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:	Aras Mhathair Phoil
Name of provider:	Health Service Executive
Address of centre:	Knockroe, Castlerea, Roscommon
Type of inspection:	Unannounced
Date of inspection:	09 May 2024
Centre ID:	OSV-0000652
Fieldwork ID:	MON-0043006

About the designated centre

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

The designated centre provides 24-hour nursing care to 24 male and female residents over 18 years of age, who require long-term and short-term care including dementia care, convalescence, palliative care and psychiatry of old age. The centre premises is a single story building. Accommodation consists of 12 single and six twin bedrooms. Communal facilities included a dining room, a sitting room, a sunroom, an oratory, a visitors room and a safe internal courtyard. There are two assisted bathrooms each with a bath with chair hoist, wash hand basin and toilet facilities, one assisted shower room with easy accessible shower, wash hand basin and toilet facilities. An accessible toilet is located close to the sitting rooms and the dining room. The provider states that the centre's philosophy of care is to embrace ageing and place the older person at the centre of all decisions in relation to the provision of the residential service.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	20

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
Thursday 9 May 2024	09:45hrs to 17:15hrs	Catherine Rose Connolly Gargan	Lead
Thursday 9 May 2024	09:45hrs to 17:15hrs	Gordon Ellis	Support

What residents told us and what inspectors observed

Overall, residents were comfortable in the centre and their feedback to the inspectors regarding the service they received and their quality of life in Aras Mhathair Phoil was positive. Residents told the inspectors they were happy living in the centre and that staff were kind, caring and attentive to their needs.

Some of the comments from residents included 'I am happy here', 'staff are very good to me' and 'what I like most is that Aras Mhathair Phoil is small and we all know each other'. One resident told the inspectors that they chose to come to live in the centre themselves and they were very happy with their choice. Other residents spoken with confirmed that they were satisfied with the layout of their lived environment, the facilities provided and the standards of environmental maintenance and hygiene.

There was a warm, unhurried and happy atmosphere in the centre and this was reflected in the residents' relaxed and content dispositions. Staff were observed to be attentive to residents' needs and were very respectful, kind and patient in their interactions with individual residents. Staff knew residents well and were observed to engage residents in conversations about what was planned for the day, their individual interests, past lives and their families. Inspectors observed that staff greeted residents by name and residents were seen to enjoy being in the company of staff. Residents told the inspector that there was never any delays with staff answering their call bells and they felt that staff were not rushed and had enough time to spend with them.

This was an unannounced inspection and on arrival to the centre, the inspectors met with the person in charge. Following a short introductory meeting, the person in charge accompanied the inspectors on a walk around the centre. This gave the inspectors opportunity to meet with residents and staff and to observe practices and residents' experiences of living in the centre. The provider had recently applied to the Chief Inspector for registration of the basement area of of the designated centre. The inspectors included this area as part of their walk around the premises with the person in charge. The inspectors observed that the basement contained a room with a central heating oil tank in it, a boiler room and two storage rooms.

Aras Mhathair Phoil designated centre is located in a quiet residential area and the premises is designed in a quadrangle with all residents' accommodation located on the ground floor level. The centre's interior and exterior was well maintained. The premises surrounded an outdoor garden area which was easy for residents to access as they wished. This outdoor garden had outdoor seating and paths covered with a rubberised surface to promote residents' safety. A variety of shrubs were growing in beds and in planters around a central water feature. One side of two of the circulating corridors had views of the enclosed garden and of the front of the centre which provided points of interest for residents who liked to walk along the corridors.

Residents' bedroom accommodation was provided in 12 single and six twin bedrooms. Residents told the inspector that there bedrooms were comfortable and met their needs. The inspectors observed that many of the residents had personalised their bedrooms with family photographs, small items of furnishings and their own artwork. Each bedroom was fitted with a ceiling hoist unit and contained appropriate furniture and fixtures to meet residents' needs. Each of the bedrooms had sufficient storage space for residents' clothing and personal possessions. Residents communal accommodation was observed to be spacious and decorated with traditional memorabilia that was familiar to the residents.

On the day of this inspection, most of the residents spend their day in the sitting room or in the dining room during mealtimes. Residents social activities were facilitated in the sitting room by a member of staff who was replacing planned leave by the activity coordinator. Residents told the inspectors that they enjoyed participating in a variety of social activities that were scheduled each day. This concurred with the inspectors' observations of the residents laughing and interacting with each other during the group activities. However, this was in contrast to the inspectors observations of a small number of residents with cognitive impairment who spent most of their day in bed in their bedrooms. While, staff were observed to visit these residents, this was mainly to carry out tasks of care for them and although televisions were on in their bedrooms, these residents were not actively watching the programmes televised.

Residents told the inspectors that their general practitioner (GP) visited them without delay whenever they needed medical care. A number of residents expressed high levels of satisfaction that a physiotherapist was available to them on two days each week. One resident attributed the support they received from the physiotherapist to their improving mobility.

Residents told the inspectors that they felt very safe and secure in the centre and that they would speak to a staff member or their relatives if they had any concerns or were dissatisfied with any aspect of the service they received. Residents spoke about the residents' meetings they attended and welcomed this forum to contribute to the running of the centre.

The next two sections of the report describe the provider's levels of compliance with the Health Act 2007 and the Care and Welfare Regulations 2013. The findings in relation to compliance with the regulations are set out under each section.

Capacity and capability

This announced inspection was completed to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). The inspectors also followed up on the actions the provider had committed to take in their compliance plan following the previous inspection in August 2023 and on the statutory notifications and other information

received since the last inspection. The provider had applied to the Chief Inspector for renewal of the registration of Aras Mhathair Phoil designated centre and registration of the basement in the premises and this application was reviewed as part of this inspection.

Due to the known fire safety non compliance and risks to residents identified on a previous inspection in December 2021, the Chief Inspector had attached a restrictive condition to the designated centre's registration reducing the centre's occupancy to 24 residents and restricting fire compartments to six residents in each. Notwithstanding the works that had been completed by the provider to improve fire safety, this inspection found significant non compliance under regulation 28 due to the provider's failure to ensure that adequate measures were in place to protect residents from risk of fire. The provider had commissioned completion of a fire safety risk assessment on 6th March 2024 but this information was not available to staff and managers working in the centre or made available to the inspectors when requested. Furthermore on the day of the inspection the inspectors issued an urgent action plan to the provider to remove combustible materials from the boiler room in the basement. In the days following the inspection, the provider confirmed that this action was completed. The findings in relation to fire precautions are discussed under Regulation 28: Fire precautions.

The registered provider of Aras Mhathair Phoil is the Health Service Executive (HSE), and a general manager was assigned to represent the provider. As a national provider involved in operating residential services for older people, Aras Mhathair Phoil benefits from access to and support from centralised departments such as human resources, information technology, fire and estates, staff training and finance.

The provider failed to ensure that the management structure in place in the designated centre was in line with the management structure as set out in the provider's statement of purpose. The clinical nurse manager (CNM) post had been vacant since September 2023. This meant that there was no support for the person in charge and no clinical manager to deputise for them in their absence. This inspection found that the provider's failure to appoint a suitable clinical nurse manager was negatively impacting on the governance in the centre. For example, auditing of key areas of the quality and safety of the clinical and non clinical service provided was limited and a number of audits had not been completed in line with the provider's 2024 audit schedule. Therefore, the quality assurance systems in place could not be relied on to inform continuous improvement and to give assurances regarding the quality and safety of the service to residents.

There were enough staff on duty on the day of the inspection to meet the needs of residents and to support residents to spend their day as they wished. However, adequate staffing resources were not made available to fully replace unplanned leave by the activity coordinator and as a consequence did not ensure that residents who remained in their bedrooms had equal access to social activities.

The person in charge had a system in place to monitor staff training and all staff were facilitated to complete mandatory training and a programme of professional

development training to ensure that they had the necessary skills and competencies to meet the needs of residents. The inspectors' observations of staff practices and discussions with staff gave assurances that they were familiar with residents' needs.

Records were held securely and most records that should be held in the centre were made available to the inspector for the purpose of this inspection.

Arrangements for recording accidents and incidents involving residents in the centre were in place and were notifications as required by the regulations were notified to the Health Information and Quality Authority within the specified timeframes.

Regulation 14: Persons in charge

The person in charge was appointed in October 2022 and their qualifications and experience met the requirements of the regulations.

Judgment: Compliant

Regulation 15: Staffing

Although, an additional member of staff was rostered to facilitate residents' social activities during planned leave by the activity coordinator, this additional staff member was rostered for only three days. As a consequence, assurances were not available that residents could participate in social activities that interested them in line with their capacities. This was especially evident for a small number of residents who remained in their bedrooms.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Staff were not appropriately supervised according to their roles and as a result, the inspector found that not all residents' care documentation was completed to a standard that adequately directed their care needs.

Judgment: Substantially compliant

Regulation 19: Directory of residents

A directory of residents in the centre was maintained and included all information pertaining to each resident as specified by the regulations.

Judgment: Compliant

Regulation 21: Records

Records as required by schedule 4 of the regulations were not maintained in the designated centre as follows;

- annual certification for the fire alarm system was not available in the centre for inspection

This information was requested by and forwarded to the inspectors in the days following this inspection.

Judgment: Substantially compliant

Regulation 23: Governance and management

The registered provider had failed to ensure that resources in the centre were planned and managed to ensure person-centred, effective and safe services.

- Planned leave by the activity coordinator was not adequately replaced and was impacting on residents' access to social activities in line with their interests and capacities.

The management structure in place was not clearly defined with clear lines of accountability and responsibility, in line with the centre's statement of purpose. The provider had failed to ensure the service had sufficient staffing resources to;

- ensure the management structure was maintained in line with the centre's statement of purpose. This impacted on effective governance and oversight of the service. For example, the clinical nurse manager position was vacant since September 2023. As a result, suitable deputising arrangements were not available in the event of an absence by the person in charge.
- Furthermore, the absence of a clinical nurse manager was negatively impacting on effective support and supervision of the nursing and health care staff teams.

Management systems were not in place to ensure that the service provided was safe, appropriate, consistent and effectively monitored. Therefore, the quality assurance systems in place could not be relied on to inform continuous improvement

and to give assurances regarding the quality and safety of the service to residents.

- Auditing of key areas of the quality and safety of the clinical and non clinical service provided was limited and a number of audits had not been completed in line with the provider's 2024 audit schedule.
- Action plans were not consistently developed to address the deficits that were identified on audits that had been completed and evidence of completion of the action plans developed was limited. The oversight and management of fire safety was not effective. Consequently, there were poor systems in place to identify, manage and respond to risk. The oversight and management of infection prevention and control required improvement. These findings are set out under Regulation 27.

Judgment: Not compliant

Regulation 31: Notification of incidents

A record of accidents and incidents involving residents in the centre was maintained. Notifiable events and quarterly reports were submitted to the Health Information and Quality Authority within the specified timeframes as required by the regulations.

Judgment: Compliant

Quality and safety

Overall, this inspection found residents' were provided with good standards of nursing and healthcare. Although, residents' rights were mostly respected by staff, actions were found to be necessary to ensure all residents had access to social activities and were facilitated to enjoy fulfilling and meaningful lives in the centre.

The provider had completed extensive fire safety upgrade works in the designated centre in regards to; fire stopping throughout the attic spaces, upgrading of the fire detection alarm system, the emergency lighting system and fire doors. However the final certification to provide assurance that these works had been completed to the required standards had not been made available to the chief inspector when requested.

In addition to this, the providers own updated fire safety risk assessment dated May 2024 had identified a number of high and medium rated fire risks. These were in regards to deficiencies in fire compartmentation to high risk areas, compartmentation to support progressive horizontal evacuation, means of escape, gas detection, ventilation duct work, fire doors and non-fire rated glazing.

Furthermore, historical fire safety risks identified in the providers own fire safety risk dated 2015 and fire safety risks identified on a previous inspection carried out in December 2021 were again identified in the May 2024 fire safety risk assessment report and during the course of this current inspection. These and other fire safety concerns are detailed further under Regulation 28: Fire Precautions.

The oversight of fire safety and the processes to identify, and manage fire safety risks were ineffective to ensure the safety of residents living in the centre. This was evident from a number of fire doors that had been found to be wedged open and an immediate action was issued by the inspectors in regards to inappropriate storage of flammable items in a boiler room which necessitated urgent removal of these items. This fire risk had not been identified on the routine fire safety checks completed in the basement.

Service records were available for the most of the fire safety and building services and these were all up to date. However, annual service and maintenance records were not available on the day of the inspection to ensure the fire detection alarm system was being regularly serviced by a competent technician. This was subsequently received from the provider.

There was a fire safety management plan and emergency fire action plan in place. These were found to be comprehensive. Fire audits were being carried out by the person in charge to aid in improving fire safety management.

Staff were familiar and confident on evacuation procedures and all staff were up-to-date with fire training. The residents' personal emergency evacuation plans (peeps) were found to be clear and detailed.

In summary, this inspection had found that progress had been made by the provider to address some of the fire risks in the centre since the previous inspection. Notwithstanding this, more progress was required. The number of repeated and additional fire safety risks combined with an immediate action that were identified on this current inspection raised significant concerns about fire safety management in this centre. As a result, the inspectors were not assured that there were adequate measures in place to ensure that residents living in the designated centre are safe and protected from the risk of fire.

The provider had measures in place to protect residents from risk of infection. However, further actions were necessary to ensure effective cleaning and hand hygiene in the basement and used laundry collection practices to mitigate risk of infection transmission.

Residents' living environment was maintained to a good standard. Communal spaces were comfortable and residents were provided with a variety of spacious communal areas, including dining and sitting room facilities. The centre was decorated in a traditional style that was familiar to residents and residents were encouraged and supported to personalise their bedrooms in line with their individual preferences. Residents were accommodated in single and twin bedrooms. The floor space in the single bedrooms measured from 7.6 to 8.0 square meters and met the minimum requirements of the regulations. The provider had installed overhead ceiling hoists in

all bedrooms so that residents who required hoist transfers did not need to use mobile hoists as some of the single bedrooms did not have sufficient space to use a mobile hoist safely. The layout of these bedrooms met the needs of the current residents. However, the space in some rooms did not provide sufficient floor space for residents to use mobility equipment with ease to mobilise safely around these bedrooms. The inspectors observed that a number of rooms were in use for storage of residents' assistive equipment but were not identified for this purpose on the centre's statement of purpose and the conditions of the designated centre's registration.

Residents' nursing care and support needs were met to a high standard by staff and residents were facilitated with timely access to their GP and health care professionals. However, a number of the residents' care plan documentation did not clearly direct the care and supports staff must provide for each resident to meet their needs.

Residents could access the outdoor courtyard as they wished. A varied social activity programme was facilitated to residents' needs but assurances were not available regarding residents participation in this programme or that residents who remained in their bedrooms had equal access to social activities that interested them and were in line with their individual capacities..

Staff had been facilitated to attend training to ensure that they had up-to-date knowledge and skill with managing residents predisposed to experiencing episodes of responsive behaviours (How residents who are living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). Staff maintained an effective and supportive approach to managing residents' responsive behaviours and this had a positive impact on residents' wellbeing and quality of life. There was a low use of restraint in the centre and the national restraint policy guidelines were implemented. Alternatives to restrictive equipment were assessed and procedures were in place to ensure they and any other arrangements did not pose prolonged or unnecessary restrictions on residents.

Residents were supported to practice their religion and clergy from the different faiths were available as residents wished. Residents were supported to speak freely and provide feedback on the service they received.

Residents who had difficulty communicating were well supported. Issues brought to the attention of staff were addressed. Residents had access to televisions, telephones and newspapers and were able to avail of advocacy services.

Measures were in place to safeguard residents from abuse and residents confirmed that they felt safe and secure in the centre. Staff had completed up-to-date training in prevention, detection and response to abuse. Staff who spoke with the inspectors were knowledgeable regarding the reporting arrangements in the centre and clearly articulated their responsibility to report any concerns they may have regarding residents' safety.

Regulation 10: Communication difficulties

Residents with communication difficulties were supported to communicate freely and staff were aware of their needs. The inspectors found that each resident's communication needs were regularly assessed and a person-centred care plan was developed for a small number of residents who needed support from staff and specialist assistive equipment to support their communication needs.

Judgment: Compliant

Regulation 11: Visits

Residents' families and friends were facilitated to visit and practical precautions were in place to manage any associated risks. Residents access to their visitors was not restricted and suitable facilities were available to ensure residents could meet their visitors in private outside of their bedrooms if they wished.

Judgment: Compliant

Regulation 12: Personal possessions

Residents had access to and were supported to maintain control of their own personal clothing and possessions. Each resident had enough space to store their clothes and personal possessions in their bedrooms. Residents' bedside lockers were placed by their beds which supported them to easily access their personal belongings in their lockers when they were in bed or resting in their chairs by their bedside.

Judgment: Compliant

Regulation 13: End of life

Staff provided end of life care to residents with the support of the residents' general practitioner.The centre had established good links with the community palliative care team and this service was available to support residents as needed. An up-to-date policy was available to inform staff on the centre's procedures to ensure residents' end -of-life needs were met.

The inspectors reviewed a sample of residents' care plans and their end-of-life physical, psychological and spiritual care and their wishes and preferences regarding their preferences regarding where they wished to receive end-of-life care were established and kept updated. This gave residents opportunity to be involved in and to make decisions regarding their end-of-life care while they were well. A pain assessment and monitoring tool was in use by staff to ensure any pain experienced by residents was appropriately managed. Pain medications were administered as required and monitored to ensure effectiveness.

Single rooms were available for end of life care and relatives were supported to be with residents during this time. Overnight facilities and refreshments were available to residents' family members and friends during this time.

Judgment: Compliant

Regulation 17: Premises

There was not adequate storage facilities provided in the designated centre for storage of residents' wheelchairs, hoists and other assistive equipment within the designated centre. The inspectors observed that residents' assistive equipment was stored in two rooms that were not identified as store rooms in the centre's statement of purpose or conditions of registration.

Judgment: Substantially compliant

Regulation 27: Infection control

The centre's environment in the basement floor and residents' laundry was not being managed in a way that minimised the risk of transmitting a health care-associated infection. This was evidenced by the following findings;

- The floor surfaces in the store rooms used for storage of residents' supplies in the basement were of a porous material and did not facilitate effective cleaning. Dust and grit were visible on the floor surfaces. These rooms were not included in the centre cleaning schedule and therefore assurances were not available that procedures were in place to ensure these areas were appropriately cleaned.
- Residents' used bed linen and towels was stored in a trolley outside the centre awaiting collection on one day each week. The inspectors observed that the trolley was open and there was a malodour coming from the contents. Furthermore, this trolley was stored outdoors and was not adequately protected from access by fleas and other vermin.
- A sink for hand washing was not provided in the basement of the designated

centre. This finding did not support effective hand hygiene practices.

Judgment: Not compliant

Regulation 28: Fire precautions

The registered provider was failing to meet the regulatory requirements on fire precautions in the centre and had not ensured that residents were protected from the risk of fire. The provider was non-compliant with the regulations in the following areas:

Day-to-day arrangements in place in the centre did not provide adequate precautions against the risk of fire. In a basement fuel store room, the inspectors found a steel oil tank of considerable capacity and age. The tank is located directly below a resident's bedroom, adjacent to a boiler room, and a room used to store oxygen. Limited access into the oil tank room was only possible via a ventilated window. The inspectors observed an open bucket with what appeared to be oil and another plastic oil container. In two areas, pipe work appeared to penetrate the concrete ceiling of this room and required sealing.

The inspectors were not assured regular servicing and inspections of the large oil tank, pipework, base and surround area were being carried out due to the limited access provided and lack of inspection documentation from a competent person available on the day. Evidence was not available that the provider had identified and taken action to ensure that an oil tank in a room located in the basement did not pose a risk to residents' safety. The registered provider was required to conduct a risk assessment and provide mitigation measures to ensure that the presence of this tank did not pose a risk to residents living in the designated centre.

- An Immediate action was issued to the provider in regards to inappropriate storage of flammable items found in a boiler room next to a generator. The person in charge had arranged for these to be removed.
- A number of oxygen cylinders were found to not be securely stored in an external oxygen storage room. This created a risk of cylinders from falling over.
- A number of fire doors were found to be wedged open. This interfered with the closing mechanism and created a path for smoke and fire to spread uninhibited.
- A deep fat fryer was in use in the kitchen, however there was no fire suppression system in place and the inspectors was not assured the shutter in place between the kitchen and dining room was a fire rated shutter linked to the fire detection alarm system. This created a fire risk.

The registered provider did not make adequate arrangements for detecting and containing fires. For example:

Assurances was required if a shutter between a kitchen hatch and a dining room was a fire rated shutter and linked to the fire detection alarm system. This was a repeated finding from the providers own fire safety risk assessment dated 2015 and subsequently again in an updated version dated 2024.

Areas of Georgian wire glazing were found at a nurse's station, some 60 minute fire rated doors and a clinical room. Assurances are required that the glazing achieves both integrity and insulation rated glass as required. This was a repeated finding from the providers own fire safety risk assessment dated 2015 and subsequently again in an updated version dated 2024.

Gap were observed between fire door frames and structural openings which were not properly fire stopped or sealed. This was evident at a sluice room and equipment room. Fire doors to some bedroom areas had gaps between the floor and the bottom of the fire door over the permissible tolerance. Doors appeared to not meet the fire door criteria along an office corridor and a hatch between a reception and main entrance constituted a lack of compartmentation.

Recessed lighting was found to penetrate the ceiling in some areas and compromised the fire integrity. This was evident in the lobby area.

The provider needed to improve the means of escape including emergency lighting. For example:

There was a lack of emergency lighting to some external areas of the centre to provide the required illumination to evacuate residents to the designated assembly points during a night time evacuation.

Some fire exits with magnetic locking mechanisms were not fitted with a manual over-ride. This could potentially delay instant egress if the magnetic lock failed to release.

The registered provider did not make adequate arrangements for maintaining the means of escape, building fabric and building services. For example:

A lobby corridor in a kitchen was in use as a storage area and resulted in this escape route from being obstructed and cluttered with a large trolley.

A tall wooden cabinet on an escape route was in use as a storage area. An electrical board was housed in the wooden cabinet. However, the cabinet was not encased in fire rated construction and could potential compromise the escape route.

Assurances were required to the fire rating of timber panelling found along some corridors. This was a repeated finding from a previous inspection in December 2021 and had been identified from the providers own fire safety risk assessment dated 2015 and subsequently again in an updated version dated 2024.

Some areas of the centre appeared to have service penetrations through the fire-rated walls and ceilings and required appropriate fire sealing measures. These were

noted in a boiler room, pharmacy store room and a fuel store rooms.

Up-to-date annual service and maintenance records were not available on the day of the inspection to ensure the fire detection alarm system was being regularly serviced by a competent technician. This was subsequently received from the provider.

The registered provider did not make adequate arrangements for reviewing fire precautions

While the provider has a service contract in place for maintaining fire doors, checks were noted to be overdue for some of the fire doors. Furthermore, gaps were identified in the fire register in regards to emergency lighting weekly checks. Due to the observed repeated deficiencies to fire doors in the centre, improvements were required to ensure the maintenance of fire doors were of adequate extent, frequency and detail.

Following extensive fire safety improvement works, the provider had not obtained confirmation by a competent fire person that all parts of the designated centre including the basement floor were in compliance with the fire safety works carried out to date. Furthermore, an updated fire safety risk assessment dated May 2024 had identified both repeated and additional fire safety risks. This was further compounded by the repeated fire safety risks identified in the providers own fire safety risk assessment dated in 2015 and an inspection carried out in December 2021.

The displayed procedures to be followed in the event of a fire required a review by the provider.

While the fire floor plans were on display and showed the location of the compartments used for progressive horizontal evacuation, the floor plans did not indicate an the external staircase used for vertical evacuation nor did it include the location of call points or fire extinguishers.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Although, the inspectors were assured that residents received their correct medicines, actions were necessary to address the following findings;

- The prescription instructions for a number of PRN medicines (medicines only taken as the need arises) did not clearly state the maximum amount of these medicines that can be administered over a 24 hour period. This posed a risk of error as some staff working in the centre were contracted from an external agency staff provider and may not be familiar with residents' needs.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Inspectors found that actions were necessary to ensure that residents' care plan information clearly directed the care interventions staff must complete to meet their needs and to ensure that care provided is up-to-date. This was evidenced by the following findings;

- Two residents' care plans were not accurately updated with recommendations made by the speech and language therapy specialist to meet their needs. This finding did not ensure that this pertinent would be communicated to all staff to guide effective delivery of these residents' care.
- Two resident's behaviour support care plans did not clearly identify triggers to their responsive behaviours and the most effective person-centred strategies that should be used by staff to de-escalate these behaviours. This posed a risk that this pertinent information would not be effectively communicated to staff caring for them.
- Each episode of responsive behaviour experienced by residents was not documented. This meant that this information was not available to inform residents' treatment plans and was effectively utilised to inform their individual care and support needs.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had timely access to their general practitioner (GP), allied health professionals, specialist medical and nursing services including psychiatry of older age, community palliative care and tissue viability specialists as necessary. An on-call medical service was accessible to residents out-of-hours, as needed. A physiotherapist was employed to complete residents' mobility assessments and provide treatments on two days every week. This had a post impact on residents' welbeing and continuing independence. Residents were supported to safely attend out-patient and other appointments.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Staff maintained a positive and supportive approach in their care of the small

number of residents who were predisposed to experiencing episodes of responsive behaviours. Staff were facilitated to attend training to ensure they had up-to-date knowledge and skills to effectively care for residents with responsive behaviours.

The person in charge and staff were committed to minimal restraint use in the centre and their practices and procedures reflected the national restraint policy guidelines. Alternatives to restrictive equipment was tried and utilised in consultation with individual residents and their representatives.

Judgment: Compliant

Regulation 8: Protection

Effective measures were in place to ensure residents were safeguarded from risk of abuse. The procedures to be followed by staff were set out in the centre's policies and residents' safeguarding plans. These measures included procedures to ensure all incidents, allegations or suspicions of abuse were addressed and managed appropriately to ensure residents were safeguarded at all times. There was evidence that learning from investigations was implemented to protect residents from abuse. All staff were facilitated to complete training on safeguarding residents from abuse.

Judgment: Compliant

Regulation 9: Residents' rights

Residents access to meaningful activities was not assured when the activity coordinator was on planned or unplanned leave. Although, each resident had a care plan developed to direct staff regarding the social activities that they wished to participate in in line with their individual interests and capacities, records were not available regarding residents' participation in social activities. This was particularly relevant for a small number of residents who remained in their bedrooms and spent their day watching television or sleeping with little or no access to meaningful activities.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 13: End of life	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Aras Mhathair Phoil OSV-0000652

Inspection ID: MON-0043006

Date of inspection: 09/05/2024

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: An additional staff member will be rostered to fully cover the absence of activity coordinator going forward. Any extra cover required to facilitate this will be addressed by sourcing through agency staffing.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: - To ensure appropriate supervision and effective governance and oversight of the service, an audit schedule which covers different key areas will be completed by clinical nurse manager with the guidance of the person in charge. The appointed clinical nurse manger has sufficient experience in the role and familiar with different audit methodologies. Findings of the audits will be acted upon in a timely manner and the progress of actions will be discussed at the quality improvement meetings and management meetings. - The post of the clinical nurse manger has been approved for recruitment. There is a panel in place. However, this had been paused due to the embargo on recruitment. Currently this post has been applied for national derogation and awaits decision. While this appointment is awaited, a CNM1 from another CNU been appointed to the role of clinical nurse manager on an acting basis until the role is permanently filled.	

The compliance plan response from the registered provider does not adequately assure the chief inspector that the action will result in compliance with the regulations.

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
The compliance plan response from the registered provider does not adequately assure the chief inspector that the action will result in compliance with the regulations.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
- An additional staff member will be rostered to fully cover the absence of activity coordinator going forward. Any extra cover required to facilitate this will be addressed by sourcing through agency staffing.
- The post of the clinical nurse manger has been approved for recruitment. There is a panel in place. However, this had been paused due to the embargo on recruitment. Currently this post has been applied for national derogation and awaits decision. While this appointment is awaited, a CNM1 from another CNU been appointed to the role of clinical nurse manager on an acting basis until the role is permanently filled.
- To ensure appropriate supervision and effective governance and oversight of the service, an audit schedule which covers different key areas will be completed by clinical nurse manager with the guidance of the person in charge. The appointed clinical nurse manger has sufficient experience in the role and familiar with different audit methodologies. Findings of the audits will be acted upon in a timely manner and the progress of actions will be discussed at the quality improvement meetings and management meetings.
- A thorough audit of key areas will be completed with immediate effect and action plans will be developed to address the findings of the audits.

The compliance plan response from the registered provider does not adequately assure the chief inspector that the action will result in compliance with the regulations.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
- The chairs and other equipment which were stored in the empty rooms are now removed. All extra chairs and equipment which were not required for the use of residents are moved to the designated storage area.
- Staff are advised and are reminded on a regular basis to use the designated areas for storing the chairs, hoists, and other equipment.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
- Infection prevention and control department within the organisation visited the centre on foot of the findings of the recent inspection. IPC advised there is no requirement for a hand wash sink (clinical or non-clinical). An alcohol hand gel dispenser is now placed outside the store room & filing room.
- A non-porous floor covering which will facilitate effective cleaning will be installed in the rooms identified.
- All rooms now on the cleaning schedule
- The basement storage rooms are now on the cleaning schedule

- The company who does the laundering of bed linen and towels has increased the collection of dirty laundry to twice weekly. The storage containers for the dirty linen and towels are now fitted with appropriate lids/coverings to protect from access by fleas and other vermin, while awaiting collection.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Following the fire risk assessment in May 2024, a plan of action has been created which identifies the deficits and plans to mitigate the risks. The red risks items identified within the report items have been completed. The remaining amber items identified are currently in progress, scheduled to be complete Q4 of this year.

As of 18/07/2024, the following are complete

Bolt fastenings on doors to be removed and alternative measures for securing the doors are now employed. Full complement of screw fixings is provided to the doors.

These were completed by a qualified carpenter who has successfully completed a BRE Academy Fire Door Inspection Course.

Georgian wire glazing at the nurses station replaced. Certification from contractor of glazing and installation issued July 16th 2024

The timber panelling has been removed outside the smoking room/patio and beyond the lobby doors to the day care and at main entrance lobby. Certificate of compliance issued from contractor July 16th 2024. Confirmation from painting contractor, data sheet specifications including photo graphic evidence that provided to local authority on June 19th 2024.

Extract fans reviewed and contractor has complete the following,
Sitting Room 2
Removed 2 no small vents in existing ceiling and fit 2 no 150 diameter
fire rated disc valves. Alterations to ductwork in attic void and installed
2 no metal duct sections onto the fire rated valves. Installed 2 no acoustic flexible duct sections to reduce the noise level and 2 no transformer type speed controllers to suit the existing fans.

Kitchen
Complete clean of the existing kitchen canopy behind the v bank filter section.
All baffle filters degreased and cleaned. All associated extract ductwork includes the extract fan cleaned. Report and certification to TR19 Standard

Rooms 19& 24
Supply and installation of a new 150 dia fire rated disc valve in the ensuite.
Alterations to the existing duct work in the attic. Supply and fit a new section
of steel duct onto the fire rated valve.
Assisted bathroom & WC
Grilles in ceiling to be removed and ceiling closed up by others. operable
windows in this area. Additional fire stopping to be completed July 23rd 2024.

Ceiling hatches currently been replaced and additional fire stopping to be completed July 23rd 2024.

The works to remedy the ceiling throughout the bedroom accommodation is ongoing and expected to be complete by 30th September 2024

Both extract systems in bedroom 21 ensuite and sluice room are now stand alone. Each system is in the attic void of their own compartment with fire rated extract valves installed. Alteration to the existing duct work in the attic void completed including new cowl over the sluice room. Compartment wall has been reinstated

Gas slam shut is connected to the fire detection and alarm system and that gas supply to the kitchen is disconnected upon activation of the fire alarm system. Confirmation from contractor including data sheet specifications issued to local authority July 9th 2024.

A new fire shutter is installed at Kitchen. Certificate of conformity and certificate of compliance on completion issued to local authority on July 9th 2024.

Kitchen Compartment works expected to be completed September 2024.

It is expected additional Fire stopping will be complete by 23/7/2024 in some areas outstanding

Fire safety register is populated with the required information.

Floor plans are updated and in place detailing all required information

The compliance plan response from the registered provider does not adequately assure the chief inspector that the action will result in compliance with the regulations.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
- All prescription instructions are now completed to clearly state the maximum dosage can be administered over a 24 hour period.
- The Centre's audit schedule includes medication audit in regular intervals. This would ensure any shortcomings in the area will be identified and rectified in a timely manner.

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
All the nursing staff are provided with training on assessment and care planning.
- A thorough audit of the care plans and assessments will done on a regular basis and findings will be communicated to the nurses
- Each episode of responsive behavior will be documented using an appropriate system. This has been communicated to all the nursing staff.

Regulation 9: Residents' rights	Substantially Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: A staff member is now rostered to fully cover the absence of activity coordinator. The designated activity staff will be facilitated with protected time to attend the residents who prefer to stay in their rooms, to ensure they have access to meaningful activities. This staff member will be responsible for the documentation of the social activities each resident participates as per their activities care plan.	

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Substantially Compliant	Yellow	29/07/2024
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	18/07/2024
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	08/07/2024
Regulation 21(1)	The registered provider shall	Substantially Compliant	Yellow	18/07/2024

	ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.			
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	29/07/2024
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Not Compliant	Orange	18/07/2024
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	22/07/2024
Regulation 27	The registered provider shall	Not Compliant	Orange	02/09/2024

	ensure that procedures, consistent with the 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	31/12/2024
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Substantially Compliant	Yellow	28/06/2024
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	15/07/2024
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	28/06/2024
Regulation 28(2)(i)	The registered	Not Compliant		28/06/2024

	provider shall make adequate arrangements for detecting, containing and extinguishing fires.		Orange	
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	24/06/2024
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.	Substantially Compliant	Yellow	27/06/2024
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	29/07/2024
Regulation 5(4)	The person in charge shall	Substantially Compliant	Yellow	29/07/2024

	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.			
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	29/07/2024