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:	Nenagh Manor Nursing Home
Name of provider:	Foxberry Limited
Address of centre:	Yewston, Nenagh, Tipperary
Type of inspection:	Unannounced
Date of inspection:	09 October 2024
Centre ID:	OSV-0000422
Fieldwork ID:	MON-0041994

About the designated centre

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

Nenagh Manor nursing home is located a short walking distance of the town of Nenagh. It is set out over three levels and provides 24 hour nursing care. It can accommodate 50 residents over the age of 18 years and includes a dementia specific unit which accommodates 10 residents. It is a mixed gender facility catering from low dependency to maximum dependency needs. It provides short and long-term care, convalescence, respite and palliative care. There is a variety of communal day spaces provided including dining rooms, day rooms, conservatory, hairdressing room and residents have access to landscaped secure garden areas. Bedroom accommodation is offered in single and twin rooms.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	45

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 9 October 2024	09:00hrs to 17:30hrs	Mary Veale	Lead
Wednesday 9 October 2024	09:00hrs to 17:30hrs	Lisa Walsh	Support

What residents told us and what inspectors observed

This was an unannounced inspection which took place over one day by two inspectors. Over the course of the inspection the inspectors spoke with residents, staff and visitors to gain insight into what it was like to live in Nenagh Manor Nursing Home. The inspectors spent time observing the residents daily life in the centre in order to understand the lived experience of the residents. Inspectors spoke in detail with 12 residents and four visitors. All residents were very complementary of the staff who worked in the centre.

Nenagh Manor Nursing Home is situated on the outskirts of the town of Nenagh, Co. Tipperary. The centre is registered for 50 beds. The centre provides long-term care and respite care. Nenagh Manor Nursing Home was a Victorian house with a modern extension. The original house retained many of its Victorian features, for example; high ceilings, stair cases, coving, ornate fireplaces and sash windows. The centre was laid out over three storeys.

The entrance to the centre was on the lower ground floor with an open reception area. This floor was divided into two parts. To one side of the reception was the dementia unit which accommodated 10 residents in single occupancy bedrooms all with en-suite wash hand basin, toilet and shower facilities. This unit was called the Butterfly unit. Residents in the Butterfly unit had their own lounge area, which was used for activities and dining. In the Butterfly unit, residents communal space also included a conservatory. However, on the day of inspection this room was observed in use for storage equipment and not for the use of residents. The temperature in the conservatory was cold on the morning of inspection. The conservatory lead out to an enclosed garden, however, the door was locked and resident could not access the garden without staff support. The main findings on the day of inspection were that improvements were required in the lived experience for residents whom were living in the Butterfly unit.

The main house on the lower ground floor contained a lounge conservatory area and nine bedrooms. The upper ground floor included an open plan sitting/dining room, a library, a lounge and 18 bedrooms. The first floor contained nine bedrooms. Resident's bedrooms were clean, tidy and residents had ample personal storage space. Bedrooms were personal to the resident's containing family photographs, art pieces and personal belongings.

From the main house residents could access an outdoor space to the front of the centre. The inspectors observed residents walking with staff around the grounds of the centre throughout the day. The front outdoor space and courtyard had level paving, and comfortable seating, and tables.

The inspectors observed the residents in the main house spending their day moving freely through the centre from their bedrooms to the communal spaces. However; improvements were required in the access to communal space for residents living in

the Butterfly unit. This is discussed further in this report under Regulation 9: Residents rights. Residents were observed engaging in a positive manner with staff and fellow residents throughout the day and it was evident that residents had good relationships with staff and residents had built up friendships with each other.

The inspectors observed many examples of kind, discreet, and person-centred interventions throughout the day of inspection. The inspectors observed that staff knocked on resident's bedroom doors before entering. Residents were complementary of the person in charge, staff and services they received. Residents' said they felt safe and trusted staff. The inspectors observed staff treating residents with dignity during interactions throughout the day.

All residents in the main house whom the inspectors spoke with were very complimentary of the home cooked food and the dining experience in the centre. Residents' said that there was always a choice of meals, and the quality of food was excellent. The daily menus were displayed in the dining room and the lounge in the main house and Butterfly unit lounge**.** There was a choice of two options available for the main meal.

The inspectors observed the dining experience for residents in both the main house and the Butterfly unit. The meal time experience was quiet and was not rushed in the main house. The lunchtime experience was observed to differ for the residents in the Butterfly unit. Staff were observed to be kind, respectful, caring and patient with residents. However, the allocation of staff in the Butterfly unit impacted on the time they had available to support residents with their nutritional needs. This is discussed further in this report under Regulations 15: Staffing and Regulation 18: Food and Nutrition.

Residents' whom were living in the main house who spoke with the inspectors said they were very happy with the activities programme in the centre. There was a weekly activity programme in place with planned activities daily which was displayed on notice boards across the centre. The residents in the main house were observed enjoying an exercise class in the main sitting room. The inspectors observed staff and residents having good humoured banter during this activity. However, on the morning of the inspection, on the Butterfly unit there was no activity coordinator available to provide the planned activity and residents were watching a live stream of Mass on the television in the lounge. This had ended, however, the live stream was left of the television for over an hour. The residents sitting in the lounge were observed to be without meaningful activation. In the afternoon on the lower ground floor there was an activity co-ordinator available and some residents were watching gentle exercises on the television and following along. A resident spoken with in the dementia unit said they spent most of their time in the lounge watching television and people passing on the corridor.

Visitors whom the inspectors spoke with were complimentary of the care and attention received by their loved one. Visitors were observed attending the centre on the day of inspection. Visits took place in the residents' bedrooms and communal areas. There was no booking system for visits and the residents who spoke with the inspectors confirmed that their relatives and friends could visit anytime. Visitors

spoken with were complementary of staff and said they were happy with the care residents received overall. However, a visitor expressed their view that there was insufficient staff at times, which on occasion had led to 10 minute delays in the resident receiving care. In addition, a complaint was received from a family member about the wait time for the delivery of care to a resident.

Residents' views and opinions were sought through resident committee meetings. Residents in the main house said that they felt they could approach any member of staff if they had any issue or problem to be solved. The centre also held quarterly relative meetings. Minutes of these meetings included discussions of activities, menus, fire safety and staffing.

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

Capacity and capability

Overall improvements were required in the management of the service to ensure safe effective systems were in place to support and facilitate the residents in particular in those living in the Butterfly unit to have a good quality of life. Gaps in oversight systems and resources management were evident which required action by the provider to comply with residents rights, the premises, food and nutrition, and governance and management. Further measures were required to comply in areas of care planning, staffing, training, records and infection prevention and control.

The inspectors followed up on an an application to vary condition 1 of the centres registration which had been submitted to the office of the Chief Inspector.

Foxberry Limited was the registered provider for Nenagh Manor Nursing Home. The centre is part of a large group that own and manage a number of designated centres in Ireland. The company had three directors, one of whom was the registered provider representative. The person in charge worked full time and was supported by an assistant person in charge, clinical nurse managers, a team of nurses and health care assistants, activities co-ordinators, housekeeping, laundry, catering, administration and maintenance staff. The person in charge was supported by the director of clinical governance quality and risk. The person in charge had access to group resources, for example; finance, human resources and facilities management.

Improvements were required in the allocation of staff to meet the needs of residents living in the Butterfly unit, this is discussed under Regulation 15: Staffing and Regulation: 23 Governance and management.

There was an ongoing schedule of training in the centre and the person in charge

had good oversight of mandatory training needs. An extensive suite of mandatory training was available to all staff in the centre and training was up to date. There was a high level of staff attendance at training in areas such as fire safety, manual handling, safeguarding vulnerable adults, medication management, and infection prevention and control. Staff with whom the inspectors spoke with, were knowledgeable regarding fire evacuation procedures and safeguarding procedures. However; further improvements were required to ensure staff were appropriately supervised and supported in the Butterfly unit, this is discussed further in this report under Regulation 16: Training and staff development.

Records maintained in the centre were in paper and electronic format. Garda vetting disclosures in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 were available for each member of staff. Improvements were required in staff files and the safe storage of documents which is discussed further under Regulation 21: records.

There were regular management meetings and audits of care provision. Records of governance meetings and staff meetings which had taken place since the previous inspection were viewed on this inspection. The person in charge completed a weekly key performance indicator (KPI) report which was discussed with the director of clinical governance quality and risk. There was evident of trending and analysis of fall incidents, pressure sores, infections and antibiotic use which identified contributing factors such as the location of falls and times of falls, and types of infections and recurrence, and progress of healing of pressure sores. Since the previous inspection falls audits, restrictive practice audits, skin care audits, care planning audits, and infection prevention and control audits had been completed. The annual review for 2023 was available during the inspection. It set out the improvements completed in 2023 and improvement plans for 2024.

Incidents and reports as set out in schedule 4 of the regulations were notified to the Chief Inspector of Social Services within the required timeframes. The inspectors followed up on incidents that were notified since the centre was registered and found these were managed in accordance with the centre's policies.

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

An application to vary condition 1 of the centres registration was received. Room 43 which had been in use as a toilet on the upper ground floor was now converted to a sluice room.

Judgment: Compliant

Regulation 15: Staffing

The inspectors was not assured that there were adequate numbers of staff available in the Butterfly unit to ensure that the needs of the residents were being met. For example; there were two staff allocated to the dementia unit on the day of inspection. Some residents were delayed getting up and dressed as they required two staff for assistance. Some residents were delayed in being served meals at lunchtime as staff were attending to personal care of other residents. Also, while assisting residents who required support when eating, staff were interrupted during this task several times to attend to other tasks.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Staff had access to training appropriate to their role. Staff had completed training in fire safety, safeguarding, managing behaviours that are challenging and, infection prevention and control. There was an ongoing schedule of training in place to ensure all staff had relevant and up to date training to enable them to perform their respective roles. There was lack of supervision and support of staff in the dementia unit which lead to a delay in residents receiving care and services. This is detailed further under Regulation 23: Governance and management.

Judgment: Substantially compliant

Regulation 21: Records

All records as set out in Schedules 2, 3 & 4 were available to the inspectors on the day of inspection. Further improvements were required to ensure that Schedule 3 records were maintained in a safe manner. For example;

- The inspectors observed a residents' prescription record on a photocopying machine which could be seen by members of the public in the reception area on the lower ground floor.

A sample of staff files were reviewed by inspectors. In general, all the necessary information required by Schedule 2 were available. However, one staff file did not have documentary evidence of relevant qualifications and a full employment history with a satisfactory explanation of any gaps in employment.

Judgment: Substantially compliant

Regulation 23: Governance and management

The management systems to ensure that the service provided was safe, appropriate, consistent and effectively monitored, as required under Regulation 23(c), were not sufficiently robust. This was evidenced by:

- Inadequate systems of oversight were in place to monitor and respond to issues of concern found by the inspectors, particularly in relation to the lived experience of those residents living in the dementia unit. Theses issues are discussed further under Regulations 9: Residents rights, Regulation 17: premises and Regulation 18: Food and Nutrition.
- Systems of communication were not sufficiently robust. There was a lack of evidence of regular staff meetings. Inspectors were informed that staff meetings were held every quarter, however, from records reviewed only one staff meeting had taken place in January 2024 and no other staff meetings had been held. Minutes of meetings did not have time bound actions which resulted in some agenda item completions being delayed. This is discussed below.

The registered provider did not ensure the centre had sufficient resources to ensure effective delivery of care as the governance structure as outlined in the statement of purpose was not implemented in practice and as required under Regulation 23(a).

For example;

- The centres bain marie which had kept food warm in the dining rooms had been broken and out of use since 2022. The bain marie was discussed at several different management meetings with an action for it to be replaced. However, this action had not been addressed. Residents care needs in the dementia unit were impacted by this, for example, on the day of inspection some residents hot food was left on a tray for at least 15 minutes. Other residents in the dementia unit had to wait for an hour before their dinner was served.
- Inspectors were informed that the high turnover of staff in the centres kitchen was impacting on the skill mix of staff in the centre. Due to the high turn over a number of experienced healthcare assistant were relocated to the kitchen and replaced by agency healthcare assistance. This posed a risk to the continuity of resident care and residents being supported by staff who do not know their care needs.

Judgment: Not compliant

Regulation 31: Notification of incidents

Incidents and reports as set out in schedule 4 of the regulations were notified to the office of the Chief Inspector within the required time frames. The inspectors followed up on incidents that were notified and found these were managed in

accordance with the centre's policies.

Judgment: Compliant

Quality and safety

Overall, the inspectors found that the provider was, in general, delivering a good standard of nursing care; however, the gaps in oversight and resources, as mentioned in the Capacity and Capability section, impacted on the quality of life for the residents living in the dementia unit. The findings of this inspection are that further action was required to come into compliance with resident's rights, premises, and food and nutrition. Areas of improvement were required in assessments and care planning, and infection prevention and control.

The inspectors viewed a sample of residents' electronic nursing notes and care plans. There was evidence that residents were comprehensively assessed prior to admission, to ensure the centre could meet their needs. Care plans viewed by inspectors were generally person-centred. However, a review of a sample of care plans found that there was insufficient information recorded to effectively guide and direct the care of these residents. Details of issues identified are set out under Regulation 5.

Residents' health and well-being was promoted and residents had timely access to general practitioners (GP), specialist services and health and social care professionals, such as psychiatry of old age, physiotherapy, dietitian and speech and language, as required. The centre had access to GP's from local practices. Residents had access to local dental and optician services. Residents who were eligible for national screening programmes were also supported and encouraged to access these.

There were systems in place to safeguard residents and protect them from the risk of abuse. Staff were supported to attend safeguarding training. Staff were knowledgeable of what constituted abuse and what to do if they suspected abuse. All interactions by staff with residents were observed to be respectful throughout the inspection.

The centre was mostly clean and tidy. Alcohol gel was available, and observed in convenient locations throughout the building. Dani- centres were available on all floors to store personal protective equipment (PPE). Staff were observed to have good hygiene practices. Sufficient housekeeping resources were in place. Housekeeping staff were knowledgeable of correct cleaning and infection control procedures. Intensive cleaning schedules had been incorporated into the regular cleaning programme in the centre. Used laundry was segregated in line with best practice guidelines and the centres laundry had a work way flow for dirty to clean laundry which prevented a risk of cross contamination. The centre had an infection prevention control (IPC) link nurse. The link nurse had received training in IPC.

There was an up to date IPC policies which included COVID-19 and multi-drug resistant organism (MDRO) infections. There was evidence of IPC was discussed at meetings. While areas of good practice were noted, improvements were required to the premises and infection prevention and control which is discussed further in this report under Regulation: 17 and Regulation: 27.

Fire safety improvements were observed with new emergency lighting installed in all residents bedrooms and communal areas. An immediate risk was identified and removed on the day of inspection. A small table on a corridor on the lower ground floor outside the kitchen was removed as it was partially obstructing an evacuation route. The provider had effective systems in place for the maintenance of the fire detection, alarm systems, and emergency lighting. There were automated door closures to almost all bedrooms and all compartment doors, and the doors were seen to be in working order. All fire safety equipment service records were up to date and there was a system for daily and weekly checking, of means of escape, fire safety equipment, and fire doors to ensure the building remained fire safe. Fire training was completed annually by staff and records showed that fire drills took place regularly in each compartment with fire drills stimulating the lowest staffing levels on duty. Records were detailed and showed the learning identified to inform future drills. Each resident had a personal emergency evacuation plan (PEEP) in place which were updated regularly. The PEEP's identified the different evacuation methods applicable to individual residents and staff spoken with were familiar with the centres evacuation procedure. There was evidence that fire safety was an agenda item at meetings in the centre.

The residents had access to SAGE advocacy services and an independent advocate. The advocacy service details were displayed on a notice board near all stairwells. Residents has access to daily national newspapers, weekly local newspapers, Internet services, books, televisions, and radio’s. Mass took place in the centre weekly. Inspectors observed that staff engaged with residents in a respectful and dignified way.There was an activity schedule in place with two activity coordinators scheduled on the day of inspection. While there were plenty of activities observed on the ground and first floor throughout the inspection, there were insufficient meaningful activities for residents on the lower ground floor. Inspectors observed that there were lengthy periods of time where many residents were observed sitting in the communal area or their bedroom without other meaningful activation. In addition, a task-orientated culture in the dementia unit which impacted on residents rights. This is discussed further under Regulation 9: Residents rights.

Regulation 17: Premises

Inspectors found that the conservatory on the ground floor of the premises, designated for resident usage, was not being operated in accordance with the statement of purpose. For example, the conservatory was being used for storage. This was a repeated finding from the April 2023 inspection.

Inspectors found that the centre provided a premises which was mostly in conformance with Schedule 6 of the regulations, however, improvements were required for example:

- Ventilation required review in some residents bedrooms and the lower ground floor conservatory. For example, a residents room was observed to be very hot. The window was open and a cooling fan was on, however, the radiator was also on. A window closer was broken in the conservatory on the ground floor and it was noticeably cold on the morning of inspection. This was a repeated finding from the April 2023 inspection.
- Many of the residents enjoyed living in a period building however there were practical challenges with a building of its age. There were many examples where the condition of the premises did not support effective cleaning, for example, stained tile grout on floor tiles in en-suite toilets, gaps in tile grout around shower facets and scuffed and damaged wood flooring in many of the bedrooms.

Judgment: Not compliant

Regulation 18: Food and nutrition

Action was required to come into compliance with Regulation 18. For example:

- Meals served in the Butterfly unit were observed to be small portions. Two residents told the inspectors that the portion size of the main meal was small.
- Not all residents were afforded a pleasant dining experience, for example; the tables in the Butterfly unit were was not set with cutlery and condiments to create a homely atmosphere.
- Systems for serving food required review. For example:
    - On the Butterfly unit inspectors observed a tray with two hot meals and ice cream left on a trolley for a prolonged period of time.
    - The staff allocated in the Butterfly unit were attending to the personal care of a resident and no staff were available to serve the hot meal to the residents. A meal was served after 15 minutes to a resident who required assistance, however, staff were interrupted in doing this task several times due to the lack of resources. The second meal was served after 20 minutes. The remaining residents on the unit had to wait an hour from when these meals were delivered before their meals were served, with one resident saying they were hungry and another resident not hungry because they had their breakfast late.
- The inspectors observed times where there were no staff to supervise in the lounge in the Butterfly unit while residents were eating due to staff allocation as they were assisting other residents with meals in their bedrooms.

Judgment: Not compliant

Regulation 27: Infection control

While the centre was generally clean on the day of inspection, a number of areas for improvement were identified to ensure compliance with the National Standards for Infection Prevention and Control in Community Services (2018):

- Inspectors were informed that equipment stored were cleaned each night. However, two wheelchairs and two hoists which should have been clean were visibly dirty. In addition, three boxes were stored on the floor in the conservatory room which impacted the ability to clean the area.
- Some shower handrails were observed to be rusty which would impact the ability to effectively clean these.
- A review radiator covers in en-suite toilets required review as some were damaged with exposed (medium density fibreboard) MDF. This posed a risk of cross contamination as staff could not effectively clean the radiator covers.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider had good oversight of fire safety. Annual training was provided and systems were in place to ensure fire safety was monitored and fire detection and alarms were effective in line with the regulations. Bedroom doors had automatic free swing closing devices so that residents who liked their door open could do so safely. Evacuation drills were regularly practiced based on lowest staffing levels in the centre's largest compartment.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

The inspectors reviewed a sample of assessments and care plans and found that residents had care plans developed to meet the assessed needs of residents identified on both pre-admission and on comprehensive assessments. However, resident's care plan required additional information to ensure residents received person centred care. For example:

- A resident who required support to ensure they had sufficient sleep and rest had no sleep and rest care plan in place.
- A residents care plan detailed that they required 30 minute safety checks at night. However, on the previous night they only had three 30 minute safety

checks recorded.

- A number of care plans viewed outlined prompts of care which could be provided, rather then details of specific person- centred care.

Judgment: Substantially compliant

Regulation 6: Health care

There were good standards of evidence based healthcare provided in this centre. GP's routinely attended the centre and were available to residents. Allied health professionals also supported the residents on site where possible and remotely when appropriate, for example the dietitian, and physiotherapist. There was evidence of ongoing referral and review by allied health professional as appropriate.

Judgment: Compliant

Regulation 8: Protection

Measures were in place to protect residents from abuse including staff training and an up to date policy. Staff were aware of the signs of abuse and of the procedures for reporting concerns.The centre acted as a pension agent for two residents. There was a separate client bank account. There were robust accounting arrangements in place and monthly statements were furnished.

Judgment: Compliant

Regulation 9: Residents' rights

Inspectors saw that staff engaged with residents in a respectful and dignified way. However, inspectors observed a task-orientated culture aligned to staffing allocation in the dementia unit which undermined residents choice and a rights based approach to care. For example:

- On the day of inspection, there were two staff allocated to the dementia unit for nine residents. Two residents were observed to be in their bedrooms for a prolonged period of time with the television on as their only activation. For one resident, inspectors observed the rosary playing on their television at 10am. The resident said they were not interested in watching this, however, the same programme was still playing at 1.40pm. A resident who required two staff for assistance had to wait until nearly 12pm to get up and dressed.

This resident had only finished eating their breakfast which impacted on the residents' lunchtime experience, meaning they were not hungry when lunch was served.

There were opportunities for residents in the main house to engage in activities. However, inspectors observed that there was limited meaningful activities available for residents in the dementia unit to engage in on the day of inspection. Inspectors observed that there was an undue reliance on television and there were no activities available to the residents in the dementia unit on the morning of inspection.

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	
Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Not compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Nenagh Manor Nursing Home OSV-0000422

Inspection ID: MON-0041994

Date of inspection: 09/10/2024

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: To ensure compliance the Registered Provider will have the following implemented and actioned as required: • A full review of the roster, staff skill mix and Staff allocation has been completed for the Butterfly unit. A new staff allocation and day and night schedule is in place to ensure that all residents are not delayed in how their care needs are met by staff. The meal allocation and meal delivery has been reviewed also to ensure residents have an enjoyable and unrushed experience. The RPR team will support and review when in the home. The PIC will audit monthly and learnings will be communicated to staff.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: To ensure compliance the PIC will have the following implemented and actioned as required : • The staff skill mix and allocation has been reviewed for the dementia unit to ensure the staff are supported and supervised to ensure no delays to residents receiving and having access to care. The RPR team will review at each visit and the PIC will complete regular reviews and communicate learnings to the team.	

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
To ensure compliance the Registered Provider will have the following implemented and actioned as required
• All staff files have been reviewed and Schedule 2 in now compliant.
All staff have had training in GDPR document control and this will also be added as a heading at each staff meeting.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
To ensure compliance the Registered Provider will have the following implemented and actioned as required
• Additional Audits will be completed by the RPR team to provide greater oversight to monitor and respond to issues of concern. This will include Residents surveys, Residents meetings, Care experience audits. The PIC will report weekly to the DCGQR on experience in the dementia unit for residents. Actions required will be followed up weekly.
• Staff meetings will be held monthly and minutes and actions sent to the RPR team to review so if additional support required it can be out in place in a timely manner.
• A new Ban Maire is now in place.
• A full staffing review is underway with the PIC and Group HR Manager to ensure the skill mix within the kitchen can meet the needs of the residents. A weekly HR meeting now takes place and minutes forwarded to the RPR team so additional support can be provided.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
To ensure compliance the Registered Provider will have the following implemented and actioned as required
• A Plan for the conservatory is underway to ensure that it meets its function as laid out in the Statement of Purpose. Once completed it will be for residents use only. This will include appropriate heating, lighting and furniture.
• Ventilation reviews in some bedrooms and conservatory is underway. All window

closures are being reviewed and then will be scheduled for repair or replacement if required.
• The window closer that was broken in the conservatory will be repaired.
• Premises review and plan is now in place to action tiles and flooring issues found. The Homes MO together with the Silver Stream Technical team will address all issues.

Regulation 18: Food and nutrition	Not Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
Regulation 18: Food and nutrition
Not Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
To ensure compliance the PIC will have the following implemented and actioned as required;
• A full review has been completed on the size of meals each resident requests and requires. This is now displayed in each care plan and in the kitchen. The size of meal preference is discussed at pre admission and again the chef will meet all resident re the preferences. This is recorded in the care plan and all staff aware.
• The PIC continues to review the nutritional needs of all residents monthly and if weigh loss noted then action plan put in place, which includes food diary, SLT or Dietitian review, GP review, Weekly weights and MUST evaluation.
• The tables in the Butterfly unit are now set for each meal with cutlery and condiments are required by residents.
• A full review of the dining experience and meal delivery has been completed. Staff are now clearly directed and supervised at meals times to ensure residents receive their meals hot and on time.
• A staff allocation sheet re meal experience and dining is now in place that clearly supports staff in meeting their residents needs.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
To ensure compliance the Registered Provider will have the following implemented and actioned as required
• A full review of storage has been commenced and staff have been reminded to not

store anything on the floor.
• The cleaning allocation has been reviewed and equipment will be checked daily to verify it has been cleaned.
• The shower handrails that were noted to be rusting have been replaced.
All radiator covers have been reviewed and those that require repair or replacement have been scheduled for same.

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
To ensure compliance the Registered Provider and PIC will have the following implemented and actioned as required:
• A full and comprehensive review is underway of care plans with support from the RPR Clinical Compliance team. This will ensure care needs are identified and care plan in place for each resident's care needs. This will ensure that care plans are person centred and not just prompts of care.
• The resident that required rest and sleep care plan have one in place now.
All residents placed on 30 minute checks are now reviewed by Staff nurses to ensure compliance.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
To ensure compliance the Registered Provider and PIC will have the following implemented and actioned as required:
• A full and comprehensive review is underway with each resident in the dementia unit. Individual plans of activities will be then put in place to meet their needs. This will be reviewed and audited by the RPR Clinical compliance team to ensure compliance and feedback will be sought through our residents' meetings and 1-1's. The activity timetable for the Dementia unit is now agreed and will be reviewed monthly.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Substantially Compliant	Yellow	03/12/2024
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	03/12/2024
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	Not Compliant	Orange	31/03/2025

	under Regulation 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	31/03/2025
Regulation 18(1)(c)(i)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are properly and safely prepared, cooked and served.	Not Compliant	Orange	03/12/2024
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	03/12/2024
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.	Substantially Compliant	Yellow	03/12/2024
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to	Substantially Compliant	Yellow	03/12/2024

	be safe and accessible.			
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	03/12/2024
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	03/12/2024
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Substantially Compliant	Yellow	28/02/2025
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later	Substantially Compliant	Yellow	31/01/2025

	than 48 hours after that resident's admission to the designated centre concerned.			
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Not Compliant	Orange	03/12/2024
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	03/12/2024