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:	Fearna Manor Nursing Home
Name of provider:	Castlerea Nursing Home Limited
Address of centre:	Tarmon Road, Castlerea, Roscommon
Type of inspection:	Unannounced
Date of inspection:	03 May 2024
Centre ID:	OSV-0000339
Fieldwork ID:	MON-0043227

About the designated centre

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

The centre is a purpose-built facility single storey building that is registered to accommodate a maximum of 53 dependent persons aged 18 years and over. It is situated in a residential area a short drive from the town of Castlerea. Bedroom accommodation consists of 15 single and 19 double rooms all with en-suite facilities. There is a range of communal areas where residents can sit together and socialise. Other facilities include a dining area and spaces for visitors and people who smoke. There are toilets and bathrooms located near to communal areas. There are two outdoor areas that are easily accessible to residents. The centre caters for male and female residents who require long-term care and also provides care to people who have respite, convalescence, dementia or palliative care needs. In the statement of purpose, the provider states that they are committed to enhancing the quality of life of residents by providing a homely, safe and caring environment.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	36

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
Friday 3 May 2024	09:25hrs to 18:05hrs	Michael Dunne	Lead

What residents told us and what inspectors observed

On the day of inspection, the inspector observed that residents were supported to enjoy a good quality of life supported by a team of staff who were kind, caring and responsive to their needs. The overall feedback from residents was that they were happy living in the centre and with the quality of care they received on a daily basis and their life in the centre.

Shortly after arrival at the designated centre and following an introductory meeting with the person in charge, the inspector conducted a tour of the designated centre with the person in charge. The inspector observed that there had been changes made to the layout of the designated centre and the purpose of some of the rooms. These changes had not been notified to the office of the chief Inspector. For example, the provider had reduced nine twin occupancy rooms to single occupancy and had repurposed a number of other rooms as described under Regulation 17:Premises. The inspector also observed that the layout of seven other twin bedrooms impacted negatively on the quality of residents lived experience and is discussed in more detail under Regulation: 9 Residents' Rights. A tour of the outside of the designated centre found that the waste compound was not well managed and was overflowing with refuse, this is described in more detail under Regulation 27: Infection control.

There were a number of spaces available for residents to relax and spend time on their own or in the company of others. The provider had upgraded the activity room/ Post office area to a cafe style facility which enhanced the communal facilities for the residents. Changes to the seating arrangements in the main activity facility reduced the institutional feel of this area. New seating was made available for residents who used the foyer area to spend much of their time, while a new seating area had been provided for residents to use outside of the dining room.

The dining room was well-arranged with tables laid out with table cloths, cutlery, menus, and condiments. The lunch was served by the chef and kitchen staff and was well-presented and appetising. The meal option available on the day consisted of baked cod or roast turkey. There was sufficient numbers of staff available to provide support and assistance to ensure residents were able to enjoy their meal in a relaxed and dignified manner. The inspector observed that resident's who did not wish to attend the main meal service were supported to have their meals outside of these times.

Apart from the residents rooms mentioned earlier in this report the majority of resident bedrooms were well laid out for the benefit of residents. They were clean and found to be personalised by the residents with items of individual interest such as personal photos and other items. Communal areas were clean and internally the centre was free of mal odours.

Residents were observed moving about the home freely. Many residents were

observed following their own routine while others were observed being supported by staff to attend to their personal care or to attend the activity room. Residents who spoke with the inspector were in good spirits. One resident told the inspector " staff get you what you need" while another resident said "they were happy here but would prefer to be at home".There was a good sense of comradery with goups of residents observed chatting among themselves while others was observed in their rooms watching television or listening to their radio. Residents who expressed a view told the inspector that they felt safe in the centre and that they could talk to staff if they had any concerns.

There was a well-planned schedule of activities available for residents to participate in which was delivered by four activity support workers. Activities available on the schedule included arts and crafts, music, food preparation, bingo,quizzes and trips out. A trip was organised to the circus which attended Castlerea recently.

Residents who spoke with the inspectors about visiting arrangements, confirmed there was no restrictions with regard to visiting. Visitors were observed coming and going throughout the day.

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

Capacity and capability

Overall, the inspector found that management systems and current oversight arrangements were not robust and did not provide a service that was safe, appropriate, consistent, and effectively monitored. There were a number of repeat findings from previous inspections and significant effort and focus were now required to ensure that effective management systems were introduced in the centre in order to monitor and improve the quality and safety of care and services provided for the residents.

This was an unannounced risk inspection carried out by inspectors of social services to monitor compliance with the Heath Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and Health Act 2007 (Registration for designated centres for older people) Regulations 2015.

Prior to this inspection the Chief Inspector had received unsolicited information in relation to concerns about the financial resources available to operate the designated centre and, that the registered provider was not operating the centre in line with the requirements of the Health Act 2007. A review of the organisational structure of the centre and records relating to the governance and management of the centre found that this information was substantiated. The findings of this inspection were that the registered provider did not comply with their regulatory obligations with respect to the management, resourcing or the operation of the

designated centre.

The inspector issued an immediate action on the day of the inspection due to concerns identified with the amount of both clinical and general waste which had accumulated in the waste compound area. At the time of this inspection there was no active contracts in place to remove both clinical and general waste material. The provider did initiate action to remove the majority of this waste on the day of the inspection and following the inspection additional photographic evidence was submitted to provide assurances that all waste was now contained within the waste containers located on the site.

Castlerea Nursing Home Limited is the registered provider for this designated centre. There is one company director who is directly involved in the running of he designated centre, and is the line manager to whom the person in charge reports. In April 2023, the registered provider failed to notify the Chief Inspector of the departure of one of the directors, as required by the regulations. There is a person in charge who is supported in their role by two clinical nurse managers, one of whom had recently been recruited to their role. The staffing complement also consists of nursing and care staff, housekeeping, catering, administrative, and activity staff.

A review of rosters confirmed that staff numbers were consistent with those identified in the designated centre's statement of purpose. One staff member employed by the provider did not a garda vetting disclosure certificate available for review at the time of the inspection. The provider had applied for garda vetting to be processed but failed to ensure that the relevant certificate was stored and available.

A review of training records found that the provision of training was well organised. Both mandatory training such as fire safety, moving and handling and safeguarding was provided on a regular basis. Additional training such as falls management, responsive behaviours and medication management was also provided.

A review of provider meeting records did not provide assurances that the service was subject to effective oversight and monitoring by the registered provider. The inspector found that there was a disimprovement in the quality of management records maintained since September 2023. Records viewed did not provide sufficient information on the level of risk present in the centre resulting from the lack of resources available to ensure external providers provided services such as the collection of waste from the centre. Similarly there was no evidence of management discussion surrounding changes to the layout of the designated centre or the impact of these changes on the quality of life for the residents.

Furthermore the registered provider failed to ensure that records, relating to the operation of the designated centre were available in the designated centre, this meant that those working in the designated centre did not have sufficient oversight of issues pertinent to the operation of the centre or to the management of resident finances for whom the provider acted as a pension agent.

On review the inspector found that the provider's statement of purpose dated May

24 required significant amendments to comply with Schedule 1 of the regulations.

By contrast, there was a good standard of record keeping maintained by the local management team in the designated centre. Weekly management reports, and resident care records were well maintained. Castlerea Nursing Home Ltd also did not comply with their regulatory obligation to ensure that each resident had a contract of care that agreed in writing the terms on which they would reside in the nursing home. While the contracts of care reviewed on inspection set out the terms and conditions upon which residents took up residence in the centre, these contracts were found to have been made with a different registered provider. The current registered provider subsequently confirmed post inspection that they have reviewed this issue and that all contracts for the provision of services are now with Castlerea Nursing Home Limited.

This inspection found that there were insufficient resources available to ensure the safe operation of the centre, as evidenced by the lack of available financial resources in the operating bank account of the centre. There were a significant number of outstanding utility bills and the total balance of the operating bank account for the designated centre was insufficient to pay those bills. The inspector also found that debts were accruing for the removal of general and clinical waste from the centre this resulted in waste not been removed from the centre and this posed a significant health and safety risk.

The inspector also found that the provider had not completed all the actions they agreed take in order to achieve compliance with the regulations resulting from the inspection held in June 2023.

There was a complaints policy in place which required a number of amendments to comply with the requirements of Regulation 34. The inspector reviewed the complaints log and found that there were no complaints received since the last inspection. A number of comments and communications from resident's family members were held on file and confirmed that those family members were content with the care provided to their loved ones.

A risk management policy and procedure was in place to guide staff identify and manage risks, however the risks identified on this inspection were not included on the register and as such were not managed effectively. These findings are addressed under Regulation 23, Governance and Management.

Regulation 15: Staffing

There were sufficient numbers of staff available with the required skill mix to meet the assessed needs of the residents in the designated centre. A review of the rosters confirmed that staff numbers were consistent with those set out in the centre's statement of purpose.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had access to appropriate training for their roles. Mandatory training was provided in key areas such as adult safeguarding, moving and handling and fire safety. Refresher training was available to ensure staff maintained their training requirements. As a result staff were able to use this knowledge in their daily work.

Judgment: Compliant

Regulation 21: Records

The registered provider did not ensure that all records, required under Schedules 2, 3 and 4 were available for review in the designated centre.

The inspector reviewed a sample of staff records and found,

· The provider failed to ensure that there was a garda vetting disclosure certificate in place for one member of staff.

· Two references for staff were not signed by the person submitting the reference on their behalf.

The provider failed to ensure that there were robust records available in the designated centre in relation to the management of residents' finances where the registered provider acted as a pension agent. For example,

· Financial records made available for the inspector to review showed that residents' pensions were paid into the provider's business account and not into a separate resident account in line with requirements of Department of Social Protection (DSP).

· There were no records or financial statements made available to residents or their representatives to account for how and for what their finances were being used.

In general the inspector found disimprovement regarding the quality of management oversight records reviewed on inspection. The structure of the meetings held by the provider were not well organised and did not adequately address key areas of the service such as risk, resident finances, resident contracts, or changes to the layout of the centre.

Judgment: Not compliant

Regulation 22: Insurance

The registered provider had a contract of insurance in place for injury to residents and their property. The existing contract was due to expire on 31 May 2024.

Judgment: Compliant

Regulation 23: Governance and management

The designated centre did not have adequate resources in place to ensure effective delivery of care in accordance with the statement of purpose. For example; the inspector found that there was significant payments outstanding to utility companies, and a review of the operating bank account for the centre did not provide assurance that adequate resources were in place to pay the outstanding bills.

The management systems reviewed on the days of the inspection did not provide assurances that the service provided was safe, appropriate and consistent. This was evidenced by the failure of Castlerea Nursing Home Ltd to :

· Agree in writing with each resident a contract for the provision of services with the current registered provider.

· Ensure fire safety checks were robust and identified any risks. For example the inspector found gaps on two sets of fire compartment doors.

· Comply with their regulatory obligations with respect to record keeping.

· Ensure residents' finances were adequately protected.

· Adhere to the requirements of Schedule 2 regarding the availability in the centre of garda vetting disclosures.

· Comply with the provider's conditions of registration.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

The inspector reviewed a sample of resident's contracts for provision of services. All contracts reviewed were found to have been made between residents and Fearna Manor Nursing Home Limited and not with the current registered provider Castlerea

Nursing Home Limited.

Judgment: Not compliant

Regulation 3: Statement of purpose

There was a statement of purpose in place which was revised in May 2024 which set out the services that were offered by the provider in accordance with Schedule 1 of the regulations however this document required further review to ensure that it gave a clear information about the centre, For example:

- The document did not identify the designated centre as Fearna Manor Nursing Home.
- The current registration conditions had not been updated in accordance with the certificate of registration effective from 5 June 2022.
- The procedure for the management of complaints did not comply with the requirements of Regulation 34.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Statutory notifications were submitted to the Chief Inspector in accordance with the requirements of the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

The inspector reviewed the complaints log and found that there were no complaints received since the last inspection. There was a policy and procedure in place however it had not been updated in accordance with the legislative changes to regulation 34 made by SI: 628, For example the policy did not make reference to:

- The provision of a written response to the complainant following an investigation.
- The provision of a written response to the complainant following a request for a review.

Judgment: Substantially compliant

Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration

The registered provider failed to submit an application to vary the Condition 1 and Condition 3 of their registration under section 52 of the Health Act 2007 to notify the Chief Inspector of their intention to make changes to the occupancy, function and use of a number of rooms in the designated centre. These changes included;.

- The residents prayer room was now a staff canteen facility.
- An equipment store was now the prayer room.
- Nine twin rooms had been re-designated as single rooms.
- A single room had been re purposed as a treatment room.
- The resident smoking room was now a storage facility.

Judgment: Not compliant

Quality and safety

Overall, the inspector found that staff were working to improve the quality of life for residents living in the centre and to provide them with a service to meet their assessed needs. While the inspector acknowledges that the provider had completed some of the actions set out in their compliance plan response to the findings of the previous inspection carried out in June 2023, there were a number of recurring non compliance's found on this inspection which impacted negatively on the quality and safety of the service provided to residents. Overall, the inspector found disimprovement across many of the regulations reviewed on this inspection, particularly with regard to Regulation 17: Premises, Regulation 27: Infection Control and Regulation 8: Protection.

The inspector did find that residents' needs were comprehensively assessed using validated assessment tools at regular intervals and when changes were identified to a resident's healthcare status. There was a good standard of care planning in the centre, with a focus on person-centred care. Care interventions were specific to the individual concerned and there was evidence of family involvement when residents were unable to participate fully in the care planning process.

A review of care records for residents assessed with communication needs found that there was a focus on determining how best to support residents in this area. The provider was keen to ensure that residents rights were protected and that their views were incorporated into the delivery of their care support. Similarly for residents who were assessed as having responsive behaviours, there was a holistic and person centred approach to providing support with a focus on how residents

wanted their care to be delivered.

Residents were in receipt of regular input from medical professionals and these arrangements were well-managed by the person in charge. There was effective oversight of residents clinical needs which were reviewed on a regular basis.The GP regularly visited the centre on a weekly basis or as and when required and there were referral arrangements in place for residents who required psychiatric support. There was evidence of training made available for staff to maintain their clinical skills.

The inspector reviewed systems in place to manage residents finances, particularly for those residents for whom the provider acted as pension agent. There were insufficient records available in the centre to show how this arrangement was managed and to provide assurances that resident's finances were adequately protected and that residents had access to their own monies when they wanted.

While most twin bedrooms measured more than the minimum required floor space for two residents (14.8 m2), the configuration and layouts of four twin rooms which impacted eight residents did not ensure that residents could attend to carry out personal care activities in private. In addition, these residents did not have sufficient space beside their bed to have a comfortable chair due to the positioning of privacy screens around each bed.

Furthermore, the measurements taken by the inspector in twin bedrooms 2, room 7 and room 8 showed that these rooms did not provide the required 14.8m2 space to be able to accommodate two residents. These measurements did not reflect the information provided by the provider in relation to the size of these bedrooms in their statement of purpose which stated that the bedrooms were more than 14.8 m2.

The provider was found to have made a number of changes to the layout of the designated centre and the use of some rooms While, it is acknowledged that the provider was attempting to improve the storage facilities in the centre, these changes had resulted in the reduction of resident communal facilities due to the relocation of the prayer room. For example, the prayer room had been relocated to an area which did not provide the same level of space for residents to use.

Although the provider had made significant improvements in relation to fire safety over recent years, two sets of fire doors which had been installed as part of these improvements appeared to have gaps around their door frames. This has not been identified on the schedule of regular checks and had the potential to impact on the effectiveness of these door to provide adequate protection from the risk of fire and smoke.

The provider failed to ensure that clinical and general waste were managed safely. This is a repeat finding from the last inspection.

There was a good range of activities provided for residents. Observations on the day confirmed that residents were encouraged to participate in organised activities and

were also provided with additional supported where needed.

Resident meetings were scheduled to occur on a monthly basis however the last recorded meeting available for review was dated February 2024 and covered activities, food and laundry. The inspector did note that a resident satisfaction survey occurred in March 2024 and was currently being reviewed.

Regulation 10: Communication difficulties

Residents who were assessed as having a communication need were provided with the required levels of support to be able to communicate effectively. Care plans set out residents' skills and abilities and the areas where they required additional support, For example,

- Care plans were specific to the needs of the individual resident concerned and set out clearly the strategies and interventions on how best to support residents with their communication needs.
- There was an awareness among the staff team in relation to residents communication needs and on how best to support residents communicate their views and preferences.

Judgment: Compliant

Regulation 17: Premises

Some areas of the premises did not conform to the requirements set out under Schedule 6 of the regulations:

- The layout of seven twin bedroom meant that residents sharing these rooms did not have sufficient space around their bed to have access to a comfortable chair in which they could sit out.
- The cleaners store did not have a hand hygiene sink in place.
- The requirement to upgrade flooring outside a resident’s room identified at the last inspection had not been addressed.

In addition there had been changes made to the layout of the designated centre where a number of rooms had been repurposed without the Chief Inspector being notified, these included:

- The residents prayer room was now a staff canteen facility.
- An equipment store was now the prayer room.
- Nine twin rooms had been re-designated as single rooms.

- A single room had been re purposed as a treatment room.
- The resident smoking room was now a storage facility.

Judgment: Not compliant

Regulation 26: Risk management

There was a risk management policy in place which met the requirements of the regulations. However, the inspector found a number of risks in the centre which had not been identified or assessed and had the potential to cause harm to residents. These findings are addressed under Regulation 23: governance and management, Regulation 17: Premises and Regulation 8: Protection.

Judgment: Compliant

Regulation 27: Infection control

The waste compound area was not well managed. A review of this area confirmed that a number of clinical waste bins had not been emptied for months and there was also build up of of clinical waste bags which were stored on top of these bins. General waste bins were also found to be overflowing with waste material with some food products on the ground. This area was unsecured and open to the public. This was a repeat finding from the last inspection and posed an infestation risk to the centre.

Upon further review it was found that the registered provider had not maintained service contracts with waste contractors and therefore did not ensure that effective governance arrangements were in place for the sustainable delivery of safe infection prevention and control interventions. The inspector issued an immediate action to the provider to remove the waste material which the provider complied.

Judgment: Not compliant

Regulation 28: Fire precautions

While the provider had made significant improvements in relation to fire safety arrangements in the centre, the inspector found that the registered provider did not make adequate arrangements in respect of the following:

- The inspector observed that there were gaps found in two compartment fire door which had been installed as part of the overall fire safety upgrade of the

premises. This compromised the effectiveness of these doors to prevent the spread of fire and smoke in the event of a fire emergency.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

The inspector reviewed a selection of residents care plans and found them to be well-written with a focus on identifying appropriate interventions to meet residents individuals needs. There was evidence that resident care plans were based of a comprehensive assessment of their needs.

Records reviewed on inspection confirmed that residents were consulted about their care needs and on how they would like these needs to be met. In instances where residents were unable to participate in the development of their care plans, their relatives were consulted for their views on how care should be delivered.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Staff were experienced and knowledgeable in the management of residents who presented with responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment). On the day the inspector observed interactions between staff and residents and found that staff were able to use de-escalation and distraction techniques effectively manage potentially risky situations.

Staff were respectful and empathetic to these resident and provided reassurance to reduce the responsive behaviours being expressed by these residents.

Judgment: Compliant

Regulation 8: Protection

While there were policies and procedures in place to ensure residents were protected from abuse, the inspector found that the provider had not taken all reasonable measures to protect residents from potential abuse. The inspector found that the provider was acting as a pension agent for five residents living in the designated centre but did not provide adequate assurances that residents personal

finances were protected. For example,

- Residents' social protection benefits were not paid into a separate bank account to that of the registered provider.
- Residents or their designated relatives were not provided with statements accounting for how the resident's monies were used and what monies were available in their account.

In addition, the provider failed to ensure that all staff working in the designated centre had a valid garda vetting disclosure available for review. This is discussed in more detail under Regulation 21.

Judgment: Not compliant

Regulation 9: Residents' rights

The inspector found that the layout of seven twin rooms meant that residents accommodated in these bedrooms could not undertake personal activities in private.

For example there was not sufficient room between the beds for residents to use assistive equipment such as hoists without impacting on the other residents in the room.

The proximity of the beds to each other did not provide adequate privacy for residents when they were receiving personal care.

Additionally, there was only one television provided for residents residing in twin which impacted on residents choice of viewing.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Not compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration	Not compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Fearna Manor Nursing Home OSV-0000339

Inspection ID: MON-0043227

Date of inspection: 03/05/2024

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 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
Quarterly staff file audit now in place and will ensure the staff files are checked and updated on a regular basis. The audit will be completed by the admin staff and reviewed by director of nursing. There is now a robust process in place in relation to required documentation prior to a staff member commencing post which includes receiving two signed references from previous employers.

A resident pension account has been opened since the 1st of June 2024 by the registered provider and is a separate account from the general business account, all pensions are paid weekly into the account. MO'D is the appointed pension agent but only acts in this role as a last resort and currently does so for 4 residents.
A system was already in place to record all residents' finances and maintained in head office. These records are now shared each month with the centre and copies are retained in the centre. The financial statements will be shared with the residents on the monthly basis and a copy to the representative with the resident consent.
All information contained within these records will be itemized- for example hairdresser, chiropody, outings and contribution towards nursing care etc.
The care monitor system will be used to record in line with policy to manage the resident petty cash finances which are held in the designated centre. This includes requiring two staff signatures for all transactions, the resident who has the financial capacity shall sign for any monies given, and receipts for any monies spent on resident's behalf are kept and stored securely in resident safe. Policy has been reviewed & reflects with this process.
Provider meetings will have structured agenda that will include - Updates on status of actions/quality improvement;
Audits completed; HIQA Compliance Plan updates; HIQA correspondence, inspections, reports, PAR; Risk management & Fire Safety, Safety concerns; Clinical updates; Serious Incidents/ Safeguarding/ Complaints reviews; Overview of quarterly targets for operational & corporate KPI's; Financial updates; HR updates; Specific operational concerns; Bed occupancy status
The minutes of the meeting will identify the content of the discussion and the agreed

outcome. There will be a detailed action plan following each meeting with time frames for completion, and at the beginning of each meeting will be a review of action plan from previous meeting. All records, processes & systems will be discussed and reviewed during visits with the registered provider representative.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Where necessary agreements have been made with some providers regarding payment schedules. There is no interruption to any services at present All suppliers to the designated centre have either an agreed payment plan in place and/or received payment covering outstanding bills, this has ensured that the designated centre now has regular supplies for all utility, food and required services for safe provision of services.
Tax clearance cert has been restored which allows the Fair Deal payment to issue from HSE to the centre each month.
The fire door issue will be sorted inside by 15th of August 2024 as per advice from person responsible completing the work.
The provider is very committed to staff development, and since last inspection the staff member who is responsible for fire checks and audits attended a Fire Safety and marshal instructor course through QUALTEC on Friday the 28th of June.

The designated centre has in place a staff file audit which is completed by admin staff and reviewed by DON on a quarterly basis, any actions identified are transferred into a quality improvement plan. All staff files are now up to date with the correct documentation always contained within their staff file. There is process for staff recruitment & onboarding, staff follow this for all staff filing.
All records are maintained in line with regulatory obligation & in line with GDPR. Al records & systems are reviewed by registered provider representative during site visits.
Due to a lapse in process one employee was on site and Garda vetting certificate not available in file. This will not reoccur as the importance of checking that Garda Vetting cert on file before employment commences has been reinforced.
The provider has practices in place to protect residents from potential abuse. Any monies received by the provider on behalf of the residents are clearly documented to ensure transparency & protection for all parties involved. This account is opened and the DSP have been given details to do direct transfers.
Residents will receive monthly statements to ensure they are aware of the monies held for them and they will have 24/7 access to their monies through individual petty cash & ledgers with associated receipts maintained and available in the Nursing Home. The current policy relating to Resident's finances has been updated .The Person in charge and local management now have access and are aware of the 4 residents that the registered provider is a pension agent for, all information and records are maintained, kept on site and available in the designated centre. Each resident, that the provider is a

pension agent for, will receive a monthly statement identifying monies held on their behalf
The Provider adheres to all requirements of Schedule 2 for Garda vetting – all vetting certificates are maintained and available in the designated centre
Any conditions of registration are fully complied with and statement of purpose is updated when any conditions are imposed,

Regulation 24: Contract for the provision of services	Not Compliant

Outline how you are going to come into compliance with Regulation 24: Contract for the provision of services:
Since our last inspection, all residents living in the centre have a contract in place with the registered provider, Castlerea Nursing Home Limited, that meets the requirements of Regulation 24. All contracts of care have now been updated and resigned by residents and/or NOK.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
All identified issues in relation to the Statement of Purpose have been amended and a draft copy sent to HIQA inspector for comments and review.
Changes to the layout of the designated centre were made following the findings from previous inspections. A number of rooms were temporarily reduced to single occupancy due to current layout in these rooms. The chapel was moved to a more visible central area and following on from a residents meeting, this was discussed, and minutes recorded. The residents who attended the meeting are happy with the placement of the chapel as they are able access the chapel with ease at any time of day or night. Also, it has allowed for some residents to become more involved in the preparation for Mass as they are able to help to set up for the communion. One resident commented that they were involved in helping in the church prior to admission and have found much enjoyment in being involved in this small job.
The provider accepts that these changes were not reported to HIQA and whilst there was discussion with management re: changes there is no evidence of discussion documented in meeting minutes.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
Required changes to the complaints policy have been made. A copy of the updated complaints policy has been provided by the registered provider.

Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration	Not Compliant

Outline how you are going to come into compliance with Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration:
The registered provider accepts that an application to vary was not submitted as required. Any further changes to the internal layout of building will be discussed with HIQA and appropriate documentation submitted.

An application to vary is being prepared and will include additional proposed changes to the use of some rooms / creation of new rooms / spaces. In most cases these are going to be minor changes and are being worked on with our engineer at present. The bulk of the work will involve the reconfiguration of the double rooms and will not involve change of use of these rooms.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The layout of seven twin bedrooms is to be reviewed by the registered provider and architect. Meeting for this review to be completed by end of July.
Hand hygiene sink will be installed in cleaning store by end of July. Additional hand sanitizers have been installed in the corridors.
The replacement flooring outside one bedroom will be completed by end of July.
Registered provider accepts that changes to layout was not linked with HIQA and appropriate process followed. A single room that has been repurposed as a treatment room was done so following fire authority and HIQA inspection. The rationale for this is

due to the location on a narrow corridor and nearness to the laundry.
Due to fire risk, passive smoking risk and the residents being unable to use small activity room beside smoking room due to smell and smoke, the smoking room was decommissioned with residents' agreement and was relocated to the garden area. There are plans to create a canopy area in a section of the garden.
The residents' prayer area was moved to a more central location as it was noted that the prayer room in its previous location was not frequented by residents. There was a need for an area for staff to have their breaks so the previous prayer room was repurposed for this.
An application to vary is in process of being prepared which will include further detailed information on the change to these areas. In addition other proposed changes to double rooms and the creation of additional rooms will be incorporated into same.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
A new contract is in place with general waste collection provider and with a separate provider for the clinical waste.
There is a risk assessment and a risk on risk register relating to clinical & general waste storage, maintenance and removal.
Waste storage area is included in the daily maintenance walkabout checklist and issues are recorded and reported to management.
This is also included as part of the infection prevention and control policy. All suppliers to the designated centre have either an agreed payment plan in place and/or received payment covering outstanding bills, this has ensured that the designated centre now has regular supplies for all services required for safe provision of services.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
We are waiting for parts to be delivered and work to be completed, the time frame to complete the work will be the next 2-3 weeks.
Maintenance staff member completed fire safety and warden instructor course on 28th June. Maintenance staff member will have responsibility for the fire safety management within the centre and this will be overseen by the DON and registered provider. A more robust fire safety checklist and audit system is being developed to ensure that all fire safety risks are identified and addressed within an appropriate time frame. This will include checklists for fire safety management documentation, fire safety management

policies and procedures, building compartment, fire door assessment, fire containment. Fire doors are checked weekly and exit doors and escape routes are checked daily by maintenance. Any issues are reported to DON and an action plan will be put in place to address with issues with the appropriate persons. Fire safety risks are on the clinical governance meeting agenda and have been added to the weekly managers report submitted by DON to registered provider on a weekly basis.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
There is now a resident pension account which has been opened since the last inspection by the registered provider and is a separate account from the general business account. A more robust system is now in place in relation to ensuring that residents who the registered provider is pension agent for is able to access their money as and when needed and is provided with a monthly statement and an outcome of a quarterly audit completed by DON and registered provider. All financial records relating to all residents, including those who registered provider is pension agent for, are forwarded to the designated centre on a monthly basis. All information contained within these records will be itemized- for example hairdresser, chiropody, outings and contribution towards nursing care etc. The designated centre is in the process of ensuring a more robust system is in place on care monitor system and in line with own policy to manage the finances which are held in the designated centre. This includes having two staff signatures in place for all transactions, the resident who has the financial capacity to be able to sign for any monies given, receipts for any monies spent for resident are kept and stored securely in resident safe.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
The layout of seven twin bedrooms is to be reviewed by the registered provider and architect. Meeting for this review to be completed by end of July.
It has been agreed that two mini TV's or viewing devices will be provided in all twin rooms over the coming months.
Privacy curtains will be installed in all twin rooms. Given time frame for sourcing these curtains it would be hoped this will be completed by end of August

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
Registration Regulation 7 (1)	A registered provider who wishes to apply under section 52 of the Act for the variation or removal of any condition or conditions of registration attached by the chief inspector under section 50 of the Act must make an application in the form determined by the chief inspector.	Not Compliant	Orange	31/08/2024
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation	Not Compliant	Orange	31/08/2024

	3.			
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	31/08/2024
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Not Compliant	Orange	20/06/2024
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Not Compliant	Orange	20/06/2024
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	20/06/2024
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and	Not Compliant	Orange	20/06/2024

	accountability, specifies roles, and details responsibilities for all areas of care provision.			
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	20/06/2024
Regulation 24(1)	The registered provider shall agree in writing with each resident, on the admission of that resident to the designated centre concerned, the terms, including terms relating to the bedroom to be provided to the resident and the number of other occupants (if any) of that bedroom, on which that resident shall reside in that centre.	Not Compliant	Orange	20/06/2024
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated	Not Compliant	Orange	20/06/2024

	infections published by the Authority are implemented by staff.			
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.	Substantially Compliant	Yellow	20/06/2024
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	20/06/2024
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose relating to the designated centre concerned and containing the information set out in Schedule 1.	Substantially Compliant	Yellow	20/06/2024
Regulation 34(2)(b)	The registered provider shall ensure that the complaints procedure provides that complaints are investigated and concluded, as soon as possible and in any case no later than 30 working days after the receipt of the complaint.	Substantially Compliant	Yellow	20/06/2024
Regulation 34(2)(e)	The registered provider shall ensure that the complaints procedure provides	Substantially Compliant	Yellow	20/06/2024

	that a review is conducted and concluded, as soon as possible and no later than 20 working days after the receipt of the request for review.			
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Orange	20/06/2024
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Substantially Compliant	Yellow	31/08/2024
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Substantially Compliant	Yellow	31/08/2024