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:	Nephin Nursing Home
Name of provider:	Willoway Nursing Home Limited
Address of centre:	132 - 134 Navan Road, Cabra, Dublin 7
Type of inspection:	Unannounced
Date of inspection:	27 February 2024
Centre ID:	OSV-0005880
Fieldwork ID:	MON-0042893

About the designated centre

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

Nephin House is a purpose built facility and has a combination of single and shared accommodation over three floors. The centre can accommodate 62 residents, both male and female over the age of 18 years. There is an enclosed garden area located to the rear of the building which is accessible from the large dining room. Nephin House is situated on the busy Navan Road, and a variety of bus routes stop close by. Prior to admission to Nephin House, the resident is fully assessed by the director of nursing. A range of activities are provided which encourage residents to keep mobile and take an interest in life. Outings to the nearby community parks can be arranged. Full time nursing care is provided, for residents with needs that range from mild dependency to full dependency.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	58

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
Tuesday 27 February 2024	08:35hrs to 17:25hrs	Niamh Moore	Lead

What residents told us and what inspectors observed

During this inspection, there was a calm environment within Nephin Nursing Home. The inspector observed that residents appeared relaxed and those spoken with were content with the care they received within the centre. Resident and staff interactions were seen to be friendly and respectful, and staff were seen to allow residents to go at their own pace. The general feedback from residents was that staff were kind and caring, with comments including "staff are caring and approachable".

When the inspector arrived at the centre, they were met by the receptionist who conducted a signing-in process. Following an introductory meeting with the person in charge, the inspector was accompanied on a walk around the centre. Many residents were dressed and spending time in communal areas during this time, with breakfast being served. It was evident from the walk around that the person in charge was well known to all residents as friendly interactions between both were observed.

The designated centre is located in Cabra, Dublin 7. The building comprises four storeys with residents' bedrooms set out across the ground, first and second floors, which are accessible by stairs and lift. The laundry, kitchen, staff changing facilities, staff break area, oratory, visitors room and hairdressers room are located within the basement floor. The centre provides accommodation for 62 residents in 54 single and four-twin bedrooms. Residents have access to en-suites or shared bathrooms.

A number of residents' bedrooms were viewed and were seen to have been personalised with flowers, plants, family photographs, ornaments and decorative items, including decorative blankets and pillows. The inspector observed that the planned reconfiguration of the twin bedrooms had not been complete and as a result, some residents did not have the minimum of 7.4 m2 of floor space, which will be further discussed within this report.

Overall the premises was found to be clean and efforts to have a homely environment were evident. Residents said they were satisfied with the level of cleanliness of their rooms and the communal areas. There was access to an enclosed garden with a designated smoking area.

Activities on offer were displayed on noticeboards. The main day room on the ground floor was decorated in seasonal decoration such as balloons and banners to celebrate Valentine's Day. Residents reported to enjoy these decorations. Activities were on offer from Monday to Sunday facilitated by dedicated activity staff. These included colouring, with music playing on the day of the inspection. A resident told the inspector they were looking forward to a quiz being held that afternoon.

Residents could attend the individual dining rooms or have their meals in their bedroom if they preferred. On the day of the inspection, residents were provided with a choice of meals which consisted of pork or a beef stew dish, while dessert

options included ice cream. There was a cooked breakfast option, different choices for the tea-time meal and sandwiches available in the evening. The inspector also saw that where residents were not eating the option provided, they were offered alternative options as per the residents' preference. There was a relaxed and positive dining experience seen where residents were enjoying their meals, being assisted and supervised discreetly by staff. Residents were complimentary regarding the food choices and meals within the centre and feedback was sought within residents' meetings. The inspector viewed a quality improvement plan which was in place to review menu choices for 2024.

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

Capacity and capability

This was an unannounced inspection to review compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People Regulations 2013). The registered provider has a well-organised management structure in this centre, ensuring good quality clinical care was being delivered to the residents. While, the inspector found there were systems in place to monitor the service through a variety of management systems, these systems were not effective for all areas of care.

Nephin Nursing Home Limited is the registered provider for Nephin Nursing Home. There were clear roles and responsibilities outlined with oversight provided by the Chief Executive Officer and a Chief Operations Officer. The person in charge reported directly into the Chief Operations Officer. The person in charge was a registered nurse who was full-time in post and had the necessary experience and qualifications as required by the regulations. They engaged positively with the inspector during this inspection.

The registered provider had prepared a statement of purpose which contained all of the information set out in Schedule 1.

The person in charge was supported in their role by an administration team and an assistant director of nursing. There was a vacancy for a Senior Household Coordinator and this role was being covered by the person in charge and assistant director of nursing. Other staff included nurses, healthcare assistants, housekeeping, catering, and maintenance and administration staff.

Staff were supported to attend mandatory training such as manual handling, safeguarding vulnerable adults from abuse and infection control. New staff were awaiting training on fire safety which was planned for the coming weeks following the inspection. Supplementary training was also offered to staff in areas such as the

management of actual or potential aggression, and for staff nurses' additional training was available on cardiopulmonary resuscitation and medication management.

The person in charge and assistant director of nursing worked in the centre Monday to Friday, with a a senior nurse who worked Saturday and Sunday to ensure effective supervision. In addition, there was an on-call roster in place for management support at night. The inspector reviewed evidence of supervision records such as the completion of probation forms for two recent recruits. An induction form was in progress for a staff member who commenced work in January 2024. The person in charge told the inspector that they had identified a gap in their current induction and on-boarding of staff and plans were in progress to address this through an induction programme which would allow new recruits a full week of induction and training prior to commencing post in the designated centre.

An annual review of the quality and safety of care delivered to residents had been completed for 2023. A quality improvement plan for 2024 was developed to include improvements required following feedback from residents and their families.

There was evidence of management systems in place such as management meetings and audits. The person in charge reported to their senior manager during monthly Senior Management Team (SMT) meetings. This forum was used to discuss and report on areas such as occupancy, staffing, training, activities, policies and health and safety. Meeting minutes provided evidence that there was management oversight occurring within the centre with most actions identified having a person responsible and timeframe identified. Clinical data was gathered monthly through key performance indicators including occupancy, clinical care such as skin integrity, falls, restraints and incidents. However, the inspector found that notwithstanding the good governance and management arrangements in place to oversee the service, some improvements to the management systems in place were required to ensure that the service provided was appropriate, consistent and effectively monitored. For example, not all actions discussed at meetings for service improvements were given a person responsible or a timeframe to complete the action by. This is further discussed under Regulation 23: Governance and Management.

Regulation 15: Staffing

The staffing levels and skill-mix were sufficient to meet the assessed needs of the 58 residents on the day of inspection. Recruitment was ongoing for posts such as five health care assistants which were being covered on a short-term basis through the registered provider's staff team.

Judgment: Compliant

Regulation 16: Training and staff development

Overall mandatory training provided to staff was up to date and there was a training plan in place for further refresher training to ensure that staff maintained the necessary skills and knowledge for their roles. Records showed that staff were appropriately supervised in their work.

Judgment: Compliant

Regulation 23: Governance and management

There was insufficient resources to ensure the effective delivery of care in accordance with the statement of purpose, the Senior Household Coordinator post remained vacant since December 2023. While recruitment was ongoing, the duties of this post were being covered by the person in charge and assistant director of nursing which reduced their time for clinical oversight. Gaps were seen in residents' care planning and documentation.

Evidence of where further management oversight was required included:

- There was no recorded clinical oversight within the SMT minutes. Therefore there was no evidence that trending and service improvements were identified.
- Further action was required to ensure all actions identified in compliance plans from inspection of October 2022 were progressed. Repeat findings remained in relation to some actions from the previous inspection. For example:
    - care plans were not accurate and therefore not guiding current care. This is further outlined under Regulation 5: Individualised Assessment and Care Plan.
    - the inspector viewed three out of four multi-occupancy rooms and found that these rooms did not afford all residents an area of not less than 7.4m2 of floor space as required under Schedule 6 of the regulations further discussed under Regulation 17: Premises. These bedrooms had not been reconfigured as set out in the registered provider's compliance plan with a time frame of 31 March 2023.
- Audits did not identify all areas seen by the inspector on the day of the inspection. For example, the environmental audit in December 2024 reviewed the sluice rooms but did not identify that the solution used for one bedpan washer was out of date.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The register provider had prepared in writing a statement of purpose relating to the designated centre and this document had been revised at intervals of not less than one year.

Judgment: Compliant

Regulation 4: Written policies and procedures

The inspector found three occasions where the policy on Nutrition and Hydration had not been followed:

- A resident whose weight had decreased should have had weekly weights commenced, records showed this resident was weighed monthly.
- A resident had not been re-referred to the dietitian following continued weight loss.
- Newly admitted residents did not have food diaries commenced on their admission.

Judgment: Substantially compliant

Quality and safety

Residents in Nephin Nursing Home appeared content living in the centre and overall had good access to healthcare services. Some improvements were required to ensure a safe and good quality service for residents, particularly in the areas of care planning, the premises, transfer documentation and infection control.

The inspector was told the registered provider was currently in the process of changing all care plans to a comprehensive care plan with additional care plans for specific needs. This was ongoing during the inspection and training was due to take place for management and staff. The inspector reviewed a selection of care plans on the day of inspection for four residents. Gaps were seen in almost all records. For example, a new resident did not have a pre-admission, assessments or care plans completed by the designated centre. In addition, the inspector found that where changes had occurred, the corresponding care plans had not been updated to guide staff on how to manage the resident's changing needs. While care was seen to be provided to a good level, this created a risk that temporary or new staff would not have the sufficient information necessary from care plans to provide accurate care

for residents. This is further discussed under Regulation 5: Individualised assessment and care plan.

Overall there were good standards of evidence-based healthcare provided within this centre, with a weekly visit from a general practitioner. Referrals were seen to be made to specialist health and social care professionals as required with timely access for residents. The inspector was told that eligible residents were facilitated to access the services of the national screening programme as required.

The layout of the premises promoted a good quality of life for residents. It was decorated tastefully with appropriate furniture and residents' art work on display in corridors. The centre was maintained with support provided by a maintenance team. However, some action was required to ensure all areas of the premises conformed with the matters under Schedule 6. This is noted under Regulation 17: Premises.

The inspector reviewed documentation when a resident returned from hospital, and could see that all reasonable steps to ensure that all relevant information about the resident was obtained from the hospital. In addition, recommendations were seen to have been followed. However there were gaps in relevant information regarding the temporary absence and discharge of residents. This is further discussed under Regulation 25: Temporary Absence or Discharge of Residents.

The centre was seen to be clean and residents reported to be happy with the cleanliness. Overall, there was good adherence to the standards for the prevention and control of healthcare-associated infections published by the Authority. However the inspector found that further oversight and action was required to be fully compliant with Regulation 27: Infection Control which is detailed further below.

Regulation 17: Premises

The registered provider had failed to make the changes required to multi-occupancy bedrooms. The inspector viewed three out of four double bedrooms within the designated centre and saw that for one resident of each bedroom, they had an area of less than 7.4m2 of floor space, which area shall include the space occupied by a bed, a chair and personal storage space. Measurements of these three spaces were recorded as approximately 5.6m2 of floor space. As previously stated within this report, this required action was a repeat finding as it was identified in previous inspection reports of October 2022 and remained an action on senior management meeting minutes.

Some further action was required to ensure the premises conformed to all of the matters set out in Schedule 6. For example:

- While there was a door bell in the designated smoking area, this was not connected to the call bell system. This presented a risk that if a staff member was not present in the dining room the bell would not be heard and therefore the requested response would not happen. The inspector pressed this door

bell on three occasions on the day of the inspection and staff responded on one of the three occasions.
- Wear and tear was observed to paintwork on doors, door frames and some corridor walls.
- Holes were visible in the wall in the sluice room on the second floor where wall-hanging items had been removed.
- Inappropriate storage was seen in a store room where 19 boxes were stored on the ground.

Judgment: Not compliant

Regulation 25: Temporary absence or discharge of residents

Improvement was required to ensure a record was kept of all relevant information provided about the resident who is temporarily absent from Nephin Nursing Home to the receiving designated centre, hospital or place. The inspector was told a record was not kept of transfer information as the electronic system can pull a generated transfer document. However the document shown to the inspector was not complete as there was information that required additional input such as clinical recommendations, risks and current medicines.

Judgment: Substantially compliant

Regulation 27: Infection control

There were issues fundamental to good infection prevention and control practices which required improvement. For example:

- The hydrotherapy bath in the basement was visibly unclean on the inside. While this bath was on a daily cleaning list and seen to have been ticked as complete, staff told the inspector that they cleaned the outside of the bath. These baths are potentially a high-risk source of fungi and bacteria, including Legionella if not effectively decontaminated after use. In addition, the inspector was told the bath was not in regular use. There was no record that these taps were being flushed weekly as per the registered provider's risk assessment. Flushing commenced on the day of the inspection.
- Urinals and commode lids hanging on drying racks in sluice rooms were visibly unclean. The location of these items on the drying racks indicated that these items were ready for use. This practice posed a risk of cross contamination.
- The solution being used for the bed pan washer in one sluice room had expired in 2022. This was replaced on the day of the inspection.

- Chairs in the visitors' room were visibly stained.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

The registered provider had failed to ensure care plans were reflective of the resident's current care needs. For example:

- A resident who was in the designated centre for a minimum of one month, did not have a comprehensive assessment completed immediately before or on the person's admission to the centre. In addition this resident did not have a care plan prepared within 48 hours of their admission. While records were in place, these records were from the resident's previous designated centre.
- A resident with weight loss did not have the most recent recommendations from the dietitian recorded within their care plan. This information included recommended dietary intake and therefore created a risk that the resident was not receiving the recommendations from the dietitian.
- A resident with a urinary catheter did have a specialised care plan in place. However, this resident did not have the relevant details regarding the management of the urinary catheter recorded. For example, it did not contain the date and time of the insertion of the catheter and the planned date and time for removal. As a result there was a risk this change could be missed.
- A resident who was approaching the end of his or her life, did not have an end-of-life care plan in place.
- A mobility care plan had not been updated following changes to a resident's mobility status following review from the physiotherapist. This review was prompted following a fall and their balance being re-assessed.

Judgment: Not compliant

Regulation 6: Health care

Residents had good access to medical and healthcare which was evident from reviewing residents' records. A general practitioner visited the centre once a week and was also contactable by phone and email outside of visits. There was good access to specialist health professionals such as geratricians, psychiatry of older age, speech and language therapy and physiotherapy. In addition residents had access to mobile x-ray services. The inspector was told that residents also had access to local community services such as chiropody, opticians and dentistry.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 25: Temporary absence or discharge of residents	Substantially compliant
Regulation 27: Infection control	Substantially compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant

Compliance Plan for Nephin Nursing Home OSV-0005880

Inspection ID: MON-0042893

Date of inspection: 27/02/2024

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 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

1. A review of the current governance arrangements and structures to ensure effective Clinical Governance, Oversight and Support to the Management Team was completed. The Centre is now in the final stages of appointing a CNM with the candidate expected to commence post by May 2024.

2. The Centre is currently recruiting for the role of Senior Household Coordinator. The recruitment process aims to ensure that the appropriate individual with the required experience is appointed to the role. All roles and responsibilities of the successful candidate are clearly defined within the developed job description. Support with regard to the Household Service will be supported by the CNM on commencement of employment to ensure the effective clinical oversight by the PIC and ADON.

3. A review of the Senior Management Team (SMT), Terms of Reference was completed. The Terms of Reference specifically detail the purpose, aims and objectives, role and membership of the Team. Membership of the team includes a Department Representative.

4. The (SMT) meeting agenda outlines specific elements for discussion with regard to clinical oversight and quality and safety monitoring. Examples include (but are not limited to):

a. Key Performance Indicators
b. Incidents
c. Complaints
d. Audits (Internal / External) and corresponding Quality Improvement Plans
e. Infection and
f. Risk Management.

5. Minutes which specify SMART actions shall be developed following each meeting.

Actions will be appropriately allocated to key team members for review, close out and ongoing monitoring. These actions shall be reviewed at each subsequent meeting.

6. Audit findings will be discussed at the SMT. A timeline for actions and lessons learned to be disseminated to the entire team via staff meetings/ handover, notice boards and informal education will be identified with an individual identified to complete the actions.

7. Clinical KPI's will be discussed at the SMT reviewing the trends and analysis. For falls/ Pressure ulcers and medication errors.
Furthermore, an additional Clinical Governance committee has being established at Group Level to provide further oversight and governance of clinical areas such as incidents, complaints, KPI information and audit results. This will ensure the delivery of high-quality care within the centre. This commenced on the 9th of April with ongoing participation by the management team within the centre.

8. Resident assessment and care plan training was provided to all members of the nursing team.

9. All current residents and newly admitted residents are allocated a key nurse to ensure accurate and timely completion of all assessments and care plans in line with regulation.

10. An internal care plan audit scheduled was completed. These audits will be completed by ADON and CNM and group quality function. A Quality Improvement Plan which identifies SMART actions shall be developed following each audit completed. Additional audit support and validation is scheduled by the Group Quality Team.
11. Audit actions will be appropriately allocated to key team members for review, Close out and ongoing monitoring.
12. Audit training and education shall be provided to all internal auditors to ensure audits compelted identfy areas of non confirmnace and required improvmenet.
13. The Management Team are committed to ensuring an appropriate environment for all residents. A detailed plan and timeframes has been developed to review the layout of all double rooms. All double rooms to ensure they are configured to afford all residents 7.4m2 of space. This will be completed by July 31st 2024.

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
- A full review has been undertaken of the nutrition and hydration policy to ensure compliance in practice. An audit will be completed on all weights to ensure that they are completed in line with the resident's needs. The findings of all audits are shared with staff to support understanding and compliance. This was commenced in March 2024 with ongoing review.

- All residents who require referral to the dietician have been referred. The oversight of the referral process is with the Director of Nursing and the ADON who will review all required referrals on a weekly basis to ensure that no resident is not referred to appropriate healthcare professionals as required. Completed by February 28th with ongoing review.
- All newly admitted residents will have a food diary commenced on their admission in line with the policy. This will be audited on a regular basis by the management team to ensure adherence to the policy. The need for this will also be communicated at the staff meeting to support their understanding. This will be completed by April 31st 2024.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
- Multi Occupancy rooms,- a plan is in place to review the layout of these double rooms to ensure they are configured to afford all residents 7.4m2 of space. This will be completed by July 31st 2024.
- Call bell in smoking area was installed on March 8th 2024.
- There are ongoing schedule of maintenance works underway in the centre. This is delivered by the maintenance team on site and will be actioned in line with priority actions in the home.
- Holes in the sluice room on the second floor were filled in by Maintenance team on the 25th of March 2024.
- Storage within the centre will be reviewed by April 31st 2024 and ongoing management of any inappropriate items stored incorrectly will continue in the centre. There will be ongoing oversight and supervision of practices within the centre by the management team on a daily basis to ensure adherence.

Regulation 25: Temporary absence or discharge of residents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 25: Temporary absence or discharge of residents:
A review has been undertaken of the reporting available from the electronic system to ensure that all required information is included. This was completed by March 31st 2024. Additional training has been provided to all staff to support their understanding of the correct completion of documentation relating to temporary absence or discharge, and this will be included as part of ongoing audit processes in the centre which are overseen by the Senior Management Team. This will be completed by April 31st 2024.

Regulation 27: Infection control	Substantially Compliant

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

- Additional education has been provided to hygiene staff to ensure they understand how to clean the bath appropriately. Sign in sheets to evidence education provided have been completed by all relevant staff. The policy for the prevention of legionella has been reviewed in the centre to ensure clear understanding by all staff of the responsibility for the flushing of taps on a weekly basis. Clear documentation has been introduced to document this process, with additional oversight by the management team on a weekly basis. This was completed by March 31st with ongoing review.
- Further education has been provided to all staff regarding the correct cleaning and storage of equipment within the sluice rooms. This will be monitored on a daily basis through visual inspection and quality walkabouts, as well as formal environmental infection control audits conducted by the management team. Completed by March 31st 2024 with ongoing review.
- Additional checks have been introduced on the bed pan washers to ensure that all products in use in the machines are in date, and that this is monitored on an ongoing basis by the management team to prevent a reoccurrence. This was completed by March 31st with ongoing review.
- Additional schedules have been introduced to ensure that equipment such as chairs are being cleaned on a regular basis and there is a record of same, which is overseen by the management team on a weekly basis. This was completed by March 31st 2024 with ongoing review. In addition, a replacement programme for furnishings is underway in the centre on an ongoing basis. This will continue through 2024.

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:

- Care plans- there has been a full review of the processes around care planning and assessment in the centre. All residents have been allocated key nurses to ensure accurate and timely completion of all assessments and care plans in line with regulation. Additional education has been provided to all staff nurses to ensure their understanding and additional audits will be conducted by the management team to identify issues in a timely manner, and share all feedback with staff to assure high quality care and documentation. This was commenced in February 2024 following the inspection, with ongoing review.

- Additional oversight is the introduction of a metric on the Clinical Governance KPIs for the home to report on the number of assessments and care plans completed within the 48-hour period of time from admission. The oversight of this process and reporting of any issues to staff will ensure ongoing oversight and communication with all staff to ensure adherence.
- Increased audits will be conducted on all care plans to ensure that they are in line with the resident needs and preferences. These will be completed by the Management team in the centre, with all findings shared with staff to support learning and promote high quality documentation in line with the care delivered in the centre. This will be completed by April 31st with ongoing review.

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 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	31/07/2024
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.	Substantially Compliant	Yellow	01/05/2024
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate,	Substantially Compliant	Yellow	01/05/2024

	consistent and effectively monitored.			
Regulation 25(1)	When a resident is temporarily absent from a designated centre for treatment at another designated centre, hospital or elsewhere, the person in charge of the designated centre from which the resident is temporarily absent shall ensure that all relevant information about the resident is provided to the receiving designated centre, hospital or place.	Substantially Compliant	Yellow	25/04/2024
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.	Substantially Compliant	Yellow	31/03/2024
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.	Substantially Compliant	Yellow	30/04/2024
Regulation 5(4)	The person in charge shall	Not Compliant	Orange	30/04/2024

	formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.			