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:	Glengara Park Nursing Home
Name of provider:	Glengara Park Nursing Home Ltd
Address of centre:	Lower Glenageary Road, Dun Laoghaire, Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	22 May 2024
Centre ID:	OSV-0000044
Fieldwork ID:	MON-0043672

About the designated centre

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

Glengara Park Nursing Home can accommodate 66 residents, both male and female. Residents are over the age of 18 years with varying conditions, including dementia, cognitive impairment, physical, neurological and sensory impairments. Residents with end of life and mental health needs are also accommodated. Twenty four hour nursing care is provided.
Glengara Park Nursing Home is a purpose built nursing home composed of 62 single and two double bedrooms. Each room is fully decorated and furnished. Residents are encouraged to bring personal belongings and small items of furniture where appropriate. The majority of the rooms have en-suite facilities. There is one large sitting room and one large family room situated on the ground floor. Other sitting areas around the house include a coffee dock, an activities room. Outdoor facilities include two large patio areas, one of which is secure. A sensory garden is accessible at the front of the Nursing Home.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	64

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 22 May 2024	08:50hrs to 16:40hrs	Lisa Walsh	Lead
Thursday 23 May 2024	09:55hrs to 15:20hrs	Lisa Walsh	Lead

What residents told us and what inspectors observed

There was a friendly and welcoming atmosphere in the centre, and staff were observed to be helpful, playful and respectful towards residents. Residents were highly complementary of staff in the centre with one resident describing a staff member as "gifted". Other residents described staff as "very kind and patient". The inspector spent time in the communal rooms observing resident and staff interaction. Staff were observed to be familiar with the residents' preferred daily routines, care needs and the activities that they enjoyed. Throughout the two days of inspection, the inspector met many of the residents and spoke with nine residents in more detail. Overall, the feedback from residents was that they were happy living in Glengara Park Nursing Home, however, some residents said they had to wait prolonged periods of time for care to be provided.

Following an opening meeting, the person in charge accompanied the inspector on a tour of the centre. Glengara Park Nursing Home is located in Dun Laoghaire. The centre is a custom-built facility registered to accommodate 66 residents and provides long-term residential care, respite residential care and convalescence care services to adults over 18 years of age. It is set out over three levels, with access between levels via a lift or stairs. There were two vacancies on the days of inspection.

Residents were accommodated in 62 single and two twin occupancy bedrooms. One twin occupancy bedroom and 58 single occupancy bedrooms had an en-suite with a toilet and hand-wash basin. Residents bedrooms and a variety of communal areas were located on each floor. Resident bedrooms were personalised with photographs, teddies, books, knitting and other items of personal significance to them. One resident spoken with said they loved their bedroom which captured the sunlight all day.

On the lower ground floor there was a large dining room with floor to ceiling windows and doors that opened out onto a secure garden area. The garden required maintenance which was taking place on the second day of inspection. There was also a multi-purpose room which was used as a dining room during meal times. The lower ground floor also had a coffee dock which also opened out onto the gardens.

On the ground floor, there was two spacious communal rooms, a family room which was as quieter space for residents to enjoy, and a sitting room for more lively activities. These rooms were located across from each other, next to the nurses station. Residents were observed to use both of these rooms throughout the day. On the first day of inspection, in the morning, residents were observed to be in the sitting room pleasantly chatting with staff about things they were grateful for and having tea and biscuits while they waited for the pottery class to start. This was a very interactive conversation and had a very friendly atmosphere. Following this, residents attended the pottery class which they said they loved. Residents proudly

showed the inspector some of their finished work and works in progress. On the second day inspection, residents were flower-arranging which they also said they enjoyed.

On the first floor, there was a library for residents to use which was filled with books and had a television. There was also an open sitting area. On the two days of inspection, a hairdresser attended and used this space as a salon. Many residents were observed to enjoy this and chatted about their new hair cuts and styles. There was also additional smaller seated areas for residents to use throughout the centre.

Overall, the centre was nicely decorated and had a very pleasant atmosphere. However, the inspector observed that some maintenance were required in areas. This will be discussed in the report below.

While residents were very complimentary of staff overall, some described areas of care provided that required improvement. Some residents described having to wait prolonged periods of time before they received the care they required. One resident told the inspector that about half of the time they could be waiting up to 15 minutes for staff to respond once they pressed the call bell for assistance. A small number of residents told the inspector that their complaints were not responded to. For example, a resident spoken with told the inspector that they had made a complaint two weeks previous, however, they had not received a response to this. When the inspector spoke with management they were unaware of the complaint as they had not been informed nor had the complaint been documented. Residents reported that staff are kind and caring in their interactions, however, at times there are communication difficulties due to a language barrier and some residents reported that staff do not always understand what they are saying. Furthermore, a resident had raised a complaint that there was a lot of new staff who needed more training. The inspector also observed that a residents bed alarm sensor was not working. Checks had been completed the previous night before the resident went to bed and the bed alarm sensor was recorded as working. This was repaired during the inspection.

There were two meal sittings to allow for staff to assist all residents who needed support. The first sitting was for residents who required assistance and a quieter dining experience, they dined in the multi-purpose room. They were observed to receive this support in a respectful and dignified manner. The second sitting was in the dining room. Dining room tables were set and dressed with fresh flowers. Menus were available on each table for residents to choose their meals from. There was positive interaction noted at mealtimes and throughout the day between staff and residents. Overall, residents spoken with said they enjoyed the food, however a resident said the variety of food could be improved.

Visitors spoken with praised the care residents received and the staff in the centre, with on visitor saying the centre was "10 out of 10". Another visitor described recent improvements in the centre with communication and the structure of the centre.

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

Capacity and capability

Overall, the inspector found that the management systems in place were not robust enough to ensure the quality and safety of care provided to residents was safe and consistent. In particular, the systems in place with regard to oversight of staffing, individual assessment and care planning, infection control premises and records. There had been a number of new staff and changes in the operational management team. While the provider had worked hard to recruit and fill the vacancies, there was a need for enhanced focus on the development of a new management team.

This unannounced inspection was carried out over two days by one inspector in Glengara Park Nursing Home. This was a risk-based inspection to assess compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013. The inspector also followed up on a number of issues of concern received on different occasions from members of the public since the last inspection, in relation to, falls, delays in call bells being responded to and staffing arrangements. The inspector also reviewed the information submitted by the provider and the person in charge.

The registered provider is Glengara Park Nursing Home limited. There was a clearly defined management structure with identified lines of accountability and responsibility. The person in charge had commenced their role in March 2024 and reported to the group quality and clinical practice lead, who then reported to the group director of operation. The clinical management team consisted of a person in charge, an assistant director of Nursing (ADON) and two clinical nurse managers (CNM), all of which were new to their role. The person in charge also had oversight of a team of nurses and healthcare staff, activity staff, chefs, a catering and domestic team, administration, and maintenance staff.

The registered provider had audit and monitoring systems in place to oversee the service. While the audit schedule was in place, it was not sufficiently robust to identify key areas for improvement and implement plans that would affect change in areas such as, falls, call bells and assessments and care plans. For example, falls audits were completed each month which identified a number of residents as having multiple falls. However, some issues which required actions had not been addressed despite being identified in each monthly audit.

The call bells audits completed were call bell spot checks which were done each month. A full detailed call bell report was available on the system used however, the management team had no access to these. Therefore, the checking system did not identify night time responses and trends. On the second day of inspection, management got access to the reports. Regular meetings were held and minuted to

cover all aspects of clinical and non-clinical operations. Senior management meetings also took place at regular intervals.

The inspector found that the allocation of staffing was insufficient to meet the assessed needs of the residents. Staff rosters, for all staff in the centre, from the previous two weeks and the week of inspection were reviewed. At the time of inspection, the clincial management team within the centre had no vacancies, however, they were new to the role and there had been periods of time in recent months where some of these roles were vacant. This had impacted on the quality of care provided to residents. For example, there had been an increase in the number of falls in the centre, with the marjoity of these being unwitnessed by staff. Additionally, call bell reports reviewed by the inspector showed that some residents had to wait 15 minutes or more for staff to respond to the call bell to attend to their care needs. There was also one activity staff vacancy which the inspector was informed was currently being advertised for recruitment.

Staff had access to appropriate training and development to support them in their respective roles and a training schedule was in place. While there were arrangements in place for staff to receive relevant training, some staff members were out-of-date with some of their mandatory training, for example, fire safety training. Training had been scheduled in April, however, this had to be cancelled due to an outbreak of infection in the centre. Additional training dates had been scheduled for June.

The annual review of the quality and safety of care delivered to residents was available on the inspection. However, it did not demonstrate that this was completed in consultation with residents and their families. The inspector was informed that residents surveys had been completed to gather residents input, however, a number of these could not be located on the day of inspection and there was no evidence of residents input into the annual review. Other gaps in records maintained in the centre were identified during the inspection, which will be discussed under Regulation 21: Records.

Regulation 15: Staffing

A review was required of the number and skill mix of staff having regard to the needs of the residents and the size and layout of the designated centre to ensure effective delivery of care. Notwithstanding the registered providers recruitment drive, the findings of this inspection were that:

- Residents told the inspector that sometimes they had to wait for a prolonged period of time before they received the care requested. For example, some residents were having to wait over 15 minutes for staff to attend to them after using the call bell to seek assistance. The centre had also received a complaint about shortages in staff.

- From a review of falls audits from January 2024 to March 2024, there had been an overall increase in falls from the previous months with the majority of falls happening in the early morning or at night. Of the total number of falls, 85% were recorded as being unwitnessed, meaning that they were unsupervised at the time of the fall.
- Kitchen staff began working at 8.30am and the chef began working at 9am. Due to this, staff working on night duty were preparing breakfast for residents and setting the breakfast trays as residents were up early and wanting food. This reduced the time that they were available to attend to the care needs of residents.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff had access to training. However, 37 staff were out-of-date with fire safety training. Fire safety training had previously been scheduled, however, there was an outbreak of infection in the centre so this had to be cancelled. New training dates had already been scheduled for fire safety training in June.

Judgment: Compliant

Regulation 21: Records

The registered provider failed to ensure that the records set out in Schedule 3 were kept in the designated centre and available for review on inspection. For example:

- Some residents who had a high risk of falling had a care plan in place which detailed the need for safety checks at regular intervals. However, gaps were identified in some residents records with safety checks not being recorded.
- Records of an incident was recorded and notified, however, on the day of inspection there was no record available of the investigation completed.
- A residents complaint was not recorded.

Judgment: Substantially compliant

Regulation 23: Governance and management

Management systems were not fully effective to ensure that the service provided was safe, appropriate, consistent, and effectively monitored. For example:

- The management oversight of residents' individual care needs, assessments and care plans was not fully effective. This is further detailed under Regulation 5: Individual assessment and care plan.
- Some audits, for example falls audits, and the action plan in place was not effective as it had not led to a reduction in falls. For example, the January falls audit had identified that falls risk assessment were not in date for all residents and were required to be completed. However, the status of this action remained at "open" and some residents continued to have multiple falls in the following months.
- The system in place to monitor the staff response times to call bells was ineffective. The management team did not have access to call bell reports that could facilitate them to identify issues relating to response time times. The information used to audit the call bell response time was not robust and did not identify the long waits reported by residents, and therefore no quality improvement plan had been developed.
- The oversight of the documentation of restrictive practice was not robust. A restrictive practice register was in place, however, the register did not accurately reflect the use of restrictive practice used in the centre on the day of inspection. For example, the register had recorded that a resident had a bed sensor alarm in place, however they did not. Furthermore, another resident who did have a bed sensor alarm in place was not recorded on the restraint log.
- Current arrangements for the auditing and oversight of laundry processes did not adequately identify areas that did not comply with the requirements of the regulations. This is detailed in Regulation 27: Infection control.

A review was required to ensure that the registered provider had allocated sufficient resources for effective delivery of care. This is detailed under Regulation 15: Staffing.

An annual review of the quality and safety of care delivered to residents in 2023 had been completed, however, there was no evidence that this had been prepared in consultation with residents and their families.

Judgment: Not compliant

Regulation 3: Statement of purpose

The registered provider had a written statement of purpose relating to the designated centre which contained all the information set out in Schedule 1.

Judgment: Compliant

Regulation 31: Notification of incidents

All incidents that were required to be notified to the Chief Inspector were notified.

Judgment: Compliant

Quality and safety

While the inspector observed kind and compassionate staff treating the residents with dignity and respect, the management systems in place to ensure the service as safe and appropriate impacted on the quality of care being delivered to residents. The impact of this is described under the relevant regulations below, including assessment and care planning, premises and infection control.

The inspector reviewed a sample of assessment and care plans and found that some care plans were not reviewed in line with the residents changing needs. Other residents did not have can plans developed that were based on up-to-date and comprehensive assessment of residents needs. This is outlined under Regulation 5: Individual assessment and care plan.

There were systems in place to promote residents autonomy over access to their personal property and possessions. Residents had adequate space to store and maintain their personal possessions. Residents' clothes were laundered regularly within the centre and returned to them without issue.

Measures were in place to ensure that residents approaching the end of their life would receive appropriate care and comfort to address the physical, emotional, social, psychological and spiritual needs of the resident. Residents family and friends were informed of the residents condition and facilitated to be with the resident when they were at the end of their life. Care plans for residents approaching end of life were completed and individualised for each resident.

Overall, the premises was in a good state of repair and met the needs of residents. The centre was found to be warm and bright with a variety of communal and private areas observed in use by residents on the day of inspection. The provider had an on-going maintenance programme which included maintaining the garden area which had become overgrown. Work was being completed in the garden during the inspection. On the day of inspection, a shower was out-of-order in an assisted bathroom for over a week. The inspector was informed that attempts had been made to repair this, however, further issues had developed. Work was continuing to try repair this.

While the centre was generally clean on the day of inspection, the laundry systems did not fully comply with the National Standards for Infection Prevention and Control in Community Services (2018), and this will be discussed under Regulation 27.

Regulation 12: Personal possessions

Residents retained control over their personal property, possessions and finances. All laundry is completed in the designated centre daily and there is no additional charge. If residents have clothes they want dry cleaned, this is completed by the residents family. The provider was not a pension agents for residents.

Judgment: Compliant

Regulation 27: Infection control

The laundry arrangements in place were not in line with best practice. For example:

- There was no markings in the laundry room to clearly segregate the clean and dirty area.
- Multiple baskets with clean clothes were stored on the floor of the laundry room. The floor underneath the baskets was visibly dirty with debris.
- The laundry room was not cleaned to an acceptable standard. For example, the floor around the machines and ironing boards had stains on them.
- Items of dirty laundry were left on the floor of the laundry room.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

A review of residents' assessments and care plans found that they were not always reviewed and updated in line with the assessed needs of residents. For example:

- Two residents, with a history of falling, did not have their assessments and care plans reviewed following recent falls. This meant that their documented assessment of need and care plan, in place to guide staff in the management of this risk, did not include possible contributing factors and appropriate interventions to reduce the risk of falls.
- Care plans were not always implemented. For example, a residents care plan set out the requirement for them to have hourly safety checks due to their high risk of falls. However, on review of the records there were days when no

safety checks were recorded and on other days gaps of up to four hours with no safety checks recorded.

- Care plans were not always developed using a comprehensive assessment. For example, a resident was assessed as requiring assistance of two staff for their care needs. However, their care plan stated that they required the assistance of one staff.
- In addition, a residents care plan to respond to and manage responsive behaviour (how residents living with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment) was not based on a comprehensive assessment of the residents needs and therefore did not have a description of triggers and de-escalation techniques to guide the staff in safe care delivery.

Judgment: Not compliant

Regulation 13: End of life

Residents who were approaching the end of their life had appropriate care and comfort based on their needs which respected their dignity and autonomy and met their physical, emotional, social and spiritual needs. There was a policy in place to ensure residents end of life wishes were documented and individualised in their care plan. All residents had an End of Life care plan in place which detailed their religious and cultural needs and any arrangements they wished to have in place.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 12: Personal possessions	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 13: End of life	Compliant

Compliance Plan for Glengara Park Nursing Home OSV-0000044

Inspection ID: MON-0043672

Date of inspection: 23/05/2024

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 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • A recruitment drive is currently in progress to fill the remaining vacancies in the centre as outlined in the Statement of Purpose. This is monitored by the DON/PIC with the HR Department on a weekly basis. • Glengara Park Nursing Home has a Clinical and Governance Plan which audits compliance to the regulation. This includes a monthly audit of call bell responses, which the PIC/DON has oversight. The above will form part of the monthly KPI which is submitted to the senior management team every first Friday of the month. A feedback system via unit review meeting is done every 2nd week of the month to ensure that staff are informed of the audit findings as well as the necessary improvements that is required on foot of the results. The CNM on shift together with the DON and ADON monitors the responses to the call bells daily to ensure that staff are attending promptly to any calls. • A monthly falls audit is included in the centre's Clinical and Governance Plan. This audit is overseen by the DON. Following the inspection, the new ADON has been named as the local falls champion who analyses and initiates any service improvement as a result of the audit. From April 2024 to June 2024, a reduction in the number of falls has been noted following the changes that has been recently introduced. • Following the inspection, the kitchen roster has been reviewed and amended (complete). Kitchen staff now starts at 7am to ensure that breakfast is prepared and is made available to residents who are up early and wanting food. This also ensures that healthcare staff are available on the floors to attend to the care needs of residents.	
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records:	

• Care plan review and audit is part of the centre's monthly Clinical & Governance Plan, which the PIC/DON has oversight. This will form part of the monthly KPI which is submitted to the senior management team every first Friday of the month. By the end of July 2024, a review of each resident's care plan to ensure they reflect each individual's needs and guide staff appropriately to meet those needs, will have been completed. This will specifically review individual risks, i.e. falls, challenging behaviours, etc. to ensure appropriate supervision and safety measures (including triggers and steps for de-escalation) are in place and evidence of care and checks are documented.
• Following the inspection, a local SOP was developed by the new DON to ensure that investigation records are accessible following the centre's complaints management policy. All staff are reminded on their responsibilities in identifying, reporting, and recording of complaints.
• The identified complaint on the day of inspection has now been logged and closed following conclusion of the investigation (complete).

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

• Glengara Park Nursing Home has a set Clinical and Governance Plan in place to audit compliance with the regulations. A further review of the management system in place includes quarterly Clinical Governance Meeting, Falls meeting, restrictive practices, and care plan audits. The new PIC/DON maintains oversight of these audits and submits a weekly report to the Senior Management/Operations team as a complete oversight of the home. This weekly report also ensures that assessments and care plans are kept up to date. Any issues identified in the above are communicated to the relevant teams and is monitored for compliance by the PIC.
• A monthly falls audit is included in the centre's Clinical and Governance Plan. This audit is overseen by the DON. Following the inspection, the new ADON has been named as the local falls champion who analyses and initiates any service improvement as a result of the audit. Further, risk assessments have been reviewed and are now in date. An action plan tracker has also been introduced to with management oversight to ensure actions identified are closed timely. From April 2024 to June 2024, a reduction in the number of falls has been noted following the changes that has been recently introduced.
• New DON/PIC has been given access to the call bell reports and is monitored monthly by the management team as part of the Clinical & Governance Plan. A feedback system is also in place to ensure that staff are informed of the audit findings as well as the necessary improvements that is required on foot of the results. The CNM on shift together with the DON and ADON monitors the responses to the call bells daily to ensure that calls are attended promptly.
• Current oversight on restrictive practice was completed in June 2024 to ensure accuracy and is included in the Clinical & Governance Plan of the centre. This is reviewed monthly to ensure that any changes are reflected in the register. The DON/PIC maintains oversight of the register in coordination with the ADON/CNMs.

• Weekly audit is in place to ensure standards of practice are adhered to in the Laundry Department. Deep cleaning of the laundry was completed following the inspection and a schedule of same was also put in place and the DON/PIC with the assistance of the ADON and the Housekeeping Manager maintains oversight of same. Spot checks are also carried out by the management team to ensure compliance and to address any issues on a timely manner.
• Staffing review was completed by the DON/PIC with the HR Business Partner in June 2024 and will be done on a weekly basis until further notice to monitor safe staffing levels. A full review with the Registered Provider Representative will be done monthly and is also an agenda item in the quarterly governance meeting.
• A new annual Review template is being rolled out for 2024. Resident and family survey is planned in August 2024. All feedback from the survey will be included in the annual review and will be fully completed by end of October 2024.

Regulation 27: Infection control	Substantially Compliant

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

• Following the inspection, a clear demarcation in the laundry room was put in place to segregate the clean and dirty areas (complete).
• Deep cleaning of the laundry was completed following the inspection. Schedule of regular deep cleaning was also put in place and the DON/PIC with the assistance of the ADON and the Housekeeping Manager maintains oversight of same with daily spot checks being done in between to ensure compliance, until further notice.
• Laundry staff have been advised not to store clean clothes on the floors and to use the shelving available in the laundry room. Staff were also advised to not leave dirty laundry on the floors and to utilise the available baskets/hampers. Compliance to the above advise is done by the management team during daily spot checks and weekly inspection.
• New ironing boards been ordered (complete). State of repair of the laundry equipment is monitored by the management team and will be replaced/repaired as necessary.

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:

• The two residents identified in the inspection report had their reassessments and care plans reviewed (complete). A system of monitoring has been introduced and a named management staff is allocated to ensure that care plans and assessments are kept up to

date, as discussed above.
• A review of internal communication system was conducted by the new DON. Following this, a change in practice has been introduced to ensure that handover and communication are kept relevant and crucial information are not missed amongst staff. The DON/PIC supported by the ADON spot checks the documentation on a weekly basis to ensure compliance.
• Care plan review and audit is part of the centre's monthly Clinical & Governance Plan, which the PIC/DON has oversight. On top of this, the PIC reviews assessments and care plans on a weekly basis and communicates any overdue actions to the clinical team for completion.
• Following the inspection, all new residents admitted to the centre has a care plan based on their initial assessment completed within 48 hours of admission. An admission checklist is in place to ensure compliance with the regulations.
• By the end of July 2024, a review of each resident's care plan to ensure they reflect each individual's needs and guide staff appropriately to meet those needs, will have been completed. This will specifically review individual risks, i.e. falls, challenging behaviours, etc. to ensure appropriate supervision and safety measures (including triggers and steps for de-escalation) are in place and evidence of care and checks are documented.
• By the end of September 2024, all nurses will have completed a refresher training on Care Planning.
• By the end of September 2024, staff will have completed a refresher training on managing behaviours that challenge.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	30/09/2024
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	31/08/2024
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the	Substantially Compliant	Yellow	30/09/2024

	effective delivery of care in accordance with the statement of purpose.			
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	30/09/2024
Regulation 23(e)	The registered provider shall ensure that the review referred to in subparagraph (d) is prepared in consultation with residents and their families.	Not Compliant	Orange	31/10/2024
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	31/08/2024
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have	Substantially Compliant	Yellow	30/09/2024

	been assessed in accordance with paragraph (2).			
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Substantially Compliant	Yellow	31/07/2024
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Not Compliant	Orange	31/08/2024