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:	Kylemore House Nursing Home
Name of provider:	Kylemore House Nursing Home
Address of centre:	Sidmonton Road, Bray, Wicklow
Type of inspection:	Unannounced
Date of inspection:	04 December 2023
Centre ID:	OSV-0000055
Fieldwork ID:	MON-0041693

About the designated centre

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

Kylemore House Nursing Home is located in a residential area in Bray. The designated centre is a short distance from the sea front, DART train station, shops and other amenities. Kylemore House nursing home accommodates both female and male residents over the age of 18 years. Residents' accommodation is provided over two floors in 12 single and 13 twin bedrooms. One twin bedroom has full en suite facilities. En suite toilet and wash basin facilities are provided in 10 single and seven twin bedrooms. A wash basin is provided in two single and five twin bedrooms. Bedrooms on the first floor are accessible by stairs or a stair lift. A variety of communal areas are available to residents on both floors. A dining room, two sitting rooms, a visitors' room and an enclosed courtyard area is provided on the ground floor. A sitting/dining room, small dinning room and balcony area is available on the first floor. The service employs nurses, carers, activity, catering, household, administration and maintenance staff and offers 24 hour nursing care to residents. Kylemore House nursing home caters for residents with long-term, convalescence, respite, palliative and dementia care needs.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	37

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Monday 4 December 2023	17:45hrs to 20:10hrs	Helena Budzicz	Lead
Tuesday 5 December 2023	07:45hrs to 15:45hrs	Helena Budzicz	Lead
Monday 4 December 2023	17:45hrs to 20:10hrs	Mary Veale	Support
Tuesday 5 December 2023	07:45hrs to 15:45hrs	Mary Veale	Support

What residents told us and what inspectors observed

The inspection took place in Kylemore House Nursing Home over the course of two days. During this time, the inspectors took the opportunity to speak with residents and staff to gain insight into what it was like living in the centre and get feedback about the service. Inspectors greeted and chatted with residents and spoke more in greater detail with six residents. All residents were very complimentary in their feedback and expressed satisfaction with the standard of care provided.

Inspectors arrived unannounced at the centre during the evening time and were greeted by a member of staff and met the centre's administrator. The registered provider representative arrived shortly after the arrival of the inspectors. Following a brief introductory meeting, inspectors walked through the centre and spent time speaking with residents and staff and observing the care environment and interactions between residents and staff.

The centre was decorated to a high standard, and the décor was tasteful and aligned with the age of the building. The centre appeared clean throughout. Alcohol hand gels were readily available in all bedrooms and communal areas throughout the centre to promote good hand hygiene. Dedicated clinical staff hand hygiene sinks were available on both floors.

The centre was originally a Victorian house which had been adapted and extended over time and could accommodate up to 38 residents over two main floors. The upper floor of the original building had split-level landings with residential accommodation on both of these levels. The centre had a two-storey extension built to the rear. The corridors were sufficiently wide to accommodate residents mobilising with walking aids, and handrails were installed in all circulating areas.

The inspectors observed half of the residents on the first floor and Victorian floor moving freely through the centre from their bedrooms to the communal spaces. The upper floors were accessible by a chair lift; therefore, residents who lived in the upper levels needed to be able to use the chair lift safely or be assisted by staff to use the chair lift. All split-level staircases on the first floor and steps on the ground floor between the Victorian house and extension had chair lifts. However, inspectors observed staff having difficulty manoeuvring a resident's comfort chair in a corridor on the first floor of the centre. This chair was large and supported a resident who required full assistance with their mobility. The resident who required the use of the comfort chair could be moved with the assistance of staff on the first floor but could not access the ground floor as there was no suitable passenger lift available, only the stair chair lift.

The centre had 12 single-occupancy bedrooms and 13 twin-occupancy bedrooms. There are six bedrooms on the ground floor and 11 bedrooms on the first floor with toilet facilities. One twin-occupancy bedroom on the first floor of the Victorian house had an en-suite shower. The bedrooms were homely and personalised with pictures

of residents' families framed and memorabilia in their rooms. Residents' bedrooms were clean and tidy and contained ample personal storage space.

Residents had access to one assisted shower on the ground floor, two shower rooms on the first floor, and one bathroom on the first floor, which had a shower and a mobile trolley-style bath. 14 residents on the ground floor had access to a single assisted shower room, and 24 residents on the first floor had access to three assisted showers.

The inspectors observed on the days of inspection that residents on the ground floor with maximum and high-dependency needs who required the use of a hoist could not access their bedroom en-suite toilets. There was one communal toilet on the ground floor, which was not wheelchair accessible, and one communal assisted shower facility with the toilet. This was impacting on the privacy and dignity, and continence needs of the residents, which is discussed further in this report under Regulation 9: Residents Rights.

There was a choice of communal spaces; for example, the ground floor contained a dining room, sitting room, quiet room, and day room and opened out to a small courtyard at the rear. There was an open plan sitting/dining room on the first floor, and from this level, there was open access onto a secure terrace, which was observed to be frequently used by residents during the second day of inspection. The sitting room space was decorated with a marble fireplace, comfortable sofas and armchairs and old furniture in line with the Victorian style of the house. Communal spaces were spacious and comfortable. However, due to the presence of stepped level floor landings with stair lifts, not all communal spaces and outdoor spaces were accessible to all residents living in the centre.

Residents were observed in the sitting room on the first floor. Residents were observed engaging in a positive manner with staff and fellow residents throughout the days, and it was evident that residents had good relationships with staff and residents had built-up friendships with each other. There were many occasions throughout the days in which the inspectors observed laughter and banter between staff and residents. It was observed that staff were available to supervise residents in communal rooms throughout the day. Staff were seen to encourage participation and stimulate conversation. The inspectors observed residents calling staff by their first names and having good exchanges of conversations.

The inspectors observed many examples of kind, discreet, and person-centred interventions between staff and residents throughout the days of inspection. The inspectors observed that staff knocked on the resident's bedroom doors before entering. Residents were very complimentary of the staff and services they received.

A number of residents on the ground floor were living with a cognitive impairment and were unable to fully express their opinions to the inspectors.

Residents with whom the inspectors spoke were complimentary of the food and the choice being offered. Residents had access to drinks and snacks throughout the day. Fresh jugs of water and cordial were observed in communal areas and residents'

bedrooms.

Residents who were independent were observed having their dinner in the dining room on the ground floor and residents who required assistance were observed to have their dinner in the sitting room near the nurses station or in their bedroom. Five residents were observed sitting at a table, three residents were sitting in comfort chairs in the sitting room at dinner time and five residents were observed having their dinner time meal in their bedrooms on the ground floor. The inspectors observed independent residents having their dinner in the dining room on the first floor and observed that staff were positive, patient, and kind to residents during this mealtime dining experience. There was a choice of main meal and dessert on the day. The Menu was easy to read and was displayed prominently in both dining rooms on the ground and first floors. However, due to the presence of steps, residents with impaired mobility could not access communal spaces such as day rooms and dining room on the ground floor and on the first floor.

The centre had contracted its laundry service for residents' clothing to a private provider. All residents whom the inspectors spoke with on the days of inspection were happy with the laundry service, and there were no reports of missing items of clothing.

The inspectors observed one visitor attending the centre during the first day of the inspection. Residents told the inspectors that there was no booking system in place and that their visitors could call to the centre anytime.

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

Capacity and capability

This was an unannounced inspection which took place over the course of an evening and the following day by inspectors of social services. This inspection was a risk-based inspection to monitor ongoing compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. The inspectors followed up on the written representation submitted by the provider in respect of the proposed decision to renew the registration of the designated centre. The inspectors also followed up on the compliance plan submitted by the provider following the inspection of the centre in April 2023.

There had been engagement with the registered provider prior to the inspection. The centre has not had a person in charge (PIC) in post since August 2023, and the registered provider provided assurances to the Inspectorate that they were actively seeking to recruit a person in charge.

In the absence of a person in charge inspectors were not assured that management

systems in place were sufficient to monitor the quality and safety of the care and services provided to residents. In the absence of clear leadership, there were significant findings that reflected the registered provider's failures both in respect of their capacity and capability to ensure appropriate governance and management of the designated centre, as well as effective clinical oversight for the provision of a safe and high-quality service for the residents. On this inspection, further action was required by the registered provider to address Regulation 15: Staffing, Regulation 16: Training and Staff Development, Regulation 23: Governance and Management, Regulation 29: Medicines and pharmaceutical services, Regulation 31: Notification of incidents, and Regulation 34: Complaints procedure, Regulation 3: Statement of purpose, Regulation 4: Written policies and procedures, Regulation 5: Individual assessment and care planning, Regulation 8: Protection, Regulation 9: Residents Rights, Regulation 17: Premises, and Regulation 24: Contracts of provision.

Kylemore Nursing Home Limited is the registered provider for Kylemore House Nursing Home. The company has two directors, one of whom is actively involved in the daily operations of the centre. In the absence of a person in charge, the registered provider representative was supported by an administrator manager and team of nurses, health care assistants, activities, housekeeping, catering staff and maintenance staff.

On the days of inspection there was no nursing management employed in the centre. This did not ensure sufficient clinical oversight of the care of the residents. Staff were knowledgeable of the needs of older persons in their care and respectful of their wishes and preferences. However, actions were required in staffing in the centre, which is discussed further under Regulation 15: Staffing.

Improvements were required in the oversight of staff training and supervision of training in the centre. Nursing staff had completed audit training in line with the previous compliance plan submitted following the inspection in April 2023. The staff with whom the inspectors spoke were not all knowledgeable regarding safeguarding and complaints procedures, which did not provide assurance that incidents or safeguarding allegations would be appropriately investigated and followed up. Further improvements were required to ensure staff were appropriately identified, supervised, and this is discussed further in this report under Regulation 16: Training and staff development.

Management systems in place to monitor the centre's quality and safety required urgent review. There was evidence of audits of two residents' care plans and nutritional assessments in May 2023 and a restrictive practice audit in May 2023. Since May 2023, there was no evidence that any other audits of care had been undertaken, for example, wound care, falls, or medication management. This lack of clinical oversight is further detailed under Regulation 23: Governance and management. There was evidence of monthly infection prevention and control and health and safety audits taking place.

Regular risk management meetings, infection prevention and control meetings, fire safety meetings, and staff meetings took place. Minutes of meetings were detailed and included the items discussed, the outcome and any further actions required.

The annual review for 2022 has been completed in line with the national standards. It set out the improvements completed in 2022 and improvement plans for 2023.

Requested records were made available to the inspectors throughout the days of inspection, and most records were appropriately maintained, safe and accessible. However, some improvements were required in the management of staff files and residents' records. For example, the inspectors requested information in respect of residents' dependency levels and location in the centre. On the second day of inspection, the inspectors were provided with a list called 'dependency level form', which included the following information: there were seven residents with maximum-dependency care needs, two residents with high-dependency care needs, three residents with medium-dependency care needs and one independent resident living on the ground floor. On the first floor, there were seven residents with maximum-dependency care needs, three residents with high-dependency care needs, seven residents with medium-dependency care needs and four independent residents. There was one resident with maximum-dependency care needs, one resident with medium-dependency care needs and six independent residents living on the Victorian floor. In addition, a handover sheet that was used by staff to inform care provision was also given to the inspectors. It accounted for 36 residents and was dated 7 November 2023. Residents requiring maximum-dependency were immobile and required two to three staff to assist with their care needs.

The inspectors reviewed a sample of residents' contracts of care. These were seen to be agreed on admission to the centre and detailed the services provided to each resident along with fees, including for services to which the resident was not entitled under any other health entitlement. Some contracts did not include the room number as required by the regulation.

Incidents and reports, as set out in Schedule 4 of the regulations, were not notified to the Chief Inspector of Social Services within the required time frames. This is discussed further in this report under Regulation 31. In addition, the monitoring and oversight of safeguarding procedures were not sufficient; this is detailed under Regulation 23: Governance and management.

There was a complaints management policy within the centre, and a complaints procedure was displayed near the ground-floor dining room. A sample of complaints management records were reviewed. Inspectors observed complaints had been assessed and managed promptly and that improvements and recommendations arising from the complaint had been communicated to staff members to improve the overall quality of care and resident experience. Not all staff members with whom the inspectors spoke were aware of who the complaints officer was; two staff members told inspectors it was the person in charge, and four staff members told the inspectors it was the administrator. Actions were required to align the complaints procedure with SI 628 of 2022 - Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) (Amendment) Regulations, and this will be addressed under Regulation 34: Complaints of this report.

Regulation 15: Staffing

Staffing levels were not in line with the statement of purpose (SOP). For example:

In their statement of purpose, the registered provider had committed to having a person in charge (PIC), a clinical nurse manager (CNM) and seven registered nurses. However, there was

- no person-in-charge
- no clinical nurse manager
- only four full-time nurses were employed.

The post of person-in-charge had been vacant since August 2023, and the registered provider was actively recruiting for this position. However, on the day of the inspection, the post was vacant.

The post of Clinical Nurse Manager had been vacant for a long time, and the registered provider representative said that they would appoint a suitable person for this post in the coming months.

The provider had recruited three nurses who were awaiting registration with the Nursing and Midwifery Board of Ireland (NMBI). In the interim, deficits in the number of nurses were addressed through the use of agency staff.

The centre had a deficit of approximately 1.4 whole-time equivalent (WTE) healthcare assistants. In their statement of purpose, the registered provider had committed to having 20 WTE healthcare assistants. On the days of inspection, there were 15 full-time healthcare assistants and five part-time healthcare assistants.

Judgment: Not compliant

Regulation 16: Training and staff development

Not all staff had completed the appropriate training to support them to perform their respective roles. For example, four staff required training in safeguarding, and eight staff had not completed fire safety training. Eight staff members had not completed training in responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) in line with the centre's mandatory training requirements.

As the posts of the person in charge and clinical nurse manager were vacant at the time of inspection, there were inadequate clinical supervision arrangements in place. This was evidenced by the following findings:

- Three alleged safeguarding incidents and several incidents of unexplained

bruising were not appropriately investigated with trending analysis according to the centre's policy. Appropriate assessments and care plans were not always completed, and some of the safeguarding incidents were not submitted to the Office of the Chief Inspector as required by the regulation.
- Inspectors found a lack of clinical supervision and oversight of the medication management practices, which resulted in only one nurse signing the balances for the Medicines Controlled by Misuse of Drugs (MDA) legislation book.
- There was a lack of oversight in personal care. For example, a care plan for a resident who lives on the ground floor stated that the resident should have a shower/bath in the specialised shower bed, but this was not available for residents on the ground floor. In addition, there was no evidence that residents were promoted to active bladder/ toilet training, where applicable. This resulted in residents not receiving optimum levels of care support in line with the assessed care needs.

This evidence is detailed under Regulation 31: Notification of incidents, Regulation 23: Governance and management, Regulation 34: Complaints, Regulation 5: Individual assessment and care plan, Regulation 7: Managing behaviour that is challenging, Regulation 29: Medicines and pharmaceutical services, Regulation 8: Protection and Regulation 9: Residents' rights.

Judgment: Not compliant

Regulation 19: Directory of residents

The registered provider had established and maintained a directory of residence, which included all the information as specified in Schedule 3 of the regulations.

Judgment: Compliant

Regulation 21: Records

The management of records was not in line with the regulatory requirements. For example;

- In a sample of four staff files viewed, one of the files did not have two written references, including a reference from the person's most recent employer, in line with Schedule 2 requirements.

Inspectors observed significant gaps in the recording of daily recreational activities for residents. For example, the last activity recorded for the residents was two weeks prior to the inspection day.

Judgment: Substantially compliant

Regulation 22: Insurance

There was a valid contract of insurance against injury to residents and additional liabilities.

Judgment: Compliant

Regulation 23: Governance and management

The designated centre had insufficient resources to ensure the effective delivery of care in accordance with the statement of purpose. This was evidenced by:

- The registered provider did not ensure that all residents had access to adequate and accessible premises and facilities that met residents' assessed needs, as further detailed under Regulation 17: Premises. For example, all residents could not avail of the registered communal spaces such as dining rooms or day rooms due to the presence of steps leading to these rooms. Furthermore, there were insufficient showers and accessible toilet facilities available to the residents located on the ground floor.
- The registered provider did not ensure that there was a clearly defined management structure in place, with clearly defined lines of accountability and responsibility. The governance structure outlined in the statement of purpose was not in place. For example, the person in charge post and the clinical nurse manager post were vacant.
- Reporting structures were not clear, and staff members gave conflicting answers as to who was responsible for various aspects of care provision, including management of safeguarding allegations or reporting of complaints.
- As a result of the absence of clinical and managerial oversight, staff were not appropriately supervised, and there was a lack of assurance with respect to the quality and safety of the service provided.

The management systems to ensure that the service provided was safe, appropriate, consistent and effectively monitored, as required under Regulation 23(c), were not sufficiently robust. The poorly defined organisational structure and the absence of clinical management and oversight in the centre adversely impacted the management systems in place. This was evidenced by;

- Mandatory reportable incidents were not notified to the Chief Inspector of Social Services in accordance with the requirements of Schedule 4 of the regulations. For example, the quarterly notifications for quarter 3 of 2023 and three incidents of allegations of abuse had not been submitted.
- The oversight arrangements in place for the review of incidents failed to

identify the occurrence of a significant number of episodes of unexplained bruising in the centre. Furthermore, inspectors identified incidents since August 2023 where the provider's systems failed to identify the level of clinical risk associated with these occurrences, and the incidents were not subject to thorough review and investigation. As a result, the inspectors were not assured that the learning from the incidents had been communicated to all staff and that the improvements in care delivery would be identified and consistently implemented in the centre.

- The provider failed to identify the risks to health and safety that the premises posed for residents with high-dependency needs who were not able to use the stair lift on the top floor safely, and as a result, they were limited in their accessibility to all communal areas in the centre.
- Inspectors found that there were ineffective systems to ensure that key performance indicators (KPIs) of clinical information in respect of residents' care needs and audits were completed or trended for early identification of areas that require improvement. The inspectors found that the last record for KPIs on the electronic system available was from May 2023. As a result, further data collection, analysis and trending were required in order to elicit learning and devise an action plan to ensure effective and safe care delivery.
- The inspectors were not assured that the oversight of the centre's complaints management system was adequate as the centre's policy was not updated according to the S.I. No. 628 of 2022 as detailed under Regulation 34: Complaints.
- The provider failed to implement the centre's safeguarding policy to appropriately document and investigate any potential safeguarding incidents. The inspectors were not assured that a comprehensive analysis, review and all necessary actions were taken to prevent re-occurrences of safeguarding incidents as discussed under Regulation 8: Protection.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

From the sample of contracts of care reviewed, some residents' contracts had not been updated to include their current room numbers.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

Amendments were made to the centre's statement of purpose (SOP) during the inspection. Arrangements for the management of the centre in the absence of the person in charge were not outlined in the centre's statement of purpose. Inspectors

also identified areas used by the residents in the designated centre and storage facilities necessary for the centre's operation that had not been included in the description of services and facilities.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Not all statutory notifications were submitted to the Office of the Chief Inspector of Social Services in accordance with regulations and in the time frames set out. For example, three alleged incidents of peer-to-peer abuse had not been notified. In addition, the quarterly notifications for quarter 3 of 2023 had not been submitted.

Judgment: Not compliant

Regulation 34: Complaints procedure

The centre's complaints policy and procedure had not been updated to meet amendments to the regulations that had come into effect in March 2023 (S.I. No. 628 of 2022). For example:

- The complaints procedure and policy did not include the required timelines to investigate and conclude a complaint.
- There was no nominated complaints officer in the centre.
- The complaints procedure and policy did not include the nominated review officer.
- The complaints procedure and policy did not include information in respect of independent advocacy services that could assist the complainant with making a complaint.
- Staff involved in the complaints procedure had not completed suitable training to deal with complaints.
- The updated complaint procedure was not displayed in a prominent position in the centre.
- Staff whom the inspectors spoke with were not aware of the centre's complaints procedure.

Judgment: Not compliant

Regulation 4: Written policies and procedures

Policies and procedures, as set out in Schedule 5, were available to all staff in the centre. However, the following policies had not been reviewed or updated at a three-year interval:

- Admission policy
- Communication policy
- End-of-life policy
- Recruitment, selection and Garda vetting of staff policy
- The creation of, access to, retention of, maintenance of and destruction of records
- Fire safety management policy.

Judgment: Substantially compliant

Regulation 14: Persons in charge

The designated centre did not have a person in charge. There has been no person in charge working in the centre since August 2023.

Judgment: Not compliant

Quality and safety

The inspectors found that the interactions between residents and staff were kind and respectful throughout the inspection. Nonetheless, the findings of this inspection were that the lack of clinical governance and management oversight of the service directly impacted the quality and safety of care provided to residents, as evidenced by the level of non-compliance with regulations discussed throughout this report.

The inspectors reviewed a sample of assessments and care plans, and while there was evidence that some of the residents' needs were being assessed using validated tools, some care plans reviewed did not reflect guidance on the current care needs of the residents, and some of the required assessments had not been completed. Specifically, there was inappropriate oversight and management of bruising and wound care, as further outlined under Regulation 5: Individual assessment and care plan.

Residents with communication difficulties had personalised care plans in place, and staff were aware of their specialist communication needs.

End-of-life decision-making incorporated residents, their nominated representatives and residents' general practitioner (GP). Following appropriate assessment,

residents' wishes and preferences were sought in a timely manner and recorded in individualised care plans to ensure their end-of-life care needs were respected.

The centre was a pension-agent for seven residents. Residents had access to and control over their money. Residents who were unable to manage their finances were assisted by a care representative or family member. All transactions were electronically accounted for and signed by the resident or representative and a staff member.

While the provider had a safeguarding policy with outlined measures to protect residents from any form of abuse, the management systems and arrangements were not in line with best practice guidelines and required review. This is further discussed under Regulation 8: Protection.

Inspectors reviewed the medication practices on the day of the inspection and found that some medicines management practices and procedures in the centre were not in line with professional nursing standards or local policy and had the potential to pose a risk to residents' safety, as discussed under Regulation 29: Medicines and pharmaceutical services.

Residents who experienced 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) had behavioural care plans in place, which provided guidance to staff on how to manage responsive behaviour issues in the centre.

While the centre promoted a restraint-free environment, and there was monitoring of the incidence of restrictive practices in the centre, some improvements in the oversight arrangements are required as discussed under Regulation 7: Managing behaviour that is challenging.

Premises were not used in line with the registered SOP as communal spaces were not accessible to all the residents due to steps leading to them. While there was a stair chair lift in the centre in most of the areas where the stairs were present, these stair chair lifts were not always accessible and suitable for residents with high-dependency and seating needs where their seating ability to keep a straight posture was affected. Additionally, the space for the hoist manoeuvre to transfer residents into the stair lift could be limited in some of the areas on the first floor. Furthermore, inspectors observed residents with high-dependency needs having their meals either in their bedrooms or the day communal area on the ground floor due to the limited access to the dining room on the ground floor. As a result, the infrastructural limitations of the premises directly impacted residents' rights to access all communal and dining facilities in the centre as discussed under Regulation 9: Residents' Rights.

The inspectors observed overall some good infection control practices in the centre with respect to cleanliness, with areas for improvements detailed under Regulation 27: Infection Control.

Regulation 10: Communication difficulties

The inspectors reviewed care plans for residents with communication difficulties and requirements and saw that the communication needs and support were outlined in their care plans.

Judgment: Compliant

Regulation 13: End of life

From a review of a sample of residents' records, end-of-life care assessments and care plans included consultation with residents and, where required, their relatives. Residents approaching their last days had access to a palliative care specialist nursing team if required.

Judgment: Compliant

Regulation 17: Premises

The inspectors saw that the premises of the designated centre were not in accordance with the centre's Statement of purpose (SOP) prepared under Regulation 3 :

- The inspectors were informed by the staff of the centre and observed on the day of the inspection that the sitting room beside the entrance on the ground floor was mainly used by the registered provider. This was a communal space registered for the use of the residents that was not available to all residents on the day of inspection.

The registered provider did not, having regard to the needs of the residents at the centre, provide premises which conform to all the matters set out in Schedule 6 of the regulations. For example:

- The inspectors found that there was a lack of appropriate storage facilities in the designated centre's units. This was evidenced by the storage of three hoists, wheelchairs, and specialised wheelchairs in residents' bedrooms.
- While there were seating, dining and recreational spaces other than a resident's private accommodation for all residents accommodated on the ground floor, the dining room and sitting room beside the entrance were not accessible to all residents. There were steps to access these spaces, and a stair chair-lift was available; however, this was not suitable for high-

dependency residents who were seated in specialised wheelchairs or for residents with limited seating and posture-holding abilities. The inspectors observed that five resident were using the dining room on the ground floor. Two residents in specialised wheelchairs were assisted with their meals in the sitting room on the ground floor, with the remaining residents on the ground floor having their meals in their bedrooms.

- The inspectors observed and were told by staff that residents with maximum-dependency care needs could not use the chair lifts in all stair areas. The dependency levels documented in the centre and given to the inspectors on the day of the inspection showed seven residents requiring maximum care on the first floor and one resident requiring maximum care on the Victorian section. This resulted in limited access for residents living in the Victorian section and upper floor unit to access the stair lift chair and to access registered dining and sitting room facilities on the ground floor.
- Inspectors observed that there was only one assisted shower/ toilet and one another communal toilet, which was not wheelchair accessible, available for the use of 14 residents located on the ground floor, seven of which had been assessed as having high and maximum dependency needs. While there were en-suite toilet facilities in some of the residents' bedrooms, these were not accessible for residents with high-dependency needs who required the use of a hoist to transfer to or from specialised wheelchairs.

Judgment: Not compliant

Regulation 25: Temporary absence or discharge of residents

The inspectors saw that a copy of all transfer letters when the resident was recently temporarily transferred to the hospital was kept in the resident's file. The nursing staff also ensured that upon residents' return to the designated centre, all relevant information was obtained from the discharge service, hospital and health and social care professionals.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

Some of the medication management processes, such as storing, checking and disposing of medicines, required a review. This was evidenced by the following:

- The balances for medicines controlled by misuse of drugs (MDA) legislation were not checked appropriately, as the records for four residents and their MDA medicine were signed by one nurse only. This was not in line with best practice or local policy.

- Opened bottles of liquid medicines on the medication trolley did not contain an opening date. One medication which was open and in use was not labelled with the resident's name and instructions for administration. This could pose a safety risk to the residents.
- The 'house stock' for medicines was not monitored in the 'stock register', and the protocol for emergency stock was not followed as per the centre's policy.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

A review of residents' assessments and care plans found that care plans were not always revised when there was a change in a resident's condition. For example:

- Residents with a history of seizure activity and prescribed anti-epileptic medication did not all have a care plan in place with relevant details to guide the staff on how to provide immediate and urgent care in case the resident experiences a seizure activity.
- There were a number of residents with unexplained bruising. However, appropriate skin and risk assessment, observation of bruising healing progress, and associated care plans were missing.
- Wound care plans were not updated when the wound was healed or if there was a change in the treatment or type of dressing. For example, there were discrepancies between the dressing recorded in the skin assessment and the care plan, which could potentially lead to incorrect care delivery with the staff that may not know the resident well.

Judgment: Not compliant

Regulation 7: Managing behaviour that is challenging

Inspectors observed that some restrictive practices, such as low-low beds, floor mats, and key-pad locks on the doors used in the centre, were not recognised and monitored as restrictive practices in the centre's Restraint register, in line with national policy. As a result of the use of the key-pad locks leading to the first-floor balcony and the garden on the ground floor, the residents were obstructed from moving freely into these areas.

Where physical restraints were used, there was no evidence in residents' files that alternatives were offered to the residents and trialled before implementing a restrictive practice to ensure the least restrictive measures were implemented.

Judgment: Substantially compliant

Regulation 8: Protection

Inspectors reviewed a number of potential safeguarding incidents, and there was no evidence documented and available to inspectors on the day of the inspection that the provider recognised and responded appropriately in a timely manner to an allegation of abuse when this arose and acted in line with the centre's policy. Furthermore, there was no evidence available that these incidents of suspected/allegations of abuse were investigated in a timely manner. While the provider representative verbally informed the inspectors that all reasonable measures were taken to prevent further occurrences in one incident, there was no evidence of any investigation records presented to the inspectors or available on the resident file. Additionally, safeguarding care plans were not in place to reflect the measures taken.

Judgment: Not compliant

Regulation 27: Infection control

The inspectors observed that the shower chair used in the assisted shower on the ground floor for several residents on the day of the inspection was stained and unclean and was not washed in between uses on the day of the inspection, which could pose a risk of cross-contamination in the transmission of infections.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Action is required to ensure the registered provider is in compliance with Regulation 9: Residents' Rights:

The registered provider could not ensure that the dignity and privacy of residents were maintained at all times and that residents' privacy needs were met at all times. For example:

- The inspectors observed on the days of inspection that residents on the ground floor with maximum and high-dependency needs who required the use of a hoist could not access their bedroom en-suite toilets. Inspectors spoke with one of the residents on the ground floor, who told them that they used "the pads, not the commodes or assisted toilets". There was also no

evidence in the electronic record that there was active bladder/ toilet training for residents, where applicable. This had the potential to further negatively impact on the residents' personal care needs and incontinence needs.

- Not all residents could exercise their choice to access dining and communal facilities in the centre as described under Regulation 17: Premises.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Substantially compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Not compliant
Regulation 4: Written policies and procedures	Substantially compliant
Regulation 14: Persons in charge	Not compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 13: End of life	Compliant
Regulation 17: Premises	Not compliant
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Not compliant
Regulation 27: Infection control	Substantially compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Kylemore House Nursing Home OSV-0000055

Inspection ID: MON-0041693

Date of inspection: 05/12/2023

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 PIC is in situ. Weekly clinical governance meetings will be carried out setting out realistic goals that are achievable and set within a realistic timeframe. • The Centre is fully staffed without deficit. However, we will continue to recruit, manage, and organise our workforce to ensure enough staff are available at the right time with the right skills and expertise to reduce the risk of harm and promote the rights, health and wellbeing of our residents. • The CNM will also be given specific tasks. The outcome each week will be measured against a performance indicator. • 7 Nurses employed full time will be encouraged to avail of all training offered. • SOP has been allocated to the Manager to update any changes within the centre. Currently updated to reflect the ratio of Health Care Assistants	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • The Provider supports staff to reduce the risk of harm and promote the rights, health, and wellbeing of each person by providing training, development, and supervision. All staff currently employed have completed safeguarding, responsive behaviour and fire safety training. • A realistic timeframe is set out, so all staff have access to appropriate training to support them in performing their respective roles. • All new employees will have mandatory training as part of their induction. • Further training will be offered in a realistic timeframe.	

• This will be achieved by adhering to a timetable as set out by various training bodies. • The posts of the PIC and CNM have been filled.

Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: • The management of records is in line with regulatory requirements and will be discussed within the Governance meetings with the PIC • One of two references relating to staff member had been omitted from the staff file because her work experience was in the same hospital but in different units. • This reference was immediately requested and placed in her staff file. The time fame was immediate.	

Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The compliance plan response from the registered provider does not adequately assure the Chief inspector that the action will result in compliance with the regulations. • Arrangements have been put in place by the Provider for clear accountability, decision-making, risk management and performance assurance to reduce the risk of harm and respond to safeguarding concerns, underpinned by effective communication among staff following a meeting with the PIC and Provider • All Residents have access to communal spaces/day rooms and are reminded that they are there for their use at any time. • All statuary notifications and incidents will be submitted by the PIC as discussed in our clinical weekly meetings. • PIC is responsible for the review of incidents accidents and document. • All residents on the first floor have been assessed through a Mobility Screen Assessment – Manual handling chart, FRASE, Falls Risk Assessment and Bartel. • Chair /chairlift risk assessment carried out for all residents on the first floor. • The Key Performance Indicators are now recorded on the electronic system. • The Centres complaints management system is compliant as the centre policy has been updated to comply with S1.NO.628 of 202. • A Comprehensive review of all possible indicators of abuse has been discussed and analysed at our weekly clinical governance meeting. • Care Plans have all been reviewed to reflect the issues of concern raised.	

• All staff have been reminded to be vigilant, and any indicators of alleged abuse will continue to be followed up immediately, reported and recorded accurately reflecting the outcome.
• Safeguarding information is included in the induction program for all staff which also includes recognising possible indicators of abuse in vulnerable residents.
• All staff are facilitated to complete online validated safeguarding training within 7 days of commencement of employment and will attend further external validated training at the earliest possible dates available.
• The PIC or her deputy will inform the appropriate agencies within the required timeframes if analysis of incidents suggests an incident of alleged abuse may have occurred and will also ensure that their instructions are completed.
• All staff are informed of actions necessary to take to attempt to minimise the risk of re-occurrence of any such incident.
• We have spoken to all residents/families on the ground floor in relation to their dining needs and they all confirm that their choices remain the same as they did on the day of this inspection.
• In the interim period between now and the completion of any refurbishing works, we will continue to offer sufficient sittings to cater for the residents concerned.

In relation to the number of showers, accessible toilet facilities, dining areas and communal spaces on the ground floor the provider has requested three architects/engineers to provide quotations for undertaking the review and evaluation of the existing facilities and making recommendations as regards the sufficiency of these resources and any additional facilities required. This is set out in a specific format below which is measurable achievable and in a realistic timebound manner.

• Quotations due 8th March 2024
• Instruction to be given by Provider on the 15th of March 2024
• Report to be completed 12th April 2024.
• Proposals to be submitted to HIQA for approval following review by provider.
• Tenders for required works to be prepared by 10th May 2024.
• Tender return due date 31st May 2024.
• Works commence 7th July 2024
• Completion as per contractor programme provided with tender. Anticipated completion date 7TH September ,2024

The compliance plan response from the registered provider does not adequately assure the Chief inspector that the action will result in compliance with the regulations.

Regulation 24: Contract for the provision of services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 24: Contract for the provision of services:
• All Contracts of Care have been updated to include their current room numbers.
• The manager will ensure they are kept updated if any changes occur.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
• The SOP has been updated to reflect the arrangements for the management of the centre in the absence of the PIC.
• Storage Facilities & Terrace included in revised floor plans and submitted.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
• The 3 alleged incidents of peer – peer abuse and the quarterly notifications have now been submitted. The PIC is responsible for ensuring that all further notifications are submitted on time.
• Quarterly 3 2023 notifications have been submitted.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
• The policy of the Centre is to promote is a culture of openness and transparency that welcomes feedback, the raising of concerns and the making of suggestions and complaints. Staff have been reminded of our policy.
• All staff have been informed of the correct procedure to follow if they are in receipt of a negative comment or a complaint.
• The complaints policy and procedure has been updated to include the required timelines to investigate and conclude a complaint.
• It also includes information in respect of independent advocacy services to assist a

complainant.
• Provider representative has been identified as the complaints officer. She will continue in this role with the intention of handing over to the PIC within a timeframe of 3 months.
• The policy now includes the nominated review officer.
• Review officer has been identified.
• Any negative comments or complaints will be discussed in the Clinical Governance meeting with a view to appropriate action needed in accordance our policy.

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
The following policies were reviewed and updated where necessary:
• Admissions, Communication, End of Life, Recruitment, Selection and Garda Vetting of staff policy, the creation of, access to, retention of, maintenance of and destruction of records and the fire safety management policies.
• Moving forward we have advised our external providers that Policy change updates need to be emailed to us in a timely manner This will ensure our reviews can be updated within a specific timeframe.

Regulation 14: Persons in charge	Not Compliant

Outline how you are going to come into compliance with Regulation 14: Persons in charge:
• Strenuous efforts were made by the Provider from the date the Provider was advised of the sudden, without notice resignation of the former P.I.C
• The Area Manager of HIQA was informed immediately and kept informed via email on an on-going basis until the Provider recruited the present PIC.
• PIC now in place and approved.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

The compliance plan response from the registered provider does not adequately assure the Chief inspector that the action will result in compliance with the regulations.

In relation to the premises the provider has requested three architects/engineers to provide quotations for undertaking the review and evaluation of the existing premises and making recommendations as regards ensuring the premises compliance with Regulation 17.
This includes alleged infrastructural limitations of the premises and access to all communal and dining facilities in the centre as discussed under Regulations 9 and 23.

This is set out in a specific format below which is measurable achievable and in a realistic timebound manner.

• Quotations due 8th March 2024
• Instruction to be given by Provider on the 15th of March 2024
• Report to be completed 12th April 2024.
• Proposals to be submitted to HIQA for approval following review by Provider.
• Tenders for required works to be prepared by 10th May 2024.
• Tender return due date 31st May 2024.
• Works commence 7th July 2024
• Completion as per contractor programme provided with tender. Anticipated completion date 7TH September ,2024

The compliance plan response from the registered provider does not adequately assure the Chief inspector that the action will result in compliance with the regulations.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
• All Staff Nurses will be facilitated to re-read our Medication Management policy and have been instructed by the PIC that they must always adhere to the policy.
• Staff Nurses will also be facilitated to complete the HSE Medication Management module on HSE.
• The PIC will review the Controlled Drug register to ensure that two nurses sign for the administration of Controlled drugs.
• Prominent signage has been placed on each medication trolley to remind nurses that they must always document the date an item was opened, and date opened labels are available in each medication trolley.
• Nurses have also been instructed that they must never administer any medication that is not labelled with the resident's name or instructions for its administration.
• House stock will be monitored monthly and protocol for emergency stock is now in line with our policy.

• The PIC will complete a two monthly Medication Management audit to ensure compliance. • All the above will be monitored and discussed in the Clinical Governance meetings with the PIC on an ongoing basis.

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: • Care plans reviewed and updated on a 4 monthly basis or edited as needed if changes occur. • Two residents who are prescribed anti-seizure medication but have no history of seizures. on the advice of GP bloods to be reviewed 3 monthly • Care Plans updated to reflect the possible causative factors in unexplained bruising such as their medication or the fact that they unintentionally bang their arm off a door frame. • Protective Sleeves were purchased and are now in use for ambulant residents to make every effort to attempt to minimise the risk of reoccurrence of minor bruising • Staff have been instructed to inform PIC immediately if bruising noted. • Recording and preventative actions which include care, support and interventions designed to promote the safety, wellbeing, and rights of our residents will be discussed and analyzed in the Clinical Governance Meetings • We operate from a person-centered approach by respecting our residents, empowering our residents by giving them choice, talking to their representatives, and seeking advice from their respective GP and other allied health professionals as to the best practice. • Wound Care Plans updated to reflect the current dressing in use and prescribed for the resident. • Goal setting and a timeframe will be discussed to include the allocation of specific areas to each Nurse i.e. Wound Care Nurse, Falls Nurse, Infection Control Nurse, and their areas of responsibility in these roles will be defined. • A defined timeframe of 3 months is seen as realistic, which gives adequate time for training and cohesion between clinical staff.

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:

Residents are encouraged to move freely throughout the Centre.

• All forms of restraint are recorded on the restrictive practice register.
• All forms of restraint are trialed prior to their use and documented in their care plans.
• Our Policy is in line with the National Policy on restraint.
• There is a keypad on the door on the ground floor rear which is not in the locked position during the day leaving residents to move freely to the garden area.
• A risk assessment has been carried out and documented for residents of the first floor regarding access to the balcony area.
• The use of the keypads is a safety measure relating to some residents who have been assessed as being at risk of injury from entering the first-floor balcony unaccompanied by a staff member and these residents have no issues with this process.
• There is a keypad lock on the first-floor door balcony which is in the locked position. The reason for this is that it is used as a preventative measure relating to certain residents. Our findings outcome after carrying out a risk assessment on the residents on the first floor was that in some cases the risks posed to these residents against the preventative measure justify the use of the keypad.
• The outcome of our findings has been discussed with residents families / representatives and their responses are recorded in the resident care plans. Residents frequently request access to balcony area for a smoke and their requests are never obstructed or denied and these residents are accompanied by a staff member.
• The keypad numbers are written clearly above all keypads and residents who are assessed as not being at risk of injury while accessing the first-floor balcony are shown the codes.
• Keypads logged in the restraint register.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• Records reviewed and updated.
• Safeguarding Care Plans have all been reviewed to reflect the issues of concern raised by the Inspector.
• All staff will continue to be vigilant, and any indicators of abuse will continue to be followed up immediately, reported and records accurately reflecting the outcome.
• All measures are in place to attempt to reduce the risk of bruising and staff are reminded that while the incident is recorded a full closure of any incident must be recorded.
• Protective sleeves have been purchased for the ambulant residents prone to bruising their arms.
• Staff are all trained in manual handling.
• Our Moving and Handling policy states that there is a minimum of 2 staff when a
• resident is being moved with a hoist or has any difficulty with their mobility.
• This process is monitored by senior staff daily.
• All residents who require sliding sheets to assist their movements have them in place

and this process is also monitored by senior staff daily.
• Any resident who needs bed rails with padded bumpers have routine Maintenance checks carried out and any defects highlighted are addressed immediately and all faults are reported to the manager and maintenance person and actioned.
• Safeguarding information is included in the induction program for all staff which also includes recognising possible indicators of abuse in vulnerable residents.
• All staff are facilitated to complete online validated safeguarding training within 7 days of commencement of employment and will attend further external validated training at the earliest possible dates available.
• Comprehensive review of all possible indicators of abuse discussed and analysed at weekly clinical governance meetings.
• The PIC or her deputy will inform the appropriate agencies within the required timeframes if analysis of incidents suggests an incident of alleged abuse may have occurred and will also ensure that their instructions are completed.
• All staff are informed of actions necessary to take to attempt to minimise the risk of re-occurrence of any such incident.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
• Staff were reminded of the importance of infection control particularly the cleaning of equipment between residents' use.
• On going training is provided
• Infection control is monitored and managed daily by senior staff.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
The compliance plan response from the registered provider does not adequately assure the Chief inspector that the action will result in compliance with the regulations.

• The PIC has made contact with the Continence Promotion Unit and advice has been provided.
• Staff are remined to be respectful of personal/emotional needs when assisting residents with incontinence issues.
• Residents can be assisted to use the hoist accessible toilet or a commodore for their sole use.

In order to assess if residents are enabled to exercise their choice to access dining and communal facilities in the centre as described under Regulation 17: Premises, the provider has requested three architects/engineers to provide quotations for undertaking the review and evaluation of the existing premises and making recommendations as regards ensuring the premises compliance with Regulation 17 and 23 including accessing dining and communal facilities in the centre.

This is set out in a specific format below which is measurable achievable and in a realistic timebound manner.

• Quotations due 8th March 2024
• Instruction to be given by Provider on the 15th of March 2024
• Report to be completed 12th April 2024.
• Proposals to be submitted to HIQA for approval following review by provider.
• Tenders for required works to be prepared by 10th May 2024.
• Tender return due date 31st May 2024.
• Works commence 7th July 2024
• Completion as per contractor programme provided with tender. Anticipated completion date 7TH September ,2024

The compliance plan response from the registered provider does not adequately assure the Chief inspector that the action will result in compliance with the regulations.

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 14(1)	There shall be a person in charge of a designated centre.	Not Compliant	Orange	31/01/2024
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	20/12/2023
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	06/12/2023
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	31/01/2024
Regulation 17(2)	The registered provider shall, having regard to	Not Compliant	Orange	07/09/2024

	the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.			
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	06/12/2023
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	07/09/2024
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Not Compliant	Orange	31/01/2023
Regulation 23(c)	The registered provider shall ensure that management	Not Compliant	Orange	20/12/2023

	systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.			
Regulation 24(1)	The registered provider shall agree in writing with each resident, on the admission of that resident to the designated centre concerned, the terms, including terms relating to the bedroom to be provided to the resident and the number of other occupants (if any) of that bedroom, on which that resident shall reside in that centre.	Substantially Compliant	Yellow	11/12/2023
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Substantially Compliant	Yellow	06/12/2023
Regulation 29(4)	The person in charge shall ensure that all medicinal products dispensed or	Substantially Compliant	Yellow	19/02/2024

	supplied to a resident are stored securely at the centre.			
Regulation 29(5)	The person in charge shall ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.	Substantially Compliant	Yellow	06/12/2023
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	16/12/2023
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.	Not Compliant	Orange	11/12/2023
Regulation 31(3)	The person in charge shall provide a written report to the Chief Inspector at the	Not Compliant	Orange	06/02/2024

	end of each quarter in relation to the occurrence of an incident set out in paragraphs 7(2) (k) to (n) of Schedule 4.			
Regulation 34(1)(b)	The registered provider shall provide an accessible and effective procedure for dealing with complaints, which includes a review process, and shall display a copy of the complaints procedure in a prominent position in the designated centre, and where the provider has a website, on that website.	Not Compliant	Orange	31/12/2023
Regulation 34(2)(a)	The registered provider shall ensure that the complaints procedure provides for the nomination of a complaints officer to investigate complaints.	Not Compliant	Orange	11/12/2023
Regulation 34(2)(d)	The registered provider shall ensure that the complaints procedure provides for the nomination of a review officer to review, at the request of a complainant, the decision referred to at paragraph (c).	Not Compliant	Orange	11/12/2023
Regulation	The registered	Not Compliant	Orange	11/12/2023

34(5)(b)	provider may, where appropriate assist a person making or seeking to make a complaint, subject to his or her agreement, to identify another person or independent advocacy service who could assist with the making of the complaint.			
Regulation 34(7)(a)	The registered provider shall ensure that (a) nominated complaints officers and review officers receive suitable training to deal with complaints in accordance with the designated centre's complaints procedures.	Not Compliant	Orange	11/12/2023
Regulation 34(7)(b)	The registered provider shall ensure that all staff are aware of the designated centre's complaints procedures, including how to identify a complaint.	Not Compliant	Orange	14/12/2023
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3	Substantially Compliant	Yellow	20/12/2023

	years and, where necessary, review and update them in accordance with best practice.			
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.	Not Compliant	Orange	29/01/2024
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	22/12/2023
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.	Substantially Compliant	Yellow	11/12/2023
Regulation 8(1)	The registered	Not Compliant	Orange	06/12/2023

	provider shall take all reasonable measures to protect residents from abuse.			
Regulation 8(3)	The person in charge shall investigate any incident or allegation of abuse.	Not Compliant	Orange	06/12/2023
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Not Compliant	Orange	06/12/2023
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Not Compliant	Orange	31/01/2023