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:	Our Lady of Lourdes Care Facility
Name of provider:	Melbourne Health Care Limited
Address of centre:	Kilcummin Village, Killarney, Kerry
Type of inspection:	Unannounced
Date of inspection:	07 February 2024
Centre ID:	OSV-0000265
Fieldwork ID:	MON-0042763

About the designated centre

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

Our Lady of Lourdes Care Facility is a designated centre located within the rural setting of the village of Kilcummin and a short distance from the town of Killarney, Co. Kerry. It is registered to accommodate a maximum of 66 residents. It is a two-storey facility set out in three wings: Dun Beag is a dementia-focused unit accommodating 18 residents; Tus Nua on the first floor accommodating 27 residents; and Deenagh on the ground floor accommodating 21 residents. Our Lady of Lourdes Care Facility provides 24-hour nursing care to both male and female residents whose dependency range from low to maximum care needs. Long-term care, dementia care, convalescence, respite and palliative care is provided.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	59

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 7 February 2024	09:30hrs to 17:30hrs	Siobhan Bourke	Lead
Thursday 8 February 2024	09:20hrs to 17:10hrs	Siobhan Bourke	Lead

What residents told us and what inspectors observed

This was an unannounced inspection which took place over two days. Based on the observations of the inspector, and discussions with residents, staff and visitors, Our Lady of Lourdes Care Facility was a nice place to live, where residents' choices were supported and respected. There was a warm and welcoming atmosphere in the centre. Residents appeared to enjoy a good quality of life. The inspector spoke with six visitors and 12 residents living in the centre. In general, residents and visitors gave positive feedback on the quality of care they received. Residents' stated that they were well looked after and that staff were kind and caring. One resident told the inspector that staff made it like a "home from home" for them and another resident outlined how quickly nursing staff responded when they were unwell.

The inspector arrived unannounced to the centre and was greeted by the centre's receptionist staff, who outlined the signing in procedures for the centre. The inspector saw that there were displays in place for the upcoming St. Valentine's Day. Scheduled activities along with the complaints procedure were also displayed near reception. Following an opening meeting with the person in charge and a clinical nurse manager(CNM), the CNM accompanied the inspector on a walk around of the centre. During the walk around, it was evident that the CNM was well known to residents and that she was knowledgeable regarding their assessed needs.

Our Lady of Lourdes Facility is registered to accommodate 66 residents over two floors. The centre is set out in three units: Deenagh on the ground floor and Tus Nua and Dun Beag, units are upstairs. The centre's upper floor units can be accessed by both a large lift and stairs. The centre has 46 single rooms and ten twin rooms; 33 single rooms and seven twin rooms had en suite shower, toilet and hand wash sink and the six rooms that were not en suite had a hand wash basin. There was an adequate number of shower and toilet facilities in the centre for residents whose rooms did not have en suites. There was good directional signage throughout the home to guide residents and staff.

The design and layout of the centre met the individual and communal needs of the residents. The inspector observed that many bedrooms were decorated with residents' personal photographs, possessions and memorabilia. Pressure relieving specialist mattresses, falls injury prevention mats and other supportive equipment was seen in residents' bedrooms. The inspector saw that shelving had been added to some bedrooms so that pictures and cards could be displayed. The inspector saw that residents had the access codes for the doors and lifts displayed in their rooms so that they could use the codes to move freely around the home. Bedrooms had ample storage for residents' clothes and belongings. The majority of residents bedrooms were well maintained, however, flooring was worn in a number of bedrooms near the en suite entrances and paintwork in a few bedrooms required repair. The curtains in a number of bedrooms required readjustment, as they were off the hooks and this was addressed by maintenance staff during the inspection.

The inspector saw that there were plenty communal spaces for residents' use throughout the centre. The ground floor of the centre had a large day room, an oratory and a well laid out hairdresser's room as well as a dining area. The end of the unit opened out to an enclosed garden area, which was also the smoking area for residents. The inspector saw that while there was a fire blanket and apron within easy reach in this area, there was no call bell to alert staff if a resident needed assistance. One of the residents used this area to grow plants and vegetables during the year. However, the inspector saw that this garden area had not been renovated or developed to ensure it was an accessible space for residents' use, as outlined in the compliance plan, submitted following the previous inspection. This will be discussed further in the report.

The upper floor had plenty communal spaces with a large day room, dining room and smaller dining room and day room in the Dunbeg unit. There was a secure patio area, that was easily accessible from the large day room upstairs, and this was furnished with patio furniture, raised flower beds and chairs. This secure patio area off in Tua Nua had additional clear re-enforced perspex on top of the wall, ensuring the area was safe. However, the veranda upstairs from a number of residents' bedrooms that had patio access, had yet to have the balcony wall heightened as outlined in the previous compliance plan.

In general, the inspector saw that the centre was clean and warm throughout. A corner of the day room in Tua Nua was unclean as was the meeting room on the first day of inspection, but these were addressed by the end of the day. The inspector saw that oxygen was stored in the same room as a hoist was charging and in another store room that had combustible material. These were removed during the inspection.

During both mornings, personal care was being delivered in many of the residents' bedrooms and observation showed that this was provided in a kind and respectful manner. The inspector observed that staff knocked on residents' bedroom doors before entering. The inspector observed that staff provided care and support in a respectful and unhurried manner during the days of inspection. The inspector saw that residents were neatly dressed, in accordance with their preferences, and appeared well cared for. Those residents who could not communicate their needs appeared comfortable and content. On the first day of inspection, a number of residents were attending the hairdresser and told the inspector that they looked forward to the hairdresser's visits.

The inspector saw that a number of hand hygiene sinks along the corridors had been replaced with sinks that met recommended guidance since the previous inspection. The CNM informed the inspector that the replacement of the remaining sinks was underway. A bedpan washer had also been purchased for the second sluice room. There was easy access for personal protective equipment for staff use, throughout the centre.

Residents who spoke with the inspector gave positive feedback, regarding the choices of meals and the quality of food, served to them in the centre. The inspector met with one of the centre's chefs, who had many years of experience working in

residential services. They told the inspector how they asked residents their likes and dislikes and worked to get them food they liked. The inspector saw that residents who required assistance was provided with it in a respectful and unhurried manner. The lunch time meal appeared appetising on both days of inspection and the inspector saw that residents who required specialised texture modified diets also had a choice of main course. These meals were well presented and appeared appetising. Residents could choose to eat their meals in the dining rooms or in their bedrooms. The inspector saw that the lunch time meals and evening meal appeared to be a sociable dining experience for residents.

The inspector saw that there was a schedule of activities available for residents, to enable them to participate in meaningful activities, should they choose. There were two activity staff, working in the centre, to coordinate the activities programme. These included both one-to-one activities and group activities. Activities available, included an exercise class led by the physiotherapist, arts and crafts, ball games, reminiscence sessions. Mass was celebrated in the centre once a month and two external music groups also attended each week. On the first day of inspection, the activity staff were attending rooms doing one-to-one activities with residents, followed by a group reminiscence session and sing song. The inspector saw that residents were given sheets, with song lyrics, so that they could join in the singing. In the afternoon, students from a local secondary school provided residents with beautiful traditional singing, music and dancing, that residents appeared to enjoy. On the second day, a number of residents engaged in a flower arranging activity on the ground floor as well, as a lively bingo session. Residents were consulted in the running of the centre through surveys and regular residents' meetings. From a review of feedback from residents' surveys, improvements to the outdoor facilities was also requested by residents. Activities, food choices and services available to residents were agenda items for residents' meetings and it was evident that the management team consulted with residents during these meetings. Residents who required it, had access to independent advocacy and the provider had arranged for the national patient advocacy service to attend one of the residents' meetings in 2023 and had plans to have them return to the centre in 2024.

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

Capacity and capability

This was an unannounced inspection, carried out over two days, by an inspector of social services, to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). The inspector also followed up on the actions, taken by the provider, to address issues identified on the last inspection of the centre, in February 2023. Findings of

this inspection were, that while many of the findings of the previous inspection had been actioned, further action was required with regard to notification of incidents, care planning and fire precautions. These findings will be detailed under the relevant regulations.

Melbourne Health Care Limited is the registered provider for Our Lady of Lourdes Care Facility. It is registered to accommodate 66 residents. The registered provider company has three directors, one of whom is actively involved in the management of the centre and is the nominated person representing the provider. There was a clearly defined management structure in place. The person in charge worked full time in the centre and was supported in their role by a clinical nurse manager (CNM) 2, two CNM 1s and team of nursing, care, household, catering, activity, maintenance and administration staff.

There was an appropriate number and skill mix of staff available in the centre having regard for the assessed needs of residents and the size and layout of the centre. The centre had a minimum of three nurses rostered 24 hours a day and they were supported by the clinical nurse manager who was supernumerary, four days a week. The person in charge and the CNM 2 alternated the on call rota for the centre.

The inspector saw that staff were appropriately supervised in the centre during both days of inspection. Both in person and online training was provided for staff appropriate to their role. From a review of training records and from speaking with staff, all staff were up-to-date with fire safety training, manual handling and safeguarding vulnerable adults as well as cardiopulmonary resuscitation training and infection control. The CNM2 was due to commence link nurse training in infection control for the centre in the coming weeks, to enhance their role as lead for infection prevention and control for the centre. The inspector found that a number of nursing and care staff had yet to undergo formal training on management of responsive behaviour as actioned under Regulation 16; Training and staff development.

Each resident had a written contract of care that outlined the services provided and fees to be charged, however, action was required to ensure that the room number was recorded on contract reviewed, this was addressed during the inspection.

A record of incidents occurring in the centre was maintained electronically. However, not all incidents had been reported in writing to the Chief Inspector as required under the regulations. This is actioned under Regulation 31. Notification of incidents.

The provider had a scheduled of formal meetings with the management team and staff, in relation to the oversight and management of the centre. Meetings such as quality and safety meetings, infection control meetings and fire safety meetings were held regularly in the centre. Minutes of these meetings, provided to the inspector, indicated that key clinical and operational issues were discussed and actioned. Well being meetings were also facilitated by the person in charge and staff with responsibility for the activities programme, to discuss the activity plan for the month and daily activities.

The person in charge collected and monitored key clinical risks to residents such as dependency levels, incidents, weight loss, restrictive practices, wounds and infections. There was a schedule of audits in place in the centre and the inspector saw that practices such as medication management, nutritional assessment, infection prevention and control and care planning were audited by the person in charge. Action plans were developed to address any areas that required improvement. However, the inspector found that the systems in place to ensure oversight of notification of incidents, fire precautions and care planning required strengthening as outlined under Regulation 23 Governance and management.

The provider had a complaints procedure displayed in the centre and verbal and written complaints were recorded electronically, investigated and actioned by the management team. Residents who spoke with the inspectors were aware how to make a complaint.

Regulation 15: Staffing

From a review of the staff duty rota and speaking with residents and staff, it was the found that the levels and skill mix of staff at the time of inspection were sufficient to meet the assessed needs of the 59 residents living in the centre. There was a minimum of three registered nurses rostered 24 hours a day.

Judgment: Compliant

Regulation 16: Training and staff development

From a review of the training records maintained in the centre, it was evident that a number of staff were due training on management of responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment). The person in charge assured the inspector that face-to-face training was scheduled for these staff in the coming weeks.

Judgment: Substantially compliant

Regulation 23: Governance and management

The governance and management systems in place required further strengthening, to ensure the service provided to residents was safe, appropriate, consistent and effectively monitored, in particular in relation to;

- oversight of incidents that required notification to the Chief inspector resulting in non-notification of a number of issues, as required by regulation and actioned under Regulation 31; Notification of incidents.
- Oversight of fire precautions as outlined under Regulation 28; Fire Precautions.
- Oversight of care planning documentation as actioned under Regulation 5. Individual assessment and care plan.

Judgment: Substantially compliant

Regulation 24: Contract for the provision of services

From a review of a sample of contracts of care, the inspector found that one contract did not have the correct room number, therefore did not include the terms relating to the bedroom to be provided, to the resident as required in the regulation. This was addressed during the inspection.

Judgment: Compliant

Regulation 31: Notification of incidents

While a record of incidents occurring in the designated centre was maintained, a number of incidents that required three day notification had not been reported to the Chief inspector as set out in the regulations, for example:

- an incident relating to a resident sustaining an injury in the centre that required medical assessment and treatment.
- two allegations in relation to safeguarding.

Judgment: Not compliant

Regulation 34: Complaints procedure

The complaints procedure was displayed in the centre. Residents who spoke with the inspector were aware how to make a complaint. The inspector reviewed a sample of complaints and found that the outcome was recorded and whether the complainant was satisfied with the outcome. The person in charge made some minor amendments to the complaints' procedure, on the day of inspection, reflecting the recent changes in legislation regarding complaints.

Judgment: Compliant

Quality and safety

Overall, the inspector found that management and staff working in the centre supported residents to have a good quality of life, where residents' rights were promoted. The inspector found improvements had been made to the residents' dining experience, personal possessions and infection control. However, further action was required in relation to care planning, fire precautions and premises as outlined further in this report.

Residents had good access to general practitioner (GP) services and were reviewed regularly and as required. The inspector saw that GPs were in the centre on both days of the inspection, reviewing residents. Residents also had good access to health and social care professionals such as dietetics, physiotherapy and speech and language therapy and occupational therapy. A physiotherapist attended the centre two days a week and was on site the second day of inspection. The inspector saw that the physiotherapist provided both individual assessments and a group exercise class in the centre. Where medical or specialist practitioners had recommended specific interventions, nursing and care staff implemented these.

The inspector reviewed a sample of care plans and found that nursing staff completed a comprehensive assessment of residents' health, personal and social care needs on admission. However from a review of care plans, further action is required to ensure they meet the requirements of regulation as outlined under Regulation 5; Individual assessment and care plan.

The inspector saw that behaviour support plans were in place for residents with responsive behaviours and the inspector saw staff engage with residents in a dignified and respectful way during the inspection. Staff and management working in the centre, promoted a restraint free environment and there were low numbers of residents allocated bed rails on the day of inspection, in line with reported quarterly notifications.

Residents' hydration and nutritional needs were being well supported. There was sufficient number of staff available at mealtimes to assist residents with their meals. The inspector saw that there were improvements to the dining experience for residents since the last inspection.

Arrangements were in place to provide residents with appropriate care, and comfort, during their end-of-life. Care plans reviewed demonstrated that staff consulted with residents to gather information with regard to residents' needs and wishes to support the provision of end of life care.

Action had been taken in relation to personal possessions and increased storage for residents' clothing and belongings had been purchased. The inspector saw that

shelving had also been added to some residents' bedrooms to enable displays of photographs and cards. The twin bedrooms had been reconfigured to ensure residents had access to their personal storage. However, work remained outstanding in relation to the balconies and outdoor garden area as outlined under Regulation 17; Premises. The provider outlined to the inspector how this work was delayed due to poor weather conditions in the preceding months and difficulty sourcing material for the outdoor barrier.

The clinical nurse manager was the lead for infection prevention and control for the centre. The inspector saw that there was good oversight and monitoring of residents colonised with multi-drug resistant organisms (MDRO). The management team had managed an outbreak of COVID-19 in October 2023 and onward transmission was limited to a small number of residents. There was adequate resources to ensure the centre was cleaned as required and there was a schedule of daily and deep cleaning of residents' rooms. The inspector saw that a number of clinical hand wash sinks that complied with recommended guidance had been purchased, with some installed and others due installation in the coming weeks to improve access to hand hygiene facilities for staff. A bedpan washer had been installed in the second sluice room since the previous inspection. The inspector saw that some fabrics on seating in communal area was worn and therefore could not be effectively cleaned. These and other findings are outlined under Regulation 27; Infection Control.

Risk management systems were underpinned by the centre's risk management policy which detailed the systems to monitor and respond to risks, that may impact on the safety and welfare of residents. A risk register was maintained and regularly reviewed and included potential risks to residents' safety.

The inspector saw that action had been taken in relation to fire drills and simulations in the centre and these were conducted regularly to ensure that staff, were competent and confident with evacuation practices, should a fire occur in the centre. Residents had personal emergency evacuation plans in place that were updated regularly. Evacuation floor plans were displayed in the centre and staff were up-to-date with fire safety training and those who spoke with the inspector were well-informed regarding fire safety procedures. Fire fighting equipment records indicating that these were serviced annually, were available. However, the inspector noted that quarterly servicing records for fire alarm systems were not. These and other findings are detailed under Regulation 28;Fire precautions.

Regulation 10: Communication difficulties

From a review of residents records, it was evident that residents who had specialist communication requirements had these recorded in their care plan.

Judgment: Compliant

Regulation 11: Visits

The registered provider had arrangements in place for residents to receive visitors. Visiting was not restrictive and the inspector saw lots of visitors coming and going during the days of inspection.

Judgment: Compliant

Regulation 12: Personal possessions

There were adequate arrangements in place for the management of residents' personal possessions. Each resident had appropriate space for storing personal possessions, including wardrobe space and a bedside locker with a lockable drawer. There were effective systems in place for the return of residents' clothing following laundering. Bed linen were laundered by an external laundry company.

Judgment: Compliant

Regulation 13: End of life

Residents' care preferences for their end of life were discussed with them and recorded in their care plan and there was evidence of general practitioner and specialised palliative care services involved in residents care at end of life. Residents' spiritual preferences were recorded.

Judgment: Compliant

Regulation 17: Premises

While many of the findings of the previous inspection had been addressed by the provider, the following required action;

- Flooring in a number of bedrooms and on corridors near two of the hand hygiene sinks were cracked and worn and required repair
- Paintwork on a number of residents' bedrooms was chipped and required repair.
- A number of curtains were off their hooks in residents bedrooms, these were addressed by maintenance staff during the inspection

- Maintenance work to the outdoor garden spaces on the ground floor, and work to raise the height of the balconies from the veranda outside residents' bedrooms on the first floor, as outlined in the previous compliance plan, had yet to be undertaken by the provider. This is a repeat finding.

Judgment: Not compliant

Regulation 18: Food and nutrition

Residents who spoke with the inspector, gave positive feedback, regarding the quality and choice of food available, for their meals. This was supported by the observations of the inspector who saw that food was attractively presented, and appeared wholesome and nutritious. Residents had nutritional plans in place that were regularly reviewed. The inspector saw there was an adequate number of staff on duty to provide assistance to residents who required it.

Judgment: Compliant

Regulation 26: Risk management

The provider had an up-to-date risk management policy that met the requirements of the regulation. The provider had an emergency plan in place for responding to major incidents, should such an incident occur in the centre.

Judgment: Compliant

Regulation 27: Infection control

The inspector found that while the registered provider had taken action to improve compliance with the National Standards for infection prevention and control in community services (2018). The following findings required action;

- Seating for residents, near the nurses station on the upper floor, was worn and therefore could not be effectively cleaned. Furthermore, some of the fabric seating in the centre could not be effectively cleaned.
- Facial masks on oxygen cylinders were uncovered and therefore at risk of cross contamination.
- The hand hygiene sink in the sluice room was not in line with recommended guidance.

- A number of shower drains were visibly unclean.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The following findings in relation to fire safety management required action;

- There were gaps in the quarterly servicing of the fire alarm and this had not been carried out since July 2023. The provider assured the inspector that this would be carried out after the inspection.
- A number of smoke detectors recommended during the previous servicing had yet to be installed by the provider
- The storage of oxygen in the centre required review, as the inspector saw that one oxygen cylinder was stored where a hoist was charging, while another was stored near combustible items. These were removed during the inspection.
- There were gaps in the daily records of escape routes, these are required to provide assurance that escape routes are clear at all times.
- A cross fire door was not closing correctly and risked the escape of smoke in the event of a fire, this was actioned by the provider during the inspection.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

The following required action with regard to care planning records to ensure care plans were appropriate to the assessed needs of residents.

- A resident did not have a comprehensive assessment completed within 48 hours of admission as required in the regulations.
- A validated assessment tool was incorrectly completed for a resident and did not reflect the resident's current well being.
- Two care plans had not been updated for residents who had wounds that required management.

These may result in errors in care delivery.

Judgment: Substantially compliant

Regulation 6: Health care

From a review of a sample of residents' medical and care records, it was evident that residents had good access to general practitioners (GP) and to other health and social care professionals as required. Residents who required end of life support and care had timely access to community palliative care services.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

There was a restrictive practice policy in place to guide staff on the management of responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment). Records showed that when restrictive practices were implemented, a risk assessment was completed and there was a plan in place to guide staff. Alternatives to restrictive practices were trialled. There was a restrictive practice register in place, which was kept under review by the clinical team. Staff who spoke with inspectors had up-to-date knowledge, appropriate to their roles, to positively react to responsive behaviours. However, as outlined under Regulation 16, a number of staff were due training on responsive behaviours.

Judgment: Compliant

Regulation 9: Residents' rights

The inspector found that residents' rights and choices were promoted and respected in the centre. Residents had opportunities to participate in meaningful social activities that supported their interests and capabilities. Two staff members were designated as activity staff for the centre, with one staff member assigned to each floor. Residents were supported to continue to practice their religious faiths and had access to newspapers, radios and televisions. During the two days of inspection, the inspector saw residents enjoying a lively musical and dancing performance from local secondary school students, a flower making session, lively ball games and a bingo session. Residents had access to advocacy services.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 13: End of life	Compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Our Lady of Lourdes Care Facility OSV-0000265

Inspection ID: MON-0042763

Date of inspection: 08/02/2024

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: With regards to Regulation 16, the PIC had assured the Inspector that Responsive Behaviours Training had been planned for the staff and that it would be a classroom style training. This training is scheduled for 04.04.24, 10.04.24 & 06.06.24 for all Nurses, Healthcare Assistants & Wellbeing staff. It will be held at Our Lady of Lourdes and facilitated by an external provider.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: With regards to Regulation 31, as there appeared to an oversight of some notifications to HIQA, the PIC had a debriefing meeting with CNMs. A new system was agreed that going forward, when an incident occurs within the Facility, the Director of Nursing and Clinical Nurse Manager 2 will meet to review the incident within 3 working days. A plan will be actioned and HIQA / other relevant authority will be notified at that review. Regarding Regulation 5, the PIC has arranged Care Planning education for Nurses. Auditing of care plans & clinical risk assessments will continue throughout 2024. Extra support will be given to any Nurses who require it. Care Planning education commenced in February 2024 & is ongoing. This is an online training facilitated by an external provider. The PIC & CNM2 have reflected on the current system for imparting Care plan knowledge	

to newly hired Nurses & recognise that this may require a more robust practice whereby the DON/CNM2 will review care plans to ensure new Nurses are putting their care planning education into practice.

Considering regulation 28, External providers have completed all relevant reviews and servicing on 14 February 2024 as already submitted by email to HIQA. A full review of our Fire policy & procedures is being undertaken.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
The PIC takes it's role seriously and strives to achieve the best possible outcome for all residents post incidents.
It is the practice at our Lady of Lourdes, that when an incident occurs, whereby a resident has sustained an injury, a Doctor is informed immediately. A decision is made by the Doctor whether or not the resident may require hospital attention. Doctor's instructions are followed. Doctor review post treatment ensues.
The incident is reviewed by the PIC/CNM2 and a plan of action is completed with the view to preventing further occurrence. HIQA/other relevant authorities are informed of the incident within 3 working days. Unfortunately, on this occasion, an oversight on notifying HIQA occurred. A new system is now in place since February 2024, whereby incidents are reviewed by management within 3 working days of occurrence and HIQA will be notified during that review. The new system will have a positive outcome for residents and ensure compliance with regulations.

In relation to safeguarding of residents, the PIC puts a safeguarding plan in place for any resident who may be considered at risk.
The Safeguarding and Protection Team are contacted for advice or notification. They discuss the issue with the PIC and ask for a safeguarding plan to be developed. The plan is sent to the Team for approval. The safeguarding Team decides whether the incident requires further safeguarding action and if they should review the resident.

With regards to Regulation 31, the PIC had a meeting with CNMs regarding notifications to HIQA. As there appeared to an oversight of some notifications to HIQA, a new system was agreed that the Director of Nursing and Clinical Nurse Manager 2 would review incidents within 3 working days and send notification to HIQA at the time of review, thereby strengthening the safeguarding of the residents.

The PIC recognises its deficit in not notifying HIQA of 2 safeguarding incidents and wishes to give assurance that going forward all relevant incidents will be notified to the Chief Inspector.

Elder Abuse training and Safeguarding the Vulnerable adult Training has been completed by all staff, including the PIC.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The new Registered Provider took over OLOL on Wednesday March 20th, and plans to do an extensive program of internal & external works over the short & medium term. These works will commence over the coming months & the timing schedule of works will be sent to HIQA once confirmed by relevant contractors.
The new Registered Provider is aware of the above issues and will be completing these issues as a matter of urgency

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
Considering regulation 27, the PIC has met with Head of Housekeeping and a new system for cleaning fabric seating has been developed. Any seating which cannot be cleaned satisfactorily will be removed from circulation. All other fabric seating will be steam cleaned on a rotary basis. This will be checked & signed by Head of Housekeeping. Staff working on the units have been reminded to inform Head of Housekeeping if a fabric chair is visibly unclean. This chair will be removed & cleaned immediately.
Consideration will be given to replacing the fabric covered chairs.

The Infection Control Nurse has reminded all Nurses that face masks should remain in their plastic covering until they are required. Once used, they must be replaced. The IPC Nurse has checked the oxygen cylinders since inspection and has found the Nurses to be compliant with instruction and procedure.
Infection control training is in progress at present & is ongoing.

Regarding the hand hygiene sink in the sluice room, these sinks are currently in store at the Facility and we are awaiting delivery of a part to fit correctly.

With regards to the shower drains, the Maintenance Team have now scheduled cleaning of all shower drains monthly or as required. They will also replace any worn seals around the drains. Housekeeping clean shower trays daily and will report any drain issues to the Maintenance Team. Head of Housekeeping will spot check showers weekly.

As referenced above, this will form part of the repairs & maintenance schedule the new Registered Provider will undertake.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
As already referenced in response to regulation 23, an external company has completed all relevant reviews and servicing on 12 February 24 & has already been submitted by email to HIQA. A full review of our Fire policy & procedures is being undertaken
The new Registered Provider is awaiting confirmation of a date by the fire company to install recommended smoke detectors.
As noted by the Inspector, the O2 cylinder was removed on the day of inspection and staff have been advised the O2 cylinder can no longer be stored in this area. It was removed to the external cage used for storage of O2.
Since inspection, all staff have been reminded of their duties regarding fire precautions and are now signing & completing the fire register.
As already referenced, the new Registered Provider is carrying out a full review & assessment of all Fire doors & will replace as required.

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
Regarding Care planning & Clinical Risk Assessment, this has already been addressed in Regulation 23.

Regarding Regulation 5, the PIC has arranged Care Planning education for Nurses. Auditing of care plans & clinical risk assessments will continue throughout 2024. Extra support will be given to any Nurses who require it. Care Planning education has already commenced & is ongoing since February 2024. This is an online training facilitated by an external provider.
The PIC & CNM2 have reflected on the current system for imparting Care plan knowledge to newly hired Nurses & recognise that this may require a more robust practice whereby the DON/CNM2 will review care plans to ascertain that the new Nurses are practicing their care planning knowledge appropriately.

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 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	10/06/2024
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	31/07/2024
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Substantially Compliant	Yellow	31/03/2024
Regulation 27	The registered provider shall ensure that	Substantially Compliant	Yellow	30/06/2024

	procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.			
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Orange	08/02/2024
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	12/02/2024
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	15/04/2024
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within	Not Compliant	Orange	29/02/2024

	3 working days of its occurrence.			
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	09/02/2024
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.	Substantially Compliant	Yellow	29/02/2024