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:	Abbeygale House
Name of provider:	Health Service Executive
Address of centre:	Farnogue, Old Hospital Road, Wexford
Type of inspection:	Unannounced
Date of inspection:	06 March 2024
Centre ID:	OSV-0000743
Fieldwork ID:	MON-0037138

About the designated centre

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

This is a purpose built centre opened in 2012. It is a split level building divided into two units with Abbeygale House situated on the top level while the ground floor is a unit for psychiatry of old age. Abbeygale House is a 30-bedded unit dedicated to older persons' services. The centre is staffed by qualified nursing and care staff at all times and caters for residents whose dependency levels range from low to maximum. It accommodates both female and male residents over the age of 18 years with a wide range of care needs. The location, design and layout of Abbeygale House are suitable for its stated purpose. There are 24 single en suite bedrooms and two three-bedded en suite rooms. All bedrooms were equipped with overhead hoists. There were sufficient additional and accessible toilet and bathroom facilities for residents. Meals are prepared off site and there is a kitchen located between two dining rooms. Other communal areas include two sitting rooms, a visitors' room, a treatment room, hairdressing salon and utility rooms. There is also a quiet room. There was suitable and sufficient storage for equipment. There is a well maintained enclosed garden which residents can access freely.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	29

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 6 March 2024	09:30hrs to 18:15hrs	Aisling Coffey	Lead
Wednesday 6 March 2024	09:30hrs to 18:15hrs	Noel Sheehan	Support

What residents told us and what inspectors observed

The overall feedback from residents was that Abbeygale House was a nice place to live. The residents spoken with were highly complimentary of the staff and the care they received. Staff were aware of the residents' needs and were striving to provide good quality care. Inspectors observed warm, kind, dignified and respectful interactions with residents and their visitors throughout the day by staff and management.

Inspectors arrived at the centre in the morning to conduct an unannounced inspection. The provider had recently appointed a new proposed person in charge of the centre. Following an introductory meeting with this proposed person in charge, the inspectors were guided on a tour of the premises. During the day, the inspectors spoke with several residents and their families to gain an insight into the residents' lived experience in Abbeygale House. The inspectors also spent time observing interactions between staff and residents and reviewing a range of documentation.

Abbeygale House is located on the first floor of a purpose-built two-storey building, which is situated just outside Wexford town and in close proximity to the local hospital. The centre offers accommodation for both males and females with varying levels of dependency and care needs. It is registered to house 30 residents on a long-term basis. At the time of the inspection, there were 29 residents in the centre, with one vacancy.

Access to Abbeygale House was via stairs or a passenger lift. The main entrance to the designated centre was locked, and entry was facilitated with a doorbell system answered by staff. Within Abbeygale House, the centre's design and layout supported residents' free movement, with wide corridors, sufficient handrails, and comfortable armchair seating within communal areas. The centre was bright and pleasantly decorated. The amount of communal space was adequate, consisting of several relatively small rooms, two sitting rooms, two dining rooms, a visitor room and a quiet room. While these rooms were suitably furnished to meet residents' needs, inspectors observed that access to the visitor room, which was being used as a third dining area, was challenging for an independent wheelchair user due to the narrow entry. A physiotherapy and occupational therapy suite was available for resident use; however, staff were using this facility for mealtime breaks on the inspection day. There was a snoezelen room opposite the front door to the centre, another communal space for residents. The purpose of this room, as per the statement of purpose, was to provide a comfortable multisensory room for residents who are distressed or agitated. However, this room would benefit from refurbishment as it contained no multisensory equipment to support a distressed resident. Residents had access to a secure internal garden. This area had seating for residents and, while pleasantly decorated with trees, plants and birdhouses, required post-winter maintenance. The garden was also the designated area for residents who chose to smoke; however, there was inadequate protective equipment for those residents in this area, which will be discussed under Regulation

28: Fire precautions. While the centre was generally clean throughout, some areas were experiencing wear and tear, requiring redecoration and repair. These findings will be discussed further within the report.

The bedroom accommodation is comprised of 24 single en-suite bedrooms and two three-bedded en-suite rooms. En-suite facilities contained a toilet, wash-hand basin and shower. All bedrooms were equipped with overhead hoists. Bedrooms had been personalised with photographs, pictures, art and other items of personal significance. Bedrooms were appropriately sized, with space in all rooms for a comfortable chair at each bedside. All residents had a bedside locker, and there was adequate wardrobe space for residents' clothing. Bedroom and bathroom accommodation was generally to a good standard; however, inspectors found that both multi-occupancy bedrooms had significant paint peeling from the walls, while several en-suite bathrooms had broken shower doors. These issues will be discussed under Regulation 17: Premises. Within one of the three bedded en-suite rooms, privacy curtains on overhead tracking did not extend sufficiently to provide residents with privacy. Staff informed inspectors that portable privacy screens were no longer in use following an accident involving the screens. While there were call-bell points in each room, call-bells were missing from a small number of bedrooms, while other call-bells were inaccessible to the resident. These privacy and call bell issues are discussed further under Regulation 9: Residents' rights.

Mealtimes were observed in the three dining areas to be a relaxed and sociable experience, with residents laughing and chatting with staff and each other. Meals appeared nutritious and appetising. There was a choice of chicken or salmon for the main course in addition to a third vegetarian lasagne option. Residents who required assistance at mealtimes were observed to receive this support in a respectful and dignified manner. Some residents were facilitated to eat at their bedsides, aligned with their preferences. Ample drinks, including soup, juices, cordial, tea and coffee, were available for residents at mealtimes and throughout the day. Residents commented positively about the quality and variety of food.

While the residents and families stated that Abbeygale House was a nice place to live and spoke positively about the staff, residents informed the inspectors that they were bored and expressed their longstanding dissatisfaction with the inadequate activities available in the centre. Residents informed the inspectors "I have nothing to do", "boredom is the word", and "we want more activities". Residents also told the inspectors that when group activities occur, there is an over-reliance on bingo, with residents telling the inspectors, "Up to now, it's only bingo". Inspectors observed minimal activity on inspection day, mainly consisting of one-to-one conversations with a small number of residents. Most residents spent considerable time in their bedrooms with minimal stimulation other than the television, radio or a visitor. For example, at 2:15 pm on inspection day, seven residents occupied two sitting rooms with no group activities. The remainder of the 22 residents were in their bedrooms.

Residents could receive visitors in the centre in communal areas or the privacy of their bedrooms. Inspectors also observed visitors coming and going throughout the

day. Visitors who spoke with inspectors were generally positive about the centre and complimentary of the staff.

The following two sections of the report present the findings of this inspection concerning governance and management arrangements in place in the centre and how these arrangements impacted the quality and safety of the service being delivered. The areas identified as requiring improvement are discussed in the report under the relevant regulations.

Capacity and capability

Overall, inspectors found that significantly more robust management and oversight systems were required to ensure that the service provided to residents was safe, appropriate, consistent, and effectively monitored.

This was an unannounced inspection to monitor the ongoing compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 as amended and to review the registered provider's compliance plan arising from the previous inspection. While the provider had progressed with certain aspects of the compliance plan following the last inspection in June 2023, this inspection demonstrated significant deficits in the overall governance and management of the service, with several repeated findings impacting the quality and safety of service provision for residents and new areas of non-compliance identified as requiring improvement.

There was repeated non-compliance found in Regulation 21: Records, as well as new findings of non-compliance in Regulation 23: Governance and management, Regulation 31: Notification of incidents, Regulation 5: Individual assessment and care plan and Regulation 9: Residents' rights. Following the inspection, an urgent action plan request was issued to the registered provider regarding significant identified risks and associated non-compliance with Regulation 28: Fire precautions. The provider reverted with an interim plan to manage the risks identified on the inspection day and committed to a series of actions to ensure that these risks were controlled and mitigated going forward.

The registered provider is the Health Service Executive (HSE). The centre is operated and managed through the governance structures of St. John's Community Hospital, Enniscorthy, also a designated centre caring for older persons. There was a clearly defined management structure for the centre, and staff members were clear about their roles and responsibilities. The person in charge of Abbeygale House reported to the Director of Nursing in St John's Community Hospital, Enniscorthy, who in turn reported to the Manager of Older Persons Services, the nominated person representing the provider for regulatory matters. The person in charge was supported by three clinical nurse managers, two of whom were dedicated to overseeing the day-to-day care of residents at ward level, while one clinical nurse manager supported the person in charge in managing the centre. This latter clinical

nurse manager post was a recent addition to the centre's staffing. Further care and support were provided to residents by a team of nurses, healthcare assistants, catering, and housekeeping staff, reporting to the person in charge.

Since the last inspection on the 21st June 2023, there have been several changes in the governance and management of the centre, including five changes to the proposed person in charge. The current person in charge, an experienced nurse manager, had been in the position one week on the inspection day. While the provider previously had systems to monitor the quality and safety of care delivered to residents and had prepared an annual review of quality and safety for 2023, these systems had not been robustly adhered to and required urgent attention to ensure that service provision was safe, appropriate, consistent, and effectively monitored. For example, the centre did not have several mechanisms in operation to track and trend quality data on matters such as incidents, accidents, complaints or restraint usage. Despite being in position for a week, the person in charge had identified these deficits and developed time-bound action plans to address these areas. They also showed the inspectors proposed templates they had developed and acquired for this purpose.

There was documentary evidence of communication between the director of nursing and the person in charge. Two minutes of governance meetings in 2023 were available, confirming the discussion of human resources, finance, incident and risk management, and health and safety. Within the centre, communication occurred at ward meetings where aspects of quality service delivery, including human resources, health and safety, safeguarding, medication management, and infection prevention and control, were discussed. Notwithstanding this good practice, the records available confirmed these meetings occurred infrequently, impacting the effectiveness of this oversight mechanism in driving quality improvement and learning.

Data concerning incidents occurring within the centre was not collated and analysed within the centre to establish trends, such as the causal and contributing factors in resident accidents, information which could be used to reduce risk and promote residents' safety. While the provider was analysing incident data across several of its services, Abbeyagle House was being represented as a ward within St John's Community Hospital, when Abbeygale House is a stand-alone designated centre. This made the provider's data more challenging to interpret.

Auditing practices in the centre were mixed regarding their effectiveness and impact. Inspectors saw that in the week before the inspection, a range of audits in the area of infection prevention and control, including hand hygiene practices, environmental cleanliness of the sluice room facilities, and the cleanliness of resident care equipment, had taken place. These audits identified similar deficits in infection prevention and control practices found on inspection day. Management had drawn up time-bound quality improvement plans to address these risks. Notwithstanding this good practice, other audit documentation was noted to be incomplete, for example, the malnutrition universal screening tool audit and a pressure ulcer audit, which had commenced in January 2023 and stopped after two months. Incomplete audits were missed opportunities to quantify the residents at risk of malnutrition and

ensure care plans were in place to meet their needs, as well as an opportunity to improve the prevention and management of pressure ulcers in the centre. In other cases, audits were not sufficiently robust to identify risk. For example, in the case of call-bell audits that took place in January and February 2024, there were discrepancies between the finding that 100% of call bells were accessible to all residents and what inspectors found on inspection day, where there were two residents without any call bell, while several other residents could not access their call bell as it was on the floor, behind the bed frame or on their locker and out of reach.

There was a similar lack of clinical oversight evident when notifications were reviewed. The Chief Inspector of Social Services had not been notified of relevant prescribed incidents within the required time frames, which is discussed under Regulation 31: Notification of incidents.

There was sufficient staff on duty to meet the physical care needs of residents. The centre's directly employed staff were supplemented by agency staff, as there were insufficient staff to meet the needs of the roster. There was a minimum of two nurses on duty over 24 hours. While the resident's physical care needs were being met, a review of staffing allocated to the activities programme was urgently required. Residents informed the inspectors that they were bored and expressed their longstanding dissatisfaction with the inadequate provision of activities aligned with their interests and capabilities available in the centre. This finding is discussed further under Regulation 9: Residents' rights.

There was a suite of centre-specific policies and procedures to guide practice in the centre; however, a sample of those reviewed had not been updated in line with regulatory requirements. Inspectors reviewed a sample of residents' files and found a contract of care in place for each resident, setting out the majority of requirements; however, some improvements were required to ensure full regulatory compliance, outlined under Regulation 24: Contract for the provision of services.

Inspectors noted that resident records were securely stored, aligned with the provider's commitment after the June 2023 inspection. While inspectors could review the paper-based files for volunteers working in the centre and confirm regulatory compliance, including Garda Siochana (police) vetting for each volunteer, inspectors could not access the electronic records of staff members directly employed by the provider. Notwithstanding staff efforts to identify and retrieve the Schedule 2 documents for the inspectors, these documents were unavailable for inspection. This system requires review to ensure adequate oversight of staff files, which is discussed under Regulation 21: Records.

The centre displayed its complaints procedure at reception and had complaint information leaflets for residents and relatives. Advertisements for advocacy services to support residents in making a complaint were displayed in the centre. Residents and families said they could raise a complaint with any staff member and were confident in doing so if necessary. Staff were also knowledgeable about the centre's complaints procedure. Notwithstanding this good practice, some improvements were

required to comply fully with the regulation, which will be outlined under Regulation 34: Complaints procedure.

Regulation 14: Persons in charge

The provider had proposed a new person in charge following the relocation of the previous person in charge to a role in another designated centre. A review of information supplied to the Office of the Chief Inspector indicated that the proposed person in charge is an experienced nurse and manager with the required knowledge, experience and qualifications for the role.

Judgment: Compliant

Regulation 15: Staffing

The registered provider ensured that the number and skill mix of staff was appropriate, considering the care needs of residents and the design and layout of the centre. Two registered nurses worked in the centre at night. The centre was reliant on external staff to provide activities for residents.

Judgment: Compliant

Regulation 19: Directory of residents

While the centre had a directory of residents, the directory did not contain all the information required under Schedule 3 of the regulations. For example, the residents' date of discharge, date of death and cause of death were not consistently recorded.These gaps in information was a repeat finding form the June 2023 inspection.

Judgment: Substantially compliant

Regulation 21: Records

Improvements were required in relation to the overall system of storing staff records to ensure these documents were readily available for inspection. The inspectors sought to review Schedule 2 documents, such as photographic identification, Garda Síochána (police) vetting, professional nursing registration, references and

employment history from four staff records. Inspectors were informed that personnel records were recently scanned and uploaded to an electronic records management system. Notwithstanding staff efforts to identify and retrieve the Schedule 2 documents for the inspectors, these documents were unavailable for inspection. This was a repeat finding from the June 2023 inspection.

Judgment: Not compliant

Regulation 22: Insurance

The registered provider had insurance in place which covered injury to residents and loss or damage to residents' property.

Judgment: Compliant

Regulation 23: Governance and management

Management systems in the centre required strengthening to ensure the service provided was safe, appropriate, consistent, and effectively monitored, as evidenced by the findings below.

- The registered provider was required to take significant actions regarding fire safety management in the centre. Following the inspection, an urgent action plan request regarding the risks identified was issued. This will be discussed under Regulation 28: Fire precautions.
- Commitments made in the last two compliance plans following inspections in June 2023 and October 2022 regarding assurances that residents had access to call bells were not implemented.
- Several rooms designated for residents' usage were not being operated in accordance with the statement of purpose. For example, the physiotherapy and occupational therapy suite was observed being used by staff at mealtimes; the snoezelen room did not contain any multi-sensory equipment, while the centre's only assisted bathroom was being used as a store room. This is discussed further under Regulation 17: Premises.

There were inadequate systems of oversight in place to monitor and respond to issues of concern found by the inspectors, particularly in relation to assessment and care planning, residents' health care and maintenance of the premises for the benefit of residents.

- Individual assessments and care plans required robust monitoring by management to ensure that care plans were developed in line with regulatory timeframes and accurately reflected the residents' care needs.

- Gaps were identified in post-fall management and screening for malnutrition.
- Systems available within the centre to access maintenance and repair needed review for the centre to be fully compliant with Schedule 6 requirements.

The oversight and maintenance of incident reporting and other mechanisms to monitor quality data needed to be more robust, as evidenced by inspectors' findings that:

- Statutory quarterly notifications to the Chief Inspector of Social Services had not been submitted within the required time frames.
- The centre was not routinely reviewing and analysing data concerning matters such as incidents, accidents, complaints and the use of restraint, in order to identify trends, evaluate the effectiveness of care delivery, enhance safety and promote quality improvement.

Auditing processes needed to be more robust in identifying risk and driving quality improvement.

- With respect to identifying risk, there were disparities between the full levels of compliance reported in the centre's call bell audits and inspectors' findings.
- In terms of driving quality improvement, some audits had started but were never completed in malnutrition and pressure ulcer prevention and management.

The oversight of staff practice needed to be more robust and responsive to residents' needs, as evidenced by the inspectors' findings that:

- The organisation of the activities programme required urgent review, given the widespread and longstanding dissatisfaction being vocalised by residents in person to inspectors, via resident committee meetings over the previous 14 months and in resident questionnaires.
- Cleaning and storage practices were not fully compliant with the National Standards for Infection Prevention and Control in Community Services (2018).

Judgment: Not compliant

Regulation 24: Contract for the provision of services

Residents had a written contract and statement of terms and conditions agreed with the centre's registered provider. However, as required by the regulation, the terms relating to the resident's bedroom and the number of other occupants (if any) were not consistently recorded in the sample of contracts of care reviewed by the inspectors.

Judgment: Substantially compliant

Regulation 30: Volunteers

The person in charge ensured that individuals involved in the nursing home on a voluntary basis had their roles and responsibilities set out in writing. They received supervision and support, and provided a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012.

Judgment: Compliant

Regulation 31: Notification of incidents

The Chief Inspector of Social Services had not been notified of relevant prescribed incidents within the required time frames. For example, quarterly notification of pressure ulcers sustained by residents had not been notified, as required, for over a year.

Judgment: Not compliant

Regulation 34: Complaints procedure

The centre's complaints policy and procedure required updating to meet the amendments to the regulations that had come into effect in March 2023 (S.I. 628 of 2022). For example:

- The centre's complaints procedure referenced a complaints officer but not a review officer, and there were no associated timeframes for completing a review.
- The nominated complaints officer had not completed training to support them in their role of managing complaints.
- The annual review of quality and safety did not reference the level of resident engagement with independent advocacy services in 2023 nor the number of complaints received.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

While the registered provider had prepared policies and procedures outlined in Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations, a sample seen by the inspectors had not been reviewed at intervals not exceeding three years as required by the regulations.

Judgment: Substantially compliant

Quality and safety

While inspectors observed kind and compassionate staff treating residents with dignity and respect, enhanced governance and oversight were required to significantly improve the quality and safety of the service provided to residents. Action was required concerning the following areas of non-compliance with regulatory requirements: fire precautions, residents' rights, individual assessment and care plan and premises. Other areas also requiring improvement included healthcare, managing behaviour that is challenging, infection control, temporary absence or discharge of residents, and information for residents.

The oversight of fire safety management and systems to identify fire safety risks were ineffective at ensuring the safety of residents living in the centre. Following the inspection, an urgent action plan request was issued to the registered provider regarding significant identified risks and associated non-compliance with Regulation 28: Fire precautions.

Significant actions were required to uphold residents' rights pertaining to activity provision, call-bell access and privacy. The centre had no directly employed activities coordinator and relied solely on external staff to provide onsite activities for residents. These external staff worked weekdays, meaning no coordinated activities occurred on weekends. On inspection day, minimal activity was observed, and residents were highly vocal in informing inspectors of their boredom and longstanding dissatisfaction with the activities programme. By the early afternoon, 22 of the centre's 29 residents were in their bedrooms for the rest of the day with minimal opportunities for social interaction. Some residents did not have call bell access to summon assistance, a repeat finding from the previous two inspections. While residents in one of the multioccupancy rooms had their right to privacy impacted as the curtains surrounding the bed space did not extend sufficiently to provide privacy. These issues will be discussed under Regulation 9: Residents' rights.

While the premises of the designated centre were appropriate for the number and needs of residents, actions were required in relation to the usage of rooms contrary to the statement of purpose and access to maintenance and repair of the premises. Three rooms were found not being operated in accordance with the centre's statement of purpose, while multiple areas required maintenance and repair to fully comply with Schedule 6 requirements. These matters will be discussed under

Regulation 17: Premises. The centre's interior was generally clean on the inspection day, chemicals were securely stored, there was access to clinical hand hygiene sinks and good hand hygiene practices observed. Notwithstanding this good practice, environment and equipment management required improvement to minimise the risk of transmitting a healthcare-associated infection. This will be discussed under Regulation 27: Infection control.

The centre had a pictorial information guide for residents which contained the majority of Regulation 20(2) requirements, such as information about the services and facilities provided in the centre; however further additions were required which will be discussed under Regulation 20: Information for residents.

The centre had a paper-based resident care record system. The person in charge had arranged to assess residents before admission into the centre. Upon admission, residents' needs were evaluated in detail using validated assessment tools, which in turn informed the development of care plans to guide staff on care delivery. However, not all care plans reviewed had been prepared within 48 hours of admission as required by the regulations. Where care plans were reviewed, these reviews did not always occur at required intervals nor involve consultation with the resident and their family. Additionally care plan reviews were not always based on an accurate reassessment of the resident care needs at that time. Gaps and discrepancies were observed in care plans following falls, which could negatively impact the quality of care provided to residents and their safety in the centre. These matters will be discussed under Regulation 5: Individual assessment and care plan.

The health of residents was promoted through ongoing onsite medical review and access to a range of community and outpatient-based healthcare providers such as chiropodists, dietitians, physiotherapy, occupational therapy, speech and language therapy and palliative care services. Notwithstanding this good practice, inspectors found that action was required to ensure that residents had access to appropriate medical and healthcare based on their assessed needs, including a high standard of evidence-based nursing care. This will be discussed under Regulation 6: Healthcare.

Overall, inspectors found that the centre promoted a restraint-free environment and person-centred care. Most nursing and care staff had undergone training in restrictive practices and managing responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment). There was unrestricted access to a secure outdoor area for residents to enjoy. Improvements were required to ensure that any restrictive practices were used in accordance with national policy and were appropriately risk-assessed and reviewed. These findings will be discussed under Regulation 7: Managing behaviour that is challenging.

Staff were observed communicating appropriately with residents who were cognitively impaired and those who did not have a cognitive impairment. Inspectors found that residents with sensory needs had these communication needs documented during their assessment. These assessments outlined the communication devices used by the resident to enable them to communicate effectively and to facilitate their inclusion. For residents with hearing or visual

difficulties, the documented assessment referred to their usage of hearing aids or glasses to enable their effective communication and inclusion. Staff spoken with were knowledgeable about the communication devices used by residents.

Inspectors reviewed records of residents transferred to and from the acute hospital. Inspectors saw that where the resident was temporarily absent from a designated centre in an acute hospital, relevant information about the resident was provided to the designated centre by the acute hospital to enable the safe transfer of care back to the designated centre. Upon residents' return to the centre, the staff ensured that all relevant information was obtained from the hospital, incorporated into the resident's care plan, and follow-up appointments and referrals were made. Records showed that discharges to the hospital were discussed, planned and agreed upon with the resident and, where appropriate, with their family. Additionally, residents were reviewed by the centre's doctor upon their return. Notwithstanding this good practice, inspectors were not assured that the transfer of residents from the centre was carried out in line with the requirements of the regulations as there were no records available of the information sent from the designated centre to the receiving hospital. This will be discussed under Regulation 25: Temporary absence or discharge of residents.

Regulation 10: Communication difficulties

Inspectors found that residents with communication difficulties had their needs assessed and a communication care plan developed. These care plans outlined the communication aids, tools, and devices used by residents to enable their effective communication and inclusion effectively.

Judgment: Compliant

Regulation 13: End of life

Residents approaching the end of life had appropriate care and comfort based on their needs, which respected their dignity and autonomy and met their physical, emotional, social and spiritual needs. Residents' family and friends were informed of the resident's condition and permitted to be with the resident when they were at the end of their life.

Judgment: Compliant

Regulation 17: Premises

Inspectors found three rooms in the centre not operating in accordance with the statement of purpose:

- The physiotherapy and occupational therapy room, designated for resident therapy, was used by staff at mealtimes and breaks. Some physiotherapy clinical equipment had been moved outside this designated room onto the corridor for residents to use. Inspectors issued an urgent action to restore this room to its purpose and reinstate the clinical equipment into the room as it could block an evacuation route in an emergency.
- The snoezelen room, opposite the front door to the centre, contained no multi-sensory equipment for residents to find relief and relaxation when distressed or anxious. On the day of inspection it contained two small standard tables, three chairs and two bins.
- Residents' access to the one assisted bath in the centre was impeded by the storage of seven wheelchairs, specialised seating and a broken trolley in this assisted bathroom.

While the premises were generally well designed and laid out to meet the number and needs of residents in the centre, multiple areas required maintenance and repair to be fully compliant with Schedule 6 requirements, for example:

- The doorway to the visitor's room, which was being used as a dining room, required review as a wheelchair user was observed finding it challenging to enter through this narrow doorway independently.
- Shower doors were broken in multiple en-suite bedrooms. The broken panels were placed behind radiators, which meant the shower could not be used without the increased risk of water exiting the shower tray onto the floor, posing a falls risk. Additionally, placing a broken shower door behind a radiator is not an appropriate storage solution and could injure a resident if it becomes displaced.
- The seat coverings on some resident's armchairs were peeling and torn, meaning that they could not be cleaned effectively.
- There was significant peeling paint on the walls in the two multi-occupancy bedrooms.
- The residents' garden required post-winter maintenance.
- The ceiling in one of the assisted bathrooms had significant staining and required examination to ensure no leak or other risk to residents using this bathroom.
- The door from the corridor to the residents' garden area was not closing correctly and required review.

Judgment: Not compliant

Regulation 20: Information for residents

While the centre had a pictorial information guide for residents, it required updating to contain all of the requirements outlined in Regulation 20(2), for example, the procedure concerning complaints, including external complaints processes such as the Ombudsman and information regarding independent advocacy services.

Judgment: Substantially compliant

Regulation 25: Temporary absence or discharge of residents

Inspectors reviewed records of residents who had been transferred from the centre to the acute hospital. It was not possible to verify the transfer of relevant information about the resident from the centre to the receiving hospital, such as the reason for transfer, current health status, medical diagnosis, and medications, as there were no records available to review. This information is integral to ensuring that the hospital is aware of all pertinent information and can provide the resident with the most appropriate medical treatment.

Judgment: Substantially compliant

Regulation 27: Infection control

Multiple areas required attention to ensure residents were protected from infection and to comply with the National Standards for Infection Prevention and Control in Community Services (2018).

The oversight of cleaning practices required improvement, for example:

- Residents' crash mats were observed to be dirty with footprints and other debris. They were not observed to be on a cleaning schedule.
- The last recorded entry in the deep cleaning schedule was September 2023. There were no records of any rooms being deep cleaned from October 2023 to the inspection date.
- The staff informed the inspectors that the contents of commodes, bedpans, or urinals were manually decanted into the sluice hopper before being placed in the bedpan washer for decontamination. The area around the sluice hopper was visibly dirty with brown staining. Decanting risks environmental contamination with multi-drug resistant organisms (MDROs) and poses a splash/exposure risk to staff. Bedpan washers should be capable of disposing of waste and decontaminating receptacles.
- Commodes, bedpans and urinals were not inverted to dry after cleaning. Instead, they were lying on their sides on the drip tray.

Several storage practices posed a risk of cross-contamination, for example:

- Residents' clean clothing was observed stacked on the couch in the quiet room, which was a communal area used by residents. Clean laundry should be stored in a dedicated clean area until it is returned to the resident.
- While the centre had a labelling mechanism to identify whether clinical equipment used by residents, including wheelchairs, hoists, mobility aids, mattresses, and weighing scales, was clean or dirty, this system was inconsistently used. Therefore, it was not possible to identify whether the equipment provided to a resident was clean.
- Visibly stained and unclean clinical equipment such as crash mats, cushions and hoist slings were observed being stored beside clean linen and towels in two store rooms.
- Residents' seating, mobility aids, and wheelchairs were observed being stored in their toilets, both in the single ensuite toilets and in the shared three-bedded room toilets. This practice posed a risk of cross-contamination.
- Store rooms throughout the centre had objects and boxes stored on the floor, impacting the ability to clean the area effectively.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The oversight of fire safety management and systems to identify fire safety risks were ineffective at ensuring the safety of residents living in the centre. Following the inspection, an urgent action plan request was issued to the registered provider to address these risks as follows:

The registered provider had not taken adequate precautions against the risk of fire and provided suitable building services, for example:

- A resident was observed smoking outside the sitting room. There was no protective equipment for the residents in this area while they smoked, such as a smoking apron. In the event of a fire, there were no fire blankets or fire extinguishers in this area. There were no accessible emergency call bells for the resident to summon assistance. There was no first aid kit should they sustain a burn.
- Additionally, supervision arrangements outlined in the care plan were not being adhered to.
- Oxygen cylinders were stored beside electrical clinical equipment charging in a store room. One oxygen tank was not secured, and the room was not well ventilated.

The registered provider had not provided adequate means of escape, for example:

- The vertical escape route from sub-compartment A led to the garden, which had a gate with a keypad lock. The staff did not know the code for this gate, and it was not displayed to provide a means of escape in an emergency.

The registered provider had not made arrangements for maintaining means of escape, for example:

- The stairs beyond the locked garden gate contained significant moss and other garden debris, posing a potential slip hazard for residents and staff evacuating in an emergency.
- A large volume of clinical equipment was stored in the corridor outside the physiotherapy and occupational therapy room. This corridor is a horizontal escape route and provides access to the single evacuation lift in the building. Fire escape routes must be kept clear at all times.

The registered provider did not make adequate arrangements for staff in the centre to receive training in vertical evacuation and fire prevention, for example:

- Inspectors found no records of staff training/drills in vertical evacuation.
- 30% of current staff providing direct resident care were overdue for annual mandatory fire safety training.

The registered provider had not made adequate arrangements to evacuate all persons in the designated centre.

- The centre's fire evacuation maps identified three internal staircases as vertical escape routes, as well as an external staircase in the garden. The majority of the residents in the centre had high to maximum dependency care needs and would be unable to descend stairs on foot. The provider did not have any evacuation aids located in or close to the stairwells to support the safe vertical evacuation of residents.
- A sample of the centre's personal emergency evacuation plans had not been reviewed regularly in accordance with the reassessment of residents' needs. These plans did not contain a photograph of the resident.

Following the issuing of an urgent action plan, the provider gave assurances that the centre would come back into regulatory compliance.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Action was required concerning individual assessment and care plans to ensure the needs of each resident are assessed and an appropriate care plan is prepared to meet these needs. For example, in the sample of residents' nursing notes viewed, a care plan was not prepared within 48 hours of admission. Similarly there was no

written evidence of resident consultation in respect of care plan reviews and residents spoken with by the inspectors stated they were not consulted.

Care plans were not always reviewed and updated at required intervals. For example, a resident who had fallen did not have their falls care plan updated until six weeks after the fall, and at that point, it was recorded that the resident had no recent falls despite reports to the contrary on their file. The same resident fell again some months later and similarly did not have their falls care plan updated after the fall. The practice of not updating care plans after falls is a missed opportunity to identify the possible factors causing or contributing to the incident, develop a plan to mitigate these risks, and enhance the resident's comfort and safety.

For a resident with a pain management care plan, this had not been updated in line with the required regulatory timeframes. A timely review of the resident's pain management care plan would enhance their comfort and well-being.

While there was evidence of person-centred detailed care plans, other care plans were generic pre-populated templates where the resident's name was inserted at specific intervals, for example, the "meaningful activity programme care plan". The activities recorded for a resident with one such plan in the preceding one-month period were "bed" and "television". The lack of a person-centred assessment outlining the resident's interests and capabilities was a missed opportunity to provide the social support necessary to enhance their satisfaction, maximise their quality of life and promote their inclusion within the centre.

Judgment: Not compliant

Regulation 6: Health care

Notwithstanding the access residents had to a range of healthcare professionals to support their well-being, there were gaps in clinical oversight and rigorous monitoring of weight loss and unwitnessed falls noted in the records reviewed. Action was required to ensure that residents had access to appropriate medical and healthcare based on their assessed needs, including a high standard of evidence-based nursing care, for example:

- Inspectors found insufficient clinical oversight and rigorous monitoring of weight loss. Gaps were noted in the monthly weight recording of residents at risk of malnutrition. Additionally, the Malnutrition Universal Screening Tool (MUST) was not consistently scored correctly to identify residents at high risk of malnutrition. One resident had lost over 10% of their body weight in a six-month period; however, the MUST was not accurately completed to identify the significance of this finding. However, this resident continued to be reviewed by a dietitian throughout this period.
- There were gaps in records of neurological observation assessments monitored and documented in line with the centre's policies for a resident

after an unwitnessed fall. Not completing such assessments could lead to a delay in staff recognising neurological decline or symptoms of a brain haemorrhage.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

While there was a positive culture in the centre with an emphasis on promoting a restraint-free environment, improvements were required in the oversight, risk assessment and documentation of restrictive practices, for example:

- A review of the centre's risk assessments regarding the use of restraints contained on resident files was required. Inspectors noted that some residents who were using bedrails did not have a corresponding up-to-date risk assessment completed, which meant care staff were not fully aware of the risks to this resident's safety when the restraint was in use.
- The centre's usage of restraint, such as bed rails, was not always in accordance with national policy published by the Department of Health or the centre's restraint policy, which required that consideration of all alternative interventions must be explored and deemed inappropriate before a decision on an episode of restraint is taken. There were gaps in documented evidence that alternatives had been trailed before the restrictive device was used.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Significant actions were required by the registered provider to ensure residents' rights were respected, for example:

- Several residents did not have call bells in their rooms, or the call bells were not within reach of the resident, meaning the resident was unable to summon assistance if required. This is a repeat finding from the June 2023 and October 2022 reports.
- Inspectors observed minimal activities taking place on inspection day, with a total reliance on external staff to provide activities. Residents were highly vocal on inspection day about their longstanding dissatisfaction with the activities on offer. Enhanced activities had been sought by residents in resident committee meetings dating back to January 2023 and in resident questionnaires recently undertaken in the centre by the newly appointed person in charge. The inadequacy of activities is a repeat finding from the June 2023 inspection.

- Most residents spent considerable time in their bedrooms with minimal stimulation besides the television, radio or visitors. For example, at 2.15pm on inspection day, seven residents were occupying two sitting rooms with no group activities taking place. The remainder of the 22 residents were in their bedrooms.
- Residents in one of the three-bedded rooms had their ability to undertake activities in private adversely impacted by the premises, specifically the fact that the curtains did not extend sufficiently to provide them with privacy.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 19: Directory of residents	Substantially compliant
Regulation 21: Records	Not compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Substantially compliant
Regulation 30: Volunteers	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 13: End of life	Compliant
Regulation 17: Premises	Not compliant
Regulation 20: Information for residents	Substantially compliant
Regulation 25: Temporary absence or discharge of residents	Substantially compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Abbeygale House OSV-0000743

Inspection ID: MON-0037138

Date of inspection: 06/03/2024

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 19: Directory of residents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 19: Directory of residents: The directory of residents has now been reviewed and updated to ensure all information required under Schedule 3 of the regulations is encompassed including resident's date of discharge, date of death and cause of death.	
Regulation 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: ·With support from South East Community Healthcare Human Resources, the backscanned personnel files have been reviewed and the Schedule 2 documents extracted to a separate electronic file for all staff members at Abbeygale House. A validation exercise is underway to ensure compliance. ·All new/updated documentation will be scanned separately to allow for appropriate indexing going forward.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management:	

· A comprehensive review of call bells has been undertaken and all residents have access to a call bell. Residents who are unable to use call bells have this documented in their care plans and alternative supports, such as half hourly checks, are implemented and documented in their care plans.
· A weekly call bell audit has been implemented as of 7th March to ensure any further instances of missing call bells will be resolved as required.
· The Physiotherapy/Occupational Therapy room is no longer used by staff. It is only to be used for resident's group activities and for other activities involving residents.
· The Snoezelen room has been reviewed and multi-sensory equipment is being procured to best support the residents use of the room.
· All items belonging to Abbeygale House that were stored in the assisted bathroom have been removed from the bathroom to facilitate the use of the room for the residents. This is a shared space with Selskar Mental Health unit on the ground floor and engagement is underway with Selskar management as to removing their items from the room
· The Person in Charge has reviewed care plans and assessments for all residents. One to one training has been provided by the Person in Charge with the staff nurses to ensure care plans and documentation are completed and updated in accordance with the national guidelines and regulatory framework within the required timeframes.
· The Person in Charge has reviewed the process for post-fall management and malnutrition screening with the nursing team and will continue to monitor compliance.
· A comprehensive review of outstanding and new minor works requests have been compiled and sent to Maintenance for actioning. The urgency of these works has been escalated through the Manager of Older Persons Services to the General Manager and Head of Services for Older Persons. Many of the requests have nowe been commenced or completed. There is a maintenance log book in place to record the requests and actioning for review to support further escalation as required.

· A review of the local Incident Management system was performed by the PIC and Manager for Older Persons Services. The system has been since discussed with all staff in the Centre by the PIC. A local review of all incidents reported has been commenced. All incidents reported are now documented in a shared Excel Work book, accessible to all managers and are updated regularly. The collated data from incidents is now being plotted graphically and discussed at monthly ward meeting to ensure any possible learning outcomes are met from the incident review. Abbeygale House is also supported by the South East Community Healthcare (SECH) Quality, Safety and Service Improvement Division in accessing and comparatively analyzing incident data both from within the centre and in comparison with other local centers to identify opportunities for quality improvement.
· The statutory quarterly notifications for the first Quarter of 2024 are completed and updated to HIQA portal. This will be performed on a regular basis going forward by the PIC and management team.
· The updated complaints procedure has been displayed at the Centre, visible to all. The complaints folder has been updated and is keeping a record of all Complaints and compliments received, detailing the nature of complaint, Action plan, Follow up and how the complaint was resolved. Same is discussed on a monthly basis at ward meetings to inform further learnings and support quality improvement.

· A comprehensive review of all restraints in the Centre has been performed by PIC and Weekly Restraint Review document has been commenced and is currently in use. The

Restraints are reviewed by 2 Nurses on a weekly basis and then further reviewed by PIC. The new restraint review documentation includes Physical, environmental and chemical restraints, consent, support documentations, alternatives trialed and their use. New Restraint Care Plan commenced for all residents using any form of restraints in accordance with the national guidelines.

· Monthly Audits covering all areas of care, as detailed by the Quality Care Metrics are commenced and documented in the Centre. This includes Skin integrity, Infection Prevention and Control, Medication Management, Nutrition and Hydration, Elimination and Continence, Falls Prevention and Management, Pain Management, End Of Life Care, Psychological and Social Needs, Social Assessment, Responsive Behavior, Activities and Social Engagement and Personal Experience. These will be performed on a monthly basis and data is entered on the National System for Quality Care Metrics which are submitted to the Nursing and Midwifery Professional Development Unit (NMPDU). Action Plans are developed on a monthly basis for any resultant issues identified. The PIC will monitor the completion of the prescribed audits in line with the audit schedule
· The activities programme at Abbeygale House has been fundamentally reformed. There are now dedicated activity staff rostered on each day under the supervision of the CNM1. The Activities staff member also liaise with the CE Scheme volunteers in the provision of individual and group activities. An activities folder has been set up for all residents, with a copy of their Meaningful Activities Profile and Activities Care Plan and each resident's likes and dislikes included in the folder. All residents now have an activities work sheet that details the activities they participated and the extent of their participation on a daily basis. The folder is referred to and updated by all members of staff attending to activities. The Activities Team is in process of developing new and varied activities for the residents based on their individual interests and in conjunction with the Residents Forum.

· The storage facilities in the Centre has now been reviewed and reworked. There are individual stores identified for Dry Goods, Clinical Equipment and linen. The excess items from the store have been removed and each store is now used based on its purpose, following storage, health and safety, and IPC guidelines.

Regulation 24: Contract for the provision of services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 24: Contract for the provision of services:
The Contract of Care for all residents in the Centre have now been reviewed and updated. The contracts now reflects the room occupancy. In line with learnings from another centre, we plan to introduce a standardised form to document the reasoning and engagement around any required room allocation changes which will be included as an addendum to the contract of care if required.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
The statutory quarterly notifications for the first Quarter of 2024 are completed and updated to HIQA portal. This will be performed on a regular basis going forward by the PIC and management team.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
·The complaints procedure has been updated and is displayed at the Centre, visible to all residents, visitors and staff.
·The complaints folder has been updated to ensure comprehensive record of all complaints and compliments received, detailing the nature of complaint, Action plan, Follow up and how the complaint was resolved.
·The complaints folder is reviewed at monthly ward meetings and also reviewed at centre governance meetings to inform further learnings and support quality improvement. The folder contains the details of complaints management and contact details of the designated complaints officer and review officer.
·The PIC, CNM 2 and CNM 1 have now completed the complaints management training.
·To improve resident engagement with independent advocacy services, SAGE services have been contacted to attend the Residents Committee Meeting, to provide details with the SAGE protocols and procedures and how to avail them.
·Provision has been made to ensure the annual review of quality and safety for 2024 will include a general report of resident engagement with independent advocacy services, resident feedback from the Residents Committee and an overview of complaints received including where review was conducted.

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:

·All Schedule 5 Policies and procedures are currently being reviewed and updated as required.
·The nurse management team at Abbeygale House will work collaboratively with the governance team at St John's Community Hospital to ensure policies are updated in line with best practice and within the prescribed 3-yearly timeframe.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
· The Physiotherapy/Occupational Therapy room is no longer used by staff. It is only to be used for resident's group activities and for other activities involving residents.
· All clinical equipment has been removed from outside the therapy room back into the therapy room. This equipment will be moved to the local rehabilitation unit where it will be
· The Snoezelen room has been reviewed and multi-sensory equipment is being procured to best support the residents use of the room.
· All items belonging to Abbeygale House that were stored in the assisted bathroom have been removed from the bathroom to facilitate the use of the room for the residents. This is a shared space with Selskar Mental Health unit on the ground floor and engagement is underway with Selskar management as to removing their items from the room.

· The visitor's room is not regularly used as a dining room but is used occasionally by some residents when they prefer to have their dinner in that room if it is sunny outside. The center's staff will allows work to accommodate any such request in the resident's home. The doorway to the room has been assessed by the PIC, and is wide enough for a resident in a wheel chair to go in. A request has been made to Maintenance to install a magnetic door holder to ensure it stays open to support residents using wheelchair to have easy independent access. Staff will also support any residents wishing to use the visitor's room.
· Any broken shower doors from resident's ensuite bathrooms have been removed from all the bathrooms. Request has been submitted to Maintenance for repair of all affected units.
· Resident's armchairs have been reviewed and replaced where required to ensure effective cleaning to reduce infection risks. To date 5 resident's chairs and 15 bedside tables have been replaced to ensure compliance with IPC standards and this will remain under review.
· The staining on the ceiling tiles, peeling paint and general wear and tear marks , have been reported to maintenance for repair. A log is maintained of all maintenance requests and the request has also been escalated through the General Manager to the Head of Services for Older Persons.
· A new gardener is commencing in May who will be responsible for garden maintenance. Some minor remedial works have already been completed to improve the garden for the residents.

· The door from corridor to resident's garden area has been fixed and is now working as intended.

Regulation 20: Information for residents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 20: Information for residents:
·The updated complaints procedure has been displayed at the Centre, visible to all staff, visitors and residents including details of the centre's complaints officer and review officer as well as external complaints processes such as the Ombudsman. This has also been included in the resident's guide.
·A display of information regarding independent advocacy services has also been installed at the centre. This information is also included in the resident's guide.

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:
The National Transfer Document is used in the centre to ensure safe and effective communication of resident's details when transferring to another service. This document is completed and transferred along with the resident going into another service. All staff informed to keep a copy of the completed National Transfer Document used, in the resident's file for effective communication process and traceability.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
·The Crash Mats has since been added to the cleaning schedule. All crashmats that had tears or cuts on them has been removed from use.
·The deep cleaning schedule is added to the cleaning checklist in the Centre. All rooms in the Centre will be deep cleaned at least once a week. New Room Deep Cleaning

Schedule added to the documents for House Keeping staff to be completed on a daily basis.
·PIC led training session conducted in the Unit in relation to Infection Prevention and Control. All staff educated regarding the procedure for use of the sluice room, cleaning of sluice room, use of bed pan washers and storage of commodes, bed pans etc. All staff informed to not manually decant the hopper and to use them straight into the washer as intended.
·I Am Clean Stickers now used to ensure and identify cleaned equipment. I am Clean Stickers have provision to put the date and signature of the staff member cleaning the equipment to ensure that it is checked and cleaned regularly.
·All storage rooms in the unit has been repurposed to individualized storage rooms, with separate storage rooms identified and used for Linen, Dry Goods, Hygiene Products, Clinical Equipment etc. All excess items have been removed to ensure an orderly and appropriate storage system.
·Wheel Chair and Mobility Aids are only stored in bathrooms of residents who have En-Suite, and post risk assessment based on their mobility. No items stored in bathroom of residents who can mobilize independently. Other Wheel Chairs and Shared Equipment are now stored in the Equipment Store, and ensured to be cleaned regularly and using I am Clean Stickers.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
· The care plan for the resident that smokes has been updated with details regarding the procedure and systems in place to ensure safety of the resident. Care plan detailed regarding use of a Fire Protection Apron, Staff Supervision and Call Bell facility.
· The Fire Apron has been provided and is stored beside the entrance into the smoking area. Staff ensure the resident has donned the apron, before bringing the resident outside to smoke. PIC has discussed the same with the Resident, and resident is happy to use the Smoking Apron and to smoke under staff supervision. Same detailed in care plan and informed to all staff.
· A call bell has been ordered and is in use in the designated smoking area for residents to use, if they need to call for staff, while in the smoking area.
· A Water Mist Fire extinguisher and Fire Apron has been installed beside the smoking area in the Garden for easy access if needed.
· The Ashtray in the smoking Area has been removed and replaced at a more suitable location to facilitate easy access and use by residents on a wheelchair.
· A first aid kit containing burn shield, bandages, gloves, emergency thermal blanket, hypothermia blanket and burn gel is available in the nurse's station directly opposite to the smoking area.
· All Oxygen Cylinders have now been removed from the centre as not currently required.

· All staff are now aware of the code to open the external gate. A sign displaying the

access code to open the door to the vertical stairway (Both Top and Bottom) is displayed at the gate.
· A sign indicating 'means of escape in emergency' is placed at the location.
· The Vertical Escape Route has been power washed and cleaned and is ready for use.

· All Clinical Equipment has been removed from the corridor area back into the physio/OT room. The equipment are currently not in use and is planned to be moved to another centre where it will be used.

· All staff training records has been updated and the staff requiring face to face training has attended the training (99%). A Fire Training for all staff in the Unit has been booked for 14th May, 2024. This training will include Vertical Evacuations and Use of Ski Mats for Evacuation. This will ensure 100% compliance for all staff on Fire Training.
· Fire Drills including Fire Evacuation has commenced in the Centre. There is one Fire Compartment Evacuation Drill and One Fire Safety Walk Around monthly integrated into the fire management plan. Since inspection, 2 Compartmental Evacuation Drill and 3 Fire Safety Walk Around have been completed. Plan to continue the same and keep documents and feedback from the same to include in staff training.
· 6 Ski Mats have been ordered and delivered to the centre. The plan is to install 2 Ski Mats at each vertical evacuation staircase. Awaiting completion of the training on the use of the ski mats on 14/5/24, to commission use of same.
· All PEEPS has since been updated with complete details and residents photographs available on them.

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
· The Person in Charge will ensure that an identified nurse is allocated to each new admission to ensure the initial admission assessment and requisite care plan is completed within 48 hours of arrival.
· The Person in Charge has reviewed care plans and assessments for all current residents. One to one training has been provided by the Person in Charge with the staff nurses to ensure care plans and documentation are completed and updated in accordance with the national guidelines and regulatory framework within the required timeframes. This will include written evidence of resident consultation in respect of care plan reviews.

· All residents will have their falls care plan reviewed and updated as required post-fall as part of the standard falls management procedure at Abbeygale House.
· Aggregate falls and other incident data will be tracked and analysed so as to best ensure all learnings can be shared with staff to drive quality improvement.

· The Meaningful Activities Care Plans have been updated in consultation with all residents, based on their interests, likes and dislikes. An activities folder has been set up for all residents, with a copy of their Meaningful Activities Profile and Activities Care Plan are included in the folder to ensure that the activities for the resident are identified in accordance with their meaningful activities profile and that the resident's personal preferences drive the development of the activities programme at Abbeygale House.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
·Monthly Audits covering all areas of care, as detailed by the Quality Care Metrics are commenced and documented in the Centre. This includes Skin integrity, Infection Prevention and Control, Medication Management, Nutrition and Hydration, Elimination and Continence, Falls Prevention and Management, Pain Management, End Of Life Care, Psychological and Social Needs, Social Assessment, Responsive Behavior, Activities and Social Engagement and Personal Experience. These will be performed on a monthly basis and data is entered on the National System for Quality Care Metrics which are submitted to the Nursing and Midwifery Professional Development Unit (NMPDU). Action Plans are developed on a monthly basis for any resultant issues identified. The PIC will monitor the completion of the prescribed audits in line with the audit schedule.
·The Person in Charge will ensure that required neurological observations post an unwitnessed fall are completed, documented and monitored for the required period.

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
A comprehensive review of all restraints in the Centre has been performed by PIC and Weekly Restraint Review document has been commenced and is currently in use. The Restraints are reviewed by 2 Nurses on a weekly basis and then further reviewed by PIC. The new restraint review documentation includes Physical, environmental and chemical restraints, consent, support documentations, alternatives trialed and their use. New Restraint Care Plan commenced for all residents using any form of restraints in accordance with the national guidelines.

The use of restraints for any resident has been updated on their care plan with consent and risk assessment documentation in place, detailing the reason for use of restraints,

alternatives trialed before use of restraints, breaks from use of restraints and ongoing monitoring.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
· A comprehensive review of call bells has been undertaken and all residents have access to a call bell. Residents who are unable to use call bells have this documented in their care plans and alternative supports, such as half hourly checks, are implemented and documented in their care plans.
· A weekly call bell audit has been implemented as of 7th March to ensure any further instances of missing call bells will be resolved as required.

· The activities programme at Abbeygale House has been fundamentally reformed. There are now dedicated activity staff rostered on each day under the supervision of the CNM1. The Activities staff member also liaise with the CE Scheme volunteers in the provision of individual and group activities. An activities folder has been set up for all residents, with a copy of their Meaningful Activities Profile and Activities Care Plan and each resident's likes and dislikes included in the folder. All residents now have an activities work sheet that details the activities they participated and the extent of their participation on a daily basis. The folder is referred to and updated by all members of staff attending to activities. The Activities Team is in process of developing new and varied activities for the residents based on their individual interests and in conjunction with the Residents Forum.

· An urgent request has been logged with Maintenance to review and extend the curtain tracking in one of the three-bedded rooms to ensure privacy. This request has been escalated through the General Manager to Head of Services for Older Person as a priority. In the interim, a mounted patient privacy screen is being utilized to provide privacy to the resident in question.

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(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.	Not Compliant	Orange	30/09/2024
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	30/09/2024
Regulation 19(3)	The directory shall include the information specified in paragraph (3) of Schedule 3.	Substantially Compliant	Yellow	01/05/2024

Regulation 20(2)(e)	A guide prepared under paragraph (a) shall include information regarding independent advocacy services.	Substantially Compliant	Yellow	01/05/2024
Regulation 20(2)(c)	A guide prepared under paragraph (a) shall include the procedure respecting complaints, including external complaints processes such as the Ombudsman.	Substantially Compliant	Yellow	01/05/2024
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Not Compliant	Orange	30/06/2024
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Not Compliant	Orange	30/06/2024
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	31/08/2024
Regulation 24(1)	The registered provider shall agree in writing	Substantially Compliant	Yellow	30/06/2024

	with each resident, on the admission of that resident to the designated centre concerned, the terms, including terms relating to the bedroom to be provided to the resident and the number of other occupants (if any) of that bedroom, on which that resident shall reside in that centre.			
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	Orange	01/05/2024
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated	Substantially Compliant	Orange	31/05/2024

	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	Red	14/03/2024
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Red	14/03/2024
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	Red	14/03/2024
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and	Not Compliant	Red	14/05/2024

	escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.			
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.	Not Compliant	Red	14/03/2024
Regulation 31(3)	The person in charge shall provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of an incident set out in paragraphs 7(2) (k) to (n) of Schedule 4.	Not Compliant	Orange	30/04/2024
Regulation 34(2)(d)	The registered provider shall ensure that the complaints procedure provides for the nomination of a review officer to review, at the request of a complainant, the decision referred to at paragraph (c).	Substantially Compliant	Yellow	01/05/2024

Regulation 34(2)(e)	The registered provider shall ensure that the complaints procedure provides that a review is conducted and concluded, as soon as possible and no later than 20 working days after the receipt of the request for review.	Substantially Compliant	Yellow	01/05/2024
Regulation 34(6)(b)(i)	The registered provider shall ensure that as part of the designated centre's annual review, as referred to in Part 7, a general report is provided on the level of engagement of independent advocacy services with residents.	Substantially Compliant	Yellow	30/01/2025
Regulation 34(6)(b)(ii)	The registered provider shall ensure that as part of the designated centre's annual review, as referred to in Part 7, a general report is provided on complaints received, including reviews conducted.	Substantially Compliant	Yellow	30/01/2025
Regulation 34(7)(a)	The registered provider shall ensure that (a) nominated complaints officers and review officers receive suitable training to deal with complaints in accordance with	Substantially Compliant	Yellow	01/05/2024

	the designated centre's complaints procedures.			
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Substantially Compliant	Yellow	30/06/2024
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	01/05/2024
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Not Compliant	Orange	01/05/2024

Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.	Substantially Compliant	Yellow	01/05/2024
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.	Substantially Compliant	Yellow	01/05/2024
Regulation 9(1)	The registered provider shall carry on the business of the designated centre concerned so as to have regard for the sex, religious persuasion, racial origin, cultural and linguistic background and ability of each resident.	Not Compliant	Orange	01/05/2024

Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Not Compliant	Orange	01/05/2024
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Not Compliant	Orange	30/06/2024
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Not Compliant	Orange	30/06/2024