented in relation to weights and must score of two and will be reviewed by DON to ensure compliance.

Nualtra Online Training has been made available to all nursing staff and their progress is monitored by the DON. All staff will receive training on the nutritional policy and has been commenced.

Residents Comment cards are reviewed monthly by the Trinity Care catering manager and actioned accordingly. Menus were also reviewed, and choices have been made available with new dishes offered and less popular foods have been removed. The chef will attend resident feedback meetings. New picture menus are being updated in line with the 4-week menu cycle to show meals being served on the day.
A monthly dining experience audit is completed monthly.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
A risk assessment is in place for all visitors to the center.

IPC refresher training has taken place for all staff to ensure PPE and hygiene are followed and in compliance with current guidelines.

Chemical stores are locked, and daily checks are completed by the household manager.

Laundry trolleys are no longer kept in sluice rooms and sinks are kept free. A review of the cleaning schedules has been completed. Household manager will continue to complete spot checks on each area and report to DON.

First floor balcony has been power washed; A designated smoking area has been located at the rear of the building. Staff and residents have been advised and the balcony area is now a smoke free zone

Sangenic bins have been removed and staff are using individual small bin bags to collect used incontinence wear. Nurses station and wash hand sink on the first floor are to be replaced.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• The designated smoking area has been re equiped with a fire extinguisher and nurse call bell. It is now the only designated smoking area for the three residnets who smoke.
• All full review of the building has been completed and there are no devices holding open doors.
• The electrical room and the boiler room are being cleared of all combustable materials and boxes.
• A full inspection of all fire doors has been completed by a fire stopping contractor, work has been completed to replace seals around the doors and in areas which were noted to be damaged or missing. The fire door checks will be completed by the onsite maintenance staff who will report defects immediately and arrange repair. Emergency lighting has been serviced and certs have been submitted 01/09/22
• Bin has been removed from causing obstruction of a final exit from an escape stairs.
• Sitting room curtain has been removed so as not to cover the escape door or exit sign.
• The laundry store has been fitted with a smoke detector which replaced the heat detector.
• A fire drill record highlighted delays in evacuation where an agency staff member was not familiar with the use of the evacuation aid. The agency staff learned from the fire drill, an agency induction is completed to ensure all agency staff are aware of procedures in the event of a fire.
• A full review of the fire containment system including gaps, fire doors and sealing on frames and the recessed nook highlighted has been completed.
• The floor plans displayed for the purpose of evacuation have been made more visable and highlight the "you are here" to make it easier to read.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
Medication fridge temperature checks list forms have been updated to include the recommended temperature range and the time the temperature was taken. All nurses have been given instructions on the recommended temperatures and the reporting structure and actions should the temperatures exceed the recommended amount.

The Pharmacist has been requested to complete medication reviews of all residents.

The GP has been spoken to regarding correct prescribing of medications and all nurses

are currently receiving medication management training and competencies by an outside trainer.

Expired medications are removed by pharmacy fortnightly, and this will be audited by the ADON completing the monthly medication management audit, random checks will also be completed weekly on the medication trollies for open dates on all liquid medications.
An audit of the length of time for medication rounds will be completed by the DON and a review of the electronic records for the time the medications have been administered will be completed weekly to identify discrepancies and time delays.
An independent external audit is due to be completed in the coming weeks.

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:
Since the time of the inspection, 9 new full time HCA staff have commenced with a further 5 recruited and are awaiting garda vetting and paperwork. With the introduction to more regular staff the residents' individual needs will be known and their needs will be met in a timelier manner. Each resident has received "This is me booklets" which will detail their daily routines and preferences. This assists the care staff with identifying the residents own preference, for example their wish to be showered or bathed, and how frequently.

Nurses have been re-assigned as key workers for named residents and will be responsible for care plans.

A review of each resident's care plan is in process with emphasis on individual preferences with regards, personal care, nutrition, and activities.

A comprehensive preadmission assessment is completed immediately prior to admission by the DON/ADON and is made available to the admitting nurse.
A new comprehensive assessment has been put in place for all new residents to be completed within 48hrs of admission and will be reviewed for all current residents.

All new residents will have care plans implemented within 48hrs of admission.

Training is in process for all nurses in the use of the EpicCare system and care planning.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
An application has been made to the Community Psych team again for access to their services. The GP has referred this same resident and is as yet awaiting a reply. A referral has been requested for review by the residents previous community psychiatrist.The Physiotherapist had extended planned maternity leave and a replacement part time physiotherapist has been recruited for the duration of the leave.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
"This is me booklets" have been provided to residents and family members to complete. The information detailed in the booklets will be used to create person centered care plans specific to the individual's needs and preferences when it comes to daily routines, choices, and activities.

Activities and HCA staff have received training in the recording of one-to-one activities on the EpicCare system.

A system of work has been put in place to ensure all individual activities provided by outside groups such as Artists, Aromatherapists, beauty therapist etc. are documented in individual Epic Care records rather than in group reports.

Time allocated for one-to-one activities will be included on the weekly activity plan provided to residents and displayed throughout the home and individual activities will be planned according to the wishes of the individual residents.

Residents meetings will be attended by the DON who will respond to feedback in person and will action and follow up with residents during the following meeting.

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	31/10/2022
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	31/07/2022
Regulation 18(1)(b)	The person in charge shall ensure that each resident is offered choice at mealtimes.	Substantially Compliant	Yellow	31/10/2022
Regulation	The person in	Substantially	Yellow	30/10/2022

18(1)(c)(iii)	charge shall ensure that each resident is provided with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional assessment in accordance with the individual care plan of the resident concerned.	Compliant		
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	31/10/2022
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	31/10/2022
Regulation 27	The registered provider shall ensure that procedures, consistent with the	Substantially Compliant	Yellow	31/10/2022

	standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.			
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Orange	30/11/2022
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	30/08/2022
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	28/02/2023
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	Substantially Compliant	Yellow	31/08/2022

	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.	Not Compliant	Orange	30/09/2022
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.	Substantially Compliant	Yellow	30/10/2022
Regulation 28(3)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place in the designated centre.	Substantially Compliant	Yellow	15/11/2022
Regulation 29(4)	The person in charge shall ensure that all	Not Compliant	Orange	29/09/2022

	medicinal products dispensed or supplied to a resident are stored securely at the centre.			
Regulation 29(5)	The person in charge shall ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.	Not Compliant	Orange	29/09/2022
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 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	Not Compliant	Orange	29/07/2022

	product concerned can no longer be used as a medicinal product.			
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Substantially Compliant	Yellow	30/10/2022
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.	Substantially Compliant	Yellow	30/10/2022
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Substantially Compliant	Yellow	30/10/2022
Regulation 5(4)	The person in charge shall formally review, at	Not Compliant	Orange	30/11/2022

	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.			
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.	Not Compliant	Orange	30/11/2022
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Substantially Compliant	Yellow	29/09/2022
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably	Not Compliant	Orange	15/12/2022

	practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned.			