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:	Aperee Living Callan
Name of provider:	Aperee Living Callan Ltd.
Address of centre:	Friary Walk, Callan, Kilkenny
Type of inspection:	Unannounced
Date of inspection:	18 April 2023
Centre ID:	OSV-0004449
Fieldwork ID:	MON-0038702

About the designated centre

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

Aperee Living Callan is located within the urban setting of Callan, Co. Kilkenny. It is registered to provide care to 60 residents. It is a two-storey facility with lifts and stairs access on either side of the centre to enable easy access. All bedroom accommodation comprises single rooms with en-suite facilities of assisted shower, toilet and handwash sink. There are day rooms, dining rooms and activity rooms on both floors as well as seating areas throughout. Residents have access to a secure mature garden with walkways, garden furniture and raised flower beds. Strathmore Lodge Nursing Home provides 24-hour nursing care to both male and female residents. It can accommodate older people with a range of diagnoses and younger people whose assessed needs can be met by the centre. Long-term care, convalescence care, respite and palliative care is provided and low to maximum dependency residents can be cared for in Strathmore Lodge.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	47

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
Tuesday 18 April 2023	10:20hrs to 20:00hrs	Catherine Furey	Lead
Tuesday 18 April 2023	10:20hrs to 20:00hrs	Niall Whelton	Support
Monday 15 May 2023	10:00hrs to 13:00hrs	Noel Sheehan	Support

What residents told us and what inspectors observed

On the first day of inspection, two inspectors arrived unannounced to the centre. The second day of inspection was announced in advance, to facilitate one inspector to review of a number of documents pertaining to the protection of residents' finances. Inspectors spoke with a number of residents in their bedrooms and in the communal areas of the centre throughout the inspection. Overall, residents reported satisfaction with the standard of care, activities and choice of food in the centre, and were complimentary of the staff and management. One resident told the inspector "I'm as happy here as I was at home". Inspectors also spoke to visitors, who also reported satisfaction with the care provided to their loved ones. One visitor stated "They took time to talk us through the admission, and I can come and visit whenever I like".

On arrival to the centre, the inspectors were welcomed in, and met with the director of nursing who brought inspectors on a tour of the entire premises. Later in the day, the regional manager attended the centre. The regional manager had been recently appointed and was the previous director of nursing in the centre, and was very familiar with the residents, staff and the organisation of the service. The centre is registered for 60 beds, and there were 47 residents living in the centre on the days of inspection. Inspectors observed that many residents were up and dressed and had finished breakfast. Throughout the tour of the premises, inspectors saw that staff were busy attending to residents who had remained in bed longer, or who required assistance. Staff who spoke with inspectors said that they enjoyed their jobs, however they sometimes felt rushed, and felt that if there was any more residents admitted to the centre then it would be difficult to do their job properly.

Aperee Living Callan is situated in the town of Callan in Co. Kilkenny. The centre is a two-storey, purpose built nursing home that can accommodate 60 residents. Bedroom accommodation is laid out over both floors and all rooms are single occupancy with ensuite facilities. Bedrooms varied somewhat in size and shape, however all rooms contained sufficient storage for clothing and belongings, and areas to display photographs and ornaments. Residents were encouraged to personalise their rooms with familiar objects, furniture and memorabilia. A lockable facility to store precious or private items was provided in each bedroom. Residents were satisfied with their laundry arrangements and said that their clothing was returned to them without delay.

Unrestricted access between floors is facilitated by passenger lifts. Inspectors saw that there was adequate communal and dining space on each floor. The centre's oratory had been used during the COVID-19 pandemic to facilitate window visiting. A temporary partition with transparent screen to facilitate visits remained in the oratory and this, in addition to the storage of a number of high-support chairs, wheelchairs and walking aids, detracted from the purpose of the oratory and it was unclear if this room was used as its stated purpose or as a store room.

The inspectors observed that although the centre appeared for the most part to be clean, the carpet, which covered all of the corridors on both floors, remained stained and worn in some areas. This was despite a scheduled 11 hours of cleaning each week, which was designated to the maintenance staff to complete. Additionally, inspectors noted that there was a foul malodour from the carpet cleaning machine which permeated the corridors during the cleaning process. Staff were unclear as to why this occurred on operating the carpet cleaning machine, and acknowledged that it was uncomfortable to withstand the odour. Some other areas of the premises were required to be addressed, which is detailed further in the report.

Residents were seen to gather in the main sitting room downstairs in the morning for activities. This was a nice and bright area with comfortable seating and small side tables for residents' refreshments. There was a jovial atmosphere in the sitting room and inspectors saw nice interactions between residents and staff, who were seen to be very courteous and kind when speaking to residents, while still enjoying chat and laughter. Residents could access access the large garden via the downstairs sitting room. The centre's chickens and ducks were wandering through the garden, and residents were feeding them and assisting to put them back into their coop. Inspectors saw that the garden, while still retaining a homely feel, had not been maintained to the high level seen on previous inspections, for example, the pathways were in need of attention as inspectors observed loose paving, and the grass was overgrown and unsightly. There was no sheltered smoking area in the garden, and as a result residents smoked directly outside of the main door from the sitting room.

Inspectors observed lunchtime in the main dining areas downstairs. Residents who required assistance with their meals were seated in a smaller dining room, while those residents who were more independent were served their meals in the larger dining room. There appeared to be sufficient staff to supervise and assist residents with their meals. Twelve residents received their meals in the upstairs dining room. The food was delivered in a heated trolley and was served in a warm and appetising fashion to residents. A staff member was present for the duration of mealtimes in this area. Some residents chose to remain in their rooms for meals and inspectors saw that staff were assigned to deliver the food, and to check on residents in their rooms during mealtimes.

The next two sections of this report will present the findings of the inspection under the relevant regulations. These are divided into two sections, based on the capacity and capability of the service, and how the governance arrangements impact upon the quality and safety of care delivered to residents.

Capacity and capability

Inspectors were not assured about the governance and management of the centre especially in areas of residents' finances and in areas of continued non-compliance

which had not been addressed by the provider. During this inspection, actions resulting from the previous inspection in July 2022 were reviewed and inspectors found that the commitments outlined in the centre's compliance plans had not been fully actioned, specifically in relation to fire safety, the premises, and governance and management. Additionally, this inspection found that the staffing arrangements in the centre were not sufficiently robust to ensure a sustainable and safe staffing model.

This inspection was carried out following receipt of an application to renew the registration of the centre. The registered provider had applied to renew the registration of 60 beds. Day two of the inspection was undertaken following receipt of unsolicited information relating to the alleged mismanagement of residents finances and pension agent arrangements for residents whom the registered provider acted as a pension agent for. The inspectors found that the provider did not take all reasonable measures to protect residents finances as evidenced by the findings under Regulation 08, Protection below.

Aperee Living Callan is operated by Aperee Living Callan Limited, the registered provider. The Chief Inspector is concerned about the registered provider's ability to sustain a safe quality service. There had been ongoing regulatory engagement with the provider including provider meetings, cautionary meetings and warning meetings in relation to governance and management and fire safety. As part of the provider's commitment to improve the governance of the centre, the provider had appointed a new Chief Executive Officer in January 2023 but the inspectors were subsequently informed that this person was no longer in the employ of the provider. The current governance structure is supported by a company external to the registered provider comprised of two newly appointed regional managers, a newly appointed HR manager, HR and finance team and a chief operations officer. On site, the management team comprised the person in charge, assistant person in charge, clinical nurse manager, care team and accounts manager. The inspectors were informed the regional manager attended the centre on a regular basis and the chief operations officer was available to the service. Inspectors were concerned that in the absence of strong governance, there was an over-reliance on the person in charge and the clinical management team to provide the governance and leadership for this service.

The registered provider had submitted the appropriate notification advising the regulator of the appointment of persons participating in management (PPIMs) of the service. These notifications were for the regional managers and the chief operations officer who inspectors were informed were available to the service. The duty roster was examined and showed that the person in charge and assistant director of nursing worked full time in the centre, in a supernumerary capacity. Nursing staff levels were in line with those outlined in the centre's statement of purpose and there were two nurses on duty on each shift. The person in charge took up her role in March 2022, having previously worked as the assistant director of nursing in the centre. The person in charge was responsible for the overall direction of clinical care within the centre. She was supported in this role by a team of nurses and healthcare assistants, supported by domestic, catering, activities and administrative staff. A full review of the staffing arrangements including a review of planned and worked

rosters, identified serious deficits in the staffing strategy for the centre, including an over-reliance on healthcare assistant agency staff. Findings in this regard are detailed under regulation 15: Staffing.

Fire safety risks had been identified in the provider's own fire safety risk assessment in November 2021. The provider had addressed a number of the fire safety risks and an updated fire safety risk assessment was completed in July 2022. Five of the nine red rated fire safety risks still persisted and there was no definitive plan in the centre to address these risks. Actions from the previous inspection in relation to fire precautions had not been addressed and remained outstanding on this inspection.

A company-wide schedule of audits was in place. These were completed predominantly by the director and assistant director of nursing. The outcome of some audits included well-developed plans for improvement, including audits of call bell response times, medication management and care plans. The person in charge ensured consistent monitoring of the service by maintaining a log of data including residents weights, infections, falls and restraints and these contributed to the wider audit system. The person in charge was making an effort to ensure good communication channels were maintained amongst staff by holding meetings with each department in the centre. Regular governance and management meetings were held with members of the other Aperee centre's management teams. This allowed for opportunities for shared learning.

Staff had access to a suite of training courses appropriate to their role. There was an ongoing schedule of both online and in-person mandatory training. The recently appointed regional manager had provided in-person training to staff in safeguarding of vulnerable adults, and the management of dementia and responsive behaviours. From a review of training records, the inspectors saw that the vast majority of staff had completed all the relevant training, and a system was in place to ensure new staff completed this training as soon as possible following commencement of employment. Records pertaining to staff as required under Schedule 2 were maintained in line with the regulation, stored safely and were accessible on request. A review of these files identified that each staff member had a tailored induction which was overseen by a senior member of staff. The regional manager provided assurances that the HR department had oversight of agency staff training, and that this was organised via the supplying agencies.

Registration Regulation 4: Application for registration or renewal of registration

The registered provider had submitted a complete application for the renewal of registration within the required time frame.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge worked full-time in the centre. She had the necessary experience and qualifications to fulfill the regulatory requirements of the role.

Judgment: Compliant

Regulation 15: Staffing

- The centre was not fully operating in line with the staffing levels outlined in their statement of purpose which outlines that there are 25.8 whole time equivalent (WTE) health care assistants. The rosters provided to inspectors showed that there were currently 16 healthcare assistants employed, two of whom were on long term absences. The management team confirmed that there were 14 vacant healthcare assistant posts.
- The provider needed to take action to ensure there was not an over reliance on agency staff. The shortfall of healthcare assistants was supplemented in part by agency staff from three different agencies. A review of rosters showed that in the previous two weeks, 424.5 hours of agency healthcare assistant staff was required. The additional shortfall of 72 hours was supplemented by registered nurses working above their contracted hours, as care assistants. This is not a sustainable model for staffing the centre.
- Due to recent extended absences, there were insufficient housekeeping staff on duty to support effective cleaning and decontamination of the centre. This was not in line with the WTE set out in the centre's statement of purpose. The roster showed that in the current week, there was only one day where the required two staff were rostered on duty. On the day of inspection, one housekeeping staff was on duty. Staff confirmed that as a result, the majority of bedrooms and communal areas on the first floor were not cleaned.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff had access to a programme of training that was appropriate to the service. Important training such as fire safety and the management of behaviours that challenge was completed for staff. The inspector was assured that staff were appropriately supervised by senior staff in their respective roles and that there was appropriate on-call management support available at night and at weekends.

Judgment: Compliant

Regulation 21: Records

The service records for the maintenance of the emergency lighting and fire alarm system were not available in the centre for review.

Judgment: Substantially compliant

Regulation 23: Governance and management

The governance and management systems in place in the centre were not stable and not clearly defined. The senior management team had seen a number of changes in the previous months, with further changes advised during the inspection. The provider, Aperee Living Callan Limited, comprised of only one director. The availability and access to the director was limited and the current lines of authority and accountability were not clearly defined. Issues of serious regulatory concern had not been fully addressed, and additional issues were identified during this inspection, which further evidenced that the management structure in place was not sufficient to provide a safe service. For example,

- there were inadequate staffing resources in place to ensure the effective delivery of care in accordance with the centre's statement of purpose, as discussed under Regulation 15: Staffing.
- resources were not sufficient to ensure the safety of residents in the centre in relation to fire risks in the centre. The provider had arranged for an external consultant to conduct a fire safety risk assessment of the premises in November 2021, which was reviewed again in July 2022. This assessment identified a number of high and medium-rated fire safety risks in the centre. The inspector found that a number of these risks had yet to be addressed on the day of inspection and many of the issues remained outstanding. These are further discussed under Regulation 28: Fire precautions.
- not all control measures in the risk register pertaining to the identified fire safety risks were being implemented
- the systems in place for the management of residents finances required immediate action to ensure the service provided is safe, appropriate, consistent and effectively monitored. The current systems in place were wholly inadequate and did not ensure residents were safeguarded from financial abuse.

In addition, there were significant concerns about the availability of sufficient resources to ensure the effective delivery of care, in line with the statement of purpose. A review of the banking records showed residents monies were used on a number of occasions to pay the ongoing costs of running the centre. Whilst this

money was returned to the account, this was not appropriate or correct use of residents monies.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose had been updated in February 2023, however the description of the following items, as required under Schedule 1 of the regulations were found to be incorrect;

- the total staffing complement, in whole time equivalents, for the designated centre
- the organisational structure of the the designated centre

Judgment: Substantially compliant

Regulation 31: Notification of incidents

A record of all incidents occurring in the centre was maintained and all required notifications were submitted to the Chief Inspector within the time frames as stipulated in Schedule 4 of the regulations.

Judgment: Compliant

Regulation 4: Written policies and procedures

The registered provider had prepared in writing, adopted and implemented policies and procedures on the matters set out in Schedule 5 of the regulations.

The policy on infection prevention and control was due for review, as discussed under Regulation 27: Infection control

Judgment: Compliant

Quality and safety

Overall, the findings of the inspection indicated that residents of Aperee Living Callan were supported to sustain a good quality of life, with the encouragement and assistance of staff, who promoted independence and respected residents' wishes. Residents had good access to healthcare services. Nonetheless, residents' rights were not being fully met, and serious issues were identifed in relation to the management of residents finances. Notwithstanding some work completed to date to address some of the actions in the fire safety risk assessment, further action was required to address those outstanding, five of which were assessed as red rated risks.

The person in charge had implemented quality improvement initiatives, including weekly huddles with different staff to discuss a specific fire safety topic. The fire alarm system, emergency lighting and fire fighting equipment were being serviced at the appropriate intervals, however the records were not kept in the centre as required under regulation 21. Some fire doors on corridors were observed to be hooked open. It was explained to the inspectors that these doors were surplus fire doors and were not required. Further assurance was required from the registered provider in this regard.

Day-to-day practices in the centre were contributing to fire safety risks, these are explored further under Regulation 28.

The centre appeared to be cleaned to a good standard, with good routines and schedules for cleaning and decontamination. However, as discussed above, on the day of inspection there was only on cleaning staff member on duty, meaning adequate cleaning and decontamination of all areas could not be undertaken. The management team completed infection control audits, including observational audits and audits of practice. Staff were seen to use personal protective equipment (PPE) such as face masks and gloves appropriately. Risk assessments had been completed for actual and potential risks associated with COVID-19 and the provider had put in place many controls to minimise the risk of harm to residents and staff. Some required improvements to the current infection prevention and control procedures are detailed under regulation 27: Infection control.

Residents' health, social care and spiritual needs were well catered for. It was evident that staff knew the residents very well and this knowledge was reflected in the resident's individualised care plans which were developed with the resident or their representative where required. Care plans were implemented and reviewed on a regular basis, reflecting residents' changing or additional needs. Residents had access to a GP of their choice, local geriatricians and palliative care services. There was a focus on preventative measures to prevent pressure-related skin damage, including the use of appropriate pressure-relieving equipment such as mattresses and cushions, in conjunction with appropriate clinical assessment. This led to a low level of pressure ulcer formation. The inspector reviewed wound management documentation and found evidence of good practice that ensured healing of wounds had occurred. Other validated assessment tools were used to screen for risks such as malnutrition, falls and wandering.

There were systems in place to monitor restrictive practices in the centre and the restraint register identified that all restraints were documented clearly and subjected to regular review. Corresponding individual care plans were in place for residents using restraints such as bedrails. There was good evidence to show that the centre was working towards a restraint-free environment in line with local and national policy. The inspector saw that advice was sought from consultant psychiatry for residents who displayed responsive behaviours (how residents living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). There was evidence that these reviews resulted in positive outcomes for the residents, for example, appropriate adjusting of medications leading to a decrease in behaviours. Overall medication management procedures were good. There were strong policies and procedures in place in relation to the storage and control of medications in the centre. Out-of-date medicines and medicines which were no longer is use were segregated from in-use medications and were returned to the pharmacy.

There was a safeguarding policy in place. Staff had completed safeguarding training and were aware of what to do if they suspected any form of abuse. Staff spoken with on the day of the inspection were aware of what abuse is and what they would do if they witnessed or suspected such an incident.The management team outlined that the centre was not acting as a pension agent for any residents. However, inspectors noted that the financial arrangements in place were inadequate to protect finances of deceased or past residents from financial abuse and will be discussed further under Regulation 8: Protection and Regulation 9: Residents' rights below.

The inspector found that residents had access to television, radios, newspapers, telephones and internet connection. Residents had access to a programme of activities which was scheduled from Monday to Friday. There was dedicated staff in place to support the implementation of the activities programme. The planned rota for the coming week included two additional shifts dedicated to activities. The person in charge gave assurances that activities would be planned for over a seven day week going forward. Residents who spoke with the inspectors said that they enjoyed the activities on offer. This was echoed in the minutes of residents meetings, whereby satisfaction with the activities programme was a standing agenda item for each meeting. These meetings were held frequently and there was evidence that all suggestions and feedback brought forward by residents was followed up and actioned. Residents who did not attend meetings were spoken to individually, to ensure that they had a mechanism to voice their feedback on the service. Action was required to ensure that residents' rights were fully upheld in the centre. The findings in relation to maintaining privacy and dignity for residents are outlined under regulation 9: Residents' rights.

Regulation 11: Visits

The registered provider had arrangements in place for a resident to receive visitors in so far as is reasonably practicable. The arrangements did not pose unnecessary restrictions on residents.

Judgment: Compliant

Regulation 12: Personal possessions

Residents were supported to maintain control of their clothing and personal belongings. Residents had adequate storage space in their bedrooms, including a lockable space for their valuables if they wished.

Judgment: Compliant

Regulation 17: Premises

Actions were required to ensure compliance with Regulation 17 and Schedule 6:

- there was damage to walls in bedrooms caused by impact from door handles and equipment. In one room there was significant damage to the wall
- carpets in some locations were stained
- paint was peeling from handrails, making them difficult to clean effectively
- Ceiling tiles in a number of areas were stained from former leaks
- the call bell at the smoking area was not accessible due to the outward doors swing and the paving slabs in this area were subsiding, presenting a risk of falling
- externally, the outdoor space required maintenance. The grass was overgrown. Some paving slabs were loose under foot and one was missing a section of the slab, creating a risk of falling. Plant containers were damaged and required repair.
- There was inadequate storage space for equipment as equipment was seen to be stored in communal rooms such as the oratory

Judgment: Substantially compliant

Regulation 20: Information for residents

The registered provider had prepared a guide to the centre, a copy of which was made available to each resident. The guide included a summary of the services and

facilities in the centre, terms and conditions relating to residence in the centre, the procedure respecting complaints and visiting arrangements.

Judgment: Compliant

Regulation 26: Risk management

There was a risk management policy in place to inform the management of risks in the centre. This contained reference to the five specified risks as outlined under Regulation 26.

Judgment: Compliant

Regulation 27: Infection control

Improvements were required in order to ensure the centre was compliant with procedures consistent with the *National Standards for Infection prevention and control in community services (2018).* For example;

- the infection control policy was last reviewed in March 2020, therefore it did not contain up-to-date and relevant guidance
- cleaning equipment was routinely stored in the sluice room, which is not in line with best-practice guidance. The sluice room is a high-risk area and presents a risk of cross-contamination if items to be used for cleaning are stored therein
- sinks throughout the centre which were used for clinical handwashing were normal domestic sinks and were not compliant with current recommended specifications. For example, staff needed to turn the taps to discharge water, thereby potentially contaminating hands when turning the tap back off after handwashing. Therefore, correct hand hygiene practices could not be assured
- there was wear and tear of furniture including bed frames and bedside lockers where the veneer had worn away leaving exposed surfaces that could not be effectively cleaned
- severe rusting was seen on the legs of a shower chair, preventing effective cleaning and decontamination
- a holy water font in the oratory had a visible build up of grime

Judgment: Substantially compliant

Regulation 28: Fire precautions

The registered provider was not taking adequate precautions against the risk of fire, nor adequately reviewing fire precautions in the centre;

- five red risks, first identified in November 2021 and further reviewed in July 2022, had not been actioned
- fire doors were routinely propped open by means other than appropriate devices connected to the fire detection and alarm system. This included doors held open by furniture and the floor covering. The door to the dining room was difficult to close with force as it was sticking to the floor. The device to hold open the door to the lift lobby was functional, however staff did not engage the device, which meant that the door was inappropriately propped open and would not release
- there was unnecessary storage in reception area and the administration office door in this area was propped open; there were two residents bedrooms located in this area
- the smoking area was not a designated location
- the centres in-house fire safety checks were not identifying risks noted by the inspectors
- hoist batteries were on charge in a store room adjacent to combustible items

Actions were required to ensure adequate means of escape, including emergency lighting, was provided:

- clarification was required to confirm if doors from some day spaces, were exits or not
- the external escape routes were not provided with adequate emergency lighting to guide residents and staff towards the assembly points
- new pathways had been provided outside exits; these pathways were short and led to a stone chipped track around one side of the building, which would was not a suitable surface for evacuation aids or for residents who experienced mobility impairments. Furthermore, there was a drop off the edge of the new paths where the ground was not graded up
- the route to the assembly point in the front was not accessible and required negotiating a step to a grass area
- the gate which provided escape from the enclosed garden was padlocked. There was no effective system in place to ensure that staff could open the gate.
- exit signage was not visible along some corridors owing to previously constructed fire compartment walls
- a temporary partition was placed in front of a fire exit from the oratory to facilitate visiting during the covid pandemic. The person in charge confirmed that this was due to be removed.

The arrangements in place for evacuating residents were not adequate

- assurance was required from the provider to ensure that all evacuation aids in use could fit along escape routes and through exit doors as required

- the procedure for vertical evacuation was not part of the evacaution strategy explained to the inspectors and was not reflected in the simulated evacaution drill reports. This was a repeated finding, identified to the provider in a previous inspection in August of 2021
- the assessed evacuation requirements for residents was documented in a personal emergency evacuation plan (PEEP) and a consolidated PEEP schedule; these contained inconsistencies which were noted by inspectors. The person in charge immediately arranged for this to be addressed
- the inspectors reviewed the reports of the simulated evacuation drills. While regular fire drills took place in different areas of the building, and staff demonstrated a good knowledge of aspects of the evacuation procedure, the simulated time taken to evacuate the fire compartments when staffing levels were lowest, was excessive

The arrangements for the containment and detection of fire were not adequate:

- there was outstanding work required to seal up service shafts to ensure adequate contaiment of fire; there was also no fire detection within the service shafts. This was identified in the provider's own fire safety risk assessment
- the maintenance deficits to fire doors meant that fire doors were not capable of restricting the spread of fire and smoke in the centre
- there was outstanding requisite work to fire compartment boundaries, identified as a red rated risk in the fire safety risk assessment
- there were breaches in fire rated walls and ceilings for utility services, which required to be sealed up to maintain the fire resistance of the wall or ceiling.

The arrangements for maintaining fire equipment were not adequate:

- fire doors were not being maintained in good working order. Examples of deficiencies included: excessive gaps where double leaf doors met, absent seals and doors catching on the floor covering and automatic closers not effective to fully close the door
  the swing free automatic closing device in one bedroom was not working and did not hold the door open
- the batteries to some acoustic hold open devices had expired and as a result, a number of fire doors were inappropriately being propped open

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The pharmacists who supplied residents' medicines were facilitated to meet their obligations to residents. There were procedures in place for the return of out-of-date or unused medicines. Medicines controlled by misuse of drugs legislation were

stored securely and they were carefully managed in accordance with professional guidance for nurses.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Resident care plans were seen to be detailed and person-centred, and were informed by an assessment of clinical, personal and social needs. A comprehensive pre-admission assessment was completed prior to the resident's admission to ensure the centre could meet the residents' needs. A range of validated assessment tools were used to inform the residents care plans.

Care plans were formally reviewed at intervals not exceeding four months. Where there had been changes within the residents' care needs, reviews were completed to evidence the most up to date changes.

Judgment: Compliant

Regulation 6: Health care

The health care needs of residents were well met. There was evidence of good access to medical practitioners, through the local GP and out-of-hours services. There were established pathways for referral to, and review by health and social care practitioners, including speech and language therapists, dietitian services and tissue viability specialists.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

The staff in the centre promoted a restraint-free environment in line with local and national policy. The management team regularly reviewed the use of restrictive practises to ensure appropriate usage. A risk assessment was completed prior to the use of restraints such as bedrails. Each resident using bedrails had a corresponding care plan in place.

There was evidence that residents who presented with responsive behaviours were responded to in a very dignified and person-centred way. Care plans were seen to outline de-escalation techniques and ways to effectively respond to behaviours.

There was evidence of residents being referred to a clinical specialist for advice and supportive plans.

Judgment: Compliant

Regulation 8: Protection

The provider did not take all reasonable measures to protect residents finances as evidenced by the following findings:

- a review of information pertaining to the Aperee Living Callan Limited current account showed that it contained a large sum of money belonging to a number of residents who have passed away and their funds have yet to revert to their estates. Contrary to good practices and assurances given to the Chief Inspector in November 2022, Aperee Living Callan does not have a separate resident client account, therefore residents monies are paid into the centres current account and residents monies remain in this current account. Additionally, for five current residents who paid their fees monthly by standing order there was a build up of excess monies in the centre current account, which was not returned to these residents.
- a review of the bank statements since the end of January 2023 showed that the current account regularly went below the amount that is the property of these residents and which should have been protected for their use. A review of available records suggest that at times residents would not have been able to access their monies should they wish to do so and that their money was used to support the day to day operations of the centre.
- it was seen during the inspection that money was transferred out of the current account in Aperee Living Callan to other accounts and many of these transfers were seen to include residents monies, meaning that the registered provider directed residents funds to be used for purposes other than the residents own use.

Judgment: Not compliant

Regulation 9: Residents' rights

Inspectors identified that residents rights were not being protected in the centre as residents were not made aware that their monies were being used at times to fund the centres day to day running of the centre and residents permission was not sought in relation to this practice.

In addition to those residents funds kept in the registered provider's bank account, residents could also choose to keep some sums of money in a secure safe. The

inspector saw that balances of personal money stored in this way tallied with receipts and a log was kept of all money handed in for safekeeping. However, residents could not access this money at the weekend. This was not in line with a human-rights based approach, and had not been considered as being a violation of a residents' personal autonomy and a paternalistic approach to care.

Residents' privacy could not be assured in a communal bathroom. There was no lock on the inside of the door. Additionally, there was a significant gap in the door frame at such a level that the resident could potentially be viewed while in the bathroom.

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 4: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
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	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Aperee Living Callan OSV-0004449

Inspection ID: MON-0038702

Date of inspection: 18/04/2023

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The Statement of Purpose has been updated to reflect the current WTE staffing levels in the home. The Statement of Purpose is a live document and will be continuously updated to reflect changing staffing levels as they occur. Since inspection, the home has successfully onboarded 5 fulltime HCAs. The company continues to work on recruitment and retention of staff so that there is not an overreliance on agency staff. The PIC manages occupancy in the context of available staffing. This, coupled with the new staff members has resulted in a decrease in agency usage. The company acknowledges that high agency usage is not sustainable and is not ideal so is working towards a goal of zero agency usage. Occupancy remains the same since the day of inspection, but the home has the additional 5 HCAs on the roster. The home has successfully recruited an additional staff member to fill the deficit in the household dept caused by staff sick leave. This ensures that all rooms are cleaned daily and that the deep cleaning schedule is maintained.	
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: The company charged with the maintenance of the home's emergency lighting and fire alarm system have since released the relevant reports and these are in place in the home and displayed at the fire panel. The PIC will ensure that the company releases all relevant reports in a timely manner so that we can meet our regulatory obligations.	

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Current Governance and management systems in place is undergoing change/ review to include addition of further Director/s. Management restructure will include a process to provide robust review arrangements and oversight of the service provided in Aperee Living Callan.

The lines of accountability and authority will be clearly defined at individual, team and service level, all staff will be informed of the management structure and facilitated to communicate regularly with management.

The organizational structure will be outlined in the Statement of Purpose.

Aperee Living Callan commits to employ an appropriate workforce that has sufficient numbers and skill mix of staff, with the necessary experience and competencies to meet the needs of the residents and which reflect the size, layout and purpose of the centre.

The management of fire safety, and the systems associated with Fire Safety will be enhanced to ensure the service provided is safe. The Registered Provider is committed to ensure all outstanding risks identified in the homes fire safety risk assessment and recent inspection findings shall be addressed.

As the required works are implemented, The RPR in conjunction with the Director of Nursing shall take steps to mitigate the issues and implement any controls or improvements identified.

The policy for management of personal property, personal finances and possessions has been updated to include the process for managing residents personal monies and deceased residents funds in the centre and the requirement for a resident specific account.

Deceased funds arrangements in Aperee Living Callan are being updated in line with National Guidance by the Provider. The process of setting up a resident client account has commenced. On opening of same, any deceased resident monies will be transferred immediately to this designated client account.

In the interim/ timeframe of the opening of this new Resident Client account all deceased residents monies are protected, and balances monitored by the Accounts Department. Residents' funds will not be used for any other purpose other than the resident's own use.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
Statement of purpose has been updated with the current staffing and WTE.

The home's organizational chart has been updated and this will continue to be updated as changes occur.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The bedroom identified as having significant damage to the wall has been repaired and re-painted.

The grass in the garden has been cut and is now part of the maintenance man's weekly work schedule.

The loose and damaged paving slabs in the garden have been repaired and replaced.

A second call bell has been installed in the smoking area and residents alerted to its position. This will enable residents on both sides of the smoking area to alert staff should they need assistance.

The oratory has been returned to the residents for their use and benefit and equipment which was stored in this area is now stored in a designated storeroom.

Carpet cleaning continues weekly or as needed, and replacement of carpets is part of planned capital works.

The Don and maintenance staff have a program drawn which includes painting walls, disposing broken garden pots, replacing ceiling tiles that are stained, sanding and painting handrails, using fillers for the bedroom walls that are damaged.

Refurbishing the physical setup of the home is capital project which will be delivered in the home based on priority.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
The Infection control policy was updated in May 2023 and staff have been appraised on the updates therin. This updated policy is now readily available in the policy folder for all to peruse.

All cleaning equipment is now stored in the cleaner's store cupboard.

Hand washing sinks will be replaced with sinks which comply with best practice.

Equipment / surfaces that are worn or otherwise damaged shall be repaired or replaced.

The shower chair which had rusty legs has been replaced with a new one.

The holy water font in the oratory is now part of the cleaning schedule for the housekeeping department.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The Registered Provider commits and undertakes to complete all outstanding risks identified in the Fire safety risk assessment and current Inspection findings. During progress of works and subsequent to Inspection, the below points have been completed.

Doors are no longer wedged open in the home and all door wedges have been disposed of.

An audit of all door closure devices has been completed and all batteries were replaced. This audit is now a regular part of the maintenance staff's weekly audits.

Admin office door remains closed.

The reception area is now decluttered and re-organized.

The space between the rack used for stocking the incontinent wear and the hoist battery charging point is widened and the rack is secured. There is adequate space for charging hoist batteries. The hoist batteries are now wall mounted when charged and there is risk assessment recorded for the same.

Both the garden gates have now been replaced with new coded lock and all staff are aware about the code. The lock is now on the inside of both the gates.

All mattresses and wheelchairs can fit along the escape routes and exit doors.

Vertical evacuation is also incorporated in the fire drills. Additional education and guidance is provided to staff.
PEEP folder was reviewed for all residents and updated. All nurses are educated about the need to update PEEP when changes occur.

The temporary partition in the oratory to facilitate visiting during the covid pandemic has been removed.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
Residents have been informed that the company is updating its policy and all additional funds currently being held in the company main account will be transferred to a separate Resident Client account immediately on the opening of same. Records will be maintained and available.

Monies of deceased residents have been returned to appropriate persons leaving 2 deceased residents monies in the company account. The PIC is engaging actively on the remaining two cases to advance the transfer of these monies to their estates. In the interim and until the separate resident bank account is open, the accounts person in the home provides the accounts dept in head office with a weekly balance of resident's monies. This process safeguards the resident's funds by ensuring that the balance of the company account never falls below the balance of the resident funds.

This compliance plan response from the Aperee Living Callan Limited did not adequately assure the Health Information and Quality Authority that the actions will result in compliance with the Regulation 08 Protection.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Resident monies and valuables stored in the DON office safe, can be accessed anytime over 7 days. The roster provides for a CNM to be on duty every weekend and he/she has

access to the DON office safe and will facilitate the residents to access their monies or property at will.

The communal bathroom lock has been repaired and the gap in the door has reduced with a curtain now in place to provide privacy for residents who use it.

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	23/10/2023
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Orange	31/10/2023
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre	Substantially Compliant	Yellow	23/06/2023

	and are available for inspection by the Chief Inspector.			
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	30/08/2023
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Not Compliant	Orange	30/08/2023
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	30/08/2023
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and	Substantially Compliant	Yellow	30/09/2023

	control of healthcare associated infections published by the Authority are implemented by staff.			
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Orange	30/11/2023
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	30/11/2023
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	30/11/2023
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	30/11/2023
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre	Substantially Compliant	Yellow	31/07/2023

	to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.			
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Orange	31/07/2023
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	30/11/2023
Regulation 28(2)(iv)	The registered provider shall make adequate	Not Compliant	Orange	30/11/2023

	arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.			
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	23/07/2023
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Red	30/08/2023
Regulation 9(3)(e)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise their civil, political and religious rights.	Not Compliant	Orange	30/06/2023