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:	Patterson's Nursing Home
Name of provider:	Ormond Healthcare Ltd
Address of centre:	Lismackin, Roscrea, Tipperary
Type of inspection:	Unannounced
Date of inspection:	03 April 2024
Centre ID:	OSV-0005573
Fieldwork ID:	MON-0039330

About the designated centre

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

Patterson's Nursing Home is situated in a rural setting approximately four miles from Roscrea town. The centre is a one-storey building that was established in 1991 and can accommodate 24 residents. There are grounds to the front with parking and a small enclosed garden area to the rear of the building, which provides a secure outdoor space with tables and chairs for residents use. The main entrance leads to a hallway with a visitors' room for residents and visitors to meet privately. Communal accommodation includes a large living room and a separate dining/multipurpose room and some seating areas on the corridors. The centre also provides a nurses' office, kitchen, sluice room and a staff changing room. Residents' accommodation comprises four single bedrooms with en-suite toilet facilities; nine twin-bedded rooms, four of which have en-suite toilets, and one three-bedded bedroom with a wash hand sink. There are three communal shower rooms two of which have toilets and wash-hand basins, one assisted bathroom with bath, on toilet, and an additional assisted toilet; there is a visitors toilet available near the nurses' office. The centre offers 24 hour nursing care and caters for male and female residents generally over the age of 65 years, including residents with dementia. Care was provided to residents under the age of 65, as required. The following categories of care are provided in the centre, which includes both long and short stays and caters for all dependency levels: General Care, Physical Disability, Dementia Care, Respite Care and Convalescence Care.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	22

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 3 April 2024	09:50hrs to 17:15hrs	Mary Veale	Lead
Wednesday 3 April 2024	09:50hrs to 17:15hrs	Aisling Coffey	Support

What residents told us and what inspectors observed

This was an unannounced inspection that took place over one day. Based on the inspectors' observations and discussions with residents, staff, and visitors, Patterson's Nursing Home was a nice place to live. There was a welcoming and homely atmosphere in the centre. On arrival, the inspectors were met by a member of the nursing staff and signed the centre's visitors log. After an opening meeting with the person in charge to outline the inspection format, the inspectors walked around the premises.

Kind and competent staff supported and promoted residents' rights and dignity. The inspectors spoke in detail with seven residents and two visitors on the inspection day. All residents spoken with were very complimentary in their feedback and expressed satisfaction with the standard of care provided. Residents appeared to enjoy a good quality of life and had many opportunities for social engagement and meaningful activities, and dedicated staff team supported them. Residents stated that they were well looked after and that staff were always available to assist with their personal care. Residents noted that the staff were kind and caring and that they were happy living in the centre. Residents said they felt safe and trusted the staff. Several residents were living with a cognitive impairment and were unable to express their opinions to the inspectors fully. However, these residents appeared to be content, appropriately dressed and well-groomed.

The centre was registered to accommodate 24 residents. The centre was homely, clean, and calm and relaxed. The centre is a single-storey building with five single bedrooms, eight twin rooms and one triple room. All the bedrooms had a wash hand basin, while nine had access to an en-suite with a toilet and wash hand basin. Residents had access to three showers in the centre. The inspectors observed that the bathroom was used as a storage room for linen and equipment on inspection day and that the bath had been removed. This reduced the options available for residents who could not use a shower.

Residents' bedrooms were clean and tidy. Bedrooms were personalised and decorated in accordance with residents' wishes. Lockable storage space was available for all residents, and personal storage space comprised of a locker with a double or a single wardrobe. The inspectors observed that two twin bedrooms required reconfiguration as both residents' wardrobes were in one-bed space. This meant that one of the residents sharing these twin rooms had to enter the other resident's bed space to access their personal belongings. Falls prevention alert devices and pressure relieving specialist mattresses and cushions were observed in residents' bedrooms.

The design and layout of the centre were appropriate for the number and needs of residents. The centre had a visitor's room decorated with artwork, comfortable seating and a coffee table. A hand wash sink was available in this room. The lounge area was open-plan and bright, with comfortable chairs for residents to relax. There

was a separate dining room. The centre had a large outdoor area at the back of the centre. This area was covered with a perspex canopy and had artificial grass on the floor, garden tables and chairs, and an outdoor heater. Residents had access to a small courtyard designated as an outdoor smoking area.

Residents said they were happy with the activities programme in the centre. The weekly activities programme was displayed in the centre, and group activities were observed in the lounge area throughout the day. The inspectors observed staff and residents having good-humoured banter during the activities. The inspectors observed the staff chatting with residents about their interests and family members. The inspectors observed residents walking around the corridor areas of the centre. The inspectors observed residents reading newspapers, watching television, listening to the radio, and conversing. Newspapers and games were available to residents. The centre provided pet therapy, and the inspectors were informed that the centre had a dog.

Residents' views and opinions were sought through resident meetings and satisfaction surveys. Residents said they could approach any staff member if they had any issue or problem to be solved.

Residents enjoyed home-cooked meals and stated there was always a choice of meals, and the food quality was very good. The inspectors observed the dining experience for residents in the dining room and lounge area. The mealtime experience was quiet and unhurried. Staff were observed to be respectful and discreetly assist the residents during meal times. The dinner meal was appetising and well presented. The dinner time experience was a social occasion where residents were seen engaging in conversations and enjoying each other's company.

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

Visitors were observed attending the centre on the day of the inspection. The inspectors spoke with two family members who were visiting. The visitors told the inspectors that outside of mealtimes, they could call the centre anytime. Visitors were very complimentary of the staff and the care that their family members received. Visitors knew the person in charge and were grateful to the staff. They said that staff were very good at communicating changes, particularly relating to the medical care needs of their loved ones.

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

Capacity and capability

While the designated centre had established management and oversight structures, actions were required in the centres management systems to ensure that the service provided could ensure that the residents were supported and facilitated to have a good quality of life.

This was an unannounced inspection to monitor the ongoing compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 as amended and to review the registered provider's compliance plan following the previous inspection. While the provider had progressed with some aspects of the compliance plan in relation to Regulation 28: Fire precautions, this inspection found repeated actions were required in relation to Regulation 17: Premises, Regulation 27: Infection control and Regulation 5: Individual assessment and care plan. Improvements were also required in Regulation 9: Residents' rights, and Regulation 34: Complaints procedure. While new areas of non-compliance concerning Regulation 8: Protection, Regulation 21: Records, and Regulation 31: Notification of incidents demonstrated deficits in the overall governance and management of the service.

The registered provider had made changes to the floor plan of the centre since the previous inspection. The centre's bathroom was observed to be a store room on the day of inspection. The change of use of the room, and the removal had been completed without engaging with the office of the Chief Inspector, as required by condition 1 of the centres registration. Following the inspection, the registered provider was requested to submit an application to vary condition 1 of the registration for Patterson's Nursing Home.

The registered provider is Ormond Healthcare Limited. The centre had a clearly defined management structure, and staff members knew their roles and responsibilities. The person in charge worked full-time in the centre, was responsible for overall governance and reported to the registered provider representative, who also held the finance manager position. A team of registered nurses, health care assistants, activities staff, catering, housekeeping, administration and maintenance staff supported the person in charge. The centre had a vacant clinical nurse manager post, and the provider was recruiting a person for this role. In the absence of the person in charge, a senior nurse deputised.

There was documentary evidence of communication between the person in charge and the company directors. There were governance meetings every two months to discuss audit findings, corrective action required, incident and risk management, health and safety, resident feedback, complaints, records management, human resource management and staff development. Within the centre, formal communication occurred at staff and nurse meetings where aspects of quality service delivery, including activities provision, staff training, infection prevention and control, incident and risk management, were discussed. An annual review of the quality and safety of care delivered to residents was completed for 2023. The review was a comprehensive summary of some of the systems in place in the centre to ensure residents received good quality and safe care.

The person in charge routinely collected and analysed data weekly concerning medication management, restrictive practice, wound care, falls management, and complaints management to identify trends, evaluate the effectiveness of care delivery, enhance safety and promote quality improvement. This data collection was complemented by a comprehensive monthly audit schedule, which identified gaps in service delivery and led to the development of time-bound action plans to address the findings. Notwithstanding these good practices, the auditing system was not consistently effective in identifying gaps and risks in the service and driving quality improvement. For example, there were discrepancies between the audit finding that 100% of call bells were accessible to all residents and what inspectors found on inspection day. The safeguarding and staff file audits did not identify the gaps in regulatory compliance found during this inspection, which are discussed under Regulation 8 and Regulation 21. Similar gaps in oversight were evident when notifications were reviewed. The Office of the Chief Inspector of Social Services had not been notified of statutory notifications within the required time frames. This is discussed under Regulation 31: Notification of incidents.

There were sufficient staff on duty to meet the needs of residents living in the centre on the inspection day. The centre had a staff team that was supported in performing their respective roles. They knew the needs of the older persons in their care and respected their wishes and preferences. Staff were supervised by the person in charge and a senior staff nurse. However, improvements were required in staff resources in the centre as staffing levels were not in accordance with the centre's statement of purpose. This is discussed further under Regulation 23: Governance and Management.

Staff had access to appropriate training and development to support them in their roles. Records reviewed documented that staff received an induction on commencing in the centre, and appraisals took place afterwards to support their professional development. Staff training within the centre was provided via an online platform and face-to-face training. Training in areas such as safeguarding, infection prevention and control, fire safety and medication management were provided. Inspectors were informed that several nursing staff had completed a learning programme in delivering palliative, end-of-life, and bereavement care to residents. There was a plan for all nursing staff to complete this learning programme to support enhanced quality of life and end-of-life care for residents.

Staff files were reviewed. All staff files contained Garda Siochana (police) vetting and identification. However, the personnel files did not contain all of the Schedule 2 documentation required. While the centre had a system for incident recording, inspectors found that specific incidents, such as allegations of suspected or confirmed abuse, were not being recorded as incidents in line with the centre's policies and Schedule 3 requirements. This is discussed further under Regulation 21: Records.

The centre displayed its complaints procedure prominently within the centre. Information posters on advocacy services to support residents in making complaints were also displayed. Residents and families said they could raise a complaint with any staff member and were confident in doing so if necessary. Staff were

knowledgeable about the centre's complaints procedure. The person in charge had undertaken complaint management training to support her in this area. The person in charge maintained an electronic record of complaints received, how they were managed, the outcome of complaints investigations and actions taken on foot of receiving a complaint. Notwithstanding this good practice, there were gaps in complaints management practices and some improvements were required to comply fully with the regulation, which will be outlined under Regulation 34: Complaints procedure.

Regulation 15: Staffing

On the inspection day, staffing was found to be sufficient to meet the residents' needs. There was at least one registered nurse on duty in the centre at all times.

Judgment: Compliant

Regulation 16: Training and staff development

There was a high level of attendance at mandatory training and only a small number of staff were overdue attendance at training on safeguarding of vulnerable adults, fire safety, and infection control. A training plan was in place to ensure all staff received up to date training.

Judgment: Compliant

Regulation 21: Records

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

- Staff personnel files did not contain all the necessary information required by Schedule 2 of the regulations. For example, three of four files did not contain written references from the most recent employer, as required by regulation; one nursing staff member's file did not contain documentary evidence of their nursing qualification, and one personnel file did not contain a full employment history.
- Where there were two confirmed verbal abuse incidents, there was no record of the incident, investigation and actions taken in one incident while there were incomplete records in relation to a second incident. These gaps in

documentation were not in line with the centre's own safeguarding policy, or as required by Schedule 3(4)(j) of the regulations.

Judgment: Not compliant

Regulation 23: Governance and management

Although the provider had good oversight of the centre, management systems required review to ensure that the service provided was safe, appropriate, consistent and effectively monitored, as required under Regulation 23(c).This was evidenced by:

- Auditing processes required review to be more robust in identifying risk. There were inconsistencies between the full levels of compliance reported in the centre's audits and inspectors' findings in the audits concerning call bells, staff files and safeguarding.
- The oversight and maintenance of incident reporting and recording needed to be more robust, as evidenced by inspectors' findings. Four statutory notifications to the Chief Inspector of Social Services were not submitted within the required time frames.

While there were sufficient staff working in the centre on the day of inspection to meet the needs of the residents, the provider was required to maintain staffing in line with the statement of purpose Ormond Healthcare Limited was registered against. For example:

- While there was an ongoing recruitment process for staffing the centre. Rosters viewed by the inspectors evidenced that there were staff vacancies across catering, housekeeping, maintenance and activities departments.

Changes made to the premises were not in line with the statement of purpose, which Ormond Healthcare Limited was registered against premises and had not been communicated to the Office of the Chief Inspector. For example:

- The bath had been removed from the bathroom, and the room was observed as a store room on the inspection day.

Judgment: Not compliant

Regulation 31: Notification of incidents

A review of the records in relation to incidents in the centre showed that there were four incidents as set out in Schedule 4 of the regulations that were not notified to the office of the Chief Inspector within the required time frames. The person in

charge was requested to submit these notifications following the inspection, relating to safeguarding concerns.

Judgment: Not compliant

Regulation 34: Complaints procedure

While residents were familiar with the complaints process and overall complaints were well managed, the centre's complaints policy and procedure required updating to meet the amendments to the regulations that had come into effect in March 2023 (S.I. 628 of 2022). For example:

- The centre's complaints policy did not reference a review officer or specify the timeframes for the review officer to issue their written response.
- There were gaps in recording the outcomes of complaint investigations and actions taken after complaints were received.
- There were discrepancies between the nominated complaints officer referenced in the complaints policy and the complaints procedure displayed within the centre.
- The annual review of the quality and safety of care 2023 did not reference the level of engagement of independent advocacy services with residents.

Judgment: Substantially compliant

Quality and safety

Overall, the inspectors were assured that residents living in the centre enjoyed a good quality of life. Residents' health, social care, and spiritual needs were well catered to. Improvements were required to fully meet the requirements regarding protecting residents from abuse and premises. Other areas that required improvements included individual assessment and care planning, residents' rights, infection prevention and control, and fire safety.

Residents' health and well-being were promoted via timely access to general practitioners (GP) and specialist services and professionals, such as mental health professionals, physiotherapists, dietitians and speech and language therapists, as required. The centre had access to GPs from local practices, and the person in charge confirmed that GPs called the centre. Residents had access to a mobile x-ray service referred by their GP. Residents had access to nurse specialist services such as community palliative care, public health nurses and tissue viability nurses. Residents had access to local dental, optician and pharmacy services. Residents who

were eligible for national screening programmes were also supported and encouraged to access these.

Residents' needs were comprehensively assessed following admission. The residents' assessments were undertaken using various validated tools, and holistic care plans were developed following these assessments. There was a good standard of care planning in the centre. In a sample of four nursing notes viewed, residents' needs were comprehensively assessed by validated risk assessment tools. Care plans were sufficiently detailed to guide staff in the provision of person-centred care. Care plans had been updated to reflect changes required concerning falls, pressure sores and communication needs. However, further improvements were required, as discussed under Regulation 5: Individual assessment and care planning.

Staff were observed to communicate appropriately with residents who had communication difficulties. They afforded time for the residents to express themselves and did not hurry them. A review of the residents' records showed that when a resident had a communication difficulty, it was appropriately assessed, and all relevant information was recorded in a personalised care plan. The care plan was regularly reviewed and updated to reflect changes to the resident's communication needs.

Residents at the end of life had access to appropriate care and comfort. The centre had arrangements to support providing compassionate end-of-life care in line with their assessed needs and wishes.

Appropriate arrangements were in place to ensure that when a resident was transferred or discharged from the designated centre, their specific care needs were appropriately documented and communicated to ensure the resident's safety. The inspectors observed an evidence-based transfer document completed for a resident transferred to the hospital. Copies of the documents were available for review and contained all relevant resident information, including infectious status, medications, and communication difficulties where relevant.

Evidence showed that the registered provider had taken measures to protect residents from abuse. For example, before commencing employment in the centre, all staff were subject to Garda Siochana (police) vetting. All residents spoken with stated that they felt safe in the centre. The registered provider was not a pension agent but did hold quantities of money in safekeeping for the benefit of residents and at their request. There were transparent recording arrangements in place to safeguard residents' finances. Receipts and balances of any money withdrawn were kept and signed by two staff and, where possible, the resident. Notwithstanding these good practices, there were deficits in management and staff identifying potential safeguarding issues in the centre. While there was a policy and procedure for the prevention, detection and response to allegations or suspicions of abuse, which detailed the appropriate steps for staff to take should a safeguarding concern arise, this policy had not been followed in four circumstances reviewed. This will be discussed under Regulation 8: Protection.

Residents were actively involved in the organisation of the service. Regular resident meetings and informal feedback from residents informed the organisation of the service. The centre promoted the residents' independence and their rights. The residents had access to independent advocacy services, and contact details were displayed in the main entrance corridor. The activities planner was displayed in the lounge room in the centre. Residents had access to daily national newspapers, weekly local newspapers, books, televisions, and radios. Mass took place in the centre weekly. Musicians attended the centre regularly. Group arts and crafts activities and a rosary recital took place on the inspection day.

The premises of the designated centre was appropriate to the number and needs of the residents. There were sufficient communal spaces for residents and their visitors to enjoy. However, the layout of some multi-occupancy bedrooms did not ensure residents' right to privacy and dignity, as residents had to enter other residents' bed spaces to access their clothing. This matter will be discussed under Regulation 9. Some areas required maintenance and repair to fully comply with Schedule 6 requirements.

Staff were observed to have good hygiene practices, and alcohol gel was available throughout the centre. Sufficient housekeeping resources were in place on the day of the inspection. Intensive cleaning schedules and regular weekly cleaning programmes were available in the centre. The centre had a curtain cleaning schedule for curtains in communal areas and corridors. Single-use privacy curtains were in place around the resident's bed space and had installation dates within the recommended guidance for curtain usage. The centre had carpet flooring in several bedrooms and corridor areas. The inspectors were informed that all carpets were vacuumed daily and steam cleaned regularly. There was evidence that infection prevention control (IPC) and COVID-19 were agenda items on the minutes of the centre's staff meetings and management meetings. IPC audits included environmental and hand hygiene. There was an up-to-date IPC policy, which included COVID-19. However, a small number of improvements were required in relation to infection prevention and control. This will be discussed further under Regulation 27.

The centre had automated door closures for all compartment and bedroom doors. Effective systems were in place to maintain the fire detection, alarm systems, and emergency lighting. The centre's emergency lighting, alarm system and fire equipment had been serviced at required intervals since the previous inspection. Fire doors were checked on the day of inspection, and all were in working order. There was evidence that fire drills took place regularly. Fire drill records were detailed, containing the number of residents evacuated, how long the evacuation took, and learning identified to inform future drills. There was a system for daily and weekly checking of means of escape, fire safety equipment, and fire doors. Each resident had a personal emergency evacuation plan (PEEP) that was updated regularly. The PEEPs identified the different evacuation methods applicable to the individual residents. Fire evacuation maps were displayed throughout the centre. The staff spoken with were familiar with the centre's evacuation procedure. There was evidence that fire safety was an agenda item at meetings in the centre. On the day of the inspection, two residents smoked, and detailed smoking risk assessments

were available for these residents. A call bell, fire aprons, fire blanket, fire extinguisher and fire retardant ashtray were in the centre's smoking area. Oversight of fire drills and evacuation procedures required improvement, which is discussed further in the report under Regulation 28.

Regulation 10: Communication difficulties

Residents with communication difficulties were being facilitated to communicate freely. Their care plans reflected their communication needs and were appropriately reviewed and updated. All residents had access to audiology, ophthalmology and speech and language services, as required.

Judgment: Compliant

Regulation 13: End of life

The inspectors were assured that each resident received end-of-life care based on their assessed needs, which maintained and enhanced their quality of life. Each resident received care that respected their dignity and autonomy and met their physical, emotional, social, and spiritual needs.

Judgment: Compliant

Regulation 17: Premises

Parts of the premises did not conform to the matters set out in schedule 6 of the regulations, for example:

- Parts of the centre, such as radiators, walls, and skirting boards, required painting to ensure they could be effectively cleaned.
- There was evidence of wear and tear of the carpet particularly near the lounge room which could be a potential safety risk for residents and staff.
- Call bells were required in bedroom 5A and the en-suite toilets of rooms 6, 7, 8, 9, 10, 12, 13 and 14. This was a repeated finding from the previous inspection.
- The hot press adjacent to room 3 required review as it contained items such as staff coats, water bottles, and residents' linen. This posed a safety risk to staff working and residents living in the centre, a repeated finding from the previous inspection.

- The storeroom ceiling between a resident's toilet and bedroom 3A required repair. Extensive mould had developed due to a roof leak that had been temporarily repaired. This posed a safety risk to staff working and residents living in the centre.

Judgment: Substantially compliant

Regulation 20: Information for residents

A guide for residents was available in the centre. This guide contained information for residents about the services and facilities provided including, complaints procedures, visiting arrangements, social activities and many other aspects of life in the centre.

Judgment: Compliant

Regulation 25: Temporary absence or discharge of residents

The inspectors reviewed residents' records and saw that where the resident was temporarily absent from a designated centre, relevant information about the resident was provided to the receiving hospital. Upon residents' return to the designated centre, the staff ensured that all relevant information was obtained from the discharge service, hospital and health and social care professionals.

Judgment: Compliant

Regulation 27: Infection control

While many good practices were observed, actions were required to ensure the service complied with the National Standards for Infection Prevention and Control in Community Services (2018). For example;

- Shower chairs had visible rust on the leg or wheel areas. This posed a risk of cross-contamination as staff could not effectively clean the rusted parts of the shower chair.
- There was visible rust on a commode in the en-suite of room 10. This posed a risk of cross-contamination as staff could not effectively clean the rusted parts of the commode.
- Incontinence wear was stored on open shelves and cisterns of communal toilets which posed a high risk of contamination and transmission of infection.

- The staff informed the inspectors that the contents of commodes, bedpans, and urinals were manually decanted into the sluice hopper before being placed in the bedpan washer for decontamination. The area around the sluice hopper was visibly dirty with brown staining. Decanting risks environmental contamination with multi-drug resistant organisms (MDROs) and poses a splash/exposure risk to staff. Bedpan washers should be capable of disposing of waste and decontaminating receptacles.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Action was required by the provider to ensure that adequate arrangements were in place to protect residents from the risk of fire. For example:

The arrangements for fire drills required improvement, for example:

- The drill records reviewed did not contain sufficient information to demonstrate that the evacuation procedure was adequately tested during periods of lowest staffing levels.

The registered provider had not made adequate arrangements for evacuating, where necessary in the event of a fire, all persons in the designated centre and safe placement of residents, for example:

- Personal emergency evacuation plans (PEEP) required review to accurately record residents' supervision requirements following an evacuation. While three PEEPs documented the residents' need for supervision after evacuation, a significantly higher number of residents were at risk of leaving the assembly point and perhaps walking back into an unsafe area, and the PEEPs did not reflect these needs.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

While some care records were seen to be person-centred and reflect residents' needs, action was required in individual assessment and care plans to ensure the needs of each resident are assessed and an appropriate care plan is prepared to meet these needs. For example:

- A sample of care plans reviewed were not formally reviewed every four months to ensure that care was appropriate to the resident's changing needs.

- A sample of care plans viewed did not all have documented evidence to support if the resident or their care representative were involved in the review of their care in line with the regulations. This is a repeat finding from the April 2023 inspection report.

Judgment: Substantially compliant

Regulation 6: Health care

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

Judgment: Compliant

Regulation 8: Protection

While the registered provider had taken measures to protect residents from abuse, the systems for recognising and responding to abuse incidents and allegations required improvement.

Risk assessment and complaints documentation reviewed by the inspectors identified two confirmed incidents of verbal abuse and two suspected incidents of financial abuse. These four abuse concerns were not investigated and managed in line with the centre's safeguarding policy. Action was therefore required to ensure that:

- all staff were able to detect, prevent and respond to an allegation of abuse in a timely manner.
- the person in charge investigated any incident or allegation of abuse.

Judgment: Not compliant

Regulation 9: Residents' rights

The layout of some multi-occupancy bedrooms did not ensure residents' needs for privacy and dignity were maintained, as residents had to enter other residents' bed spaces to access their clothing. For example, within twin bedrooms 5 and 5A, the wardrobes were located in one resident's bed space. This meant one resident had to

leave their private space and enter another resident's space to access their clothing and other personal belongings. In removing the bath from the centre, the provider had removed the choice of between a bath or a shower for residents.
Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 13: End of life	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 20: Information for residents	Compliant
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Patterson's Nursing Home OSV-0005573

Inspection ID: MON-0039330

Date of inspection: 03/04/2024

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: All 35 staff files reviewed since the inspection by the PIC. All files have references in their file. However, as discovered in the inspection some files do not have their most recent previous employers reference included. Two of the staff member files have been part of the staff for more than 10 years. The PIC deems that it is very difficult now to obtain their previous employers' references. However, we will going forward ensure that all staff files are in compliance with the regulation, this will include references, explanation for gaps in employment history, copy of qualifications etc. The two mentioned confirmed verbal abuse incidents which were reviewed by the HIQA inspectors were documented on the EpicCare system under resident communication and not under "incidents" section in EpicCare. The PIC took all relevant action to address these incidents at the time, Sage advocacy services were involved and our own independent advocacy officer. The gap identified in documentation was that an outcome was not provided by the PIC, even though all other parties submitted written feedback to both parties and the issues were resolved. No disciplinary action was deemed necessary through the investigation process and outcome. The PIC at the time of the incidents made a judgement that this was not a notifiable event, but since meeting with the inspectors on the day, the PIC now understands the rationale for notification.	
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 in response to the removal of the bath in the centre from the registered provider does not adequately assure the chief inspector that the action will result in compliance with the regulations.

Auditing – The PIC acknowledges that there are discrepancies between the 2023 and 2024 audit findings. The PIC has undertaken to review all audits completed to date and will ensure that they are an accurate reflection and will ensure that an action plan is compiled and completed in a timely manner.

Notifications –As above mentioned, on the day of inspection the PIC spoke with both inspectors and received clarification around the submission of notifications, i.e. when a resident was suspected of being financially abused by their relative, this should have been notified. In this case, the PIC engaged with Sage advocacy services, our own advocate, to resolve the issue. The PIC was unaware at the time, this was a notifiable event. Another incident was when two residents who are relatives were shouting at each other. The inspectors stated that this should have been notified to HIQA at the time. Again, this was resolved locally by the PIC and documented at the time of the incident.

However, the PIC will going forward ensure that all incidents like above will be notified to HIQA.

Staffing levels are in line with Statement of Purpose (SOP) – The PIC and provider have both reviewed the current Rota and the SOP which was submitted upon registration in 2022. The inspectors on the day found that we weren't in line with the SOP submitted in the areas of housekeeping, catering, maintenance and activities.

Catering – We currently have 6 staff, 2 of which are on extended sick leave and their names were not on the Rota on the day of inspection. However, in their absence, we still have 5 whole time equivalents which is in line with our SOP.

Maintenance – We have a part–time staff member who carries out maintenance. Additionally, a maintenance company which works for Ormond Healthcare Ltd, and they cover all homes under the umbrella of Ormond Healthcare Ltd and they are on call 24/7 if required. The Provider and PIC believe we have sufficient maintenance staff and support from the external independent company if required.

Activities – Our SOP states that we have one staff member as whole time equivalent employed, this is still the current situation. We provide an activity coordinator Monday to Friday. At weekends, staff on duty carry out the planned activities that the activity coordinator has scheduled. Also, external entertainment is provided most weekends for the residents.

Overall, the provider and the PIC believe that there are no gaps in staffing and no requirements for recruitment currently. We are adequately staffed in all departments.

Bath removal – In 2020, the previous registered provider of the nursing home removed the bath in consultation with the residents as it was never used and it was difficult to access. Instead, the provider created a wet room and extra storage which was lacking in the nursing home. The former inspector at the time was aware of the changes made to

this bathroom. The current provider will provide updated floor plans to indicate this change.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
As above explained under regulation 23, the PIC will ensure that all notifications will be submitted in accordance with the regulation.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The PIC acknowledges that the updated complaints policy was not in the policy folder on the day of inspection. This has since been updated, reviewed and signed by all staff. All relevant roles i.e. complaints officer, review officer etc. have been identified and documented.

All complaints have been reviewed and the PIC acknowledges that some gaps in documentation of the outcomes of the complaint were not completed. The PIC will ensure that all complaints are completely documented, and outcomes documented once all parties are satisfied with the outcomes.

The PIC has active engagement with external advocacy agencies, including our own independent advocacy service and Sage advocacy service. However, the inspector on the day found that this was not documented in our quality and safety of care annual review. The PIC will endeavor to include it in this year's annual review.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
In recent months the provider has undertaken to compile a programme of maintenance works. This includes the following:

• Remove all carpets and replace them with suitable flooring which is compliant with infection prevention and control guidelines (IPC).

• Painting of all interior rooms of the nursing home.

• Skirting boards needs attention and radiators all need to be replaced to be compliant with IPC guidelines.

• Call bell system to be upgraded.

• Sections of the roof to be replaced.

Staff belongings removed from a storage press that was not allocated for this use. The staff have a separate staff area behind the nursing home which all the staff have been given lockers to store their personal belongings.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
On the day of inspection the following findings were noted and actioned upon immediately:

• Shower chairs with rust around the wheels have been replaced.
• Commode has been replaced.
• Incontinence wear removed from the resident's bathroom – and placed in their wardrobes to adhere to IPC guidelines.
• Bedpan washer use reviewed, and all staff made aware not to decant bedpans and commodes before washing. Also, the provider is planning to purchase a new bedpan washer over the coming months to ensure that we are in compliance with IPC guidelines.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Fire drills – Since the inspection the PIC carried out fire drills with the minimum staffing levels (3 staff member scenario at nighttime staffing levels). Each month the PIC has committed to conducting two fire drills, one by day and one at night.

PEEPs – All PEEP's updated and now include their supervision needs if total evacuation is required of the building. The PEEP's are reviewed every month.

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan: The PIC will ensure that all care plans are reviewed quarterly or when required. All care plans have now reminder dates set for evaluation. All residents have named nurses to ensure continuity of care and documentation is completed in a timely manner or when required. The PIC has always operated a paper-based trail of all residents, or their family representatives review date and satisfaction levels of the care plans which are kept electronically on EpicCare. This signed document is kept in the individual resident file in the nurse's station. The PIC acknowledges that this paper document is not mentioned in their individual care plan review on EpicCare. Going forward, this will be included also in the Epiccare system during the next review by the resident or their family representative.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection: As mentioned above in regulations 23 and 31 above, the PIC acknowledges the notifications and incidents of alleged abuse and how they were managed was not in line with our safeguarding policy. The PIC has organized additional training for all staff in safeguarding training and recognizing abuse with the safeguarding team in CHO3.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: In a twin bedroom, it was observed that the layout did not allow for resident's privacy and dignity as the wardrobe was on the other side of the bedroom. Subsequently, the wardrobe has been moved so that the residents can access the wardrobe in privacy and

with dignity.

As mentioned above in regulation 23, the bath was removed in 2020 in consultation with the residents at the time before removal. All current residents are satisfied that they have access to showering facilities and do not wish to have a bath in the premises.

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 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	Yellow	31/10/2024
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Not Compliant	Orange	24/05/2024
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with	Not Compliant	Orange	24/05/2024

	the statement of purpose.			
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	24/05/2024
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Substantially Compliant	Yellow	30/09/2024
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.	Substantially Compliant	Yellow	24/05/2024
Regulation 28(2)(iv)	The registered provider shall	Substantially Compliant	Yellow	24/05/2024

	make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.			
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	24/05/2024
Regulation 34(2)(a)	The registered provider shall ensure that the complaints procedure provides for the nomination of a complaints officer to investigate complaints.	Substantially Compliant	Yellow	24/05/2024
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).	Substantially Compliant	Yellow	24/05/2024
Regulation 34(6)(a)	The registered provider shall ensure that all complaints	Substantially Compliant	Yellow	24/05/2024

	received, the outcomes of any investigations into complaints, any actions taken on foot of a complaint, any reviews requested and the outcomes of any reviews are fully and properly recorded and that such records are in addition to and distinct from a resident's individual care plan.			
Regulation 34(6)(b)(i)	The registered provider shall ensure that as part of the designated centre's annual review, as referred to in Part 7, a general report is provided on the level of engagement of independent advocacy services with residents.	Substantially Compliant	Yellow	24/05/2024
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.	Substantially Compliant	Yellow	24/05/2024

Regulation 8(3)	The person in charge shall investigate any incident or allegation of abuse.	Not Compliant	Orange	24/05/2024
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Substantially Compliant	Yellow	24/05/2024