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:	St Conlon's Community Nursing Unit
Name of provider:	Health Service Executive
Address of centre:	Church Road, Nenagh, Tipperary
Type of inspection:	Short Notice Announced
Date of inspection:	30 January 2024
Centre ID:	OSV-0000666
Fieldwork ID:	MON-0033874

About the designated centre

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

St. Conlon's Community Nursing Unit is a designated centre operated by the Health Service Executive (HSE). It is located centrally in the town of Nenagh in north Tipperary. The centre is single storey and is designed around an enclosed central garden area. The centre can accommodate up to 25 residents. The service provides 24-hour nursing care to both male and female residents. Long-term care, respite and palliative care is provided, mainly to older adults. Bedroom accommodation is provided in 15 single bedrooms and five twin bedrooms. Two of the single bedrooms and the twin rooms have en suite shower facilities. There are two assisted showers, a specialised bath and six toilets for residents occupying 13 single bedrooms. There is a variety of communal day spaces provided including day rooms, dining room, conservatory and quiet room.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	24

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 30 January 2024	08:50hrs to 17:40hrs	Mary Veale	Lead

What residents told us and what inspectors observed

This was an announced inspection which took place over one day. Based on the observation of the inspector, and discussions with residents and staff, St Conlon's Community Nursing unit was a nice place to live. There was a welcoming, calm and homely atmosphere in the centre. The inspector spoke with five residents living in the centre and two visitors. Residents' rights and dignity were supported and promoted by kind and competent staff. Residents appeared to enjoy a good quality of life and had many opportunities for social engagement and meaningful activities.

On arrival the inspector was met by the person in charge and signed the visitors log book. Following an introductory meeting with the person in charge to outline the format of the inspection, the inspector reviewed some of the documents that had been requested prior to the inspection. The inspector then walked the premises. The inspector greeted, spoke with, and observed residents' in communal areas and in their bedrooms.

The centre comprised of a single-storey building with 15 single bedrooms and five twin rooms. 2 single rooms were spacious and had en-suite bathrooms with a wash hand basin, toilet and shower. 11 single rooms were small and had a wash hand basin. These single rooms could not accommodate manual handling equipment such as hoists. Residents in these 11 single rooms did not have access to a bedside locker beside their bed due to the size of the rooms which has been highlighted in a number of previous inspection reports. This is discussed further in this report under Regulation 9: resident's rights. Twin rooms had ceiling hoists and an en-suite bathroom with a wash hand basin, toilet and shower. Residents' bedrooms were clean, tidy and had space for personal storage. Lockable locker storage space was available for all residents. Many bedrooms were personal to these resident's containing family photograph and personal belongings. Pressure reliving specialist mattresses, cushions and fall-prevention equipment were seen in some of the residents' bedrooms. Residents living in the 11 small single rooms had access to two shower rooms. The bath in the centre was out of use, it had been out of service for many years, and was decommissioned as parts were no longer available to repair it. This is discussed further in this report under capacity and capability. Communal spaces were spacious and comfortable. The sitting room had a fireplace, armchairs, bookshelves, and a large television. Residents had access to a dining room, a small sitting room, conservatory and relaxation room. The entrance foyer had a rest area with comfortable sitting and a piano.

Residents had access to an enclosed courtyard yard which contained the centres designated smoking area. The courtyard had level paving, comfortable seating, mature shrubs and a pergola. The garden was well maintained and residents were observed mobilising in the garden during the day. In addition, three exits were available into the enclosed garden and these were all unlocked and easily accessible.

The centre provided a laundry service for residents. All residents whom the inspector spoke with on the day of inspection were happy with the laundry service and there were no reports of items of clothing missing.

Residents were very complimentary of the home cooked food and the dining experience in the centre. Residents' stated that the quality of food was very good. Menus were displayed in the dining room. A water dispenser and bottles of cordial were available for residents in the sitting room and dining room. The inspector observed the dining experience at dinner time. There was a choice of main meal and desert on the day. The dinner time meal was appetising and well present and the residents were not rushed. The dinner time experience was a social occasion where residents were seen to engage in conversations and enjoying each others company. Staff were observed to be respectful and discreetly assisted the residents during the meal time. A small number of residents had meals in their room by choice. It was evident that staff were familiar with residents likes and dislikes at mealtimes.

The registered provider did not have a staff member dedicated to activities but a multi-task attendant was assigned to activities daily. Residents were observed taking part in a quiz, bingo and attending Mass in the sitting room on the day of inspection. Residents' spoken with said they were very happy with the activities programme provided and told the inspector that the activities suited their social needs. The daily activities programme was displayed on the corridor near reception and in the sitting room. The inspector observed staff and residents having good humoured banter throughout the day and observed staff chatting with residents about their personal interests and family members. The inspector observed many residents walking with their visitors around the corridor areas of the centre. The inspector observed residents reading newspapers, watching television, listening to the radio, and engaging in conversation. Books, games and magazines were available to residents. Residents confirmed that they had access to Internet services in the centre. Visits and outings were encouraged and practical precautions were in place to manage any associated risks.

Residents' views and opinions were sought through resident meetings and satisfaction surveys. Residents told the inspector that they could approach any member of staff if they had any issue or problem to be solved. Residents stated that the person in charge and all of the staff were very good at communicating changes, particularly relating to their medical and social care needs.

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

Capacity and capability

This was an announced inspection to monitor the provider's compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older

People) Regulations 2013 (as amended) and to follow up on the findings of the previous inspection of March 2023. Improvements were found in Regulation 6: healthcare and Regulation 21: records. On this inspection, the inspector found that actions were required by the registered provider to address Regulation 16: training and staff development and Regulation 23: governance and management. Areas of Regulation 4: written policies and procedures, Regulation 5: Individual assessment and care planning, Regulation 9: residents rights, Regulation 21: records, Regulation 17: premises, Regulation 27: infection prevention and control, Regulation 28: fire precautions and Regulation 34: complaints procedure required improvement.

The registered provider had applied to renew the registration of St Conlon's Community Nursing unit. The application was timely made, appropriate fees were paid and prescribed documentation was submitted to support the application to renew registration. As part of this renewal of registration the provider had included the change of a bathroom to a store room in the footprint of the designated centre. The person in charge had informed the inspector that the bath had not been used in a number of years as it was out of service due to parts no longer being available to repair it. The bath was decommissioned in November 2023. The provider had met and consulted with the residents in regard to the decommissioning of the bath and the use of the room. There are sufficient showers in this centre to meet the needs of the residents.

The registered provider is the Health Service Executive (HSE). The centre is registered for 25 beds providing long term care, respite and palliative care. There was a clearly defined management structure with identified lines of accountability and responsibility for the service. The person in charge reported to the general manager who was the registered provider representative. The person in charge was supported in the centre by a clinical nurse manager (CNM), nurses, care staff, administration and maintenance staff.

There were sufficient staff on duty to meet the needs of residents living in the centre on the day of inspection. The centre had a well-established staff team who were supported to perform their respective roles and were knowledgeable of the needs of older persons in their care and respectful of their wishes and preferences.

Improvements were required in the oversight of training needs in the centre. Staff had access to education and training appropriate to their role. The inspector noted that fire safety training and a positive behaviour support workshop were scheduled to take place in the weeks following the inspection. There were, however, gaps identified in staff training matrix. This is discussed further under Regulation 16: training and staff development. Staff with whom the inspector spoke with, were knowledgeable regarding fire evacuation procedures and safe guarding procedures.

Management systems in place to monitor the centre's quality and safety required review. Improvements were found in the centres audit schedule. The provider had introduced an electronic audit system. The clinical nurse manager had responsibility for the system and told the inspector that there was a plan for nursing staff to undertake audits of care in 2024. A falls audit was completed in July 2023 and there was a record of a report of all incidents for each quarter from the HSE quality and

safety department. Since the previous inspection there were records of restrictive practice audits undertaken quarterly in 2023, a care planning audit in January 2024, a record of a medication management audit in January 2024, and an annual medication audit in 2023. There was a comprehensive schedule of infection prevention control audits. There was evidence of governance meetings every month. There were records for one local staff meeting taking place in January 2024. The inspector was informed that staff meetings and safety pause meetings were informal and took place at handover most days. There were no records of these informal meetings. There was a comprehensive annual review of the quality and safety of care delivered to residents completed for 2023. The review was undertaken against the National Standards. It set out an improvement plan with time lines to ensure actions would be completed. Improvement were required in the oversight of audit tools, documenting of local meetings, staff appraisals, and repeating findings from inspections carried out in March 2023 and May 2022. This is discussed further under Regulation 23: governance and management.

Overall electronic and paper based records were well maintained. Requested records were available to the inspector on arrival on the day of inspection and records were appropriately maintained, safe and accessible. However; improvements were required in the centre's staff personnel files and this is discussed further under Regulation 21: records.

The centre recorded its incidents and accidents on a paper incident management form. The inspector viewed the centres incident folder for 2023. There were two incident forms available to review in the folder on the day of inspection. Incidents and reports as set out in schedule 4 of the regulations were notified to the Chief Inspector of Social Services within the required time frames. The inspector followed up on incidents that were notified and found these were managed in accordance with the centre's policies.

There was a complaints management policy within the centre and a complaints procedure displayed near the dining room and reception area. The complaints log for 2023 was reviewed. The inspector observed complaints had been assessed and managed promptly. Residents said they were aware they could raise a complaint with any member of staff or the person in charge. Actions were required to align the complaints procedure with SI 628 of 2022 - Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) (Amendment) Regulations, and this will be addressed under Regulation 34 of this report.

Registration Regulation 4: Application for registration or renewal of registration

All documents requested for renewal of registration were submitted in a timely manner.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge worked full time in the centre and displayed a good knowledge of the residents' needs and had a good oversight of the service. The person in charge was well known to residents and their families.

Judgment: Compliant

Regulation 15: Staffing

Staffing was found to be sufficient to meet the needs of the residents on the day of the inspection. The registered provider ensured that the number and skill-mix of staff was appropriate, to meet the needs of the residents. There were two registered nurses in the centre from 8:00 to 23:00 and one registered nurse in the centre from 23:00 to 08:00.

Judgment: Compliant

Regulation 16: Training and staff development

Gaps were identified in training and staff development. For example:

- Four staff required training in safeguarding.
- 24 staff had not completed training in managing behaviour that is challenging.
- Fire training was out of date for 23 staff since the 23/1/2024, this was not in line with the centres mandatory training requirements.

Judgment: Not compliant

Regulation 21: Records

Improvements were required in staff records. In a sample of four staff files viewed, one of the files did not have a satisfactory history of gaps in employment in line with schedule 2 requirements.

Judgment: Substantially compliant

Regulation 22: Insurance

The registered provider had insurance in place which covered injury to residents.

Judgment: Compliant

Regulation 23: Governance and management

Management systems required improvement to ensure that the service provided was safe, appropriate and effectively monitored. For example;

- Systems of communication were not sufficiently robust. There were no minutes of informal local meetings. There was no record of discussions of fire safety, audits reviews or action plans to ensure cascading of the governance structure to drive quality improvement .
- The centres audit tools required review. For example; the nursing documentation audit tool was not aligned to the nursing documentation system in use in the centre. This did not provide an accurate measurement of the evidence based nursing documentation in use in the centre to ensure improvements were identified in the residents assessments and care planning.
- The provider was not adhering to the re-writing of care plans as outlined in the evidence based minimum data set documentation tools for use in residential care settings.
- There was no record of staff appraisal completed in the centre. This was a missed opportunity as a staff appraisal could provide feedback to the employee on their performance, identify any areas of improvement, and ensure that the service provided is sufficiently resources to ensure the effective delivery of care.
- Improvements were required in the oversight of the centres cleaning schedule records and fire safety checks, this is discussed under Regulation 27: infection prevention and control , and Regulation 28: fire precautions.

Actions outlined in the compliance's plans from previous inspections in May 2022 and March 2023 remained. For example;

- Privacy curtains were found not to enclose fully in one of the residents bed spaces in all five twin bedrooms.
- Personnel files of staff continued to have employment history gaps.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

Residents had a written contract and statement of terms and conditions agreed with the registered provider of the centre. These clearly outlined the room the resident occupied and additional charges, if any.

Judgment: Compliant

Regulation 3: Statement of purpose

Amendments were made to the centre's statement of purpose during the inspection. The statement now contained all of the information set out in schedule 1 of the regulations and in accordance with the guidance.

Judgment: Compliant

Regulation 30: Volunteers

The provider informed the inspector that there were no volunteer's attended the centre at the time of inspection.

Judgment: Compliant

Regulation 31: Notification of incidents

Incidents and reports as set out in schedule 4 of the regulations were notified to the office of the Chief Inspector within the required time frames. The inspectors followed up on incidents that were notified and found these were managed in accordance with the centre's policies.

Judgment: Compliant

Regulation 34: Complaints procedure

The centres complaints policy and procedure required revision to meet amendments to the regulations that had come into effect in March 2023 (S.I. 298 of 2022). For example:

- The complaints procedure and policy did not include the nominated review officer.
- The complaints procedure and policy did not include information of an independent advocacy service who could assist the complainant with the making of a complaint.
- Not all staff involved in the complaints procedure had completed suitable training to deal with complaints.
- Complaints viewed by the inspector did not record if the complainants were satisfied with the outcome.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

Policies outlined below required review:

- The policy for the provision of information of residents was out of date.
- On the day of inspection the policy for health and safety, including food safety, of residents, staff and visitors was not available.

Judgment: Substantially compliant

Quality and safety

Overall, the inspector was assured that residents living in the centre enjoyed a good quality of life. The findings of this inspection evidenced that the management and staff had made improvements to the quality of life for the residents living in St Conlon's Community Nursing unit since the previous inspection. On this inspection improvements were required to comply with areas of residents rights, individual assessment and care planning, premises, infection prevention and control and fire safety.

Improvements were found in healthcare on this inspection. The inspector was informed that the residents had access to a dietitian, physiotherapist, speech and language therapist, and pharmacy services. Residents were supported to access appropriate health care services in accordance with their assessed need and preference. General Practitioners (GP's) attended the centre and residents had regular medical reviews. Residents had access to a consultant geriatrician and a psychiatric team, nurse specialists and palliative home care services. Residents had

access to a mobile x-ray service in the home. Residents had access to local dental and optician services. Residents who were eligible for national screening programmes were also supported and encouraged to access these.

The centre had arrangements in place to protect residents from abuse. There was a site-specific policy on the protection of the resident from abuse. Safeguarding training had been provided to staff in the centre and staff were familiar with the types and signs of abuse and with the procedures for reporting concerns. All staff spoken with would have no hesitation in reporting any concern regarding residents' safety or welfare to the centre's management team. The centre had procedures in place to ensure staff were Garda vetted prior to employment.

There was a good standard of care planning in the centre. In a sample of six 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 and had been updated to reflect changes required in relation to incidents of falls, infections and end of life care. However, further improvements were required to the residents care plans which is discussed under Regulation 5: individual assessment and care planning.

A choice of home cooked meals and snacks were offered to all residents. A daily menu was displayed and available for residents' in the reception area and dining room. Menus were varied and had been reviewed by a dietician for nutritional content to ensure suitability. Residents on modified diets received the correct consistency meals and drinks, and were supervised and assisted where required to ensure their safety and nutritional needs were met. Meal times varied according to the needs and preferences of the residents. The dining experience was relaxed. There were adequate staff to provide assistance and ensure a pleasant experience for resident at meal times. Residents' weights were routinely monitored.

Improvements were found in fire safety since the previous inspection. A service record was available and up to date for fire extinguishers and a fire drill had been completed stimulating night time staffing levels in the largest compartment. All bedrooms and compartments had automated door closures. All fire doors were checked over the day of inspection were found to the close properly to form a seal to contain smoke and fire. Fire training was completed by staff in 2023. The centre had an L1 fire alarm system. Each resident had a personal emergency evacuation plan (PEEP) in place which were updated regularly. The PEEP's identified the different evacuation methods applicable to individual residents. Fire safety equipment service records were up to date. Fire evacuation ski-sheets were observed on all beds in the centre. There were fire evacuation maps displayed throughout the centre, in each compartment. Staff spoken with were familiar with the centres evacuation procedure. There was evidence that fire drills took place in April, June and November 2023. Fire drills records included stimulated evacuation with night time staffing levels. Fire drill records contained details of the number of residents evacuated and how long the evacuation took. There was a designated smoking area available for residents in the internal courtyard. On the day of inspection there was one resident who smoked and a detailed smoking risk assessment was available for this resident. A call bell, fire blanket, fire extinguisher

and fire retardant ash tray were in place in the centre's smoking area. However; fire safety procedures required improvement, this is discussed further in the report under Regulation 28: fire precautions.

The centre was generally clean, tidy and found to be mostly well maintained. Communal spaces and bedrooms were bright and comfortable. Alcohol gel was available, and observed in convenient locations throughout the building. Dani-centres were available on all corridors to store personal protective equipment (PPE). Staff were observed to have good hygiene practices. Sufficient housekeeping resources were in place. Housekeeping staff were knowledgeable of correct cleaning and infection control procedures. Intensive cleaning schedules had been incorporated into the regular cleaning programme in the centre. The centre had three infection prevention control (IPC) link nurses. The link nurses had received training in IPC. There was evidence of an IPC meeting taking place in September 2023. Agenda items included training, quality improvements plans for surveillance and hand hygiene training and actions required from specific IPC audits, for example; hand hygiene and environmental audits. There were records of a hand hygiene, equipment, sharps, antimicrobial and and environmental audits. Improvements were required to the premises and infection prevention and control which is discussed further in this report under Regulations 17 and Regulation 27.

The centre acted as a pension agent for six residents. There were robust accounting arrangements in place and monthly statements were furnished. Residents had access to and control over their monies. Residents who were unable to manage their finances were assisted by a care representative or family member. All transactions were accounted for and double signed by the resident/representative and a staff member. There was sufficient storage in bedrooms for residents' personal clothing and belongings. Laundry was provided in the centre and some residents chose to have their clothing laundered at home.

There was a rights based approach to care in this centre. Residents' rights were respected. 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 SAGE advocacy services and an independent advocate. The advocacy service details were displayed on a notice board on the corridor near the sitting room. Residents has access to daily national newspapers, weekly local newspapers, Internet services, books, televisions, and radio's. Mass took place in the centre weekly. Residents had completed a satisfaction survey from the Office of the Chief Inspector prior to this announced inspections to allow residents to provide feedback on what it is like to live in a designated centre. Satisfaction surveys showed high rates of satisfaction with most aspects of the service. A small number of residents expressed their dissatisfaction with the size of their bedrooms as their bedrooms were too small and had no en-suite facilities. Improvements were required in relation to the residents right to choices which is discussed further under Regulation 9: Resident rights.

Regulation 10: Communication difficulties

From a review of residents records it was evident that residents who had specialist communication requirements had these recorded in their care plan.

Judgment: Compliant

Regulation 12: Personal possessions

Residents had adequate space in their bedrooms to store their clothes and display their possessions. Residents clothes were laundered in the centre and the residents had access and control over their personal possessions and finances.

Judgment: Compliant

Regulation 13: End of life

The inspector was 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 which 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 required repair and painting to ensure it could be effectively cleaned. For example; Medium density fibreboard (MDF) behind a number of toilets in the centre was damaged, requiring repair or replacement to ensure toilet areas could be effectively cleaned.
- The linen store room adjacent to room 17 required review as it was cluttered with personal protective equipment (PPE). This posed a safety risk to staff working and residents living in the centre.

Judgment: Substantially compliant

Regulation 27: Infection control

Action were required to ensure the environment was as safe as possible for residents and staff. For example;

- Three staff had not completed standard precautions training.
- Hand hygiene training was out of date for four staff.
- The centre did not have a local infection prevention and control policies based on best practice.
- A review of the centres bathroom radiators and pipes was required as some contained rust. This posed a risk of cross contamination as staff could not effectively clean the rusted part of the radiators.
- A review of the centres shower chairs was required as one shower was visible dirty and one shower chair contained rust on the stainless steel areas.
- There were gaps in the daily cleaning schedule records viewed by the inspector. This posed a risk of cross contamination as daily cleaning was not documented as completed for a number of days during the month of January 2024.

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 oversight of the system for daily checking, of means of escape, fire safety equipment, and fire doors required review as there were gaps in the records.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

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:

- Four of six nursing notes viewed did not all have documented evidence in their care plans to support if the resident or their care representative were involved in the review of their care in line with the regulations.

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 9: Residents' rights

Residents' right to privacy and dignity was not upheld by the registered provider. For example;

- The privacy curtains in the bed space nearest the door in all five twin rooms did not fully enclose the surround of whole bed space. The residents sharing the rooms who's bed space was by the window had to pass this bed space to access their bed space which impacted on the privacy of the other residents.
- Residents in bedrooms 3, 5, 9,10, 21, 22, 23, 24, 25, 26 and 29 could not assess their bedside locker while in bed. This impacted the residents access to drinks and personal items while in bed.

Judgment: Substantially compliant

Regulation 8: Protection

Measures were in place to protect residents from abuse including an up to date policy. Staff were aware of the signs of abuse and of the procedures for reporting concerns.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 4: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 30: Volunteers	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 13: End of life	Compliant
Regulation 17: Premises	Substantially 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 9: Residents' rights	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for St Conlon's Community Nursing Unit OSV-0000666

Inspection ID: MON-0033874

Date of inspection: 30/01/2024

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 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Actions completed : • Staff have completed safeguarding training (29.02.24) and training matrix has been updated to reflect this. • All staff have completed Safety intervention training. • Twelve staff have completed Positive Behavior Support training • Fire training: 25 staff completed fire training on 14th February 2024 and 22nd February 2024. Actions to be completed : • Positive Behaviour training is scheduled for 6th June 2024, remaining staff to attend. • Fire training: All staff will be up to date by 5th March 2024.	
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: Actions Completed : • Employment history gaps in viewed file has been rectified (29/02/24) Action to be completed : • All staff files will be reviewed by 15th March 2024 to ensure all relevant information is up to date and available.	

Regulation 23: Governance and management	Not Compliant

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

Actions Completed :

• Monthly staff meetings have commenced since January 2024. These meetings are minuted.
• Fire safety, audit reviews and action plans are standing agenda items going forward at these meetings (completed 15/02/2023).
• Cleaning records and fire safety checks are completed on a daily basis.
• The privacy curtains have been replaced, the new curtains fully enclose the resident's bedspace and this is monitored daily.
• Staff files with gaps in their employment history have been rectified

Actions to be completed :

• The audit tool is currently being reviewed and will be amended to provide an accurate measurement of the evidence based nursing documentation in use in the centre. Date to be completed 08/04/2024.
• Staff are in the process of rewriting care plans as per the documentation tools in use (every 6 months). Date to be completed 29/03/2024.
• HR Department will be delivering Performance Achievement training in April 2024, exact dates to be confirmed. Following this, the roll out of performance achievement for all staff will be completed throughout 2024
• All staff files will be reviewed by 15th March 2024 to ensure all relevant information is up to date and available.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:

Actions Completed :

• The complaints procedure and policy has been updated to include the nominated review officer. Date completed: 29/02/24
• The complaints procedure and policy has been updated to include information of an independent advocacy service who could assist the complainant with the making of a complaint. Date completed: 29/02/24

• Future complaints will include whether or not the complainant was satisfied/not satisfied with the outcome and any follow up action(s) will be progressed if required.

Actions to be completed :
• Training will be provided for staff involved in the complaints procedure to ensure they are suitably trained to deal with complaints. Date to be completed 19/04/2024.

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
Actions Completed :
• The policy for the provision of information to residents has been updated (29/02/24).
• The policy for health and safety, including food safety, for residents, staff and visitors is now available.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Actions Completed :
• Work has commenced to declutter the linen store room adjacent to room 17 and will be complete by 1/3/24

Actions to be completed :
• Maintenance work to commence in the centre on 19/03/24 to address the parts of the centre that require repair including MDF repair and painting.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
Actions completed :
• All staff had completed standard precautions training in November 2023, the training

matrix has now been updated to reflect this (29/02/24).
• Review of the shower chairs completed on 29/02/24. The shower chair that contained rust on the stainless steel areas has been removed and the other shower chair has been de-contaminated (29/02/24).
• Daily cleaning schedule records are maintained and monitored to ensure that there are no gaps.

Actions to be completed :
• The four staff requiring hand hygiene training are currently on long term sick leave, once they return to work their training will be prioritised.
• Local infection prevention and control policies based on best practice are currently being devised by the Director of Nursing and Clinical Nurse Manager and will be complete by 29/03/24.
• Maintenance work will commence on 19/03/24 to repair/replace damaged bathroom radiators and pipes.
• Two new shower chairs will be ordered by 08/03/24

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Actions Completed :
• The daily checking of means of escape, fire safety equipment and fire doors has been reviewed. The Clinical Nurse Manager / Nurse in charge will ensure that these checks are performed on a daily basis.

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:
Actions to be completed :
• Care plans will be reviewed to ensure that there is documented evidence in the residents care plans to support if the resident or their care representative were involved in the review of their care in line with regulations. Date to be completed 29/03/2024

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Actions Completed :
• Residents who are unable to access their bedside locker while in bed have their personal items and drinks placed on their bedside table for ease of access.
• The privacy curtains have been replaced, the new curtains fully enclose the resident's bed space and this is monitored daily.

Actions to be completed :
• Maintenance to review the curtain rails in the five twin rooms to ensure that both Residents have privacy at all time. Date to be completed 19/03/2024

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 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	06/06/2024
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	29/03/2024
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Substantially Compliant	Yellow	15/02/2024
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined	Not Compliant	Orange	04/03/2024

	management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.			
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	04/03/2024
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	29/03/2024
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	26/02/2024
Regulation 34(2)(d)	The registered provider shall ensure that the complaints procedure provides for the nomination	Substantially Compliant	Yellow	26/02/2024

	of a review officer to review, at the request of a complainant, the decision referred to at paragraph (c).			
Regulation 34(6)(a)	The registered provider shall ensure that all complaints 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.	Substantially Compliant	Yellow	26/02/2024
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	26/02/2024
Regulation 34(7)(a)	The registered provider shall ensure that (a) nominated complaints officers and review officers	Substantially Compliant	Yellow	19/04/2024

	receive suitable training to deal with complaints in accordance with the designated centre's complaints procedures.			
Regulation 04(2)	The registered provider shall make the written policies and procedures referred to in paragraph (1) available to staff.	Substantially Compliant	Yellow	26/02/2024
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Substantially Compliant	Yellow	26/02/2024
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	04/03/2024

Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Substantially Compliant	Yellow	04/03/2024
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	04/03/2024