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. Gladys Nursing Home
Name of provider:	Willoway Nursing Home Limited
Address of centre:	53 Lower Kimmage Road, Harold's Cross, Dublin 6w
Type of inspection:	Unannounced
Date of inspection:	5 November 2024
Centre ID:	OSV-0000686
Fieldwork ID:	MON-0044702

About the designated centre

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

St. Glady's Nursing Home is located in a suburb of Dublin and close to local shops, bus routes and social amenities such as parks. It is a period building which has been developed to each side of the original building. It is registered to provide care for up to 50 residents. There are 22 single rooms, and 14 sharing rooms. Some of the bedrooms are en-suite and there are accessible bathrooms and toilets throughout the centre. The centre provides care of the elderly, but can also support residents under retirement age. The service is provided to residents with low, medium, high and maximum dependency. They focus on meeting residents needs in relation to care of the elderly, Alzheimer's, dementia or psychiatric needs.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	49

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 5 November 2024	08:30hrs to 15:30hrs	Mary Veale	Lead
Friday 25 October 2024	10:00hrs to 14:40hrs	Helen Lindsey	Lead
Friday 25 October 2024	10:00hrs to 14:40hrs	Aisling Coffey	Support
Tuesday 5 November 2024	08:30hrs to 15:30hrs	Helen Lindsey	Support

What residents told us and what inspectors observed

This was an unannounced inspection, which took place over two days and was conducted by three inspectors. Over the course of the inspection, the inspectors spoke with residents, staff and visitors to gain insight into what it was like to live in St Gladys Nursing Home. The inspectors spent time observing daily life in the centre to understand the residents' lived experiences. Inspectors spoke in detail with nine residents. A significant number of residents were living with a cognitive impairment and were unable to fully express their opinions to the inspectors. These residents appeared to be content, appropriately dressed and well-groomed. Residents expressed their satisfaction with communication, staff, staffing levels, and attention to personal care. Residents told the inspectors, "I'm pleased with everything", I'm looked after", and "the staff are very good, I think they are hand-picked".

The centre was a two-storey building with five separate wings referred to as Mount Argus, Kimmage Lower, Kimmage Upper, Harolds Cross Lower and Harolds Cross Upper. Access to each floor was by stairs or lift. The centre was warm and there was a relaxed atmosphere. The communal areas were located on the ground floor and included three day space rooms, a dining room and a visitor's room. Over the days of inspection, the visitor's room was observed to be in use as a clinical room, impacting its availability for resident use. A storage room and staff changing facilities were located within cabins at the rear of the building. The building was well-lit, warm and adequately ventilated throughout. There were assistive handrails in all corridor areas.

The inspectors observed that the centre was busy on the first day of inspection. On arrival, staff were observed having their break in the dining room with one resident present. Staff training was being facilitated in day space 2. This meant that day space 2 was not available to residents as communal space on the first day of inspection while the dining room was noisy during the staff meal break impacting the resident's experience. On arrival on day 2 of the inspection, one resident was observed in the dining room and no other communal areas were occupied as the residents were having breakfast in their bedrooms. As the day continued, residents were observed in the dining room and day spaces.

The resident’s bedroom accommodation comprised of 20 single rooms and 15 twin rooms with shared bathrooms or en-suite facilities. Most bedrooms were personalised and decorated in accordance with the resident’s wishes. Many of the residents’ bedrooms had fresh jugs of water. Lockable locker storage space was available for all residents and personal storage space comprised of double or single wardrobes and drawers. Pressure-relieving specialist mattresses, low-to-floor beds and other supportive equipment were seen in residents’ bedrooms.

Residents had access to two courtyard gardens from day spaces 2 and 3 at the rear of the building. Garden areas were easily accessible with level footpaths for residents to safely walk around. The courtyards had circling walkways allowing

residents and their families to fully enjoy the outdoor space. The garden areas were attractive and well maintained with mature shrubs and seating areas.

The inspectors observed many examples of kind, discreet, and person- centred interventions throughout the days of inspection. The inspectors observed that staff knocked on the resident's bedroom doors before entering. Residents were very complimentary of the person in charge, staff and services they received. Residents' said they felt safe and trusted staff. The inspectors observed staff treating residents with dignity during interactions throughout the inspection days.

The practice in the centre was that breakfast was served to residents in their bedrooms in the morning and all other meals were served in the centres dining room, sitting room and day spaces throughout the day. The inspectors observed the lunch time meals on both days. On the second inspection day, the lunchtime meal was a social occasion, with some residents chatting and nice exchanges of conversation between staff and residents. The dining room was fully occupied at lunchtime. Residents requiring assistance ate in day space 2 and some residents had their meals in the sitting room and day space 3 using foldable tables. Residents who required assistance with eating and drinking were seen to be assisted discreetly and independence was promoted where possible. Food was served directly from the kitchen and was warm and appetising. Meal times were not rushed. There was a choice of main meal and desert on both days of inspection. All residents whom the inspectors spoke with were complimentary of the home cooked food, the choice of meals offered and said that snacks were available at any time.

The centre provided a laundry service for residents. Residents whom the inspectors spoke with were mostly happy with the laundry service. A resident told the inspectors that a number of trousers had gone missing and had been replaced. There were a number of reports of items of clothing missing in the centre's complaints log, and action had been taken to address the concerns raised.

Residents spoken with said they were very happy with the activities programme in the centre and some preferred their own company but were not bored as they had access to newspapers, books, radios and televisions. The weekly activities programme was displayed on a notice board near the dining room. The inspectors observed staff and residents having good-humoured banter throughout the days and observed staff chatting with residents about their personal interests and family members. The inspectors observed residents reading newspapers, watching television, listening to the radio, and engaging in conversation. Books, games and magazines were available to residents. On the second day of inspection, a large number of residents were observed attending the annual activities meeting.

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

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

There were governance and management systems in place to oversee the operation of the centre; however, action was required to ensure the policies and procedures were followed at all times. While residents told the inspectors that they were content living in the centre, inspectors identified that improvements were required in some areas including, monitoring the effectiveness of staff training, ensuring records were completed correctly, and submitting notifications to the Office of the Chief Inspector.

This was an unannounced inspection to monitor ongoing compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 (as amended), review the registered provider's compliance plan from the November 2023 inspection and follow up on information submitted to the Chief Inspector.

Since the previous inspection of 16 November 2023, the provider had appealed the Chief Inspector's decision to apply a condition to the registration of this centre, aimed at improving the quality of life for the residents with regard to the provision of adequate communal and dining space. It was agreed through the district court that the provider would come into compliance with this condition by 31 January 2025, or reduce the number of places available in the centre.

Willoway Nursing Home Limited, comprised of two directors, is the registered provider for St Glady's Nursing Home. This company is part of the Grace Healthcare (Holdings) Ireland Limited Group. The person in charge worked full time and was supported by a clinical nurse manager, a team of nurses and healthcare assistants, an activities co-ordinator, housekeeping, catering, administration and maintenance staff. The management structure within the centre was clear and staff were aware of their roles and responsibilities. The person in charge was supported by a regional operations manager and by shared group departments, for example, human resources.

On both inspection days, the person in charge was on planned leave. The clinical nurse manager was deputising for the person in charge. Over the course of the two inspection days, it was observed that there were sufficient staff on duty to meet the needs of residents living in the centre.

A schedule of training was in place for all grades of staff. Staff were facilitated to attend training appropriate to their role. Additional training had been provided to staff in complaints management, infection prevention and control, assessment and care planning, behaviours that are challenging and dementia since the previous inspection. New staff were provided with a period of induction and appropriate supervision, which was overseen by the person in charge and clinical nurse manager for the centre. While there was regular training, it was apparent that a review was required to ensure staff had the expected knowledge and skills on completion, for

example, the ability to identify abuse, as defined in the provider's policy, and take appropriate action when necessary.

Records and documentation, both manual and electronic were well-presented and organised. A sample of staff files were examined and they contained all of the requirements as listed in Schedule 2 of the regulations. Vetting disclosures, in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012, were in place for all staff. While many records were fully complete, a sample of medication administration and observation records were found to be insufficiently detailed and this is discussed further under Regulation 21: Records.

There were a range of governance and oversight processes in the centre. There were regular management and staff meetings to discuss issues relating to care and support in the centre. There was evidence of a comprehensive and ongoing schedule of audits in the centre, for example, infection prevention and control, care planning and medication management audits. The person in charge compiled regular reports on key clinical data such as falls, incidents, complaints and antimicrobial usage, which were reviewed by the management team. The annual review for 2023 was available during the inspection. It set out the improvements completed in 2023 and improvement plans for 2024.

While there were systems in place to oversee the operation of the centre, the safeguarding culture was not sufficiently embedded into practices in the centre. Following on from notifications received by the Chief Inspector, it was apparent that in some cases individual responsibilities had not been met, to reduce the risk of harm occurring. There were also examples of the provider's policies not being adhered to, which had not been picked up by the oversight mechanisms put in place by the management team.

There was a record of incidents that took place in the centre. Some notifications were submitted appropriately to the Chief Inspector. However, a number of three-day notifications were not submitted. Subsequent to the inspection these notifications were submitted retrospectively. This is discussed further in this report under Regulation 31.

Regulation 15: Staffing

On the inspection days, staffing was found to be sufficient to meet the residents' needs. There was a minimum of two registered nurses on duty in the centre at all times.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had access to training appropriate to their role. Staff had completed training in fire safety, safeguarding, managing behaviours that are challenging and, infection prevention and control. There was an ongoing schedule of training in place to ensure all staff had relevant and up-to-date training to enable them to perform their respective roles.

While all staff had completed training in relation to safeguarding vulnerable adults, inspectors were not assured all staff were appropriately supervised as the learning from this training received had not been put into practice at all times. For example, staff had not reported safeguarding concerns to management in a timely manner, as evidenced in a notification received by the Chief Inspector.

Judgment: Substantially compliant

Regulation 21: Records

Action was required by the registered provider to ensure that records as set out in Schedule 3 were recorded, kept in the centre and made available for inspection. For example:

- A record of each medication administered was not maintained. Subcutaneous fluids were observed to have been administered to a resident a number of days prior to the second day of inspection. There was no record of subcutaneous fluids signed and dated by nursing staff as having been administered.
- There were significant gaps in the documentation of 30-minute safety checks assessed as being required to protect residents from abuse after a safeguarding incident.

Judgment: Substantially compliant

Regulation 23: Governance and management

The governance and oversight arrangements in the centre required strengthening to ensure the service was operated in line with the regulations. This included oversight of the delivery of care and records in the centre.

Inspectors were not assured the provider had effective systems in place to ensure residents were safeguarded from harm at all times:

- The provider's safeguarding policy was not followed in two examples identified by inspectors.

- Examples were seen where procedures set out in staff management policies had not been followed in a timely manner
- Oversight of safeguarding plans had not identified gaps in supervision.
- Information available to the management team had not been recognised as a possible safeguarding concern.
- A policy setting out supervision requirements had not been adhered to at all times
- The policy for safeguarding vulnerable adults required updating in accordance with best practice. While the policy gave clear instructions on the procedure to investigate an allegation of abuse, it did not include the process to manage an investigation of confirmed abuse.

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

- The visitor's room on the floor plans the centre was registered against was in use as a treatment room on the days of inspection.
- The office on the floor plans the centre was registered against was in use as an office and family room on the days of inspection.

Judgment: Not compliant

Regulation 31: Notification of incidents

The provider did not notify the Chief Inspector of two safeguarding concerns, as required by the regulations.

Judgment: Not compliant

Regulation 4: Written policies and procedures

Policies and procedures as set out in schedule 5 were in place, up to date and available to all staff in the centre.

Judgment: Compliant

Quality and safety

Action was required by the provider to ensure that safeguarding guidance was followed at all times and embedded in the culture of the centre. While there was positive feedback about the service from residents, and good practice seen in relation to mealtimes, further improvements were required in a range of areas concerning healthcare, premises, care planning, managing behaviour that is challenging, safeguarding, residents' rights and medication management to fully comply with the requirements of these regulations.

The inspectors viewed a sample of residents' electronic nursing notes and care plans. There was evidence that residents were comprehensively assessed prior to admission, to ensure the centre could meet their needs. Care plans viewed by inspectors were generally person-centred. However, a review of a sample of care plans found that there was insufficient information recorded to effectively guide and direct the care of these residents in the examples seen. Details of the issues identified are set out under Regulation 5.

Residents had access to general practitioners (GPs), allied health professionals, specialist medical and nursing services including psychiatry of older age and community palliative care specialists as necessary. However, improvements were required in the clinical oversight of identification of residents with a deteriorating condition. Findings are discussed under regulation 6: Healthcare.

Mealtimes were facilitated in the dining room, sitting room and day space rooms. Some residents preferred to eat their meals in their bedrooms and residents said that their preferences were facilitated. The inspectors observed that residents were provided with adequate quantities of food and drink. Residents were offered choice at mealtimes and those spoken with overall confirmed that they enjoyed the meals provided. 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.

Safeguarding training had been provided to staff in the centre and staff spoken with were familiar with the types and signs of abuse and with the procedures for reporting concerns. All staff whom the inspectors spoke with said that they would have no hesitation in reporting any concern regarding residents' safety or welfare to the centre's management team. The provider assured the inspectors that all staff working in the centre had valid Garda vetting disclosures in place. Notwithstanding this good practice, robust action was required in the oversight of systems in place to protect residents from abuse. This is discussed further under Regulation 8: Protection.

There were eight residents who used bed rails as a restrictive device. Risk assessments were completed, and the use of restrictive practice was reviewed regularly. Less restrictive alternatives to bed rails were in use such as sensor mats and low beds. The front door to the centre was locked. The intention was to provide a secure environment, and not to restrict movement. A significant number of residents living in St Glady's Nursing Home on the days of inspection had symptoms of dementia or a confirmed diagnosis of dementia. There was policy in place to inform staff in the management of responsive behaviours (how people with

dementia or other conditions may communicate or express their physical discomfort with their social or physical environment) and restrictive practices in the centre. Residents had access to psychiatry of later life. For residents with identified responsive behaviours, nursing staff had identified the trigger causing the responsive behaviour using a validated antecedent- behaviour- consequence (ABC) tool. There was a clear care plan for the management of the resident's responsive behaviour. However, improvements were required to ensure that restrictive practices are only used when all other options have been exhausted, and the least restrictive option is used. This is discussed further under Regulation 7: Managing behaviour that is challenging.

The centre was warm and clean. Alcohol hand gel and personal protective equipment (PPE) storage units were available on all corridors. Most bedrooms were personalised and residents in shared rooms had privacy curtains and space for their belongings. Improvements were required in relation to the centre's premises, and this will be discussed further under Regulation 17.

An activity schedule documented the activities available for residents seven days per week. The inspectors observed that residents had sufficient opportunities to participate in activities in accordance with their interests and capacities. Residents had access to radio, television, newspapers and other media such as the use of tablets. Access to independent advocacy was available. Notwithstanding the good practices in the centre, some actions were identified to ensure that all residents could exercise choice which did not interfere with the rights of other residents. This is discussed further under Regulation 9: Residents rights.

There was a comprehensive centre-specific policy in place to guide nurses in the safe management of medications. Controlled drug balances were checked at each shift change as required by the Misuse of Drugs Regulations 1988 and in line with the centre's policy on medication management. A pharmacist was available to advise residents on the medications they were receiving. Further improvements were required in the storage of medications, which is discussed further under Regulation 29: Medicines and pharmaceutical services.

Regulation 17: Premises

Inspectors observed some discrepancies between the statement of purpose, floor plans against which the centre was registered and what was observed on inspection, for example:

- The visitor room was being used as a treatment room and was, therefore, unavailable for resident use on both inspection days.
- The office on the floor plans was in use as an office and family room on both inspection days.

The registered provider had until 31st of January 2025 to ensure there was sufficient communal space in the centre for the number of residents accommodated, or to reduce the number of places in the centre.

Similar to findings of the previous inspections of February and November 2023, actions were required by the registered provider to provide a premises which conform to the matters set out in Schedule 6.

- There was a lack of storage in the centre resulting in inappropriate storage of cleaning trolleys, manual handling equipment and linen skips in toilets and shower rooms. This posed a high risk of contamination and transmission of infection.
- Decor in some areas, such as corridors and bedrooms, showed signs of wear and tear, with visible damage to walls, doors, and door frames.
- A review of call bells was required as a number of call bell devices were missing from residents' bed spaces and bedrooms.

Judgment: Not compliant

Regulation 18: Food and nutrition

The food served to residents was high quality, wholesome, nutritious and attractively presented. There were choices of main meal every day, and special diets were catered for. Home-baked goods and fresh fruit were available and offered daily. Snacks and drinks were accessible day and night. Fresh water jugs were seen to be replenished throughout the day in residents' rooms and communal areas.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

The person in charge did not ensure that medicinal products were stored securely in the centre. For example;

- Subcutaneous fluids which were observed no longer in use in a resident's bedroom had not been disposed of appropriately. This posed a high risk of contamination and transmission of infection.
- Laboratory blood specimens were observed stored with medication in a fridge in the treatment room. This posed a high risk of contamination and infection transmission.

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 the resident's care needs. For example:

- Two care plans for residents with hydration and nutritional needs did not contain sufficient detail to guide nursing staff to provide appropriate care and support for these residents' dietary and hydration requirements.

Judgment: Substantially compliant

Regulation 6: Health care

Improvements were required in healthcare. For example:

- From the records provided to the inspectors, an observation was made in which nursing care was not monitored or delivered in line with the resident's needs or in accordance with the registered provider's own policies and procedures.
- Two residents who had a significant weigh loss had not been referred to a dietitian as outlined in the residents care plans. Both residents had their weights monitored monthly, were losing weight and had a MUST score of 2.

Judgment: Not compliant

Regulation 7: Managing behaviour that is challenging

The person in charge had not managed and responded to the behaviour of a resident in a manner that was not restrictive. For example:

- On two separate occasions, medication was administered to manage behaviour that was challenging without first trialling lesser restrictive alternatives.

Judgment: Substantially compliant

Regulation 8: Protection

Following a review of notifications submitted to the Chief Inspector, and information available in the centre, inspectors were not assured all reasonable measures were being taken to safeguard residents. The safeguarding policy had not been followed in all cases where the definition of a safeguarding concern was identified. Records showed examples where staff had not taken the required steps to report concerns. There had been a delay in recognising one concern as a safeguarding matter, meaning the expected procedures had not been followed.

As set out under regulations 23 and 16, oversight of the monitoring and delivery of care in the service and the training provided to staff did not ensure the policy was followed in every case where there was alleged, suspected, or witnessed abuse in the centre.

Judgment: Not compliant

Regulation 9: Residents' rights

Residents provided positive feedback about the activities available, and overall said they could spend their time in the centre however they chose. There were residents' meetings to gain feedback about how the centre operated, and actions had been taken in light of the feedback received.

While there were a range of communal spaces in the centre where residents could choose to spend their time, three were not available to residents on the first day of inspection. This included two rooms that had changed purpose from the registered floor plans and one sitting room used for staff training on the first inspection day. The residents' dining room was also used by staff throughout both days of the inspection.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Not compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for St. Gladys Nursing Home OSV-0000686

Inspection ID: MON-0044702

Date of inspection: 05/11/2024

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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: To address the identified concerns and ensure compliance, a comprehensive compliance plan will be implemented. • All staff will continue to receive training appropriate to their roles, including mandatory programs in fire safety, safeguarding, managing challenging behaviors, and infection prevention and control. • A robust ongoing training schedule will remain in place to ensure all staff maintain up-to-date knowledge and skills relevant to their responsibilities. • Specific measures have been introduced to enhance safeguarding practices and ensure the effective application of training. A refresher safeguarding course onsite was delivered to all staff, emphasizing practical applications such as timely reporting of concerns to management. • Staff competency assessment form with scenarios and case studies will be integrated into the training to reinforce learning and assess understanding of staff. • A clear protocol for reporting safeguarding concerns will be disseminated, quick references displayed in staff areas, common areas and regular reminders during team meetings and morning huddle. • A monitoring system will be established where safeguarding reports are audited monthly to verify compliance with reporting standards. Feedback sessions will be held with staff to address challenges and reinforce the importance of safeguarding practices.	
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records:	

To address the identified issues, the following compliance plan will be implemented.
• All nurses will be required to complete an additional refresher course on medication administration through an online training platform, emphasizing accurate record-keeping and adherence to best practices. This training will reinforce the critical importance of maintaining detailed and accurate records for all administered medications, including subcutaneous fluids, which must be signed and dated by the nursing staff immediately after administration.
• A medication audit will be conducted monthly for the next six months to closely monitor compliance and identify areas for improvement. If the audits demonstrate consistent adherence to best practices and a positive response, the frequency will be reduced to quarterly reviews. In addition, a weekly quality walkabout will be implemented with a specific focus on medication management. This will include reviewing storage, administration practices, and documentation to ensure ongoing compliance and safety.
• A toolbox talk on the importance of safety checks will be developed and delivered during morning huddle for all staff to emphasize the importance of regular checks and accurate documentation in maintaining resident safety. Residents requiring increased supervision will be assigned appropriate staff to ensure their safety and well-being. This staffing arrangement will be documented and incorporated into each resident's individualized care plan. The Clinical Nurse Manager (CNM) or Person in Charge (PIC) will conduct weekly spot checks of documentation to verify compliance and ensure that all required interventions are accurately recorded and implemented. These checks will serve as an ongoing quality assurance measure to support the provision of safe and effective care.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
In response to the HIQA findings regarding governance and oversight, the following actions have been detailed in the Quality Improvement Plan (QIP) for St. Gladys Nursing Home to address identified issues and ensure regulatory compliance:

• A comprehensive review of safeguarding policies and procedures is underway to address deviations noted during the inspection. The safeguarding policy will be updated to reflect best practices, including procedures for managing alleged or confirmed abuse cases. Clear workflows had been introduced to ensure timely recognition and handling of abuse concerns, making these accessible to all staff.
• To strengthen oversight, a Regional Manager (ROM) has been appointed to oversee operations. Weekly incident reports will be reviewed by the ROM and the Person in Charge (PIC), with monthly local management team (LMT) meetings to discuss high-risk issues. Additionally, critical concerns will be escalated to a monthly group meeting attended by directors.
• A group safeguarding committee has been established, and targeted training, including

scenario-based sessions, is being rolled out to staff to ensure they can recognize and respond appropriately to various abuse types, such as neglect. Regular incident reviews at organizational levels will ensure timely follow-up. Post-incident reviews will identify lessons learned to prevent recurrence. Individual cases will be evaluated to address outstanding issues and ensure compliance with safeguarding standards.
• A review of the floor plans will be completed to ensure accuracy of the floor plans and submitted with the application to vary the registration.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
To address the failure to notify the Chief Inspector as required by the regulations, the following actions will be implemented as part of the Quality Improvement Plan (QIP):

• The center will ensure that all safeguarding concerns are promptly reported to the Chief Inspector, as stipulated by the regulations. The Person in Charge (PIC), is assigned to ensure that notifications are submitted within the required timeframe. Staff will receive additional training on incident reporting requirements, including the importance of timely notifications to external regulatory bodies.
• Appointment of a Regional Manager (ROM) overseeing St. Gladys Nursing Home.
• Weekly incident reporting reviewed by ROM and PIC
• Monthly local management team (LMT) meetings to review incidents and high-risk issues.
• In addition, a monthly Clinical Governance meeting has commneced.
• A monthly group meeting, attended by directors, to escalate and address critical issues and to identify any missed notifications and implement corrective actions. These measures aim to ensure full compliance with regulatory requirements and reinforce accountability across the team.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
- A review of the floor plans will be completed and submitted with the application to vary on 31st of January 2025
- A review of maintenance works will be completed and a Maintenace upgrade plan will be put in place
- A review of storage will be completed.
- All call bells will be reviewed to ensure they are in plan and in working order.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:

• All nurses will be required to complete an additional refresher course on medication administration through an online training platform, emphasizing accurate record-keeping and adherence to best practices. This training will reinforce the critical importance of maintaining detailed and accurate records for all administered medications, including subcutaneous fluids, which must be signed and dated by the nursing staff immediately after administration.

• Immediate corrective actions were implemented during the day of inspection and the unused subcutaneous fluid was immediately removed from the room and this was communicated to all nursing staff to ensure that all unused medical supplies, including subcutaneous fluids, are disposed of properly in accordance with infection control protocols.

• To address the issue in relation to storage of medications and laboratory specimens and ensure compliance with infection control protocols, we have taken immediate action by purchasing an additional clinical fridge dedicated solely to the storage of laboratory specimens.

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:

• Care plans will be updated to include comprehensive assessments of each resident's hydration and nutritional requirements, with clear, actionable recommendations for care. This will ensure that staff have the necessary information to deliver tailored, appropriate care.

• Regular reviews of care plans will be conducted by CNM/PIC, and staff will receive refresher training as appropriate to enhance documentation accuracy and detail. This approach will ensure that each resident's care needs are met and that care plans are consistently updated with relevant, specific information.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
• A toolbox talk on the importance of safety checks will be developed and delivered during morning huddle for all staff to emphasize the importance of regular checks and accurate documentation in maintaining resident safety. Residents requiring increased supervision will be assigned appropriate staff to ensure their safety and well-being. The Clinical Nurse Manager (CNM) or Person in Charge (PIC) will conduct weekly spot checks to verify compliance and ensure that all required interventions are accurately recorded and implemented. These checks will serve as an ongoing quality assurance measure to support the provision of safe and effective care.
• A thorough review of all residents with weight loss was completed, and immediate steps will include referring residents to a dietitian for comprehensive nutritional assessment and updating their care plans with tailored interventions based on the dietitian's recommendations. Weight monitoring will be increased to weekly for residents who are consistently losing weight, and a three-day food diary will be maintained to evaluate intake and identify deficiencies.
• Nursing staff will receive a refresher session from a private provider on the importance of timely dietitian referrals and adherence to the Nutrition & Hydration Policy. Internal audits of care plans for all residents with a MUST score ≥ 2 will be conducted to ensure compliance, and accountability for monitoring and escalating weight loss concerns will be reinforced.

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
• The Person in Charge (PIC) will ensure that RGNs uses non-restrictive, person-centred behaviour management prior giving of PRN antipsychotic medications by spot checking weekly documentation of medication administration. A review of the resident's care plan will ensure it includes a comprehensive behaviour support plan with alternative interventions and proactive strategies. Documentation will be strengthened to require thorough recording of lesser restrictive interventions and the rationale for medication use.
• Regular audits will ensure compliance, and staff will undergo ongoing training on managing responsive behaviours and de-escalation techniques.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• All staff will continue to receive training appropriate to their roles, including mandatory programs in fire safety, safeguarding, managing challenging behaviors, and infection prevention and control.
• A robust ongoing training schedule will remain in place to ensure all staff maintain up-to-date knowledge and skills relevant to their responsibilities.
• Specific measures have been introduced to enhance safeguarding practices and ensure the effective application of training. A refresher safeguarding course onsite was delivered to all staff, emphasizing practical applications such as timely reporting of concerns to management.
• Staff competency assessment form with scenarios and case studies will be integrated into the training to reinforce learning and assess understanding of staff.
• A clear protocol for reporting safeguarding concerns will be disseminated, quick references displayed in staff areas, common areas and regular reminders during team meetings and morning huddle.
• A monitoring system will be established where safeguarding reports are audited monthly to verify compliance with reporting standards. Feedback sessions will be held with staff to address challenges and reinforce the importance of safeguarding practices.
• To strengthen oversight, a Regional Manager (ROM) has been appointed to oversee operations. Weekly incident reports will be reviewed by the ROM and the Person in Charge (PIC), with monthly local management team (LMT) meetings to discuss high-risk issues. Additionally, critical concerns will be escalated to a monthly group meeting attended by directors.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• Residents are informed in advance regarding any temporary unavailability of communal spaces used for training. Alternative arrangements was made for residents, such as accommodating those who use the sitting room in the main sitting room during training. Training sessions will be scheduled during times when residents are less likely to use the space, and whole-day sessions will continue to be held offsite. Plans for the 2025 refurbishment include additional communal areas to address space limitations and prevent future disruptions.

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)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	28/02/2025
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.	Not Compliant	Orange	31/01/2025
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.	Not Compliant	Orange	31/01/2025

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	31/01/2025
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	31/01/2025
Regulation 29(4)	The person in charge shall ensure that all medicinal products dispensed or supplied to a resident are stored securely at the centre.	Substantially Compliant	Yellow	31/12/2025
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.	Not Compliant	Orange	30/11/2024
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment	Substantially Compliant	Yellow	30/11/2024

	referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.			
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.	Not Compliant	Orange	30/11/2024
Regulation 7(2)	Where a resident behaves in a manner that is challenging or poses a risk to the resident concerned or to other persons, the person in charge shall manage and respond to that behaviour, in so far as possible, in a manner that is not restrictive.	Substantially Compliant	Yellow	30/11/2024
Regulation 8(3)	The person in charge shall investigate any incident or	Not Compliant	Orange	30/11/2024

	allegation of abuse.			
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Substantially Compliant	Yellow	31/01/2025
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	31/01/2025