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:	An Teaghlach Uilinn Nursing Home
Name of provider:	Knegare Nursing Home Holdings Ltd
Address of centre:	Kilrainey, Moycullen, Galway
Type of inspection:	Unannounced
Date of inspection:	17 January 2024
Centre ID:	OSV-0000309
Fieldwork ID:	MON-0042505

About the designated centre

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

An Teaghlach Uilinn Nursing Home is a purpose-built designated centre for older people. Residents are accommodated in single and twin bedrooms. A variety of communal rooms are provided for residents' use, including sitting, dining and recreational facilities. The centre is located close to Moycullen village, Galway. Residents have access to a secure enclosed courtyard. The centre provides accommodation for a maximum of 75 male and female residents, over 18 years of age. The service provides care to residents with conditions that affect their physical and psychological function. Each resident's dependency needs are regularly assessed to ensure their care needs are met.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	29

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 17 January 2024	10:15hrs to 19:00hrs	Sean Ryan	Lead
Wednesday 17 January 2024	10:15hrs to 19:00hrs	Catherine Sweeney	Support

What residents told us and what inspectors observed

Residents living in An Teaghlach Uilinn Nursing Home told inspectors that the staff worked hard to give them a good quality of life, and that they were kind and polite to them.

Inspectors arrived unannounced at the centre and were met by the person in charge. Following an introductory meeting, inspectors walked through the centre and met with residents and staff. There was a relaxed, but busy atmosphere in the centre as staff were observed responding to residents' requests for assistance.

Inspectors met with and observed residents throughout the day of inspection. They spoke with a number of residents in detail about their experience of living in the centre. Residents told inspectors that the attentiveness of staff to their requests for assistance had improved since the last inspection, and that their call bells were now answered promptly. Residents spoke about other changes that had occurred in the centre, including changes to the management and staff. Residents acknowledged how busy the staff were. One resident told the inspectors that there were 'new faces' assisting them with their care needs, and this sometimes caused delays because residents would have to 'tell them how I like things to be done'. Residents acknowledged that it would take time to get to know new staff, and that staff were kind, polite and respectful towards them. One resident told inspectors that the atmosphere in the centre did not feel 'homely', while another resident reported a poor quality of life in the centre.

Inspectors observed that staff were allocated to the supervision of residents. Residents were seen to be supervised by staff in the communal dayroom and in their bedrooms during the day.

Residents informed inspectors that they were satisfied with the food quality and that the meal service had improved. Some residents attended the dining room for their meals while other residents chose to remain in their bedroom. Staff were allocated to support and supervise residents with their nutritional care needs within the dining room and in their bedrooms. Inspectors observed residents being assisted with their meals in a respectful and dignified manner. There were adequate numbers of staff available to assist residents at meal-times.

A review of the catering and dining areas in the centre found that the kitchen and catering areas were not cleaned to an acceptable standard. Some cooking equipment and food preparation areas were visibly unclean on inspection. While damaged floor coverings had been replaced, the floor was visibly unclean under cooking equipment. This has been an ongoing issue over the previous five inspections.

This centre is a two-storey building. Residents were accommodated on the ground floor of the centre. The first floor of the premises was unoccupied by residents.

While some cleaning and redecoration of the ground floor had occurred since September 2023, inspectors did not observe further progress to redecorate areas of the centre as committed to by the provider following previous inspections of the centre. Floor coverings in the dining room were visibly damaged resulting in a build-up of dirt and debris.

While the quality of environmental hygiene had improved in some areas, inspectors observed areas that were visibly unclean including the dining room, storage areas, and sluicing facilities. Some shower drains and toilets in assisted bathrooms were visibly unclean in the morning time, and remained unclean in the afternoon. Inspectors observed poor practice with regard to the management of sluicing facilities. Multiple bags of waste were stored in this area which posed a risk of cross contamination. Inspectors observed a malodorous waste bag that contained soiled linen on the floor outside the laundry area.

Some residents were seen to participate in activities in communal areas throughout the day. Inspectors observed one-to-one and group activities taking place, including chair exercises and baking. A small number of residents chose to remain in their bedrooms, reading, listening to the radio or watching the television.

Some residents told the inspectors that they were provided with opportunities to express their feedback on the quality of the service they received. However, some residents were not satisfied with how their concerns or complaints were responded to.

The next two sections of the report will present the findings in relation to governance and management in the centre and how this impacts on the quality and safety of the service being delivered.

Capacity and capability

This unannounced risk inspection was carried out by inspectors of social services to monitor compliance with the Health Act 2007 (Care and welfare of residents in designated centre for older people) Regulation 2013 (as amended). This was the eighth inspection of this centre since June 2022, an unprecedented level of regulatory oversight. In January 2023, the registered provider committed to not admitting any new residents to the centre until such time as the Chief Inspector had found that the provider had put in place effective systems of governance and management to ensure that residents were in receipt of appropriate safe care.

Knegare Nursing Home Holdings Limited is the registered provider of An Teaghlach Uilinn Nursing Home which at the time of the inspection had a board of six directors. In December 2023, a new chief executive officer and a facilities project manager were appointed. The role of clinical facilitator, identified as an addition to the management team which would monitor staff competencies and training in September 2023 was vacant on the day of the inspection and inspectors were

informed that the provider was not recruiting to fill this vacancy.

Knegare Nursing Home Holdings Limited has a poor history of compliance with the regulations in this designated centre. Significant regulatory non-compliance's were found over a series of inspections of the centre since June 2022. On six successive inspections in June 2022, October 2022, two inspections in January 2023, February 2023, and April 2023 inspectors found that the provider had failed to take appropriate and timely action to ensure the safety of residents, and to address the findings of the previous inspections, particularly in relation to the governance and management of the centre. Additionally, there has been an inconsistent and unstable organisational structure in this centre. For example, the person in charge has changed eight times since August 2022.

As a consequence of identified repeated non-compliance with the regulations, the impact on resident's safety and well being and significant engagement with the provider, in February 2023 the Chief Inspector issued a notice of proposed decision to refuse the provider's application to renew the registration of An Teaghlach Uilinn Nursing Home and followed this in April 2023 with a notice of proposed decision to cancel the registration of An Teaghlach Uilinn Nursing Home.

Since then the registered provider has on six occasions made representations to the Chief Inspector setting out how they were going to improve the care of residents and ensure that residents received safe quality care. On each occasion the information submitted has been reviewed and an inspection carried out to determine if the provider had done what they said they would do and if these actions had improved the care of residents. To date, the findings of inspections on 03 April 2023, 09 July 2023, and 06 September 2023 were that despite repeated changes to the management structures the registered provider did not have an effective system of governance and management in the centre.

Following the inspection in September 2023 inspectors were advised that further changes had been made to the senior managers within the centre responsible for the day-to-day management and oversight of the care of residents. Both the person in charge and the assistant director of nursing had been appointed since then. An assistant director of nursing supported the person in charge to monitor the quality of care, clinical documentation, infection prevention and control, and to provide supervision and support to the staff. A clinical nurse manager was also in post. However, inspectors found that the supervision and oversight of key aspects of the service, such as infection prevention and control practices and fire precautions had not improved following these changes.

Significant non-compliance was found in relation to Regulation 28: Fire precautions. The provider had failed to address serious known deficits in the emergency lighting system whereby a significant number of emergency lights had failed during testing and maintenance. Although the provider had been aware of the deficits with the emergency lighting since April 2023, and had committed to addressing these issues following inspections in April 2023, July 2023 and September 2023, on the day of this inspection this inspection in January 2024 the emergency lights were still not working. An urgent compliance plan in relation to fire safety precautions was issued

to the provider following this inspection.

Inspectors found that lines of accountability and responsibility in the centre were not clearly defined. For example, it could not be confirmed who was responsible for ensuring appropriate laundry and housekeeping staffing levels were maintained in the centre. While accountability and responsibility for the organisation of the staffing resource was delegated to the person in charge, inspectors found that clinical and non-clinical staff were also managing the day-to-day staffing resources in the centre. This impacted on effective oversight of the staffing resource, resulting in areas of the service being understaffed.

The provider had failed to organise and manage the overall staffing resource effectively, to ensure that services were provided in accordance with the centre's statement of purpose. A review of staffing rosters found that staffing resources were not available to cover planned and unplanned staff leave in nursing, health care, and housekeeping rosters, resulting in those areas of the service being under-resourced. On the day of inspection, the impact of this was observed in the poor quality of environmental hygiene that was significantly impacted by inadequate staffing resources.

The management systems in place did not ensure that the service provided was safe, appropriate, consistent or effectively monitored. While the provider had audited some aspects of the service such as clinical care records, and infection prevention and control, those audits did not include an analysis of the findings, nor did they identify areas of learning to ensure an effective quality improvement action plan could be developed and to ensure identified issues are addressed. For example, audits of environmental hygiene carried out in December 2023 identified issues with the inappropriate storage of items in ancillary storage areas, and poor quality of hygiene in residents bedrooms and communal areas. In the absence of an effective quality improvement plan, those issues had not been resolved and had persisted when audited again in January 2024.

A review of the record management systems in the centre found continued issues of non-compliance with the requirements of the regulations. The system in place to record the planning and attendance of staffing in the centre was not effective and resulted in a confused and incomplete staffing roster. This has been a finding of multiple inspections since October 2022. Despite actions committed to in compliance plans following each inspection, an accurate record of the duty roster worked by staff was still not maintained, in line with regulatory requirements. In addition documents requested for review at the start of this inspection were not received in a timely manner. Requests for information with regard to the management systems in place such as risk management, fire safety, audits, and assessments, were presented in a disjointed and disorganised manner. Some documents in relation to residents finances and fire safety could not be provided on the day of the inspection.

The management systems in place to recognise and respond to complaints did not ensure that complaints and concerns were acted upon in a timely, supportive and effective manner. Inspectors received information consistent with a complaint regarding care delivery by staff. While this had been brought to the attention of the

management, the complaint was not appropriately documented or managed within the complaints register, or in line with the centre's own complaints management policy.

Despite being identified on previous inspections, the provider had failed to review risk management systems to effectively manage risks in the centre. Inspectors found that risks that had been identified by the provider had not been managed in line with the risk management policy. For example, risks associated with the physical environment, staffing and communication had not consistently been categorised according to their priority or level of risk, the controls in place to manage the risks were incomplete, and there was no evidence that risks or the effectiveness of the risk management plans were reviewed. Furthermore, risks identified by the provider, and on previous inspections, were not managed in line with the centre's own risk management policy. For example, while the provider had identified significant risks and deficits in the systems of fire management, there was no risk management plan in place to mitigate the risk to residents while awaiting works to address the risk. This included the risk associated with deficits in the emergency lighting systems.

The systems in place to escalate risks and concerns to the senior management team were not fully effective. A review of the record of monthly senior management meetings found that these meetings were used to escalate issues of risk or concern such as resident incidents and complaints to the senior management team and the representative of the registered provider. This was a positive change made to improve the providers oversight of the service. However, a review of the records found that a significant complaint, that was under review in the centre at the time of these meetings, was not escalated to the provider. The management team could not confirm if the provider had been made aware of the complaint.

While all staff had attended training such as fire safety and infection prevention and control, practices observed on the day of the inspection were not in line with best practice guidelines. Inspectors found that staff were not appropriately supervised to ensure the implementation of their training. For example, the management of waste in high risk areas such as the sluice room were not reflective of best practice guidelines. In addition, staff did not demonstrate an appropriate awareness of the fire evacuation procedures in the context of known fire risks in the centre.

Regulation 15: Staffing

The provider had failed to ensure sufficient staffing levels in the centre to meet the needs of the residents, and for the size and layout of the centre. For example;

- The numbers of housekeeping staff on duty on the day of the inspection was not adequate for the size and layout of the centre. A review of the roster found that over the previous two weeks, there were days when only one housekeeper was on duty. On the day of inspection, there was one housekeeper on duty to clean the centre, where there should be two, as a result of inadequate number of staff available to respond to unplanned leave.

This impacted on effective infection prevention and control and the quality of environmental hygiene.

This is a repeated finding from previous inspections.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Inspectors found that staff supervision arrangements were not appropriate to protect and promote the care and welfare of residents. This was evidenced by:

- Inadequate supervision of staff allocated to the cleaning process in the centre, and infection prevention and control practices.
- Poor supervision of the standards of hygiene in the kitchen area, communal toilet facilities, and ancillary support areas.

Judgment: Substantially compliant

Regulation 21: Records

The management of records was not in line with the regulatory requirements, and records were not kept in a manner that was safe or accessible. For example;

- Staff rosters were not accurate. Staff rosters did not reflect the staffing levels on the day of inspection and staff rosters for the week prior to the inspection were not reflective of the roster that was actually worked by staff, as required by Schedule 4(9) of the regulations. Staff that were on unplanned leave from the centre were not identified as such on the planned or worked rosters provided to inspectors on the morning of the inspection. Additionally, rosters for laundry staff were not appropriately maintained and did not reflect the roster worked by the staff. The worked roster reflected that laundry staff were not on duty on a particular day. However, the electronic roster systems identified that the staff were on duty.
- A record of all staff training was not provided for review. For example, a record of training specific to care planning was requested on four occasions. The records were not provided for inspection in line with the requirements of Schedule 4(8)(c).
- A record of a complaint made by a resident, and the action taken by the registered provider in respect of any such complaint was not maintained in line with the requirements of Schedule 4(6).
- Records of residents finances and transactions for specific dates were not made available for inspection, as required by Schedule 3(5)(b) of the

regulations.

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 23: Governance and management

The registered provider had failed to organise and manage the staffing resource to ensure the staffing levels could be maintained in line with the centre's statement of purpose. Staff rosters evidenced that there were inadequate staffing resources available to ensure nursing, health care assistants, and housekeeping staffing levels were maintained.

While there was a management structure in place, lines of accountability and responsibility were not clearly defined. On the day of inspection, accountability and responsibility for the oversight and management of key aspects of the service such as the staffing resources were unclear. This impacted on effective organisation of the staffing resource, and resulted in areas of the centre being understaffed.

The governance and management systems to ensure the service was safe, appropriate, consistent and monitored were not effective. This was evidenced by a failure to;

- ensure communication systems were in place to facilitate the escalation of key information about the service to the provider. Records of senior management team meetings evidenced that key performance indicators, such as open complaints, were not communicated to the senior management team for further review and action.
- implement effective risk management systems to monitor and manage known risks with the potential to impact the safety and welfare of residents living in the centre. For example, a number of significant risks identified by the provider had not been appropriately reviewed or recorded in the risk register. Consequently, the provider failed to put controls in place to mitigate and manage risks to the safety of residents in the centre. This included the risk associated with a resident who may attempt to leave the centre unnoticed and unaccompanied, and the risk associated with inadequate staffing levels.
- implement systems to monitor, evaluate, improve, and sustain the quality of the service. For example, audits of infection prevention and control, environmental hygiene, and clinical care records had identified deficits in the quality of the service. However, the providers failure to analyse, trend, and identify leanings from those deficits resulted in the audit system failing to identify areas for quality improvement. Consequently, there was no effective quality improvement action plan developed to address issues identified by these audits.
- ensure effective record management systems were in place to ensure

regulatory compliance. For example, there was poor oversight of the roster management system, and this contributed to ineffective organisation and management of the staffing resources.
- implement the complaints management system. There was poor oversight of the centre's complaints management system, and escalation of complaints, to ensure complaints were managed in line with the requirements of the regulations.

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 34: Complaints procedure

A review of the complaints log in the centre found that complaints were inconsistently managed in line with the centres' own complaints policy or with the requirements under Regulation 34.

A verbal concern from a resident in relation to the allocation of staffing was not managed through the complaints management process. Consequently, the complaint remained unresolved and the resident reported feeling dissatisfied and unheard. This issue was also identified during the inspection in July 2023 at which time the then person in charge had committed to addressing the issue and ensuring that it did not reoccur.

Judgment: Substantially compliant

Quality and safety

Inspectors found that the interactions between staff and residents were kind and respectful throughout the inspection. While some action had been taken to ensure the provision of care to residents was in line with their assessed needs and care plan, inspectors found that failings in the governance and management continued to impact on the quality and safety of the service provided to residents. Significant action continued to be required to ensure that residents received care in an environment that protected them from risk.

While the provider had completed fire safety risk assessments of the centre in May 2023 and October 2023, and an action plan to address some of the assessment findings was in progress, the registered provider did not have adequate mitigation arrangements in place to ensure residents were protected from the risk of fire, while awaiting completion of the required works. Inspectors found that the provider had failed to recognise and respond to known deficits in the emergency lighting systems.

Furthermore, the provider had failed to review the fire evacuation procedure and the potential impact of these deficits on the safety and welfare of residents.

A review of the care environment found that while the provider had taken some action to address the standard of cleanliness of some areas of the centre, the provider had failed to take action to sustain an appropriate standard of environmental hygiene and infection prevention and control practices. Ineffective management systems to monitor the quality of environmental hygiene and infection prevention and control measures, compounded by inadequate resources allocated to cleaning the centre impacted on the quality of environmental hygiene. Inspectors found that while the standard of hygiene had improved in residents' bedrooms and en-suites, areas such as the communal areas, assisted bathrooms, storage areas, catering areas, and sluice facilities were visibly unclean on inspection. Inspectors observed poor practice such as the inappropriate storage of equipment in the sluice room. Poor standards of hygiene and infection prevention and control were also findings of inspections carried out July 2022, October 2022, January 2023, February 2023, April 2023, July 2023, and September 2023.

The provider had engaged the services of a competent person to assess the structural integrity of the premises in December 2023. At the time of this inspection, the outcome of this assessment was not available for review. Inspectors found that parts of the premises identified on the previous inspection remained in a poor state of repair. This included areas of corridors that were not appropriately decorated, bedrooms and en-suites, and communal bathroom facilities that were poorly maintained.

On previous inspections of the centre, significant risk and non-compliance was identified in relation to the nutritional care needs of residents. The provider was required to take urgent action following two inspections of the centre in January 2023 to ensure an appropriate number of staff were on duty to supervise residents during mealtime, and to take urgent action to ensure the kitchen environment maintained an appropriate standard of hygiene. A review of the food and nutrition aspect of the care service was completed due to the high risks identified on the previous inspections. This inspection found that improvement had been made to ensure residents were receiving nutritional care in line with the requirements of the regulations.

On this inspection, the care observed appeared to be delivered in line with the residents care plans, particularly in relation to residents who required assistance at mealtimes, and supervision when mobilising.

A review of residents' records found that residents had access to a general practitioner (GP) of their choice, as requested or required. Arrangements were in place for residents to access the expertise of health and social care professionals for further assessment.

An activity schedule was displayed and residents were observed to be participating in group activities such as daily exercises and bingo.

Regulation 17: Premises

The provider had failed to maintain the premises in a satisfactory state of repair to ensure compliance with the regulation. For example,

- Floor coverings in some areas were not appropriately maintained. For example, the floor covering in the dining area was damaged and torn.
- Corridor walls were not appropriately maintained. For example, in some areas walls remained undecorated, and heavily stained from spillage.
- Wall tiles in communal bathrooms, and some bedroom en-suites were damaged and loose.
- There were visibly cracks in the structure of the building, in particular at the first floor of the premises. Plaster was falling off the wall in some rooms.
- Bedrooms designated to accommodate two residents did not have adequate storage facilities and were not configured to provide adequate usable and private space.

While the first floor of the premises remained unoccupied by residents, this area of the premises continued to be in a poor state of repair. For example, damaged plaster, loose and broken tiles, visibly cracks, stained and damaged walls impacted on the quality of the physical environment.

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 18: Food and nutrition

The provider had taken action to comply with this regulation since the last inspection.

Residents were monitored for weight loss and were provided with access to dietetic, and speech and language services when required.

A varied menu was available daily, providing a choices to all residents including those on a modified consistency diet.

Staff were available to provide residents with assistance at mealtimes in the dining room and in their bedrooms.

Judgment: Compliant

Regulation 27: Infection control

The provider did not ensure that infection prevention and control procedures were consistent with the National Standards for Infection Prevention and Control (IPC) in community settings published by HIQA.

There was poor oversight of the cleaning systems and the quality of environmental hygiene. Additionally, there were inadequate resources available to clean the centre. This significantly impacted on the quality of environmental hygiene, and infection prevention and control.

The environment and equipment was not managed in a way that minimised the risk of transmitting a health care-associated infection. For example;

- Waste was not appropriately managed. Empty boxes and bags of waste were stored on the ground in a sluice room, and in the corridor by the laundry area.
- Cleaning equipment such as buckets of water and mops were stored within the sluice room. The areas was visibly unclean and an appropriate standard of hygiene had not been maintained.
- Areas of the premises that included the dining room, kitchen area, and storage areas were visibly unclean on the ground floor.
- Equipment, such as residents beds, documented as having been cleaned, were visibly unclean on inspection.
- A communal bathroom provided for residents use on the ground floor was not clean. For example, the toilet was visibly stained and the shower drain had layers of accumulated dirt. This area was unclean on the morning of the inspection and remained in the same condition when checked by inspectors in the afternoon.

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 28: Fire precautions

Following this inspection, the provider was required to submit an urgent compliance plan to address an urgent risk. A significant number of emergency lights had failed during inspection by a competent person on 11 January 2024. This was a repeated finding and was a persistent significant risk to residents whereby emergency lights would potentially not function during a fire emergency, particularly at night time. The providers response did provide assurance that the risk was adequately addressed.

In addition to the above, arrangements for providing adequate means of escape

required action. For example;

- There was a fence enclosing a route from the building to the smoking area. As there was no gate within the fence, the only means of escape from the smoking room was to re-enter the building. This is a repeated finding from the previous inspection and no action had been taken to manage the risk.
- There was a large air handling unit along an external route used as a means of escape. This had the potential to cause obstruction or injury during an evacuation.

Arrangements for containing fire in the designated centre required improvement. For example;

- There continued to be deficits in a number of fire doors which could allow the spread of smoke and flames, and created an ongoing risk to the safety and welfare of residents living in the centre. For example, the fire doors from the escape corridor to the kitchen were not a 60 minute fire rated door. This had been brought to the attention of the provider in their own fire safety risk assessment carried out in October 2023.
- There were persistent deficits to the fire containment measures throughout the building, identified in the provider's fire safety risk assessment.

The arrangements for maintaining the fire equipment, means of escape, building fabric and building services were not adequate. There was no periodic inspection report of the electrical installation available to ensure the electrical installation was free of fault or risk.

At the time of inspection, the registered provider had not taken adequate precautions to ensure that residents were protected from the risk of fire nor were fire precautions being adequately reviewed. For example;

- Despite significant deficits being identified in the systems of containment and management of fire, the fire evacuation procedure had not been reviewed or updated to mitigate known fire risks in the centre. This included the risk associated with impaired fire doors, and the emergency lighting system.
- Actions in place to manage fire risks were not clear. A checklist had been implemented to ensure lint filters in the laundry machines were cleaned daily. However, some records were signed by staff who were not rostered on duty.
- A fire evacuation drill carried out in October 2023 had identified that two bedroom doors did not fully close during the simulated evacuation, and would therefore compromise fire and smoke containment measures. Inspectors found that the provider had taken no action to review or address the identified risk.

The arrangements for evacuating, where necessary in the event of a fire, all persons in the designated centre and the safe placement of residents required further action. For example;

- There was uncertainty regarding the location of effective fire compartment boundaries in the designated centre to support the centre's fire evacuation

strategy or progressive horizontal evacuation. This presented a risk to the welfare of residents as it was unknown if residents were protected from the risk of fire through effective containment, when evacuated from the source of a fire to a perceived safe area.

Staff were not suitably trained in the fire prevention and emergency procedures. Staff were unaware of the fire risks in the centre such as deficits in the emergency lighting system or the impaired integrity of some fire doors. Consequently, some staff did not have the required knowledge to ensure residents were protected from the risk of fire, or the potential for fire risks to impact on the safe and timely evacuation of residents from the centre in the event of a fire emergency.

From a review of fire drill reports, inspectors were not assured that adequate arrangements had been made for evacuating residents from the centre in a timely manner with the staff and equipment resources available. While simulated fire evacuation drills assessed staff response times to the sounding of the fire alarm in a specific location, the records did not consistently detail if the drill progressed to a full compartment evacuation.

Assurances could not be provided that drawings displayed to support evacuation included information such as the location of fire compartment boundaries.

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

A review of the nursing care documentation found that action had been taken since the last inspection to ensure that all residents had an assessment of their health and social care needs completed and a care plan was in place to address the needs of the residents.

The provider had ensured that care plans were implemented and reviewed, in line with the changing needs of the residents, in line with regulatory requirements.

This was a completed action since the last inspection.

Judgment: Compliant

Regulation 6: Health care

The provider had taken action to address the non-compliant findings of the previous inspection in relation to providing residents with referral and access to a general

practitioner (GP) of their choice. A referral system was in place for residents to access health and social care professionals such as dietitans, physiotherapists, psychiatry of late life and end of life care 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	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	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	Compliant

Compliance Plan for An Teaghlach Uilinn Nursing Home OSV-0000309

Inspection ID: MON-0042505

Date of inspection: 17/01/2024

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:

• The Group HR Manager continues to work within a strategic recruitment plan which includes contingency plan for unforeseen leave - completed and ongoing.

• Recruitment of additional housekeepers has been completed to ensure that the roster has a planned 2 housekeeping staff on duty daily - completed.

• The center has a robust recruitment process in place which includes a weekly review of vacancies and a monthly review of unplanned leave - completed and ongoing.

• Since Jan 2024 the center has successfully recruited 9 new members to the team; Activities x 1, Chef x 1, HCA x2; HH & L x2; HH Supervisor x 1 & Kitchen Assistant x 2.

• In addition to local recruitment strategies the center is expecting several Healthcare Assistants (HCAs) to arrive in the country in the coming weeks as part of international recruitment events, further bolstering our workforce and ensuring adequate staffing levels to support any anticipated influx of admissions - ongoing

• Currently there are an additional 3 Household staff & 4 HCA Staff in the recruitment process, this is excluding international HCA recruitment strategy - completed.

• The Housekeeping duties will be completed by external cleaning team in the interim of onboarding the extra housekeeping staff. In addition, the Center recruited a housekeeping supervisor on 22/01/24 to enhance the oversight of the housekeeping staff. This is overseen by the Support Services Manager - completed and ongoing.

• Staffing levels will continue to be reviewed weekly using a validated assessment tool as part of the Group HR Manager workforce planning meetings – ongoing.

The PIC completes the roster to ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents - completed and ongoing

Regulation 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:

• The center has appointed a housekeeping supervisor on 22/01/24 who is supported by the Support Services manager to oversee the cleanliness of the center - completed and ongoing.

• The clinical management team continue to audit the IPC practices and the environment as part of monthly IPC audit - completed and ongoing

• The clinical operations director completes a monthly spot check on the IPC practices and environment of the center with identified actions - complete and ongoing

• The Cleanliness of the kitchen is reviewed using the newly implemented Kitchen audit and record management system as part of enhancing the audit schedule in the center, this was last completed on 05/04/24 with a result of 91%. The DON and ADON are responsible for checking the kitchen cleanliness daily - completed and ongoing.

PIC completes a daily walk around to supervise the standards of hygiene in the kitchen area, communal toilet facilities and ancillary support areas - completed and ongoing.

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:

• The staff planned roster is now overseen by members of the Group senior management team to ensure that all leave is recorded appropriately - completed.

• The worked roster is updated according to any unforeseen changes by the onsite clinical management team - completed.

• The roster is updated to reflect the worked roster for staff on the electronic system daily - completed and ongoing.

• The center maintains a comprehensive training matrix with all aspects of both mandatory and non-mandatory training. This is maintained by the HR team, reviewed by the Group HR Manager monthly with actions on training disseminated to the PIC and ADON. - completed and ongoing

• The PIC has recorded the specific complaint highlighted by the inspector and this is now closed out - completed.

• Complaints are recorded as part of the monthly KPI's for trending and a monthly audit of complaints is completed as part of the audit schedule - completed and ongoing.

• Records related to residents' finance and transaction records are available to residents in the form of a monthly print out, along with a quarterly transaction statement as provided to the RPR by the relevant financial institution - completed and ongoing.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The Group HR Manager continues to work within a strategic recruitment plan which includes contingency plan for unforeseen leave.
• The center has a robust recruitment process in place which includes a weekly review of vacancies and a monthly review of unplanned leave. As part of management staffing there is a contingency plan in place to respond quickly. This includes an ongoing significant recruitment drive, panel of staff under GV process at any time to ensure cover is available and agreed SLA's with approved staff agency providers.
• Since Jan 2024 the center has successfully recruited 9 new members to the team; Activities x 1, Chef x 1, HCA x2; HH & L x2; HH Supervisor x 1 & Kitchen Assistant x 2. Currently there are 1 Household staff at GV stage and the center continues to recruit additional staff to meet the WTE of the center in preparation for increased occupancy - completed and ongoing.
• Staffing levels will continue to be reviewed weekly using a validated assessment tool as part of the Group HR Manager workforce planning meetings – ongoing.

The center has a clear organisational chart in place as per SOP outlining the management structure of the center. The PIC has responsibility for the oversight and management of rostering staff and the HR Group Manager continues to have responsibility for recruiting staff for the center.

The Governance and Management systems in place include weekly meeting between the Clinical Operations Director and the PiC, weekly SMT meetings and monthly onsite G&M meetings.
• Weekly and monthly KPI's are discussed at these meetings to ensure that the RPR is informed of KPI's, including any complaints which may arise and the status of these complaints.
• The Risk Register has been reviewed and the items outlined by the inspector in this report have been added to the Risk Register. The risk register has been reviewed by the

PIC and Clinical Operations Director monthly.
• The center has implemented an enhanced annual audit schedule of 22 clinical audits as part of implementation of an electronic system, weekly, monthly, quarterly, biannual and annual audit analysis and reports will form part of the G&M meetings. The clinical operations Director has completed a quarterly analysis of audits for Q3 & Q4 2023, Q1 of 2024, to include trending, and identifying learnings as part of quality improvement - completed and ongoing.
• The management system related to the roster has been overhauled by members of the senior management team. The planned roster is reviewed fortnightly at senior management level and the PIC updates the roster daily in the electronic system to ensure that the worked roster is live and accurate - completed and ongoing.
• All complaints are now recorded on complaints register, these are reported by the PIC as part of weekly KPI's and discussed with the clinical operations director. All complaints are trended as part of the monthly KPI's and their status discussed at the monthly G&M meetings to ensure that the RPR is informed.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
• All verbal expressions of dissatisfaction are now recorded on the complaints register, these are reported by the PIC as part of weekly KPI's and discussed with the clinical operations director.

• The residents committee meeting agenda includes reminders to residents on the process related to raising a concern.

Staff have received additional training in complaints management.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• The floor covering in the dining room will be replaced by 10-04-2024.

• Redecorating of the corridor walls has commenced and there is a robust plan in place to complete redecoration of the center with the recruitment of a second maintainence person and the oversight of the support services manager.

• A detailed programme of phased works has commenced to replace the wall tiles with

complete refurb of wall coverings in bathrooms and 3 rooms have been completed since the inspection - completed and ongoing.

• A structural assessment has been completed by a competent person. Monitoring guage's have been installed to monitor these cracks. Improvement in this area is included in the annual capex budget. There are no residents residing on the first floor currently - completed and ongoing.

• There are currently no residents sharing rooms in the center. Bedrooms designated to accommodate two residents have been reconfigured and privacy curtains in place with allocated storage facilities for the twin rooms. All residents who currently reside in the center have adequate storage. A refurbishment plan is in place for the vacant rooms on the first floor- completed and ongoing.

• The physical environment of the first floor continues to be improved and since inspection the balcony has been enhanced, made safe and there is a schedule of works collated as part of the overall capex plan for 2024 prior to any residents residing in the first floor.

The RPR has issued updates to the inspector with updates on the works completed on the premises on 19/01/24; 22/01/24; 23/01/24; 29/01/24; 31/01/24; 08/02/24; 12/02/24; 16/02/24; 01/03/24; 07/03/24; 15/03/24; 19/03/24 and will continue to keep the regulator informed of progress.

Regulation 27: Infection control	Not Compliant

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

• Additional Housekeeping staff have been recruited and a further 2 housekeeping staff are in the onboarding process - completed and ongoing

• Oversight of the IPC is completed daily by the onsite housekeeping supervisor and the clinical management team, any deficits are recorded in the relevant Maintenance and Housekeeping request book - completed and ongoing

• The Support Services Manager has provided additional training to the housekeeping team in their duties and oversees the IPC auditing of the environment including the dining room, kitchen area and storage to ensure that the standard of these areas are maintained - completed and ongoing.

• A monthly IPC audit is completed by the onsite clinical management team, analysis and trends with learnings are identified and implemented - completed and ongoing.

• The clinical operations director completes a monthly IPC spot check as part of the

onsite visits, reports provided to the onsite clinical management team with identified actions - completed and ongoing.

A extensive deep cleaning programme has been completed over 14 days to address the issues raised by the inspectors on the last inspection. A deep cleaning progamme is now in place to ensure that all areas are on a deep clean schedule - completed

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• The fence enclosing a route from the building to the smoking area has been adjusted to include a gate to ensure there is egress from the smoking area - completed.

• The air handling unit has been removed in February 2024 - completed.

• The RPR commissioned an expert consultant to complete a detailed report on the fire doors and compartmentalization in An Teaghlach Uilinn Nursing Home on 13/02/24 with a follow up actioned on 07/03/24 to complete the second and final phase of their fire risk assessment. Both of these reports supersede the reports issued from the previous fire risk assessments by consultants in October 23, May 23 and December 21. This is because previous reports were generic in detail and did not provide an itemized list of corrective actions required per individual item or room and as such could not be costed or certified as having been fully completed.

• Following receipt of the report in Mar 2024, the RPR has collated a robust action plan. A tender for the remaining fire door repairs & replacement was issued on 01/03/24, and a tender to address the compartmentation issues raised was issued on 05/03/24, a contractor has been appointed and works commence on 11/04/24 to replace fire doors - ongoing.

The RPR commenced repairs on 18/01/24 with details issued to the inspector as works progressed in the center. Works completed to date include:
• 2x fire doors have been replaced in 2023,
• 9x fire doors were repaired on 26/02/24,
• 3x fire doors are on order and installation is planned for 11/04/24,
• Other fire door repairs are planned to commence on 15/04/24,
• 8x fire hatches have been replaced in 2023,
• All emergency lights internal & external have been replaced with new emergency lights fixtures. On 05/03/24 the facilities company completed a 3-hour test for all emergency lights which showed no failures, and certification received.
• An emergency box with torches in the event of impaired emergency lighting was implemented on 18/01/24.
• The center has a specific and relevant written policy, on fire safety management and risk management, which is readily available to all staff, including agency staff.

• Risks associated with Regulation 28 are discussed and updated at team management meeting, with concerns, updates and decisions recorded in the minutes of these meetings.
• A fire safety register is maintained and are records readily available,
• The RPR has appointed an appropriate facilities management company to complete testing of the electrical equipment and a certificate confirming maintenance of the fire detection system is displayed in the center adjacent to the alarm system and certification recorded in the fire risk register,
• Ventilation systems, including kitchen extract equipment is maintained by a competent person.
• Fire detection devices are included in rooms, stairwells, corridors, storerooms, void spaces etc.
• Fire safety notices and signs are visibly displayed in the home.
• The fire evacuation procedure has been reviewed and updated to mitigate fire risks in the centre to include the risk associated with impaired fire doors, and the emergency lighting system and staff have been informed and updated accordingly- completed and ongoing.
• The lint removal record in the laundry is in place and overseen by the PIC to ensure its accuracy - completed and ongoing,
• Fire drills for evacuation of full compartments using progressive horizontal evacuation x 8 have been completed since the last inspection and continue to be completed min 2 per month. Compartment evacuation time are recorded with any identified deficits added to the risk register by the PIC and reported to the Support Services Manager - completed and ongoing.
• All staff have received training in Fire Management as well as taking part in full compartment evacuation drills of the center - completed and ongoing.
• An appropriate consultant has produced revised evacuation plans following their compartmentation review and these evacuation plans are now clearly on display around the nursing home - completed.

The RPR has provided commitment to the regulator that the center is working towards full compliance by 31-05-2024.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Substantially Compliant	Yellow	01/05/2024
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	10/04/2024
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	30/04/2024
Regulation 21(1)	The registered provider shall	Not Compliant	Orange	10/04/2024

	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 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Not Compliant	Orange	10/04/2024
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	30/04/2024
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Not Compliant	Orange	10/04/2024
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe,	Not Compliant	Orange	10/04/2024

	appropriate, consistent and effectively monitored.			
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	10/04/2024
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.	Not Compliant	Orange	31/05/2024
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Red	19/01/2024
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	30/04/2024
Regulation	The registered	Not Compliant	Orange	10/04/2024

28(1)(c)(ii)	provider shall make adequate arrangements for reviewing fire precautions.			
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	10/04/2024
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 designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the	Not Compliant	Orange	10/04/2024

	case of fire.			
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	31/05/2024
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.	Not Compliant	Orange	31/05/2024
Regulation 34(6)(a)	The registered provider shall ensure that all complaints received, the outcomes of any investigations into complaints, any actions taken on foot of a complaint, any reviews requested and the outcomes of any reviews are fully and properly recorded and that such records are in addition to and distinct from a resident's individual care plan.	Substantially Compliant	Yellow	10/04/2024