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:	Raheny House Nursing Home
Name of provider:	Raheny House Nursing Home Limited
Address of centre:	476 Howth Road, Raheny, Dublin 5
Type of inspection:	Unannounced
Date of inspection:	05 March 2024
Centre ID:	OSV-0000138
Fieldwork ID:	MON-0040893

About the designated centre

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

Raheny House Nursing Home is a centre in a suburban area of north Dublin providing full-time care for up to 43 adults of all levels of dependency, including people with a diagnosis of dementia. A core objective outlined within the centre's statement of purpose is 'To care for those who have entrusted themselves to us. To provide for their physical, social, emotional and spiritual needs to the best of our ability as per best practice nationally and globally'.

The centre is across two storeys and the upper floors are divided into two parts. Bedroom accommodation comprises 37 single and three twin bedrooms and a variety of communal rooms were available that were stimulating and provided opportunities for rest and recreation.

There is an oratory onsite close to a spacious dining room. A smoking room adjoins the main recreation room and an enclosed outdoor garden courtyard is accessible from the ground floor recreation room and from the conservatory.

The centre has a spacious car park and is in close proximity to local amenities and public transport routes.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	41

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 5 March 2024	19:57hrs to 21:58hrs	Niamh Moore	Lead
Wednesday 6 March 2024	09:33hrs to 18:19hrs	Niamh Moore	Lead
Tuesday 5 March 2024	19:57hrs to 21:58hrs	Bairbre Moynihan	Support
Wednesday 6 March 2024	09:33hrs to 18:19hrs	Bairbre Moynihan	Support

What residents told us and what inspectors observed

This inspection took place in Raheny House Nursing Home in Raheny, Dublin 5. Throughout the days of inspection, the inspectors spoke with a number of residents living in the centre. Overall, residents said they were content and they appreciated the care they received by staff who were kind and caring. Residents informed inspectors that they felt safe within the centre. One recurrent area of feedback from residents was in relation to having to wait for staff assistance to respond to their call bell and to assist them getting up in the mornings.

This was an unannounced inspection carried out over an evening and the following day. Following a brief introductory meeting in the evening, inspectors spent time talking to residents and staff, observing the care provided to residents and walking through the centre. The person in charge arrived at the centre at night to support the inspection process. Thirteen residents were in the recreation room when the inspectors arrived and two were seated at the nurses station. Residents were watching the TV and talking amongst themselves. All other residents were in bed or resting in their bedrooms. Residents expressed to inspectors that they had to wait long periods for assistance particularly in the morning time and inspectors observed call bells sounding for prolonged periods of time. However, staff who spoke to inspectors did not identify that there were any staffing deficits and felt they could respond to residents needs in a timely manner.

Raheny House Nursing Home is registered for 43 beds with 41 residents living in the centre on the days of inspection. The centre is an old building that requires ongoing maintenance and renovation and was divided over two floors referred to as the ground and first floor with access to both floors by stairs, lift or a stair lift. Residents' accommodation was in 37 single and three twin bedrooms. One of the twin rooms contained an en-suite bathroom. All other residents shared toilet, shower and bath facilities. Since the inspection in August 2023 an additional three showers were installed. Residents expressed to inspectors that the showers were a welcome addition to the centre. A number of residents' bedrooms were viewed and were seen to have been personalised with items of furniture, ornaments and family photographs. Overall residents' reported to be happy with their bedrooms with one resident commenting that she loved her room and had taken a number of her belongings from home including a side table and a chair.

Residents had access to a number of communal day spaces on the ground floor, with accommodation laid out over both floors. Additional communal areas available to all residents were a sitting room, recreation hall, oratory, conservatory and a hairdressing room. Residents appeared to be comfortable and relaxed in these spaces throughout the two days of inspection. Residents had access to the enclosed garden through the recreation room and the conservatory, the code to which was on display. A small number of residents were observed using the garden.

Since the previous inspection, the registered provider had progressed some outstanding premises works such as the creation of additional shower facilities discussed above, and ongoing works to fire safety such as the replacement of fire doors. However, inspectors found that some premises works remained outstanding such as painting and the replacement of damaged flooring. This outstanding work impacted on a homely environment for residents, in addition to infection control and fire safety precautions.

The layout of the recreation hall was mostly seen with rows of chairs facing the television which did not demonstrate a homely environment. There was one occasion where chairs were set up in smaller groups and this allowed for two to three residents to sit and chat together. During this time, Montessori children attended the centre and interacted with residents, drawing and making "flying ships". A resident informed the inspector that "they are lovely, just lovely". Inspectors saw that the layout of this room at this time allowed for pleasant and engaging social activities for residents. During the first day of the inspection, Inspectors saw there were two rows of chairs facing the television. Inspectors were told by one resident that the layout of the room was "desperate" and "you cannot see the television in the second row as the backs of the chairs are too high". Management told inspectors that they attempted to change the layout of this room but residents' keep changing the layout back to rows.

Residents were consulted about the service through resident meetings and satisfaction surveys. Two meetings had taken place since the inspection in August 2023. 31 residents attended the meeting in February 2024 and the chef was in attendance. Meeting minutes contained a time bound action plan. Residents informed staff about upgrades that were required to the centre. For example; a ceiling required painting. Residents requested to recommence the grow garden when the weather improves. A satisfaction survey was completed by residents in 2023 but it is unclear which month. The information was not collated to observe trends. For example; of the sample viewed a small number were not happy with the response time to the call bells.

Residents were seen to be offered drinks such as juice and tea with snacks such as biscuits throughout both of the days of the inspection. Menus were displayed at the entrance to the dining room on a noticeboard and on dining room tables. The lunch-time dining experience was observed. Inspectors saw that the majority of residents attended the dining room for their meals however a small number of residents chose to remain in their bedroom and in another communal area and this was seen to be supported. Lunchtime was a sociable occasion with residents chatting amongst themselves. Residents were generally complimentary about the food within the centre.

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

Capacity and capability

This inspection followed up on the compliance plan from the last inspection in August 2023. Inspectors found that overall the management systems in place required strengthening to ensure that all residents received a service that was safe, appropriate, consistent and effectively monitored, particularly in the areas of staffing levels, supervision of staff and auditing. Findings relating to the premises, infection control and fire precautions are further discussed under the theme of Quality and Safety.

Raheny House Nursing Home Limited is the registered provider of Raheny House Nursing Home. The management team was established and included the provider representative, a regional operations manager and the person in charge. The designated centre is part of the Evergreen Care group and as a result, other management supports were available from this group such as Human Resources and maintenance personnel.

The registered provider was in breach of Condition 1 of their registration as the function of rooms had been changed to allow for the creation of additional shower and storage facilities. An application to vary the registration had not been received to change the function of these room, therefore these changes had not been approved by the Chief Inspector.

There were a suite of policies available in the centre which had been implemented with the exception of one policy, this is further discussed under Regulation 4: Written policies and procedures.

From a review of the rosters, from their observations and feedback received during the inspection, inspectors found that that there were insufficient clinical staff to meet the needs of all of the 41 residents living in the nursing home. During the evening inspection, there was one staff nurse and two health care assistants to support all residents. While the majority of residents who remained in the sitting room during the inspection times of 20:00-22:00 were mobile or required assistance of one staff member. 46 percent of residents were assessed as maximum dependency and could require two members of staff to provide care and assistance at the same time. This is further discussed under Regulation 15: Staffing

Overall mandatory training provided to staff on manual handling, safeguarding and infection control was up to date. Supplementary training was provided to staff on dementia and responsive behaviour, dysphagia and wound management, upcoming training dates were scheduled for these trainings to ensure that staff had the necessary skills and knowledge for their roles. There were gaps in mandatory training for fire and in supervision of staff which is further discussed under Regulation 16: Training and Staff Development.

The registered provider ensured that staff records set out in Schedule 2 and the duty roster as required in Schedule 4 were available on the days of inspection and

were seen to be kept in a manner that was safe and accessible. However, while all these records were accessible, not all records met the criteria of the regulations. This is further discussed under Regulation 21: Records.

There were regular staff and management meetings occurring within the designated centre. These meetings were seen to discuss key information relevant to the centre such as staffing, complaints, policies, accidents and incidents, and resident clinical care data. However, while meeting minutes did record that staff reported increased busyness in the evening shift, this issue was not effectively addressed as call bells were not answered in a timely manner in the evenings. In addition, a new clinical nurse manager (CNM) had recently commenced post while the deputy director of nursing post was vacant. However on the first day of the inspection, the CNM was seen to be working as a staff nurse and not in supernumery management capacity. As a result there was limited oversight seen to occur. Inspectors found that the reduced management systems had not identified all gaps and were ineffective in identifying and sustaining areas for improvement. This is further discussed under Regulation 23: Governance and Management.

An annual review of the quality and safety of care delivered to residents in 2023 was in process. A recent resident and family survey had also been completed and the person in charge was due to develop an action plan arising from the findings to feed into this review.

The person in charge told inspectors there was currently no open complaints. Inspectors were told the centre received a low level of complaints with no complaints received during the period of October to December 2023. There was one complaint received in January 2024 which had been appropriately investigated and concluded with the complainants satisfaction level recorded.

Regulation 15: Staffing

Inspectors were not assured that there was a sufficient number and skill mix of staff available within the designated centre to meet the assessed needs of the 41 residents in accordance with Regulation 5, and the size and layout of the designated centre. For example:

- While the deputy director of nursing post was currently vacant, the duties of this post were not being fully covered and as a result there was a reduction seen in auditing and supervision of staff.
- During the first day of this inspection, inspectors observed three occasions where call bells were not responded to for six minutes. Inspectors were told by staff that the aim is for a bell to be responded within one to two minutes but the hours of 20:00-23:00 were the busiest time. Inspectors found that three staff were insufficient to allow for staff to meet all 41 residents' needs in a timely manner.

- 73 percent of residents were assessed as being maximum or high dependency. Some residents spoken with told inspectors that at times staff were slow to respond to their needs with timeframes residents would have to wait described as between 15-30 minutes. This was validated when inspectors' reviewed the call bell system from that morning with response times of eight, fourteen and twenty minutes.

Judgment: Not compliant

Regulation 16: Training and staff development

Supervision of staff required strengthening. For example:

- Three new staff spoken with were not aware of fire evacuation plans for the designated centre.
- A staff member was seen to open the front door using a buzzer located at the nurse's station without verifying or seeing who the person was entering the building.
- Two staff were observed following inappropriate infection prevention and control practices which resulted in a urinal and a bedpan remaining dirty after they had cleaned both items.

Judgment: Substantially compliant

Regulation 21: Records

The statement of purpose and staff roster did not contain all persons working at the designated centre. For example, while inspectors were informed the regional operations manager assigned to support the person in charge was onsite a minimum of one day per week, their hours worked were not recorded on either document.

Judgment: Substantially compliant

Regulation 23: Governance and management

On the days of inspection, the inspectors found that the registered provider had changed the function of rooms such as the creation of additional shower rooms and storage areas. The Chief Inspector had not been notified of these changes and no application to vary the registration of Raheny House had been received by the Chief

Inspector. This was a breach of the Health Act 2007 as the provider was not complying with condition 1 applied to the registration of the centre.

The registered provider had failed to have effective management systems in place to ensure that the service provided was safe, appropriate, consistent and effectively monitored. This was evidenced by:

- Repeat findings of non-compliance with Regulations 17: Premises, 27: Infection Control and 28: Fire Precautions were seen on this inspection and discussed in detail under each relevant regulation.
- There was limited auditing seen to occur. Inspectors were provided with evidence of two audits, related to call bells and infection prevention and control. These audits had findings which were not in line with inspectors findings. For example, the call bell audit of January and February 2024 found 100 percent compliance. Inspectors noted seven occasions when the call bell was not answered within the timeframe of 1-2 minutes. In addition, the infection prevention and control audit of February 2024 found 94 percent compliance. This was not in line with inspectors' findings.
- Some items were being raised in management meetings, however they were not being affectively addressed. For example, within meeting minutes of February 2024, January 2024 and December 2023, it identified that fire drills were to include a night time scenario with the largest compartment evacuated. There was no person responsible or timeframe allocated to this action and therefore it remained incomplete on the day of the inspection.

Judgment: Not compliant

Regulation 34: Complaints procedure

The complaints procedure for the centre required review to ensure it contained all of the required information as set out in the regulations. For example, while the procedure documented the review officer, it did not detail what the review process was for the designated centre.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

The Recruitment, Selection and Vetting of Staff policy of February 2023 had not been adopted and implemented by the registered provider. For example:

- From a sample of four staff records reviewed, one vetting disclosure was not in accordance with the National Vetting Bureau (Children and Vulnerable

Persons) Act 2012 or the centre's policy which stated that offers of employment are subject to satisfactory outcome of a garda vetting disclosure. This staff member was seen to have commenced work a few days before their garda vetting was received.

- On another occasion, the policy had not been followed in relation to the procedure taken when a disclosure occurred on garda vetting.

Judgment: Substantially compliant

Quality and safety

Overall residents were supported to have a good quality of life in Raheny House Nursing Home which was respectful of their wishes and choices. Regulations requiring action included Regulations 17: Premises, 27: Infection control, 28: Fire Precautions, 6: Healthcare and 9: Residents' Rights.

Inspectors found that residents' needs were routinely and appropriately assessed and this information was incorporated into resident-specific plans of care. Care plans were updated every four months in line with the regulations. Residents were provided with a good level of evidence-based healthcare in the centre. Residents retained their own general practitioners who attended onsite as required. In addition, inspectors were informed that there was timely access to health and social care providers including speech and language therapy and physiotherapy. Notwithstanding this, an area for improvement was identified which is discussed under Regulation 6: Healthcare.

The registered provider had an up to date policy in place on managing behaviours that challenge. Some residents in the centre had responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). These behaviours were seen to be well managed in the centre by a person centred approach to care. Behavioural trigger charts were completed where required.

The registered provider maintained a restraint register. No residents had bedrails. Less restrictive options were used for example low profile beds and floor alarm mats. However, not all environmental restrictions were identified. For example; the front door was locked and required a code to open it. The intention was to provide a secure environment and not to restrict movement.

Residents gave positive feedback regarding life and care in the centre. Inspectors identified that staff were knowledgeable about residents' likes and interests. The registered provider had employed one activities co-ordinator. On the day of inspection the staff member was on leave and a healthcare assistant was assigned to activities. The activities schedule was on display on the wall and additional activities for the month of March were on display. For example; celebrations for International Women's day. On the day of inspection, residents were playing bingo

and a reflexologist attended onsite. Residents had access to televisions in their rooms and communal areas. Residents were supported to exercise their civil, political and religious rights. Inspectors were informed that residents had voted on the week prior to inspection on the upcoming referendum. Mass was celebrated onsite once weekly. A quarterly newsletter was available for residents which included pictures of residents enjoying Halloween celebrations, a trip to the National Concert Hall and a visit by a choir at Christmas time. Residents had access to independent advocacy services. Notwithstanding the good practices in the centre, areas for action were identified which are discussed under Regulation 9: Residents' Rights.

The registered provider was in the process of painting and refurbishing the centre at the time of inspection. To date the registered provider installed three additional showers with one of the assisted baths being replaced by a shower. In addition, the carpet in the staff room was replaced and the surrounds in the toilet on the ground floor were refurbished. However, some areas of the centre remained in a state of despair.

Feedback from residents was that the food was generally good, however, some residents informed inspectors that the variety of food can be monotonous with food being on a three weekly roster. Staff were knowledgeable on the modified consistency required by some residents. Management updated the chef weekly on the changes if any to modified diets.

Improvements were observed in the laundry area, the laundry had a dirty to clean flow and the area was clean and tidy. Household staff were knowledgeable about their role, however, some infection control practices within the centre required improvement. There was no infection control link practitioner identified at the time of inspection. This is of concern in a centre that has been not compliant in Regulation 27: Infection Control on the previous two inspections. Furthermore as already discussed earlier in this report, an infection prevention and control audit completed in February 2024 scored ninety-four per cent. This is not in line with the findings on the day of inspection.

While inspectors saw that there had been works completed to address some fire safety risks within the centre, including the replacement of fire doors. In addition, the registered provider's action plan to address fire safety risks identified on the inspection in August 2023 had a completion date of 31 March 2024. Inspectors were not assured that staff received suitable training in fire prevention and emergency procedures and that staff were aware of the procedure to be followed in the case of fire. This is further discussed under Regulation 28: Fire precautions.

Regulation 17: Premises

The inspector found that some action was required to ensure the premises conformed to all of the matters set out in Schedule 6. For example:

- The flooring in some parts of the building was badly stained and damaged. For example, in corridors and on some stairwells.
- A window sill in the staff changing room was in a state of disrepair. This did not aid effective cleaning.
- There was inappropriate storage seen during the inspection. For example, wheelchairs and walking aids in a sitting room and on a corridor during the inspection. In addition, a ladder was stored on a corridor on the first day of the inspection.
- A small number of radiators and the sink unit in a sluice room were observed to be rusted.
- The architrave around two door frames had been removed. One of these had been replaced by the end of the inspection.
- Ceiling tiles in some areas were seen to be damaged.
- A bathroom did not have a toilet roll holder in place.
- While inspectors were told the chair lift had been recently serviced, there was no service record available to verify this had occurred within the last six months and that it was in safe working order.

This is a repeated non-compliance**.**

Judgment: Not compliant

Regulation 18: Food and nutrition

Residents were provided with a choice at mealtimes including those on a modified diet. Adequate quantities of nutritious food and drinks were provided, which were safely prepared, cooked and served in the centre. Support was available from a dietitian for residents who required specialist assessment with regard to their dietary needs. There was adequate numbers of staff at the day of inspection available to assist residents with nutrition intake.

Judgment: Compliant

Regulation 27: Infection control

Improvements were required in order to ensure procedures are consistent with the national standards for infection control in community services: For example;

- Staff were decanting human waste into a sluice hopper and in a small number of instances were rinsing the bedpan/urinal/bowl and not using the bedpan washer. In addition, racking in one sluice room contained human waste. These findings increased the risk of the spread of multi-drug resistant

organisms, for example; Clostridioides Difficile and Carbapenemase-producing Enterobacterales.
- A chlorine based solution was routinely used to clean floors.
- The temporary enclosures on four sharps boxes were not engaged. This was also a finding on an infection prevention and control audit in February 2024 and remained an issue.
- Two domestic rooms observed were unclean and contained debris and used stock.
- The housekeeping trolley was unclean containing dirt and debris and an inspector was informed that it was cleaned monthly.
- Bottles containing cleaning solution were being decanted from a larger bottle of solution. No bottles observed were dated when they were refilled.
- The assisted bath on the ground floor was visibly unclean.
- Recent works had occurred to fire doors. There was dust and debris visible on the new doors on the first day of the inspection.

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 28: Fire precautions

Actions were required to ensure fire safety in the designated centre:

- Ongoing work was occurring to fire doors and compartmentation, however a charging point for hoists remained in a corridor which increased the risk of fire in this area.
- While there was a record of a weekly inspection of fire doors occurring, these inspections were not finding any faults with fire doors. This was not in line with inspection findings where inspectors saw a number of fire doors were not fully engaging. For example; the door to the dining room and sluice room.
- Inspectors found that staff had not received suitable training in fire prevention and emergency procedures, one in five staff did not have up-to-date training on fire safety, including evacuation procedures. Inspectors spoke with four staff who did not have sufficient knowledge of the procedures within the designated centre including the compartment details. This procedure required staff to close resident bedroom doors in the event of a fire as doors did not have self-closures, three staff did not detail that this was a requirement.
- Fire safety management and fire drills were not ensuring that staff were aware of the procedure to be followed in the case of fire. Fire drills at the centre were not adequate to assure inspectors that staff were practicing evacuation of residents under various scenarios such as:
    - through the use of all evacuation routes such as stair cases from the first floor of the building

- using all evacuation or mobility aids in place at the centre, such as the use of ski sheets.

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

An inspector reviewed a sample of care plans and validated assessment tools. These were observed person centred and were able to guide care for the medical and nursing needs of residents.

Validated risk assessment tools were used to identify specific clinical risks, such as risk of falls and pressure ulceration. Records showed that assessments were regularly updated in line with residents' changing needs, for example following a fall.

Judgment: Compliant

Regulation 6: Health care

There was no evidence that a residents' urinary catheter was changed within the preceding three months despite the care plan indicating that this was required.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

Inspectors observed staff and resident interactions and found that residents with responsive behaviours were supported by a person-centred and consistent approach to managing these behaviours. Behavioural assessments were completed and informed a holistic approach to managing residents' responsive behaviours.

Environmental restrictions were in place and these were identified on the restraint register. Since the last inspection, a code was on display for residents to freely exit into the enclosed garden.

No residents in the centre had a bedrail in place. Less restrictive options were used, for example; bed bumpers.

Judgment: Compliant

Regulation 9: Residents' rights

Actions were required by the registered provider to ensure that residents were consulted and participated in the organisation of the designated centre:

- In line with findings from the last inspection, the majority of residents had a commode in their bedrooms. There was no evidence since the last inspection that residents were consulted about this practice.
- While residents' meetings were taking place, a small number of residents informed inspectors that items were not always addressed.
- There was evidence that residents were consulted about the layout of the recreation room. In the meeting of October 2023, staff discussed the seating arrangements in the recreation room with the agreement on how the chairs would be positioned along with a table. As discussed within this report, this solution that was discussed with the residents was not always evident on the days of inspection. Furthermore, a resident informed an inspector that they were unable to view the television with the layout of chairs in the room.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Raheny House Nursing Home OSV-0000138

Inspection ID: MON-0040893

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 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • The vacancy for the position of Deputy Person in Charge was effectively filled on April 2nd. During the inspection, while the recruitment process for the Deputy Person in Charge was ongoing, the duties were assumed by the Clinical Nurse Manager which involves a combination of nursing hours and protected supernumery hours. Audits were conducted timely, and the findings were available for review on the day of the inspection. • Three staff members are scheduled from 21:00 to 7:00, a period when the majority of residents are resting. Staffing levels will undergo assessment in collaboration with residents. We will provide training to encourage staff to interact more with residents, particularly addressing concerns about perceived lengthy waiting times for assistance, which may be exacerbated by anticipation. The care plan will be reassessed, and measures will be enacted to uphold the residents' preferences. Planned spot checks outside regular hours will be conducted by either the Person in Charge, Deputy Person in Charge, or Clinical Nurse Manager to monitor staff practices and ensure adherence to call bell response protocols. • Staffing hours will be reviewed following consultation with residents. Staff will receive further education on engaging with the residents as per the care plans. This practice will be closely monitored by the PIC/DPIC/CNM. The call bells were being activated and could have been promptly addressed even as subsequent calls were being made. It is plausible that multiple call bells were sounded during this timeframe, each being attended to sequentially, thus creating the impression of a unified call bell.	
Regulation 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
• Fire evacuation drills are now conducted on a more frequent basis, occurring weekly, encompassing comprehensive reviews of the center's evacuation plans. This initiative is aimed at enhancing staff knowledge and awareness of fire safety procedures. All new staff members will also receive personalized one-on-one sessions focusing on fire safety and evacuation protocols.

• The staff member underwent coaching and a thorough review of the visiting protocol. This aspect is a part of the induction and orientation program for all new staff, emphasizing the importance of adherence to established protocols.

• Two staff members received coaching sessions regarding the operation of the sluice machine and the prescribed protocol for disinfecting bedpans and urinals. These protocols are integral components of the new staff orientation and induction program. The adherence to these practices will be closely monitored by the DPIC, who is the designated IPC lead and the PIC, and staff knowledge and compliance will be assessed during safety pauses. It is noteworthy that all staff members have successfully completed IPC training.

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
The Regional Operations Manager dedicates a minimum of one day per week to being onsite. There is also support available over the phone or via teams on the other days should the PIC requires assistance. This commitment, however, is not reflected on the printed roster of the center due to the ROM's status as a non-employee. Instead, the ROM's presence is recorded manually on the actual roster on the day of her visit, which unfortunately was not evident on the rosters reviewed by the inspectors as the visit was the following day of the inspection for that specific week. The day of the visit is coordinated through mutual agreement between the Person in Charge and the ROM, with flexibility to adjust as needed by both parties. ROM will ensure this is reflected on the actual roster on her each visit. SOP is updated and submitted to reflect the same.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The inclusion of additional shower rooms and storage areas was carried out in accordance with the compliance plan submitted following the previous inspection, with a targeted completion date set for the end of March 2024. Initially, an application to vary was slated for submission by the end of March to align with the anticipated completion

date. However, the work was finalized ahead of schedule. Consequently, the application to vary has been submitted earlier than planned but following the recent inspection. The PIC with support of PPIM will ensure the timely submission of application to vary in the future instances.

• Compliance plan for Reg 17, Reg 27 and Reg 28 is discussed under the specific section.

• The Person in Charge has carefully examined the audit schedule for the upcoming year and has established delegations within the digitalised auditing system. Both the PIC and the team of staff will undergo further comprehensive training to proficiently conduct audits aimed at identifying non-compliances. The automated auditing system will flag the compliance, substantially compliance and non-compliance in green, amber and red respectively and the staff member completing the audit formulate an action plan. The PIC has configured the system to prompt notifications for any outstanding audits or action plans and to facilitate additional audits in areas flagged for potential issues which provides better oversight. This will include IPC and call bell audit. The call bell audit is scheduled to perform with increased frequency, encompassing various times throughout both day and night, in order to guarantee adherence to established standards. In addition, measures have been undertaken to procure additional pagers for deployment across four distinct corridors, thereby ensuring the prompt response to call bell.

• To ensure compliance monitoring, the PIC/Deputy Person in Charge DPIC/Clinical Nurse Manager will conduct out-of-hours and regular spot checks to oversee staff practices and ensure adherence to regulations.

• The management meeting now incorporates the person responsible, along with the scheduled completion date and designated areas for comments in case of any challenges to the planned completion date of action plans. This adjustment is aimed at ensuring the effectiveness of the management systems within the centre.
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Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The complaints procedure for the center was reviewed on the day of inspection and updated to include the review process.

Regulation 4: Written policies and procedures	Substantially Compliant

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

• The policy underwent review and was disseminated among the team. The Person in Charge, acting as the designated liaison, ensures that employment commencement is contingent upon satisfactory Garda vetting. In strict adherence to this policy, employees are explicitly prohibited from engaging with vulnerable adults or children until they have obtained a vetting disclosure deemed satisfactory.

• The policy is updated to accommodate exceptional cases. The PIC oversees the receipt of all Garda Vetting disclosures before employees commence their roles, ensuring that said disclosures do not reveal any criminal history that could potentially endanger residents, their families, or colleagues. In addition, routine Garda Vetting is implemented to occur at intervals not exceeding three years. Any concerns regarding an individual's suitability are directed to Nursing Home's designated liaison, who assesses the need for further action. Such action may involve additional background checks, reference inquiries, applicant interviews, or risk assessments.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• The installation of new flooring to the dining room and garden room areas will be completed by April 24. Other floor areas have been identified for replacement and will be carried out on a phased basis.
• Repair of the windowsill is scheduled.
• New storage areas have been identified, and installation of storage shelves is planned. The ladder, previously utilized due to ongoing refurbishment and fire safety works, was removed the subsequent day.

• Treatment and completion of the rusted sink in the sluice room have been carried out. Rusty radiators are being phased out for treatment.
• Architraves were removed as part of ongoing refurbishment works and subsequently replaced upon completion of the specific task.
• Phasing out of ceiling tiles for replacement is underway.
• Toilet roll holders are provided in all toilet and bathroom areas.
• Proof of completed services was submitted post-inspection. The service provider has been notified about the importance of timely issuance of service certificates.

Multiple refurbishments work including building works and fire safety works are planned. The maintenance person now commenced with a decoration diary for planning and implementation of works such as touch up painting, treatment of rusty and uneven surfaces.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
• The staff who noticed with the practices will receive coaching and counselling sessions. All staff have successfully completed IPC training. New staff members received specific training on disinfecting bedpans and urinals, as well as on the effective operation of sluice machines. This is a part of orientation and induction program. Monitoring of these practices for compliance will be carried out by the IPC lead.
• Refresher session provided ensures the team utilizes chlorine-based solutions only during high-alert periods.
• A policy refresher on the use of sharps containers was provided to the nursing team, with IPC discussions taking place at daily safety pause meetings to underscore its importance. Oversight of compliance is the responsibility of the designated IPC lead, the Deputy Person in Charge.
• Clinical waste bins were consistently present in all sluice rooms which is kept near an alcove. With the domestic team receiving refresher training on the importance of timely bag replacement after disposal, this will address the isolated issue of not having the bag. Specific staff will be receiving coaching and counselling sessions. A comprehensive cleaning schedule, along with IPC and environmental audits, is actively implemented. The domestic team lead, with protected hours allocated for monitoring staff practices, ensures safety. This oversight provides support to address flagged issues such as
• unclean domestic rooms
• unclean housekeeping trolleys
• decanting without recorded dates.
• unclean bath
• dusty surfaces post-refurbishment.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
•• A number of fire doors have been replaced. Fire doors in the dining room areas are on order for replacement at the end of June2024. The charging point was relocated to this corridor as a compliance plan following the inspection in 2023. The presence of charging points does not increase the risk of fire. PAT testing is completed for all electricals to ensure safety.
• The maintenance person is provided with training in conducting the weekly inspections for effective identification and documentation and reporting of the faults. The fire door replacement is part of the fire safety refurbishment program.
• All staff have completed fire training. As per the matrix submitted following the inspection, there was 1 month gap as the scheduled training was 1 month later than the expiry date of the certificates. The fire safety and evacuation drills are conducted more frequently weekly for the next few months. New staff will be provided with one-to-one sessions for fire safety procedures which will involve pre and post verbal evaluations of the knowledge and awareness.
• Fire drills which are done weekly will now reflect different locations including staircases and the use of mobility aids such as ski sheets or evacuation sledges. In addition,

monthly fire drill training is provided by Micom our fire training provider with both daytime and nighttime scenarios carried out.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care: Urinary catheters are logged on to the electronic nurse documentation. DPIC/CNM will audit this monthly to ensure the right documentation and correct due date is logged on to the system.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: • Documentation of discussions will be recorded within the Resident and Family Communication section of the care plans. Some residents' care plans already incorporate these consultations. The commodes are ergonomically designed as armchairs, resembling regular furniture rather than traditional commodes, and residents opt to have them in their rooms. • PIC will oversee the documentation of feedback given to the residents following the completion of the action. • According to documented consultations, available during the inspection, we will maintain our encouragement for residents to reconfigure the layout of chairs into pods. However, residents' preferences will ultimately be honored. Plans are underway to relocate the recreation room to the current dining area, with a temporary partition facilitating distinct areas tailored to specific activities for different resident groups. This is expected to support the layout of the chairs.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	10/06/2024
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	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.	Not Compliant	Orange	30/06/2024
Regulation 21(1)	The registered provider shall	Substantially Compliant	Yellow	01/04/2024

	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	30/09/2024
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	31/05/2024
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Not Compliant	Orange	31/05/2024

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.	Substantially Compliant	Yellow	30/06/2024
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.	Not Compliant	Orange	15/03/2024
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the	Not Compliant	Orange	10/06/2024

	designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.			
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	06/03/2024
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.	Substantially Compliant	Yellow	30/04/2024
Regulation 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	Substantially Compliant	Yellow	30/04/2024

	from time to time, for a resident.			
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned.	Substantially Compliant	Yellow	31/05/2024