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:	25 September 2023
Centre ID:	OSV-0000309
Fieldwork ID:	MON-0041477

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:	34

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
Monday 25 September 2023	17:00hrs to 21:15hrs	Sean Ryan	Lead
Tuesday 26 September 2023	07:40hrs to 16:15hrs	Sean Ryan	Lead
Monday 25 September 2023	17:00hrs to 21:15hrs	Brid McGoldrick	Support
Tuesday 26 September 2023	07:40hrs to 16:15hrs	Brid McGoldrick	Support
Monday 25 September 2023	17:10hrs to 21:15hrs	Niall Whelton	Support
Tuesday 26 September 2023	07:40hrs to 16:15hrs	Niall Whelton	Support

What residents told us and what inspectors observed

Overall, residents living in An Teaghlach Uilinn Nursing Home gave mixed feedback with regard to their experience of living in the centre. Residents described their daily lives in the centre as being 'inconsistent'. While residents were complimentary of the staff who provided them with care and support in a respectful manner, residents expressed discontent with the quality of care they received. Residents attributed the inconsistent care and quality of the service to changes in the management personnel and reduced staffing levels. Residents voiced that they often experienced delays in receiving assistant and support from staff.

Inspectors arrived unannounced at the centre during the evening time and were met by an assistant director of nursing. Following an introductory meeting, inspectors walked through the centre and spent time talking to residents and staff, observing the care provided to residents, and the care and catering environment. The clinical operations director attended the centre to support the inspection process.

There was a busy atmosphere in the centre during the evening of the inspection. Staff were busily attending to residents requests for assistance, attending to the arrival of visitors, answering the telephone, and serving residents their evening meals. Some residents were observed sitting in the communal day room. While staff were present to supervise residents, there was little social engagement taking place. Other residents were observed walking around their bedroom, and through the corridors unaided and unsupervised. A number of residents were observed in their bed waiting for their evening meals to be served.

Inspectors spoke with a number of residents in the communal room and in their bedrooms. Residents told the inspectors that a new chef had joined the centre, and they were complimentary of the taste and aroma of the food being served to them. However, residents told the inspectors that they often experienced delays in receiving their meals in their bedrooms, and that the food was not hot when it was served.

Inspectors observed that the supervision and allocation of staff was inadequate. While residents were observed to be supervised in the communal day room and dining room, inspectors observed that residents in their bedrooms had less supervision. This was evidenced during the evening time, and again during the morning when residents who required supervision during mealtimes were observed having their meals unaided and unsupervised. Additionally, meals were observed to be left in residents bedrooms in front of residents for an extended period of time before staff arrived in the resident's bedroom to provide assistance. Inspectors observed that a resident, who required supervision when mobilising due to being at risk of falls, was unsupervised when walking through the corridors on numerous occasions during the inspection.

Inspectors observed that the quality of hygiene in the kitchen and catering areas had improved. New floor coverings had been installed and staff reported that this supported effective cleaning. However, some items of equipment such as the hot food storage units, milk dispenser, and food preparation areas were not clean. Inspectors observed that residents dietary preferences, and prescribed modified consistency diets were displayed on a white board in the kitchen to provide guidance to the catering staff on resident's nutritional needs. However, some of this information did not accurately reflect the resident's nutritional needs. This posed a risk to residents where an inappropriate diet may be served to the residents.

Residents were accommodated on the ground floor of the centre. The provider had carried out some redecoration of corridor walls on the ground floor. Inspectors observed that the management of storage areas had improved to ensure equipment was appropriately stored. The premises was generally maintained in a satisfactory state of repair, with the exception of the first floor of the premises that was not currently used to accommodate residents. Inspectors observed that the first floor of the premises was not maintained in a satisfactory state of repair. Wall tiles in en-suits were loose, damaged, and missing in parts. Cracks were evident along the ceiling, and the area was malodourous.

Residents bedrooms were personalised with items such as family photographs, colour coordinated soft furnishings, and ornaments. Residents who had been accommodated on the first floor of the premises had been moved to the ground floor. Inspectors observed that suitable storage facilities were not provided in all bedrooms. Wardrobes within twin bedrooms consisted of a two door wardrobe, with a common shelf for residents to share above separate hanging space. The privacy curtain within a bedroom on the ground floor was not secured to the ceiling, and two brackets to secure the end of the rail had come loose from the ceiling.

Residents' personal clothing was laundered on site and residents reported their satisfaction with this service. The laundry area was not clean on inspection and inspectors observed the system in place to reduce the risk of cross infection in the laundry area was not adhered to.

While the quality of environmental hygiene had improved in some areas of the centre, inspectors observed areas of the ground floor that were not clean. This included communal toilets, some bedrooms, and equipment used by residents. On the first floor, vacant bedrooms, a communal toilet, and en-suites were observed to be visibly unclean. Inspectors were informed that this area was not frequently cleaned. Inspectors observed poor hand hygiene practices and inappropriate wearing of gloves. This posed a risk of cross contamination, and therefore risk of infection to residents.

The inspectors saw fire safety risks while reviewing the premises over the two days. This included inappropriate storage of oxygen, a lawnmower and fuel canister within an externally accessed store, equipment batteries being charged within a fire protected escape corridor. The lawnmower and fuel canister were removed during the inspection. A number of emergency lighting units and emergency exit signs were observed not to be functional. In addition, some fire doors were observed to be

impaired in a number of areas. The fire door to a sluice room was within a frame that was not secured to the wall, and some doors had warped and did not close against the latch. A number of fire doors did not have the appropriate non-combustible hinges required to keep the door securely in place. The door to a store at first floor was found open and the door was obstructed by a trolley with a printer on it. There was no automatic closing device to this door. This meant that the effectiveness of the fire doors were potentially compromised in their function to contain smoke and fire.

Residents told the inspectors that the provision of meaningful activities was not consistent, particularly at weekends. Residents stated that they preferred to remain in their bedroom as there was limited social activities in the communal dayrooms in the afternoons and at weekends. Residents who were present in communal areas told inspectors that there were limited activities provided during the day. Inspectors observed that residents were not socially engaged during the evening of the inspection.

The following section of this report details the findings with regard to the capacity and capability of the centre and how this supports the quality and safety of the service provided to residents.

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).
- follow up on the actions taken by the provider to address significant issues of non-compliance identified during a series of poor inspections of the centre on 11 January 2023, 27 January 2023, 22 and 23 February 2023, 4 April 2023, and 9 July 2023.
- review a representation submitted by the registered provider following the issuing of a notice of proposed decision to cancel the registration of the designated centre.

The findings of this inspection were that the registered provider had failed to put effective management systems in place to ensure that the service provided was safe. A disorganised and unclear organisational structure and ineffective systems of management resulted in repeated regulatory non-compliance across all regulations reviewed. Inspectors found that, where the registered provider had previously implemented systems to monitor aspects of the service, it had failed to ensure that those systems were consistently implemented and sustained. Consequently, this resulted in a deterioration in the quality of care provided and continued risks to residents.

Knegare Nursing Home Holdings Limited is the registered provider of An Teaghlach Uilinn Nursing Home. Following consistently poor regulatory compliance over repeated inspections, the Chief Inspector of Social Services issued a notice of proposed decision to refuse the application to renew the registration of the centre. In addition, a notice of proposed decision to cancel the registration was also issued.

The registered provider made representation within 28 days of the notices being issued, to detail the action that had been taken to address the non-compliance relating to the quality and safety of the service. The detail of this representation was reviewed on inspections carried out on 4 April 2023 and 9 July 2023. Incremental improvements were found in some areas during these inspections, and so the provider was afforded a further opportunity to submit a revised organisational structure, and an opportunity to clarify the management systems in place to monitor the quality and safety of the service.

The registered provider of this centre is a company consisting of five directors, one of whom represents the provider in the governance of the centre. The organisational structure detailed in the provider's representation, dated 10 August 2023, consisted of a board of directors, an operations director, commercial director, a clinical operations director, and a regional manager. Inspectors found that, on the day of inspection, the personnel for these positions were not all in post. A person participating in the management of the centre was in post to monitor clinical and operational aspects of the centre. This role, as detailed in the representation, included ensuring clinical policies and procedures were implemented, management of incidents, and regulatory notifications. Inspectors found that the changes made to the organisational structure had failed to impact the quality and the safety of the care provided to residents, the overall governance and management of the designated centre had not improved since the last inspection in July 2023, and that some aspects of the service had deteriorated. Inspectors found that the changes made to the organisational structure had failed to impact the quality and the safety of the care provided to residents.

Within the centre, the nurse management team was found to be inconsistent and ineffective. An assistant director of nursing from another centre was temporarily based in the centre to support the training and supervision of staff. In the absence of a person in charge, an assistant director of nursing facilitated the inspection and was supported by two clinical nurse managers, one of whom was newly appointed.

The lines of accountability and responsibility for the oversight of care and safety of the residents was not clear. The management teams supporting the centre both externally and within the centre had changes multiple times. For example, there had been seven changes of person in charge since August 2022.

Inspectors found that the management systems, pertinent to supporting effective governance, such as risk management systems, record management, and the systems to monitor and evaluate the quality and safety of the service were ineffective. These systems were not known to the personnel within the centre responsible for the administration and oversight of the service.

Inspectors found that the ongoing changes to the organisational structure impacted on the provider's ability to establish robust systems to ensure the service provided to residents was safe, appropriate, consistent and effectively monitored. This negatively impacted on the providers ability to recognise, respond to, and manage risk and regulatory non-compliance's in the centre, and maintain safe and quality levels of care for residents.

Communication systems in place to escalate risks and concerns to the senior management remained ineffective. Inspectors found records of adverse incidents involving residents that had not been appropriately escalated to the senior management team. This included an incident where a resident sustained an injury following a fall and required further medical assessment and treatment.

The system in place to manage risk was not effective. The centre's risk management policy detailed the interventions that should be in place for the oversight of risk in the centre. This included maintaining a risk register to record all potential risks to residents' safety and welfare. A review of the centre's risk management systems found that it did not reflect the centre's own risk management policy. The risk register did not contain the known risks in the centre. This included the risk associated with the absence of the management personnel within the centre, fire risks, and risks associated with the premises. Consequently, there were no effective risk controls in place to manage the potential risk to residents' safety. Inspectors found that the risk management systems were not known to the management team.

The management system in place to ensure adequate fire precautions was not effective. The day-to-day fire safety management required improvement to capture the risks identified during this inspection and to assure staff knowledge of the evacuation arrangements. During the inspection, action was required from the provider to address fire safety risks; these are detailed under Regulation 28: Fire precautions. In addition, plans to address the findings of the centre's own fire safety risk assessment had not been fully completed.

A review of the staffing records in the centre found that staffing rosters and the allocation and supervision of staff was poorly managed. This resulted in incomplete staffing rosters. A chaotic roster management system contributed to poor oversight of the staffing arrangements in the centre. For example, there were three roster management systems in operation. Staff who were scheduled for duty on a paper-based roster system were not scheduled for duty on the electronic roster system. Staff were unclear on which system to use to identify and manage the staff on duty. Inspectors compared the records of each system and found numerous occasions during the previous seven days where the electronic roster records did not match the paper staff roster records. On the day of inspection, the staff rostered for duty did not align with the staffing allocations, or the printed rosters provided to inspectors for review. The lack of clear direction to staff on the appropriate roster management system to use resulted in some staff not reporting for duty on the day of inspection. Consequently, the clinical management team were required to suspend their duties in order to support the care being provided to residents until

replacement staff could be found. This is a repeated non-compliance from previous inspections.

Inspectors found that staffing levels were not adequate to meet the needs of the residents. Residents were observed waiting a significant period of time to receive assistance with their nutritional care, and personal care needs. Since the last inspection in July 2023, the provider had reduced the number of health care staff on duty during the day and night. The provider had not assessed the potential risk to residents, considered the impact of reduced staffing levels on the quality of care provided to residents, or the potential impact on fire evacuation procedures at night time.

Inspectors found that the arrangements in place to supervise and support staff to implement the centre's policies and procedures, and maintain records were not effective. Inspectors observed poor care practices where residents who required assistance and supervision with their nutrition were unsupervised and unaided during their meals. Residents at risk of falls were observed mobilising unsupervised by staff. Inspectors observed that management staff were regularly reallocated to administration work. This reduced the ability of the clinical management team to fulfil the management component of their role, and impacted on the supervision of staff, clinical oversight, and governance.

A review of the records of incidents and adverse events in the centre found that the provider had failed to ensure that documentation was completed and reviewed. Two incidents involving residents were not documented in line with professional guidelines, regulatory requirements, or the centre's own policy. This meant that incidents were not fully investigated or analysed, and no quality improvement action was implemented to ensure resident safety. This significantly impacted on the registered provider’s ability to manage risk and learn from near miss and actual adverse incidents.

Notifiable incidents, as detailed under Schedule 4 of the regulations, were not notified to the Chief Inspector of Social Services within the required time-frame. For example, the Chief Inspector had not been notified of an incident with regard to a serious injury sustained by a resident.

Regulation 15: Staffing

The provider had failed to ensure that there were sufficient staffing levels in the centre to meet the assessed needs of the residents, or for the size and layout of the centre.

- Vacant shifts in the health care staff roster resulted in the management staff being redirected from their management and supervisory role to deliver direct care to the residents. This impacted on overall supervision of staff, and the supervision of the quality of care provided to residents.

- Unplanned staff leave resulted in housekeeping staff suspending their cleaning duties in order to support the care provided to residents. This impacted on the quality of environmental hygiene observed on the day of inspection.
- A review of rosters for the previous eight days showed that over 60 administrator hours had not been filled. Inspectors were informed that additional staff had not been made available to cover those hours, and that health care staff were allocated additional administrative duties during their shift.
- Residents spoken with voiced their concern with regard to staffing levels. Residents reported, and were observed, waiting long periods of time to receive assistance with their care needs.
- Residents were observed waiting long periods of time for assistance with their nutritional care needs. On two occasions, staff were not available to support residents, or provide assistance to residents assessed as requiring one-to-one care with their nutritional needs.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff were not appropriately supervised. This was evidenced by the failure to;

- Supervise nursing documentation. Residents records were duplicated from previous entries. Furthermore, there was poor documentation of an incident in which a resident suffered an injury from a fall.
- Supervise and oversee the delivery of care and the recommendations of allied health care professionals.
- Supervise and oversee medication management, in line with the centre's own policies, and relevant professional guidelines.

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 21: Records

A review of the record management systems in the centre found that records were not managed in line with regulatory requirements. For example;

- Staff rosters did not reflect the staffing levels on the day of inspection and staff rosters for the weeks prior to the inspection were not reflective of the actual rosters worked by staff. For example, there were 25 occasions in the

previous 11 days where both the electronic staff rosters, and paper based rosters did not align. Consequently, inspector could no be assured that records accurately reflected the rosters worked by staff.

- The nursing record for resident's care received following an incident in which a resident suffered harm was poorly documented and investigated. There was no documented assurance that appropriate assessment, treatment and care was delivered to a resident following a fall, and a potential choking incident.
- Records of specialist treatment and nursing care provided to residents were not maintained in line with the requirements of Schedule 3(4)(b). For example, records of repositioning charts for residents at high risk of impaired skin integrity, and records of safety checks for residents at high risk of absconsion were poorly maintained, and not available for review.
- Nursing records were not completed in line with the requirements of Schedule 3(4)(c). For example, a review of residents' nursing records found that multiple nursing notes were duplicated from previous entries. This meant that the record was not person-centred, and did not provide assurance that the daily care needs of the residents had been met.
- A record of all staff training was not provided for review. For example, a record of training specific to care planning was not available for review, in line with the requirements of Schedule 4(8)(c).
- Records were not maintain in a manner that was safe. Records required under Schedule 3 of the regulations were not securely stored. For example, records of residents medical and nursing care were stored in an unsecured area on the first floor of the premises.

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 23: Governance and management

The registered provider failed to ensure there was an effective organisational structure, with clear lines of accountability and responsibility in place. The organisational structure, as described in the centre's statement of purpose was not effective. For example, accountability and responsibility for the oversight and monitoring of key aspects of the service were not clear. This included the oversight of risk management systems, the premises, and fire safety. There were inconsistent and poorly defined systems in place to escalate risks to the senior management.

The poorly defined organisational structure impacted on the management systems in place to ensure the service provided was safe and appropriately monitored. This was evidenced by a failure to;

- Implement the centre's risk management systems to manage known risks. Furthermore, the provider failed to implement the centre's safeguarding, and

risk management policy to appropriately document and investigate a potential safeguarding incident.

- Ensure there was clinical oversight of incidents involving residents. There were over 30 open incidents relating to falls incidents, a near miss choking incident, and responsive behaviour. There ws no evidence of those incidents being investigated to identify learning, or prevent recurrence.
- Ensure residents were protected from the risk of fire. There was no clear time-bound project plan to address outstanding fire safety works, and no effective risk management systems in place to manage potential fire risks to residents.
- Implement or sustain effective systems to monitor, evaluate, and improve the quality and safety of the service. For example, audits of clinical records and fall incidents failed to identify potential contributing factors to poor audit findings as there was no analysis, trending, or learning identified. This meant that effective quality improvement action plans could not be developed.
- Ensure effective record management systems were in place to ensure compliance with the regulations. For example, there was poor oversight of records pertaining to nursing documentation, and the records of incidents were found to be poorly recorded and investigated. In addition, staffing rosters were poorly managed and impacted on effective oversight of the staffing resources.
- Implement effective systems to manage residents finances. The oversight arrangements of finances in the centre did not ensure policies and procedures were in line with national guidance. For example, resident pension arrangements in place by the provider were not in line with national guidance. Furthermore, the system in place to return monies to the estates of residents who had passed away, or residents that had been discharged was not robust.
- Submit a statutory notification to the Chief Inspector, in line with regulatory requirements.

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 31: Notification of incidents

The registered provider had failed to notify the Chief Inspector of an incident occurring in the designated centre.

- Notification had not been submitted within three working days of a serious injury to a resident that required immediate hospital treatment.

Judgment: Not compliant

Quality and safety

Inspectors found that the quality and safety of care provided to residents was impacted by inadequate governance and management as described under the Capacity and Capability section of this report. The failure of the provider to establish and sustain an effective organisational structure impacted on their ability to achieve and sustain regulatory compliance. Consequently, significant action was required in relation to the assessment and monitoring of resident's needs to ensure the delivery of safe, person-centred care to residents. While some improvements were identified in the quality of residents care plans, inspectors found that residents did not receive care and support in line with their care plans. Non-compliance in relation to health care, food and nutrition, infection prevention and control, and fire precautions impacted on residents' safety and well-being. Furthermore, action was required to ensure that residents finances were managed in line with best practice guidance.

A review of the nutritional aspects of the service found that the provider failed to ensure there were robust arrangements in place to ensure residents, identified as nutritionally at risk received care and support in line with their assessed care needs, and the recommendations of health care professionals. Despite being identified on previous inspections, residents continued to be served food that was not in line with their modified consistency diet prescribed by health care professionals due to swallow difficulties. Residents who were diagnosed with swallow difficulties, and required the supervision of staff, were observed eating their meals unsupervised. This posed a significant risk to the care and welfare of those residents. Further findings are discussed under Regulation 18: Food and nutrition.

A review of residents' records found that there was regular communication with residents' general practitioners (GP). However, a number of residents had not been referred to their GP, despite the requirement being indicated within their medical notes following discharge from hospital, or following detection of an adverse incident relating to swallowing. Additionally, inspectors found that there was poor monitoring and inadequate clinical observation of residents following adverse incidents. For example, clinical observations and assessments were incomplete for a resident who had sustained a head injury as a result of an unwitnessed fall.

While there were arrangements in place for residents to access the expertise of other health care professionals, the recommendations made by health care professionals were not implemented by staff, to ensure the best outcomes for residents.

Inspectors reviewed a sample of assessments and care plans and while there was evidence that the residents' needs were being assessed using validated assessment tools that informed the development of care plans, inspectors found that the assessed needs of the residents were not being met, in line with their care plans. This is discussed further under Regulation 5: Individual assessment and care plans.

The procedure to safeguard residents was underpinned by a safeguarding policy that provided guidance and support to staff on the appropriate actions and measures to take to protect residents, should a safeguarding concern arise. However, inspectors found that appropriate action had not been taken to investigate allegations of abuse, in line with the centre's own safeguarding policy. Furthermore, inspectors found that action was required to ensure residents finances were managed and protected. While the provider supported a number of residents to manage their pensions, this system was not in line with best practice guidelines.

Inspectors found that parts of the premises did not meet the care and safety needs of the residents. There were numerous areas of the premises such as bedrooms, bathroom facilities, and communal areas that were not maintained in a satisfactory state of repair. Walls were visibly damaged and not suitably decorated. Facilities in use by residents, such as private and communal toilet facilities were also poorly maintained. Inspectors were informed that a competent person was scheduled to attend the centre on 10 October 2023 to assess the premises. Further findings are discussed under Regulation 17: Premises.

Following the previous inspection, the provider submitted a compliance plan to address the risks identified in the systems of containment and management of fire. The provider had completed a fire safety risk assessment of the centre in May 2023 and the action plan was in progress. Inspectors found that while the provider had taken some actions to address the findings of the fire safety risk assessment, it had failed to address all the fire risks identified in the report, within the recommended time lines. In addition, inspectors found poor practice with regard to the management of storage areas that contained flammable materials, and the inappropriate storage of oxygen which posed a fire risk to residents. Further findings are detailed under Regulation 28: Fire precautions.

While the provider had taken some action to improve the physical environment and associated facilities to support effective infection prevention and control measures, inspectors found that areas of the premises, including the kitchen, resident’s bedrooms, and sanitary facilities were visibly unclean. There were areas of the centre that were malodorous. The findings identified a repeated failure by the provider to ensure consistent resources were in place to effectively clean the centre, and establish a robust infection prevention and control monitoring system. This issue is discussed further under Regulation 27: Infection Control.

Inspector found that the provision of activities was not consistent and not all residents were provided with equal access to activities, in line with their interests and capabilities.

Residents had access to television, radio, newspapers and books. Residents were provided with access to independent advocacy services.

Residents were provided with opportunities to provide feedback on the quality of the service through scheduled resident meetings and through resident surveys.

Regulation 17: Premises

The provider had failed to maintain the premises in a satisfactory state of repair. Actions were required to ensure compliance with Regulation 17: Premises and Schedule 6 of the regulations. For example;

- There were visible cracks in the structure of the building, in particular at first floor where a a previous extension connected to the main building. Plaster was falling off the wall in some rooms, and cracks were visible beneath some windows and across ceilings. The floor under the floor covering in one bedroom had loose debris. Walls along corridors and in bedrooms were visibly chipped, cracked, and damaged.
- Sanitary facilities were not maintained in a satisfactory state of repair. For example, a door lock was missing from an en-suite door. Wall tiles in multiple en-suites were loose, missing, and bulging from the wall and in some cases creating a sharp edge. Drains in communal bathrooms and en-suite were malodorous; one was observed to be blocked.
- The external grounds were not appropriately maintained or suitable for use by resident. The ground was uneven, contained sharp gravel, and posed a tripping hazard. A seating bench in an external smoking area was broken and unsafe for use.
- The layout of bedrooms designated to accommodate two residents on the ground floor did not meet the needs of residents occupying those bedrooms. For example, bedrooms were not configured to ensure residents were provided with adequate usable and private space. A privacy screen in a twin bedroom was loose and not secured to the ceiling, while privacy screens were absent in another twin bedroom.
- The balcony terrace located on the first floor did not have adequate safety measures to protect residents from the risk of falling. While the door to the terrace had an audible alarm, the guarding around the terrace was low and easy to climb.

Judgment: Not compliant

Regulation 18: Food and nutrition

The provider had failed to ensure that food and nutrition was delivered in line with the regulatory requirements. This was evidenced by;

- There was inadequate staff available to provide assistance to residents during mealtimes. For example, residents in their bedrooms did not receive assistance during breakfast and tea time. Food was served to residents, but there was insufficient staff to assist them in a timely manner.

- Food was not prepared, or provided to residents, in line with their assessed dietary needs. For example, two residents who were prescribed a modified consistency diet were served an inappropriate diet.

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 27: Infection control

The provider had failed to take action to 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. This was evidenced by:

- Poor oversight of the cleaning procedures and the quality of environmental hygiene. For example, there were areas of the premises that were not cleaned to an acceptable standard. This included the first floor of the premises that was visible unclean and malodorous. Bedrooms and en-suites on the ground floor of the centre were also observed to be visibly unclean.
- Staff demonstrated a poor knowledge of the centre's cleaning procedure, and appropriate hand hygiene to minimise the risk of cross infection.
- The kitchen area, and catering equipment was not cleaned to an acceptable standard. This included equipment used for storage of hot foods, equipment used for preparing food, and equipment used to store chilled foods.
- Poor infection control practices were observed. For example, unclean dustpans and brushes were used throughout the centre
- Laminate surfaces on some furniture was visibly damaged. This compromised effective cleaning.
- The laundry area was not managed in a way that reduced the risk of cross contamination. Linen and clothing awaiting laundering occupied both the dirty area and clean area of the laundry room. This increased the risk of cross contamination, and therefore a risk of infection to residents.

The findings identified a repeated failure by the provider to establish a robust infection prevention and control monitoring system including a robust environmental auditing system. This is a repeated non-compliance.

Judgment: Not compliant

Regulation 28: Fire precautions

Action was required by the provider in order to comply with the requirements of Regulation 28: Fire precautions.

Under this regulation, the provider was required to address immediate risks that were identified during the inspection Inappropriate storage arrangements for oxygen, equipment such as a lawnmower, fuel canister, and the storage of combustible materials against electrical panels in the laundry area created a risk of fire. The manner in which the provider responded to these risks during the inspection did not provide full assurance that they were adequately addressed. While the lawnmower and fuel canister were removed and the shelves in the laundry demounted during the inspection, the risk relating to the storage of oxygen cylinders in a medication storage area, which was identified on the first day of inspection, had not been addressed by the second day.

The provider was not taking adequate precautions against the risk of fire, nor adequately reviewing fire precautions, for example:

- the position of the external oxygen storage was in close proximity to the boiler room door and had not been appropriately assessed risk assessed to determine a safe distance for the position of the oxygen cylinders.
- there were extension cords and overloaded sockets at the first floor nursing station. This area was not in use.

Arrangements for providing adequate means of escape including emergency lighting required improvement. For example:

- Externally, the inspectors were not assured that suitable emergency lighting was provided along some external routes to illuminate the route of escape in the event of a fire evacuation, particularly at night-time.
- Internally, some emergency lighting units and exit signage were not functioning
- further assurance was required regarding the width of some sections of the external escape routes. The drill records did not provide assurance that these routes were tested with evacuation aids in use.
- There was a fence enclosing a route from the building to the smoking area. There was no gate within the fence, which meant that the only means of escape from the smoking room was to re-enter the building.
- Curtains were positioned across an exit door causing a potential obstruction
- Light wells in bedroom corridors were timber lined; assurance is required that they have been appropriately treated to prevent the surface spread of fire
- There was a large disused air handling unit along the external route. While there was sufficient width, it may cause injury during evacuation.

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

- Deficits in fire doors were impacting on the containment of fire. The fire doors from the escape corridor to the kitchen was not a 60 minute fire rated door as required in the fire safety risk assessment.
- There were breaches in the fire rated enclosure to the boiler room.

The arrangements for maintaining the fire equipment, means of escape, building fabric and building services were not adequate;

- Records to confirm the periodic inspection of the emergency lighting were not available for review, nor was there an annual certificate of inspection and testing. Instead, an annual service of the emergency lighting identified that a significant number of emergency lights failed the annual test and the certificate of conformance was withheld. This means that escape routes may not have adequate lighting in the event of a power failure during a fire. Additionally, there was no documented assurances that action had been taken to address the assessment findings of the emergency lighting systems.
- There was an annual service report for the fire detection and alarm system, however, records to confirm the periodic inspection of system were not available for review.
- There was no periodic inspection report of the electrical installation available to ensure the electrical installation was free of fault or 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 of progressive horizontal evacuation, and fire containment. Consequently, further action was required to ensure that residents were protected from the risk of fire through effective fire containment, when evacuated from the source of a fire to an adjoining perceived safe area.

Although staff were documented as having up-to-date fire safety training, the practices observed during inspection, and lack of awareness by some staff of the centres fire evacuation procedures, did not provide assurance that the fire safety training provided, captured the full extent of the requirements of the regulations. For example, staff demonstrated a poor awareness of residents evacuation plans, the evacuation strategy, and day-to-day risk identification.

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. For example, simulated fire evacuation drills did not provide assurance that residents with complex care needs could be evacuated from the centre, in a safe and timely manner when staffing resources were at a minimum.

While all residents had a personal emergency evacuation plan (PEEP) in place, the information regarding evacuation for some residents was not consistent with what inspectors were told. Peeps had not been reviewed or updated for a period of five months.

The drawings displayed to support evacuation were not clear and did not include pertinent information such as the location of fire compartment boundaries. This was an action from the fire safety risk assessment.

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The management of medicines was not in line with the requirements of the regulations.

- Medicines that were no longer required by residents were not appropriately disposed of. For example, medicines prescribed to a number of residents that had been discharged from the centre in December 2022 had not been segregated from other medicinal products, or appropriately disposed of.
- Medicinal products had not been administered in accordance with the direction of the prescriber. For a example, a resident had not received their prescribed medication five days after the medicines had been prescribed.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

A review of the residents assessments and care plans found that the registered provider had failed to arrange to meet the assessed care needs of residents, in line with their individual care plans. For example;

- A resident assessed as being at high risk of falls did not receive care and support in line with their assessed needs and mobility care plan. For example, a resident who required the assistance and supervision of staff when mobilising were observed walking in the corridors unaided and supervised.
- Residents at risk of aspiration did not received supervision and support during mealtimes, in line with their assessed needs and nutritional care plans.

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 6: Health care

The registered provider failed to provide appropriate medical and health care including a high standard of evidence-based nursing care in accordance with professional guidance. This is evidenced by a failure to;

- document an accurate assessment of a residents physical well being, including intervention or treatment received, following a fall's incident.
- provide a resident with appropriate referral to health care professionals for further assessment and expertise when clinically indicated, in line with the directive of health care professionals.
- provide care to residents in line with the recommendations of health care professionally such as physiotherapy, and speech and language professionals.

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 8: Protection

The registered provider failed to take reasonable measures to protect residents from abuse and to provide for appropriate and effective safeguards to prevent abuse. This was evidenced by failure to;

- respond appropriately to an allegation of abuse.
- investigate an allegation of abuse. An incident of alledged abuse had not been appropriately investigated or followed up in line with the centre's policy and procedure.

The provider supported a number of residents to manage their pensions in the centre. However, the management of pensions was not in line with best practice guidelines. For example, the person appointed to manage the residents pension was no longer employed by the service.

Finances and property of deceased residents, and resident who had left the centre, had not been returned to the residents, or their representative.

This is a repeated non-compliance.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Inspectors observed residents spending long periods of time without social engagement in the day room and in their bedroom. Residents were observed in their

bed, asleep in a chair at their bedside, or sitting in silence in their room in the early evening. Residents were also observed sitting in silence in the dining room, and in the dayroom facing a television that was not powered on. While staff were present in the dayroom, there was no meaningful activities, or social engagement occurring.

Residents expressed dissatisfaction with the provision of activities and social engagement both during the day time, and after their evening tea. Residents told the inspectors that there was 'nothing to do' and consequently, requested assistance from inspectors to commence a card game.

The inspectors observed that a number of residents remained in their bedrooms and did not take part in activities. When asked, residents told inspectors the activities programme did not suit their interest or capabilities and as a result, they choose not to attend the communal areas.

Residents reported that the programme of activities did not ensure that they were provided with opportunities to participate in meaningful social activities and engagement at weekends. This was confirmed through a review of the staffing rosters that showed occasions where activity staff were not rostered on duty at weekends. Where activity staff were rostered for duty on Sunday's, rosters showed that they were allocated to laundry duties. Staff informed inspectors that a reduction in staffing levels, coupled with short notice unplanned staff leave impacted on the provision of activities for residents. This was validated by the absence of requested records that referenced residents' participation in social activities that met their interests and capacities.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Not compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for An Teaghlach Uilinn Nursing Home OSV-0000309

Inspection ID: MON-0041477

Date of inspection: 26/09/2023

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • The center has a robust recruitment process in place to include 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 and ensure continuity of care for residents in the event of any potential staff shortages. 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. • A new administrator has been employed and will commence in post from 11-12-23 – complete. • Recruitment for an additional housekeeper is ongoing with 6 interviews completed on 19-12-23 and 2 new staff currently having their Garda Vetting processed – expected to commence in post in early January following mandatory training/ induction. • The Housekeeping duties will be completed by external cleaning team in the interim of onboarding the extra housekeeping staff. In addition, the Center has advertised for a housekeeping supervisor to enhance the oversight of the housekeeping staff. This will be overseen by a newly appointed Group Facilities Project Manager. • Staffing levels will continue to be reviewed monthly using a validated assessment tool as part of the Group HR Manager workforce planning meetings – ongoing. • Staffing and response times were added as a specific agenda item on the next resident's committee meeting which was scheduled for 11-12-23. This item will remain on the meeting agenda going forward. • The Provider has undertaken a review of monthly call bell audits and electronic data regarding response times and this will continue monthly – complete and ongoing. • In the event of a member of staff leaving, an exit interview will be completed. Any quality improvement items raised will be addressed and recorded as part of the annual review of the center.	

Regulation 16: Training and staff development	Not Compliant

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

• A clinical facilitator commenced additional training with all nurses to individually assess their competencies and provide additional supervision, mentorship and support to ensure that they can carry out their duties to protect and promote the care and welfare of all residents. The clinical facilitator has been onsite minimum two days per week from 02-11-23 up to 22-12-23. All nurse competency assessment documents are underway and will be completed by 30-12-23

• A new Person in Charge and Assistant Director of Nursing have been appointed and oversee clinical practice on a daily basis, review records and provide individual and group feedback to staff, at the point of care and through scheduled staff meetings – in post from 01-11-23 and 20-10-23 respectively.

• The PiC and ADON review nursing notes and residents progress notes as part of incident reviews minimum 3 times per week and following MDT reviews the residents assessments and care plans are monitored by the clinical management team to ensure they have appropriate updates - ongoing

• There are staff debrief/safety pause meetings in place led by a member of the clinical management team, to address any identified shortfalls, discuss and implement any quality improvement actions. Records of these meetings are maintained by the PiC - completed and ongoing.

• As part of the monthly oversight and monitoring systems the Clinical Operations Director and the Nurse consultant will review a sample of residents' records and nurses notes to assess the quality and standard of the documentation and the onsite supervision provided - completed and ongoing.

Regulation 21: Records	Not Compliant

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

• Staff have been reminded to utilize and consult the paper-based roster primarily and that the electronic system is to be updated retrospectively to reflect actual hours worked. As previously advised the electronic system is being reviewed and a new procedure for use will be rolled out group-wide in Qtr 1.

• Care plan audits and spot-checks of electronic record system entries are conducted by both the Clinical Facilitator when assessing competencies of staff and by the PIC/ ADON daily – Competency assessments commenced from 2-11-23.

• As part of the nursing competency assessments all nurses have been trained in understanding the requirements of reporting incidents to the clinical management team and the standard of detail required when recording in the electronic system, which includes interventions and actions. This is overseen by the PIC & ADON weekly. Review

forms part of the monthly G&M report completed by the Clinical Operations Director.
• The staff training matrix has been updated – completed. All records pertaining to training that is not recorded as part of the training matrix will be maintained on file going forward.
• Medical and nursing records have been secured in a locked filing cabinet with restricted access – completed. The monitoring of this will be completed by the PiC and ADON on a weekly basis.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The inspector has reviewed the provider compliance plan. This action proposed to address the regulatory non-compliance does not adequately assure the chief inspector that the actions will result in compliance with the regulations.

• The governance and management team, structures and systems have been strengthened to include the following:
o Appointment of new PIC – commenced in post 01-11-23.
o Appointment of new ADON – commenced in post 20-10-23.
o Appointment of new Registered Provider Representative – commenced in post 01-12-23.
o Scheduled onsite visits from the Clinical Facilitator to monitor staff competencies and provide additional training, mentorship and support – commenced from 02-11-23 until 22-12-23.
o Regular onsite visits, minimum 6 per month from the Clinical Operations Director (COD) since commencement in post in August 2023 with scheduled weekly visits commenced from 01-11-23.
• In addition, the services of an independent nurse consultant have been procured to conduct mock inspections on a monthly basis for the purposes of monitoring compliance and additional oversight – commenced from 24-11-23.
• The 30 open incidents have all been reviewed and closed out. Incidents are now reviewed daily and closed out by the PIC/ ADON in conjunction with the COD as required. Review of incident occurrence and trends forms part of the monthly governance and management meeting complete and ongoing.
• All incidents are recorded on the electronic system with investigation details, interventions and actions detailed. This is reviewed as part of the monthly G&M review carried out by the Clinical Operations Director.
• There is a clear escalation pathway in place in the center and nurses are aware to inform a member of the clinical management team in the event of serious incident. In addition the PiC & ADON are aware to contact their line manager clinical operations director for support and to raise events. A weekly DON report is completed by the PiC and this is discussed weekly with the Clinical Operations Director providing an

opportunity for G&M items to be discussed with actions identified.
• The Provider's fire safety and prevention action plan has been updated to include target dates for completion. Over 70% of items are fully or substantially complete. In addition, a structural engineer visited the centre on 10-10-23 and contractors have been procured to carry out all outstanding structural and fire safety and prevention remedial works – to be fully completed by 10-04-24.
• A full building survey was completed on 12-12-23 to further assess the building fabric and structure as well as fire, mechanical and engineering services. A full report with recommendations of works required will issue and remediation works will then commence in Q1 2024. Capital resources have been allocated and budgeted for all works.
• The center now has access to a group facilities project manager, commenced on 13-12-23 who will oversee the environment, facilities, catering and housekeeping in the center regarding IPC and facility/environmental management.
• The risk management system has been reviewed and updated by the PiC in December. Any additional risks identified are recorded as part of risk assessment. New risks are discussed at the weekly DON meeting with the Clinical Operations Director. Audit of Risk Management will form part of the nurse consultant monthly monitoring program.
• An external audit consultant has been secured to review the centers processes, complete clinical and environmental audits, instruct, direct and support staff in the implementation of a digitalized audit system. This system will provide structured reports, trend analysis, including actions plans.
• The center has reviewed its policy on managing residents' finances and implemented effective systems to include the oversight arrangements of residents' finances in line with national guidance. All residents pension agents have been identified and updated to meet best practice. Residents receive a monthly statement, and this is retained on their file. There is a robust system in place to return monies and/or valuables to the estates of residents who have passed away. Currently any outstanding property has been returned and a monthly audit will be completed on the management of the safe and residents' finances.
• As part of the PiC and ADON induction the requirements around submission of notifications have been completed. In addition, all incidents are discussed at a minimum weekly with the Clinical Operations Director to ensure appropriate submission of notifications. There is easy access to the HIQA guidance document on Notifications in the PIC office. Submission of notifications are presented and trended by the Clinical Operations Director as part of the monthly G&M meetings.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
• All incidents are reviewed daily by PIC/ ADON. Where required and in line with HIQA guidance on statutory notifications, then relevant notifications are submitted within the prescribed timeframes – ongoing.

• As part of the PiC and ADON induction the requirements around submission of notifications have been completed. In addition, all incidents are discussed minimum weekly with the Clinical Operations Director to ensure appropriate submission of notifications. There is easy access to the HIQA guidance document on Notifications in the PIC office. Submission of notifications are presented and trended by the Clinical Operations Director as part of the monthly G&M meetings.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• A structural engineer visited the centre on 10-10-23 and a further full building survey was completed on 12-12-23.
• Contractors have been procured to carry out all outstanding structural and fire safety and prevention remedial works, after which redecoration and refurbishment works will be completed – to be fully completed by 10-04-24.
• A new guard rail will be installed on the balcony terrace in tandem with the building works. Residents are currently not occupying the first floor and access to the courtyard is restricted for their safety - will be completed by 10th April 2024.
• The door lock for the ensuite and privacy screens were replaced or repaired on 26-09-23 - complete.
• Routine flushing of all unoccupied/ unused sanitary facilities and drains continues weekly in line with National Guidelines for the Control of Legionellosis in Ireland – ongoing.
• Any not fit for purpose has been removed to include the broken bench - completed.
• The group facilities project manager will oversee and monitor the quality and standard of maintenance and associated works to ensure ongoing quality improvement actions are completed. This will be reported to the Operations Director on a weekly basis.
• A tender for improving landscaping and external pathways to a high clean standard has commenced and it is expected that these works will take place early January 2024.
• The exterior of the building has been powerwashed and gutters cleaned on 16-12-23.
• The Group Facilities project manager as part of improving the living environment for residents is securing painting works to commence early January 2024. A phased approach will take place to start with residents bedrooms, dining room and corridor.
• The layout of bedrooms designated to accommodate two residents on the ground floor has been reviewed and the configuration of these rooms is underway to ensure that residents occupying these rooms have adequate usable and private space. Privacy screens have been reviewed as part of the facilities audit and these are now in place and secured.

Regulation 18: Food and nutrition	Not Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:

• The PIC has undertaken a full review of residents requiring assistance with meals and has consulted with residents in respect of their dining location preferences. Tray service directly from the kitchen has been implemented for those residents who wish to remain in their bedrooms when the staff member assisting them is available to support – commenced from 05-12-23.

• Weekly updates are provided to kitchen staff in respect of individual resident's assessed needs and dietary requirements. Meals provided by the kitchen are overseen daily by nursing staff to ensure the correct consistency meal is given to the correct resident – commenced from 05-12-23.

• Robust recruitment systems are in progress under the direction of the Group HR Manager to ensure that there are adequate staffing levels in place to assist residents at mealtimes. The PiC has implemented an enhanced allocations schedule to ensure residents are supported appropriately at mealtimes whether it is in the dining room or the resident's preference to receive their meal in their bedroom. This process is overseen daily by the senior nurse on duty and monitored using assessments completed by the clinical management team.

• Any expression of dissatisfaction received around mealtimes and food and nutrition will be recorded and managed in line with the centers complaints policy to ensure that quality improvement actions are identified, completed, and evaluated appropriately.

• Mealtime Experience and Dining forms part of the agenda of the residents committee meeting and evaluation of effectiveness meals, mealtimes, snacks and fluids will be completed as part of the residents' annual survey, which, in turn will be documented and presented as part of the center's annual review.

Regulation 27: Infection control	Not Compliant

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

• Recruitment for an additional housekeeping staff is ongoing – 3 staff in progress. In the interim external cleaning staff have been deployed to complete the housekeeping roster.

• An additional Group facilities project manager has been appointed on 11-12-23 to oversee cleaning standards and an intensive cleaning plan will be put in place immediately for all areas occupied by residents. This will be subject to ongoing audit.

• An IPC environmental audit has been developed, commenced on 14-12-23 and monitoring will be carried out on a monthly basis to identify standards and trends and develop appropriate action plans.

• The Group facilities project manager is reviewing the products and equipment in place and sourcing items to ensure that the staff have appropriate equipment to complete the IPC cleaning to a high knowledge. Part of this project will be to oversee the training of

the housekeeping team in the implementation of processes to ensure delivery of high standard of cleaning thoughout the center.
• Additional training for housekeeping staff is being sourced from the independent hygiene specialist company that supplies the cleaning products – complete by 31 December 2023.
• The kitchen items have been cleaned immediately following the inspection. A deep clean is scheduled for 14-12-23. A new cleaning protocol has been developed for kitchen staff and is being overseen by the ADON and the newly appointed group facilities project manager - complete and ongoing.
• All staff have completed training on infection, prevention and control - complete.
• Furniture will be repaired or replaced in line with redecoration and refurbishment works planned – 10-04-24.
• Environmental hygiene audits are being completed monthly. These will be reviewed, analysed, trended and corrective action plans completed and feedback will be given to all staff – commenced from 12-12-2023.
• An approved digital audit system will be implemented to ensure greater oversight – Qt1 1 2024.
• A member of the nursing team has been identified to attend training as an IPC link nurse and is awaiting a date to commence.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: The inspector has reviewed the provider compliance plan. This action proposed to address the regulatory non-compliance does not adequately assure the chief inspector that the actions will result in compliance with the regulations.

• The Provider's fire safety and prevention action plan has been updated to include target dates for completion. Over 70% of items are fully or substantially complete. In addition, a structural engineer visited the centre on 10-10-23, a further full building survey was completed on 12-12-23 and a procurement process is in place to appoint contractors to carry out all outstanding structural and fire safety and prevention remedial works – to be fully completed by 10-04-24.
• Oxygen storage has been repositioned – complete.
• Contractor attended on 19-12-23 to quote for additional of gate, around smoking area to be installed and this will be completed by mid-February 2024.
• Certification from certified contractors where work has been completed for fire hatches has been obtained and is on file - complete.
• Fire drill records have been revised and drills completed min 3 per month and includes night time simulation and a variety of areas in the center – complete and ongoing.
• An enhanced fire drill report has been rolled out from 20-12-23 to increase analysis and monitoring
• Fire training is up to date for all existing staff except for 2 recent hires and staff currently onboarded, the next fire training is scheduled for 20/12/23

• An environment audit has been completed. Items related to fire risk have been removed e.g. extension leads
• The nurse in charge completes a check on each shift of the exits to ensure there are no obstructions.
• All residents' PEEPS have been updated with the most recent updates completed on 03-12-23 and will be reviewed in line with assessments and care plans no later than four monthly – complete and ongoing.
• All residents were relocated to the ground floor between April 2023 – 26/06/23 and the upstairs communal areas are not in use by residents, meaning that there is no need for vertical evacuations at this time.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
• All medicines that were no longer required/ out of date have been segregated and returned to pharmacy for disposal with a log kept. Purple-lidded sharps bins have been procured to assist timely disposal in-house. Medication stock checks occur weekly. This process will be overseen daily by the PIC/ADON – complete and ongoing.
• The process for obtaining prescribed medications has been reviewed and revised by the PIC with both the GP and Pharmacist to ensure there are no further occurrences of delayed medication administration – complete.

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
• The PIC has undertaken a full review of residents requiring assistance with meals and has consulted with residents in respect of their dining location preferences. Tray service directly from the kitchen has been implemented for those residents who wish to remain in their bedrooms when the staff member assisting them is available to support – commenced from 05-12-23.
• Scheduled onsite visits by the Clinical Facilitator and Clinical Operations Director will supplement the clinical supervision and oversight afforded daily by the PIC/ ADON.
• Residents at high risk of falling have been reminded that they need additional support and supervision on mobilizing and staff have been reminded of the need to ensure care is provided as specified in individual residents' care plans.

• The oversight of staff to ensure that the needs and preferences of residents as identified in their careplans is allocated to the senior nurse on duty daily. Any changes to the residents' care needs following assessment are presented and discussed at the morning and night staff handover. Clinical KPI 's to include monitoring of residents MUST assessment, Skin integrity, Incidents & Complaints are reviewed and trended as part of governing the effectiveness of the care provided to residents is of high standard.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
• Clinical competency assessments for the nursing team have been completed in the areas of assessment, care planning, incident management, referral to allied health professionals and implementation of MDT recommendations as part of onsite visits by the Clinical Facilitator.
• Clinical oversight of incidents and follow up actions is in place though monitoring from the PiC & ADON on a daily basis – ongoing.
• The falls procedure has been reviewed and all staff have been reminded of the expected requirements for clinical assessment and documentation post-fall. Reviews of all incidents will be completed by the PIC/ ADON to ensure appropriate interventions are completed in a timely manner and reflected in the residents' records – completed and ongoing.
• The nursing team have a defined escalation pathway to include contacting a member of the clinical management team out of hours as part of quality healthcare and incident management.
• As part of monitoring oversight the monthly reviews by the Clinical Operations Director and Nurse consultant includes analysis and review of a sample of residents records and related incident management. The results will form part of the monthly G&M meetings.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• Staff have received training in safeguarding the older persons and this will be completed annually for all staff. Monitoring of completion forms part of the training matrix.
• Additional safety pause/staff debriefing sessions have been facilitated by the clinical management team and clinical facilitator. These will continue at intervals throughout the year to ensure staff are fully informed of actions required to maintain the residents' safety.

• The allegation has been fully investigated in line with the centre's policy and closed out – completed. All allegations or expression of dissatisfaction will be documented, reported to management and investigated to rule out any safeguarding concerns. Any identified allegations under the safeguarding remit concerns will be investigated in line with national policy and best practice to include linking in with the local safeguarding officer and notifying the regulator.
• The PIC had registered for and is awaiting date for training to be a designated safeguarding officer for the center.
• The residents committee meeting agenda will include item related to complaints and concerns and in addition a reminder to residents of the advocacy services available and the importance of reporting any safeguarding concerns and that these will be treated in a respectful and dignified manner.
• As part of the G&M structure the Clinical Operations Director will oversee the investigation process into any an allegation of abuse to ensure that any alleged incident has been appropriately investigated and followed up in line with the centres policy. Any allegations of abuse will be presented at the monthky G&M meeting and form part of the reports presented to the RPR at this meeting.
• Forms to update the assigned pension agent for three residents have been completed and returned from the Department of Social Protection – completed.
• All personal property and finances are in the process of being returned to respective residents/ residents' estates in line with statutory obligations and Guidelines.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• The provision of activities was added as an agenda item at the next residents' committee meeting to ascertain feedback and overall satisfaction levels – 11-12-23.
• Recruitment for additional activities staff is in process.
• Each resident has an individualized care plan in respect of activation and social engagement that is updated at no less frequently than every 4 months. – ongoing.
• An advocate will be recruited to provide advocacy services in-house in addition to national independent services provided – Qtr 1 2024. In the meantime residents have access to an independent advocate and the PASS advocacy services visited the residents in the center in November 2023.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	30/01/2024
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/12/2023
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	10/04/2024
Regulation 18(1)(c)(i)	The person in charge shall	Not Compliant	Orange	22/12/2023

	ensure that each resident is provided with adequate quantities of food and drink which are properly and safely prepared, cooked and served.			
Regulation 18(1)(c)(iii)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional assessment in accordance with the individual care plan of the resident concerned.	Not Compliant	Orange	22/12/2023
Regulation 18(3)	A person in charge shall ensure that an adequate number of staff are available to assist residents at meals and when other refreshments are served.	Not Compliant	Orange	22/12/2023
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by	Not Compliant	Orange	30/01/2024

	the Chief Inspector.			
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Substantially Compliant	Yellow	30/01/2024
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	22/12/2023
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	22/12/2023
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	30/01/2024

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	10/04/2024
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	10/04/2024
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	10/04/2024
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	22/12/2023
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	Not Compliant	Orange	22/12/2023

	aware of the procedure to be followed in the case of fire.			
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	10/04/2024
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	22/12/2023
Regulation 28(3)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place in the designated centre.	Not Compliant	Orange	30/01/2024
Regulation 29(5)	The person in charge shall ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the	Substantially Compliant	Yellow	22/12/2023

	appropriate use of the product.			
Regulation 29(6)	The person in charge shall ensure that a medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident shall be stored in a secure manner, segregated from other medicinal products and disposed of in accordance with national legislation or guidance in a manner that will not cause danger to public health or risk to the environment and will ensure that the product concerned can no longer be used as a medicinal product.	Substantially Compliant	Yellow	22/12/2023
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 3 working days of its occurrence.	Not Compliant	Orange	22/12/2023
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs	Not Compliant	Orange	30/01/2024

	of each resident when these have been assessed in accordance with paragraph (2).			
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.	Not Compliant	Orange	30/01/2024
Regulation 6(2)(c)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the care referred to in paragraph (1) or other health care service requires additional professional expertise, access to such treatment.	Not Compliant	Orange	20/01/2024
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Substantially Compliant	Yellow	22/12/2023
Regulation 8(3)	The person in charge shall investigate any	Substantially Compliant	Yellow	22/12/2023

	incident or allegation of abuse.			
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Not Compliant	Orange	30/01/2024