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:	Larissa Lodge Nursing Home
Name of provider:	Mountain Lodge Nursing Home Limited
Address of centre:	Carnamuggagh, Letterkenny, Donegal
Type of inspection:	Unannounced
Date of inspection:	27 June 2023
Centre ID:	OSV-0005791
Fieldwork ID:	MON-0040565

About the designated centre

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

The provider plans to provide 24- hour nursing care to 64 residents over the age of 18 years, male and female who require long-term and short-term care (assessment, rehabilitation, convalescence and respite). The building is single storey. Communal facilities and residents' bedroom accommodation consists of a mixture of 48 single and 8 twin bedrooms all with full en-suite facilities. The building is laid out around central communal facilities that include a spacious lounge with multiple areas with views outside and a variety of seating options, an internal dining room with a large skylight, an oratory/prayer room and a visitors room near reception. A variety of outdoor courtyards are accessible from many parts of the building. The philosophy of care is to provide person centred, compassionate care and services with a commitment to excellence through adherence to high standards, disciplined leadership and respect for all.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	48

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 27 June 2023	20:25hrs to 22:25hrs	Nikhil Sureshkumar	Lead
Wednesday 28 June 2023	09:15hrs to 18:45hrs	Nikhil Sureshkumar	Lead
Tuesday 27 June 2023	19:45hrs to 22:25hrs	Ann Wallace	Support
Wednesday 28 June 2023	09:15hrs to 18:45hrs	Catherine Rose Connolly Gargan	Support
Wednesday 28 June 2023	09:15hrs to 18:45hrs	Ann Wallace	Support

What residents told us and what inspectors observed

The feedback from residents was largely positive about the care provided to them at the centre, and the residents told the inspectors that they liked living in the centre. However, improvements were required to ensure that safeguarding processes were fully implemented in the centre and that all residents were adequately protected.

The inspectors spoke with a number of residents in the centre over the two days of the inspection. Residents' positive comments included "This is a good centre, staff are great", "they are kind, and they attend to my calls timely", "the food is nice, and my choice of food is available here", "I can watch my favourite television programme", "if I need any help, the staff will help me", "My room is nice and comfortable", "I have enough space to store my belongings", and "I am often busy with my activities".

However, some other residents' comments were that "there is no one here to spend time with me, and I often feel lonely ", "some staff do not have the time to spend with me, and they are always on the run", and "when they wear the mask, I can't hear them properly". One resident said that the quality of care varied. Sometimes it was good, and other times 'not so good'. Residents explained how sometimes it was difficult to make themselves understood by staff, because some staff could not speak English very well. This was validated by the inspectors, who found it difficult to converse with a small number of staff who did not have a good command of the English language.

The designated centre is located in Letterkenny Town and is close to local amenities.

The corridors of the centre were bright, well-ventilated, and clutter-free. Residents were able to walk around the centre independently. The centre appeared to be visibly clean. The centre has outdoor gardens on either side of the building, with sun shades and seating arrangements for residents, and the inspectors saw many residents accessing these gardens independently.

The day rooms of the centre had sufficient seating arrangements. There was a quiet alcove towards the rear of the main lounge; however, this was being used by one resident for their television viewing on the afternoon of the second day of the inspection. At times, the noise from this television was seen to be impacting the residents using the main communal area.

A schedule of activities was displayed in the day rooms, and most of the residents who spoke with the inspectors said they enjoyed the activities in the centre. The inspectors observed that a member of the activities team was encouraging residents to participate in activities such as ball games, word scrambles, and rosaries. However, not all residents were found to be interested in some of the activities that were on offer. Furthermore, some of the staff who were providing activities did not demonstrate adequate knowledge and skills to ensure activities were meaningful for

residents, especially those residents with cognitive impairment.

The inspector visited some residents' bedrooms and found that, overall, rooms were personalised and adapted to ensure that residents had sufficient space to store their personal belongings and the room was laid out to meet their needs. Residents told the inspector that they liked their bedrooms and were comfortable in their new home. However, some rooms viewed by the inspectors did not have enough shelf space for residents to store their personal belongings.

Residents were provided with light refreshments, and there was a choice of drinks available to them. The dining area of the centre had a relaxing ambience, and there were menu choices available for residents. Sufficient staff were available in the dining room to assist residents during their meal times.

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

Capacity and capability

The findings of this inspection were that the oversight of key areas of care and resident safety, including staff training, safeguarding, admission procedures and care planning, and records, required improvement. The provider was in the process of implementing a comprehensive quality improvement plan to ensure these changes were achieved. The actions had clear time frames for completion; however, some actions from April and May 2023 had not been completed at the time of the inspection. Significant focus and effort are now required to ensure the quality improvement plan is progressed and that the findings in this report are addressed promptly.

This unannounced inspection was carried out to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and to follow up on a number of concerns and statutory notifications that had been received in relation to the safety of residents living in the centre. The provider was required to submit provider assurance reports prior to this inspection, and the compliance plans submitted to the Chief Inspector where reviewed during this inspection.

The unsolicited information received in relation to staffing, the management of responsive behaviours and the management of safeguarding incidents in the designated centre were found to be substantiated. Furthermore, this inspection found that the current admissions procedures did not ensure that the centre could meet the ongoing needs of some of the residents. This was being addressed as part of the provider's quality improvement plan.

There was an established management team led by the person in charge who

worked full-time in the centre. The person in charge was supported in their management role by an assistant director of nursing and a clinical nurse manager, both of whom worked full-time. The management team did not work after 17.00 hours, however there was an on-call arrangement in place if staff needed to speak with a manager. On the first evening of the inspection, it was not clear who was in charge when the inspectors arrived at the centre. Staff did contact the person in charge, who arrived at the centre after a short period and facilitated the inspection, along with the assistant director of nursing who also arrived at the centre.

Housekeeping staffing resources were not in line with those committed to in the centre's statement of purpose. For example, there was a requirement for two housekeepers to be on duty per day, there was only one housekeeper on duty on the second day of the inspection. This was due to a short-notice absence. The provider was actively recruiting for these posts.

The staff resource also needed further review as there were not sufficient numbers of staff with the right knowledge and skills to provide appropriate activities for residents and to ensure residents with high levels of responsive behaviours received care and support in line with their needs. The provider had applied to funding agencies for additional funding for some residents with high levels of responsive behaviours. However, the provider's internal contingency plan to provide additional staff until the funding became available did not ensure that there were sufficient additional staff available. Furthermore, the allocation of named nurses with responsibility for residents who were admitted for short-term and respite care did not ensure key points of care, including admission and discharge, were managed effectively.

There was a training programme in place. Training records showed that all staff were up-to-date with their training requirements, including fire safety, moving and handling, and safeguarding vulnerable adults. However, some staff who spoke with the inspectors did not demonstrate adequate knowledge in relation to recognising and responding to abuse. The provider had acknowledged these shortcomings in safeguarding practices and had put an improvement plan in place. Delays in reporting and responding to concerns raised by residents were found in the records relating to three incident reports in the centre. Fundamental improvement is now required to ensure that the provider's assurance plan is implemented without delay so that any safeguarding concerns or allegations are heard and are recorded and followed up in line with the centre's own policies and procedures so that all residents are adequately protected.

In addition to the quality improvement plan, the provider had comprehensive quality assurance processes in place, including an audit calendar and monitoring of key performance indicators and risks such as falls, wounds and incidents. There was clear evidence in the records that the group general manager and the quality manager attended the centre on a regular basis. As part of their visit, they met with residents and staff and interviewed families who were visiting the centre. There was evidence that some of the issues raised at the visits were followed up and addressed with the relevant staff team.

Management meetings were held, and on request, the records of these meetings were made available for inspectors to review. Staff meetings were held regularly, and these meetings included feedback from residents, incidents and complaints that had occurred, and learning from these issues.

Staff turnover had been high in the last twelve months, and a number of staff had worked less than six months in the centre, including some staff who were newly recruited. Staff records showed that all staff completed an induction training programme with a senior member of staff. Inductions were overseen by the head of the department or by the clinical nurse manager. The induction training included fire safety, safeguarding and infection prevention and control. This formal induction training was largely online, and although competency assessments were completed by senior staff, inspectors were not assured that the staff member had achieved the learning required. This was a particular concern as a number of new staff working in the centre did not demonstrate good communication skills.

The oversight of selection and recruitment processes needed improvement as a number of staff files showed that the provider had failed to obtain satisfactory explanations for gaps in employment during recruitment interviews. This information was not available in a number of staff files reviewed by the inspectors.

Regulation 14: Persons in charge

There is a person in charge who is a registered nurse with more than three years experience in management in a health service setting. The person in charge works full time in the centre and is well known to residents and staff.

Judgment: Compliant

Regulation 15: Staffing

The provider had not ensured that there were sufficient housekeeping staff on duty to complete cleaning schedules and ensure that all areas of the centre were cleaned in line with the centre's own daily cleaning and deep cleaning schedules. There was one housekeeper on duty on the second day of the inspection to clean a centre with an occupancy of 48 residents. The provider was actively recruiting to fill these posts but no contingency arrangements had been put into place such as using agency staff to cover the gaps in the roster and ensure there were two cleaners on duty. Management records from May 2023 showed that this was an ongoing issue in the centre.

The current processes for reviewing staffing levels did not ensure that there was an effective internal interim contingency in place to increase staffing levels when a resident's needs changed and the provider was waiting for additional funding to

become available.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Appropriate and effective training was not available to staff. For example:

- Some staff demonstrated a poor understanding in relation to recognising and responding to abuse. Inspectors were not assured that some of the staff they spoke with had a clear understanding of what constituted abuse of vulnerable older persons.
- Staff who were responsible for providing activities for residents on the second day of the centre did not have the required knowledge and skills to ensure that activities scheduled for the day were delivered in a manner that provided residents with appropriate levels of stimulation and socialisation in line with their preferences and capacity.

The staff supervision processes that were in place did not ensure that those staff working with residents in the centre, but who were employed by external agencies, were appropriately supervised.

Judgment: Not compliant

Regulation 21: Records

Four out of the five staff files, which were reviewed by inspectors did not have a clear rationale to explain the gaps in the staff member's employment history as required by the regulations.

Judgment: Substantially compliant

Regulation 23: Governance and management

The following management and oversight systems required improvement;

- The oversight of the selection and recruitment procedures was not robust and did not ensure that the staff recruited had the required levels of communication skills to ensure that they were able to communicate effectively with the residents and that any concerns or complaints raised by residents were heard and addressed promptly.

- The oversight of Schedule 2 records did not ensure that staff records contained all of the required information as required under Regulation 21.
- The oversight of admission processes was not robust and did not ensure that there was a good client/ home fit and that the designated centre could meet the ongoing needs of the residents, especially those residents with complex needs and those residents under 65 years of age prior to their admission to the centre.
- The oversight of safeguarding incidents required improvement as it had not ensured that all safeguarding concerns and potential safeguarding incidents were reported promptly and recorded and that these were followed up in line with the centre's own policies and procedures.

Judgment: Not compliant

Regulation 31: Notification of incidents

Notifiable incidents were notified to the office of the Chief Inspector in line with the required time frames.

Judgment: Compliant

Quality and safety

Overall, the care provided to the residents in the centre was of good quality, with the exception of the provision of meaningful activities and one-to-one care for some residents. However, the changes the provider intended to take to improve key areas such as admissions, care planning and safeguarding were not fully implemented at the time of this inspection and more focus and effort was required to ensure these improvements were in place to ensure the quality and safety of care for the residents.

Inspectors reviewed the care files of several residents and found that some care plans were not sufficiently developed to facilitate the safe delivery of high-quality health and social care.

Residents were generally well supported to have access to general practitioners (GPs) from local practises, health and social care professionals, and specialist medical and nursing services.

The provider kept a restraint register, and a restraint log was maintained in this centre when restraints, such as bed rails, were being used for residents.

The centre had a number of residents with higher levels of cognitive needs. The

provider had secured funding to provide enhanced care support for three residents, and this had been provided through a shared agency arrangement. The provider had identified the need for this level of enhanced support for another resident and was in the process of applying for additional funding for an existing resident whose behaviours were escalating.

On the second day of the inspection, the responsive behaviours displayed by one resident interrupted a quiet rosary session, which was being enjoyed by a number of residents in the main communal area. Although staff were in the room, they did not manage the responsive behaviours in a timely manner to reduce the impact on the other residents in the communal room.

The centre had a safeguarding policy in place, and this had been recently reviewed as part of the provider assurance report submitted to the Chief Inspector following the receipt of information of concern. The provider's review of their own safeguarding processes had initiated a comprehensive quality improvement plan, which included a review of staff training in recognising and reporting potential and actual safeguarding allegations and incidents and the management of these. The person in charge was undergoing additional training in the role of designated officer with responsibility for the management of safeguarding processes in the centre. In addition to changes to safeguarding processes in the centre, the provider had recognised the need for a review of their admission procedures and the management of responsive behaviours, particularly the impacts of escalating behaviours on the other residents.

Several residents' bedrooms were personalised with personal items of significance, such as books, art collections, and glassware, and additional storage facilities were provided for some residents. However, not all residents had this additional storage space to store their personal belongings. This is further discussed under Regulation 12: Personal Possessions.

Residents' meetings were held regularly in the centre, and the records of meetings indicated that the residents were consulted with and participated in the organisation of the centre.

Regulation 12: Personal possessions

Inspectors noted that the residents' personal storage space was insufficient in some bedrooms. For example, some residents did not have additional storage space for storing their personal items of significance, such as photo albums, and these residents had to use the window sill to display their personal items.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

The provider had not ensured that an appropriate care plan was developed for residents following their admission to the designated centre. For example, although a resident's preference for a shower had been assessed at the time of their admission to the centre, an appropriate care plan had not been developed to guide staff to support this resident's care needs. In addition, the care records of this resident indicated that they did not receive a shower in line with their preference.

An appropriate system of reviewing residents' care plans was not in place in the centre to support the residents in meeting their care needs. For example, the inspectors reviewed one resident's mobility care plans and found that their care plans had not been sufficiently reviewed to ensure residents received the necessary support required to regain their mobility.

Judgment: Substantially compliant

Regulation 6: Health care

The inspectors noticed on the day of inspection that the residents have access to general practitioners (GPs) from local practices, allied health professionals and specialist medical and nursing services.

Judgment: Compliant

Regulation 8: Protection

The inspectors reviewed nine incidents of safeguarding concerns and incidents that had occurred in the designated centre since May 2023. Out of the nine incidents, five of those incidents had not been managed in line with the National Policy and Procedures for Safeguarding Vulnerable Persons at Risk of Abuse 2014. For example;

- Two potential safeguarding concerns relating to one resident had not been appropriately reported and followed up on by staff. One concern related to unexplained bruising was not followed up appropriately when identified by staff and an omission of care, where the resident had not received a shower during their stay in the designated centre had not been identified and reported as a potential safeguarding concern in line with the provider's own safeguarding procedures.
- One incident of peer-to-peer aggression resulting in injury to a resident had not been identified and reported as a potential safeguarding incident in a

timely manner.

- An appropriate safeguarding care plan had not been developed for one resident who had reported an allegation of abuse, which had been subsequently investigated and found to have occurred. As a result, the resident told the inspectors that they still did not feel safe in the designated centre.
- The inspectors observed one incident on the afternoon of the second day of the inspection, during which staff did not take prompt action to distract a resident who was shouting and using inappropriate language. Some of the residents in the same area became upset, and others started to call back, which escalated the behaviours. Furthermore, the use of inappropriate language towards other residents by a resident was not recognised as a potential safeguarding incident and managed as such.

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 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 12: Personal possessions	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Larissa Lodge Nursing Home OSV-0005791

Inspection ID: MON-0040565

Date of inspection: 28/06/2023

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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: 1. On the day of inspection there was one housekeeper on duty, instead of two due to a family emergency. The centre was midway through the recruitment process of three new housekeeping staff on the day of inspection with one awaiting induction and two awaiting Garda Vetting. The Centre continues to recruit and roster staff in line with the Centre's Statement of Purpose.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: 1. 100% of staff have completed IPC training. For successful completion of the IPC training, staff must also complete a post course assessment, which they have done, and all have achieved a 'pass' grade and certificate of completion. Some staff may choose to wear surgical masks (this is in line with Public Health & Infection Prevention & Control Guidelines on Prevention and Management of Cases and Outbreaks of COVID-19, Influenza & other Respiratory Infections in Residential Care Facilities V1.12 17.07.2023). The management of the Centre respect the preference of staff in line with the guidelines, whilst continuing to advise staff of the benefits and risks associated with not wearing masks. All staff had been provided with updates regarding the use of masks when the national guidelines changed. Staff continue to have regular updates on the use of PPE/IPC practices on the daily mid-day handovers. The Person in Charge has completed a risk assessment and has put additional control measures in place to support best practices, these include regular audits on donning and doffing of masks for staff who chose to wear them, communication cards and updated information for staff on	

enhancing communication with residents to be made available; and the wearing of masks to be discussed at the residents' forum.

2. 100% of staff have completed mandatory safeguarding training via both our online training platform and the HIQA/HSE Land prior to the inspection. Additional interactive workshops were provided to staff on 21/06/2023, 19/07/2023 and 24/08/2023 and 88% of staff completed this workshop.

3. Since the inspection the Centre has recruited 2 Activities Co-Ordinator's, and we continue to seek suitable candidates for this position.

4. Nursing staff were briefed regarding their response to a HIQA Inspector calling so that all nursing staff are aware of the procedures. Nursing staff are now aware of their collective responsibility for overall management of the center and each nurse being individually responsible for their allocated wing.

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
1. All staff records will have any gaps in employment satisfactorily explained and documented.
2. Staff file audits are carried out in the centre to identify compliance with the regulations. The most recent audit was conducted on 30/08/2023.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
1. On the day of inspection, the roster shows the CNM covered Sat or Sun every week. The CNM continues to do this.

2. All nurses are trained on admission and discharges through induction. There is a named nurse and carer system and they are responsible for their designated residents. Admission and discharge is guided by our policy and all residents were and will be safely discharged.

3. The Centre's Complaints Policy section 16.1 indicates that trends, themes etc shall be reviewed quarterly and on the day of inspection the centre was still within the timeframe

for completion of the quarterly review. Complaints continue to be reported on the weekly PIC (Person in Charge) report, these are monitored by the RPR, GGGM (Group General Manager) and QQAL (Quality and Assurance Lead) complaints are available on the complaints system for management to view and are discussed at monthly governance meetings.

4. Procedures have been put in place where possible, two staff completing interviews will ensure that potential candidates have the required communication skills to communicate with residents and this will be specifically scored as part of the recruitment process.

5. Staff records were reviewed and will address gaps in employment in line with Regulation 21.

6. The admission process including the pre-admission assessment has been reviewed and updated to ensure that the pre-admission process is robust, and there is assurance that the Centre can meet the needs of potential residents with more complex needs. A meeting with the relevant parties (to include resident, representative, MDT etc, as appropropritate) will be arranged as a part of the pre-admission process. Where it is detemined that the potential resident has a requirement for additional services, supports and resources outside of what the centre provides, these residents will only be admitted when there is a robust/ agreed plan/services available to meet their needs. Where the centre determines that they cannot meet the needs of any potential resident, they will not be admitted, and this will be communicated to the resident and family members. In addition, prior to the admission of residents of with more complex care needs a meeting will be held with RPR, GGM (Group General Manager), QAL (Quality and Assurance Lead) and PIC to determine the appropriateness of the admission. Where needs are identified for additional tranining to support new residents and staff, this will be arranged prior to the admission to the centre. The admission policy will be reviewed to ensure that the admission process for more complex cases, as outlined above, is reflected in the policy.

7. All safeguarding concerns are treated with utmost urgency with all relevant stakeholders informed as soon as possible – An Garda Siochana, HSE safeguarding team, HIQA, and independent advocacy services, GP and resident representatives. All safeguarding issues have and will continue to be managed in line with the Centre's revised safeguarding policy which is in line with national policy to ensure that residents are kept safe from abuse.

Regulation 12: Personal possessions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
1. Additional storage spaces will be provided for those residents should they require.

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:
1. The care plans identified during the inspection have been updated where appropriate (one resident was discharged prior to the inspection). The care plan auditing/ review system has been enhanced and the ADON/ CNM are now carrying out a complete review of a care plan (to include comprehensive risk assessment and plan of care) identifying where improvements are required and working on a one-to-one basis with nursing staff to update review and amend the care plan as required. Moving forward, the ADON will have oversight of one unit in terms of monitoring care plans and CNM will have oversight of the second unit. Their progress, findings etc will be presented to the PIC at the Senior Nurse monthly meetings.

2. All residents now have a meaningful activity care plan.

3. All residents now have an activity care plan in place. The PIC will ensure that an activity resident survey completed. There is a newly appointed activity coordinator who with the PIC, will be reviewing all activity care plans and key-to-me and the survey results which will inform the activity program going forward. The care plans will also be reviewed and updated in this period.

4. The Centre continues to carry out care plan audits, admission audits one-to-one care plan corrections are provided for every new initiated care plan after reviewing the care plans. All residents who wish to engage with regards to their care plan have a care plan meeting are completed. This is an ongoing process.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
1. The Safeguarding Policy is in line with national policy; however, it will be reviewed to ensure that it clearly outlines the requirements for managing and responding to unexplained bruising.

2. The safeguarding care plan identified by the inspector has been reviewed and updated.

3. The safeguarding allegation raised by the inspector during the inspection was fully investigated within timeframes in line with centre's own policy which is in line with

national policy. Following a preliminary screening, it was agreed by all parties (Resident, family, HSE safeguarding team, and nursing home management) that there was no cause of concern.

4. Inspectors verbalised that the staff had knowledge of safeguarding but communication issues were noted. The inspector indicated that the training the staff had completed in the weeks prior to the insepction had given them even more knowledge and confidence than the programmes already completed and this was noted by all three inspectors. Since the inspection staff have completed an additional safeguarding workshop delivered by the HSE safeguarding team.

5. All nurses are trained on admission and discharges through induction. All residents have a named nurse and a named HCA. There is no separate allocation of nursing staff for admissions and discharges. This practice was in place on the day of inspection and continues.

6. All staff have completed safeguarding training and as outlined above additional safeguarding workshops on 21/06/2023, 19/07/2023 and 24/08/2023. Staff have been trained to monitor residents' behaviours and where there is a concern that a resident's responsive behaviour may negatively impact on others, then they should follow the interventions/measures as outlined in the residents' care plan which supports staff to respond appropriately to responsive behaviours.

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 12(c)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that he or she has adequate space to store and maintain his or her clothes and other personal possessions.	Substantially Compliant	Yellow	30/10/2023
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Substantially Compliant	Yellow	30/07/2023

Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	10/11/2023
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	30/06/2023
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Substantially Compliant	Yellow	30/09/2023
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	30/11/2023
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Substantially Compliant	Yellow	31/01/2024
Regulation 5(4)	The person in charge shall	Substantially Compliant	Yellow	30/08/2023

	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.			
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Orange	24/10/2023
Regulation 8(3)	The person in charge shall investigate any incident or allegation of abuse.	Not Compliant	Orange	30/11/2023