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:	Esker Ri Nursing Home
Name of provider:	Blackden Limited
Address of centre:	Kilnabin, Clara, Offaly
Type of inspection:	Unannounced
Date of inspection:	23 May 2024
Centre ID:	OSV-0000733
Fieldwork ID:	MON-0043694

About the designated centre

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

Esker Ri Nursing Home is a purpose-built premises. The designated centre is situated on an elevated site off the Tullamore road on the way out of the village of Clara. The designated centre currently provides accommodation for a maximum of 143 male and female residents aged over 18 years of age. Residents' accommodation is provider on three floors. Residents are accommodated in single and twin bedrooms with full en suite facilities. The designated centre provides mainly residential care to older adults and also provides respite, convalescence and care for people with an intellectual disability, physical disability, acquired brain injury, dementia and palliative care needs. The provider employs a staff team consisting of registered nurses, care assistants, activity coordination staff, administration, maintenance, housekeeping and catering staff. The provider states in their statement of purpose for the designated centre that their aim is to provide a residential setting wherein residents are cared for, supported and valued within a care environment that promotes their health and well being.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	137

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
Thursday 23 May 2024	09:45hrs to 18:30hrs	Sean Ryan	Lead
Wednesday 29 May 2024	12:15hrs to 17:00hrs	Sean Ryan	Lead
Thursday 23 May 2024	09:45hrs to 18:30hrs	Catherine Sweeney	Support
Wednesday 29 May 2024	12:15hrs to 17:00hrs	Catherine Sweeney	Support

What residents told us and what inspectors observed

Residents living in Esker Ri Nursing Home told the inspectors that they felt safe and comfortable living in the centre. Residents complimented the staff who they described as courteous, helpful and kind.

Inspectors were met by a recently appointed director of nursing on arrival at the centre. Following an introductory meeting, inspectors walked through the centre and spent time observing the care provided to residents, talking to residents and staff, and observing the care environment.

There was a busy, but friendly atmosphere in the centre throughout the inspection. During the morning, staff were observed to respond to residents' requests for assistance promptly. Some residents were observed walking through the corridors accompanied by staff, while the majority of residents spent the morning in the communal day room or attending activities in the main dayroom. Residents appeared to be relaxed and comfortable in their environment, and chatting to staff and one another about local news and events. Staff were observed serving residents light snacks and refreshments at their request.

Inspectors observed a number of residents in their bedrooms and in communal areas. The feedback from residents was generally positive with regard to the care they received. Residents described staff as being kind and respectful towards them. Residents told inspectors that there were improvements in the quality of the service in recent months particularly with regard to the staffing. Residents described how they were familiar with the staff that provided them with care and assistance and this made them feel safe and comfortable in their home.

Inspectors observed the residents' dining experience and saw that there were adequate numbers of staff available to assist residents with their nutritional care needs. Some residents chose to have their meals in their bedrooms and catering staff were observed delivering their meals to their bedrooms. Residents were consistent in their feedback regarding improvements in the availability of staff but expressed some discontent with the dining experience. Residents told inspectors that the dining rooms were not always appropriately laid out. Condiments and drinks were not always placed on the table or were out of their reach. The inspectors observations reflected the residents' feedback with regard to their dining experience. Inspectors observed that the kitchen area was visibly clean. Information with regard to each resident's dietary requirements was displayed on a notice board in the kitchen. However, inspectors observed that residents' dietary information had not been updated since July 2023, ten months prior to this inspection. All residents were offered a choice from a menu. Staff were also observed attending to residents in their bedrooms to provide support during mealtimes.

Inspectors noted some fire safety concerns during the walk around the centre. A number of fire doors did not appear to close effectively, with significant gaps around

the doors evident when the doors were in a closed position. This may reduce the effectiveness of a fire door in the event of a fire emergency.

Throughout the days of inspection, residents were seen engaged in meaningful and enjoyable activities. Some residents chose not to participate in activities, and their choice was respected. Inspectors spent time observing the interactions between residents and staff, and observed that staff supported residents to enjoy and engage in activities.

Staff demonstrated an understanding of residents' rights in general and they supported residents to exercise their rights and choice, and the ethos of care was largely person-centred. However, residents' choice was not always respected and facilitated in the centre, particularly where residents expressed a wish to to walk around the grounds unaided and unsupervised.

Residents told the inspectors that they would talk to any member of the staff or their family if they were worried about anything or were not satisfied with any aspect of the service. During the inspectors' conversations with residents, they confirmed that they felt they were listened to by staff but that some of the issues they raised were not always addressed to their satisfaction.

Residents were provided with opportunities to express their feedback about the quality of the service during formal resident forum meetings. A few residents told the inspector that they did not feel their opinion was 'listened to', and consequently, some residents had ceased to attend those meetings.

Inspectors observed visitors coming to and from the centre throughout the day. They visited residents in their bedrooms and in the day rooms. Visitors confirmed they were welcome to the home at any time and they did not feel restricted.

The following sections of this report details the findings with regard to the capacity and capability of the centre and how this supports the quality and safety of the service being provided to residents.

Capacity and capability

This unannounced risk inspection was carried out by inspectors of social services to;

- monitor compliance with the Health Act 2007 (Care and welfare of residents in designated centre for older people) Regulation 2013 (as amended).
- follow up on the actions taken by the provider to address significant issues of non-compliance identified during a series of poor inspections of the centre on the 28 June 2023, 18 July 2023, 22 August 2023, 07 December 2023 and the 29 February 2024.

- review the detail of a representation, submitted by the provider following the issuing of a notice of proposed decision to attach a restrictive condition to the registration to stop admissions to the designated centre.
- a second day of inspection was scheduled to follow up on information received by the Chief Inspector of Social Services in relation to a concern about resident transfers from the centre to the acute services.

The findings of this inspection were that the registered provider had failed to put effective management structures and systems in place to ensure that the service provided was safe and appropriately monitored. The unclear organisational structure, and ineffective management systems of monitoring and oversight, continued to impact on the quality and safety of the care provided to residents. Inspectors found that where the registered provider had previously implemented systems to monitor aspects of the service that included maintaining appropriate records of resident transfers, it had failed to ensure that those systems were consistently implemented and sustained. This impacted on the quality and safety of the service provided to residents.

Following day one of this inspection, a second inspection day was scheduled to review unsolicited information received by the Chief Inspector. The information pertained to concerns regarding resident referral and access to medical professionals, and the high incidence of residents being transferred to the acute health care services. This information was substantiated on this inspection.

Blackden Limited is the registered provider of Esker Ri Nursing Home. Following consistently poor regulatory compliance over repeated inspections, the Chief Inspector of Social Services issued a notice of proposed decision to attach a condition to the registration of the designated centre. The purpose of this condition was to stop new admissions to the centre until the Chief Inspector was satisfied that the provider had in place an effective governance and management structure and achieved compliance with key regulations that underpin the quality and safety of care provided to residents.

The registered provider made representation within 28 days of the notice being issued, that detailed the action that had been taken to address the non-compliance relating to the governance and management, and the quality and safety of the service. The representation outlined a revised organisational structure, and the action being taken to bring the centre into compliance with the regulations. Inspectors found that the proposed organisational structure had not been fully established, and the actions taken to comply with the regulations were not sufficient to meet the requirements of the regulations. These persistent failings had a significant impact on the safety and quality of life for residents.

The registered provider of the centre is a company consisting of two directors, one of whom represents the provider in the governance of the centre. The organisational structure, as detailed in the provider's representation, consisted of the representative of the provider, a regional operations manager, general manager and a person in charge. Inspectors found that, on the days of the inspection, the organisational structure had not been fully established. The provider had failed to

ensure that the personnel responsible for the governance and oversight of the service met the requirements of the regulations to be in charge of the centre. Consequently, the management structure was not in line with the centre's statement of purpose. Inspectors found that the changes made to the organisational structure had failed to impact the quality and the safety of the care provided to residents.

The lines of accountability and responsibility for the oversight of care and safety of the residents were not clear. It was unclear who held responsibility for the implementation of management systems, pertinent to supporting effective governance, such as risk and incident management, record management, and monitoring the provision of health care to residents. Inspectors found that the absence of an effective system of governance and management, negatively impacted on the registered provider's ability to recognise, respond to, and manage regulatory non-compliances in the centre, and maintain a safe and quality care for residents.

The provider had committed to improving their oversight of the service through the implementation of systems to audit and monitor the quality and safety of the service provided. While there were management systems in place to monitor aspects of the service provided to residents, the management systems were not effective to identify deficits and risks in the service. A review of completed clinical and environmental audits found that where deficits were identified, such as clinical records, there was no quality improvement action plan developed. For example;

- Audits completed in April and May 2024 had identified that some residents did not have an appropriate care plan developed following their admission to the centre. In the absence of an effective quality improvement plan, those issues had not been resolved and residents assessed at being at high risk of falls did not have an appropriate care plan developed.
- An audit review of residents at risk of leaving the centre unaccompanied identified that care plans had not been updated to address this risk. There was no action plan developed to ensure action would be taken.
- Audits in relation to the risk of malnutrition were not developed using best practice guidelines. For example, the audit detail advised that no intervention was required for residents whose weights were reasonably high, regardless of whether the resident had been assessed as being at high risk of malnutrition using a validated assessment tool.

A revised weekly monitoring report had been implemented to monitor aspects of the service that included residents' referral and access to medical practitioners, care delivery, incidents, complaints, and transfers to hospital. This monitoring report was sent to the external senior management team on a weekly basis. However, inspectors found that the information collated for this weekly report was not accurate and was therefore not effective in identifying deficits in the quality and safety of the service or escalating actual or potential risks in the centre to the registered provider. For example, information in relation to resident transfers to hospital had not analysed or identified possible contributing factors for the high incidence of transfers to the acute health care services. This included factors such as appropriate staff training, or whether the assessment and transfer of residents was

carried out in line with the centre's own procedure. Furthermore, a review of the key performance indicator records regarding residents' transfers to hospital showed that this information was not accurately maintained and did not reflect the actual number of residents transferred to hospital on a weekly basis. This significantly impacted on the provider's ability to identify, trend, monitor and improve this aspect of the service.

A review of the record management systems found that the provider had implemented systems to ensure documents to be held in respect of each member of staff were appropriately maintained. However, inspectors found continued issues of non-compliance with the requirements of the regulations. The system in place to record the planning and attendance of senior management staff in the centre was not effective and resulted in a confused and inaccurate staffing roster. This had been a finding of a previous inspection in December 2023.

Despite being identified on previous inspections, the provider had failed to ensure that there was adequate documentation of adverse incidents involving residents. A review of adverse incident records found that incidents in which residents may have suffered harm were not documented or investigated in line with the requirements of the regulations. In addition, documents requested for review at the start of this inspection were not received in a timely manner. Requests for information with regard to the management systems in place such as risk management, training records, directory of residents, and governance meeting records were presented in a disjointed and disorganised manner. Some documents in relation to residents' clinical care and transfers records could not be provided on the days of inspection.

The policies and procedures, as required by Schedule 5 of the regulations, were reviewed by inspectors. Policies had been reviewed by the provider at intervals not exceeding three years and were made available to staff. While the provider had committed to implementing policies and procedures to underpin the provision of a safe and consistent service to residents, the registered provider had failed to ensure that some policies and procedures were implemented. This included policies and associated procedures with regard to clinical documentation, records and safeguarding of vulnerable people.

While staff were facilitated to attend training such as fire safety, practices observed on the day of the inspection were not in line with best practice guidelines. Inspectors found that staff were not appropriately supervised to ensure the implementation of their training. For example, inspectors observed repeated poor practice whereby fire doors were held open with pieces of furniture. This could compromise their function to contain the spread of smoke and fire.

A review of the centre's staffing roster on the day of inspection found that the staffing levels and skill mix were appropriate to meet the assessed health and social care needs of the residents, given the size and layout of the building. There were sufficient numbers of house-keeping, catering and maintenance staff in place.

Regulation 14: Persons in charge

There was no person in charge of the centre who met the criteria to be the person in charge. The person to be in charge of the centre did not have the necessary post-registration qualification required by the regulations.

Judgment: Not compliant

Regulation 15: Staffing

On the day of the inspection, the staffing numbers and skill mix were appropriate to meet the needs of residents in line with the centre's statement of purpose.

There was sufficient nursing staff on duty at all times, and they were supported by a team of health care staff. The staffing compliment also included catering, housekeeping, administrative and management staff.

Judgment: Compliant

Regulation 16: Training and staff development

Staff supervision arrangements were not appropriate to protect and promote the care and welfare of residents. This was evidenced by the failure to;

- oversee the systems in place to ensure appropriate transfer to hospital.
- provide oversight of the resident's clinical documentation to ensure that resident's assessments and care plans were an accurate reflection of the residents care needs.
- ensure nursing care records, including records of resident transfers and referrals to medical professionals, were appropriately maintained.
- supervise and oversee the delivery of care and the implementation of recommendations of allied health care professionals.
- ensure the fire safety procedures were consistently implemented by staff. Inspectors observed a number of instances of fire doors being held open with items of furniture, contrary to the centre's own fire procedures.
- ensure that policies and procedures in place to safeguard and protect residents were implemented.

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 21: Records

A review of the records in the centre found that the management of records was not in line with the regulatory requirements. For example;

- Records of incidents and the investigation of the incidents in which residents may have suffered potential abuse or harm were not documented in line with the centre's own policy, as required by Schedule 3 (4)(j) of the regulations. There was no documented investigation into incidents of unexplained bruising sustained by residents.
- The directory of residents provided to inspectors for review did not contain all the information required by Schedule 3(3)(f). The directory of residents did not contain records in respect of residents who transferred to hospital, the name of the hospital, or the date on which the resident was transferred.
- Records of on-going medical assessment, treatment and care were not consistently maintained, as required by Schedule 3(4)(e) of the regulations. For example, records of three residents' diagnostic test results were not maintained in the centre, or available to staff for review.
- Records of all medical referrals were not maintained in line with Schedule 3(4)(f).
- Staff rosters were not maintained in line with the requirements of Schedule 4(9), and were not reflective of the actual roster worked by staff. Rosters did not reflect the actual hours worked by the regional manager or general manager.
- A record of all training for all persons currently employed in the designated centre was not made available for review. The records provided to inspectors were incomplete and had not been updated to reflect the actual training completed by staff as required by Schedule 4(8)(c).

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 23: Governance and management

The registered provider had failed to ensure that the management structure was maintained in line with the centre's statement of purpose. There was no person in charge, that met the regulatory criteria, to provide effective leadership and governance in the designated centre. This resulted in unclear roles and responsibilities and impacted on accountability and responsibility for the oversight and management of key aspects of the service such as the management of risk, records, and the provision of health care to residents. Furthermore, ineffective

action had been taken to address the risks and non-compliance in those areas of the service.

Inspectors found that the overall governance and management of the centre was ineffective. Management systems were not sufficiently robust to ensure the service was safe, appropriate, consistent and effectively monitored. For example,

- The systems in place to monitor, evaluate and improve the quality of the service were not effective in identifying deficits and risks in the service. For example, there was a lack of robust auditing and monitoring of the nursing and health care provided to residents, staff training and supervision and clinical records. This meant that risks and deficits in the quality and safety of the service were not identified or subject to quality improvement action plans.
- There were ineffective communication systems in place to facilitate the escalation of key information about the service to the provider. Records of key performance indicators, that included information about resident transfers from the centre, were not accurately maintained or communicated to the senior management team for further review and action.
- There were ineffective record management systems in place to ensure regulatory compliance. For example, there was poor oversight of records pertaining to nursing documentation, and the records of some adverse incidents were found to be poorly recorded and investigated.
- There were ineffective systems in place to monitor and promote the well-being of residents through providing timely and appropriate referral to medical and health care services.

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 4: Written policies and procedures

The registered provider had failed to implement policies and procedures designed to support the care provided to residents, and protect residents. This included policies in relation to;

- The prevention, detection, and response to abuse.
- Record management,
- Temporary absence and discharge of residents.

This is a repeated non-compliance.

Judgment: Not compliant

Quality and safety

While the day-to-day interaction between residents and staff was kind and respectful throughout the inspection, inspectors found that the quality and safety of care provided to residents was compromised as a result of ineffective systems of governance and management described in the capacity and capability section of this report. The continued failure of the provider to implement effective quality assurance and clinical oversight posed an ongoing risk to residents in the centre with regard to their individual assessments and care plan, and timely and appropriate access to health care. Action was also required in relation to the transfer of residents from the centre, and upholding the rights of the residents.

The provider had committed to taking action to improve the quality of the nursing documentation with regard to the resident's individual assessment and care plans. While there was evidence that residents needs had been assessed using validated assessment tools, the care plans reviewed were not always informed by these assessments, and did not reflect person-centred guidance on the current care needs of the residents. In addition, not all care plans were reviewed as the residents' condition changed.

A review of residents' records showed that residents were not always provided with timely referral and access to a general practitioner (GP) services regarding their health care needs, or following early detection of signs and symptoms of physical deterioration. This impacted on the care of the residents, necessitating transfer to the acute health care services. This was compounded by a lack of clear policy, procedure and process to underpin the criteria for appropriate hospital transfers and the provision of safe and effective health care to residents.

The provider failed to sustain compliance with the regulations regarding the transfer of residents from the designated centre. There were no transfer records for three residents who had been transferred from the designated centre to the acute health care service. Consequently, assurances could not be provided that information pertinent to the care of the residents was communicated to the receiving health care facility.

There was an activity schedule in place and some residents were observed to be facilitated with social engagement during the day.

Residents had access to television, radio, newspapers and books. Residents were provided with access to independent advocacy services.

Residents were provided with opportunities to provide feedback on the quality of the service through scheduled resident meetings. However, inspectors found that residents were not always supported to be as independent as possible and to exercise personal choice in their daily lives. Management staff spoken with were not

familiar with the concept of positive risk-taking and facilitating residents rights to self-determination.

Regulation 25: Temporary absence or discharge of residents

The provider did not ensure that all relevant information about a resident was provided to the receiving hospital. There were no records maintained in the centre to provide assurances that all relevant information about the residents was provided to the receiving health care service.

Where such records were available, they did not accurately outline the health status of residents. to provide a full picture for meaningful assessment at the receiving hospital.

This is a repeated non-compliance from a previous inspection.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

A review of a sample of resident's assessment and care plans found that they were not in line with the requirements of the regulations. For example;

- Care plans were not guided by a comprehensive assessment of the residents' care needs. For example, two residents assessed as being at high risk of falls were not identified as such within their care plan. Consequently, the care plan did not reflect the residents' increased risk of falls or the interventions necessary to support the resident.
- Care plans did not accurately reflect the care needs of some residents. End-of-life care plans had not been updated to reflect residents wishes with regard to their end-of-life care. Consequently, staff did not have accurate information to guide the care to be provided to the residents.
- Residents did not always have an appropriate care plan developed, based on a comprehensive assessment, within 48 hours of their admission to the centre. For example, a resident assessed as being at high risk of a fall did not have a care plan developed to guide the care to be provided to the resident.

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 6: Health care

The registered provider failed to provide appropriate medical and health care including a high standard of evidence-based nursing care in accordance with professional guidance. This is evidenced by a failure to;

- provide timely referral and access to medical services when clinically indicated.
- provide a resident with timely and appropriate referral to health care professionals for further assessment and expertise when clinically indicated.
- ensure arrangements were in place to provide timely health care in line with the recommendations of health care professionals.

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 9: Residents' rights

The provider had not ensured that residents were facilitated to be as independent as possible and to exercise personal choice in their daily lives. Residents were not enabled to make choices about their care and possible risks associated with such choices. For example, residents' choice with regard to their refusal of medical care and their choice to access external areas of the premises independently were not upheld.

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 14: Persons in charge	Not compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 25: Temporary absence or discharge of residents	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Esker Ri Nursing Home OSV-0000733

Inspection ID: MON-0043694

Date of inspection: 29/05/2024

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 14: Persons in charge	Not Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: The Provider has recently appointed a new Person in Charge (PIC), who is a registered nurse and holds a post-registration qualification in leadership and management and meets the criteria set by the regulatory requirements. Time Frame: Completed	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: We will develop a written Governance and Management Framework for the center detailing roles, responsibilities, reporting relationships and reporting arrangements for each grade of staff. Time Frame: 26th July 2024 In accordance with the above framework, clinical nurse managers will gather information from clinical handovers about · Any new resident admitted to the center. · Any resident whose condition has deteriorated. · Any resident who has suffered an incident/event that did have or could have potential for injury or harm, for example, a fall, Absconding, medication errors, safeguarding incidents and so on.	

The CNM will then review documentation completed for the above, including incident forms, assessments and care plans for these residents to ensure that incident forms are complete, that assessments and care plans have been updated as required and any referrals needed have been made. The CNM will ensure the above is carried out during their shift.

The CNM will also liaise with nursing staff in situations where there is consideration of the need for a resident to be transferred to hospital. The Nursing staff will ensure that the transfer is appropriate and that the required documentation is sent with the resident if transfer to hospital is required. The PIC will continue to maintain oversight of all transfers from the center.

The CNM role will also include a random audit of two care plans on a weekly basis, with provision of feedback to the relevant nurses on any deficits found and the need to make changes as appropriate. The audit tool will include criteria for maintenance of referrals to allied healthcare professionals.

To support CNMs in the above, the PIC has arranged
· An in-house mentoring program for CNMs that includes auditing of residents' records.
· Training for both CNMs and nurses on the use of an evidenced based Transfer Triaging Tool in healthcare has been completed.
· Training for both the PIC and Director of Nursing on the implementation and auditing of the Transfer Triaging Tool will form part of a national project on same. The Transfer Triaging Tool training and use of the tool provides staff with direction as to the appropriate pathway of care where a resident has either an injury or deterioration in a condition requiring further assessment by their GP or transfer to hospital

Time Frame: 30th September 2024.

An audit of all transfers from the center has been completed by the person in charge. Areas for improvement and learning and subsequent quality improvement plan have been submitted to the inspectorate.

Time Frame: Completed.

The electrician is currently completing works on those fire doors that were being held open to eliminate the practice of staff keeping these open as found on inspection. Staff have been informed that these doors must not be kept open with furniture.

Time Frame: 19th July 2024.

Records of training will be updated in accordance with training completed by staff and a copy of these will be available for inspection.

Time Frame: Completed.

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
Nurses will receive training on completion of the appropriate incident forms for situations where a resident may have suffered potential abuse or harm.

Time Frame: 31st July 2024.

In accordance with the new Governance and Management Framework for the centre, CNMs will have responsibility for reviewing incident forms on a day to day basis.

Time Frame: 31st July 2024.

Currently, the person in charge is reviewing incident forms and documentation related to incidents until the CNMs have completed mentoring on same as part of the in-house mentoring programme for CNMs. Incidents related to suspicions or allegations of abuse will be referred to the Director of Nursing who has been designated as the senior manager with responsibility and overall accountability for promoting and managing safeguarding in the service. As part of the role, this manager will follow through on the investigation of all allegations and suspicions of abuse.

Time Frame: Completed.

In accordance with the new Governance and management Framework, CNMs will review documentation for all new residents and those transferred to hospital. This will include entry of information in the residents' directory.

Time Frame: 20th July 2024

All Multidisciplinary Team referrals made will be documented in the Residents notes and the recommendations placed in the residents plan of care by the Nurse on duty. This will be monitored by the Clinical Nurse Managers with responsibility for the relevant areas and through completion of the weekly activity report. The Clinical Nurse Manager will liaise with the Multidisciplinary Team members following the initial referral to ensure the residents have prompt access to the relevant services. The PIC will maintain oversight through the care plan audits and through review of the weekly KPI Reports.

Time Frame: 20th July 2024

All residents within the center will have a scheduled review each quarter with their own GP or the in-house locum GP.

Time Frame: Completed.

Going forward, all staff rosters will be maintained in line with the requirements of

Schedule 4(9) and reflect the actual roster worked by staff. The management team will be recorded as onsite when they attend the centre.

Time Frame: Completed.

A training needs analysis has been conducted within the centre. A training schedule is now in place to ensure that mandatory training is up-to-date.

Time Frame: 15th August 2024

The PIC submits some specified KPI data on a weekly basis to the Senior Governance team. A summary of all KPI activity within the center is analysed at the end of each quarter. The findings are then presented to the Registered Provider representative at the Quality, Risk & Safety committee meetings.

Time Frame: 30th August 2024

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
A PIC has being recently appointed with the necessary qualifications and experience.

Time Frame: Completed

A revised governance and management Framework will be introduced within the centre. This will outline hierarchical structures, delineate reporting lines, and specify individual roles and responsibilities across different departments and levels of management. This initiative aims to strengthen our governance framework and ensure effective supervision of nursing staff under the guidance of Clinical Nurse Managers (CNMs). This will outline specific roles and responsibilities for clinical governance and risk management at all levels using a defined clinical governance framework for the centre.

Time Frame: 30th July 2024

CNMs will complete an in house mentoring programme to ensure they have the knowledge and skills to meet their responsibilities under the new governance and management framework. These responsibilities will include daily monitoring of resident care as outlined under regulation 16 as well as responsibilities for risk management, completing audits and developing improvement plans, completing weekly KPI reports on the electronic system for review by the PIC / deputy.

The PIC submits some specified KPI data on a weekly basis to the Senior Governance

team. A summary of all KPI activity within the center is analysed at the end of each quarter. The findings are then presented to the Registered Provider representative at the Quality, Risk & Safety committee meetings.

Time Frame: 30th September 2024

We will update our risk management policy to outline the procedure for escalation of concerns related to quality and safety data reviewed on a daily and weekly basis.
We will also develop a clinical governance policy to outline the arrangements in place at all levels for continuous quality improvement in the centre.

Time Frame: 30th July 2024

We will establish a comprehensive audit framework to conduct regular audits aimed at identifying areas for improvement within the center. Leading this auditing process will be the Person in Charge (PIC) and Director of Nursing (DON). Specific areas of audit will be delegated to CNMs and senior management. CNMs will receive mentoring on completion of audits. Following the audits, a Quality Improvement Action Plan will be implemented based on the findings. This action plan will clearly designate responsible individuals for each task and define specific timelines for completion.

Time Frame: 31st July 2024

The PIC/DON in turn conduct a weekly review of the key performance indicators to identify any deficits requiring immediate actions.

Time Frame: 19th July 2024

Trending and analysis of the centres quality and safety indicators will be reviewed, trended and analysed by the Person in charge, and these will be reviewed at the Clinical Governance meeting with the regional operations manager. Improvement plans will then be agreed and recorded by the Person in charge.

Time Frame: 31st July 2024

The Quality Improvement plans derived from the Audits undertaken will form part of the on going Quality Improvement plan within the center. These findings will form part of the Quarterly analysis that are shared with the Quality, Risk and safety committee, attended by the Registered Provider representative and members of the Senor Governance team.

Time Frame: 31st July 2024

Regulation 4: Written policies and procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
The required Schedule 5 policies have been reviewed and are now in place. As part of their induction, all staff members are required to read these Schedule 5 policies and other relevant policies when they begin their roles within the center. When any policies are revised, existing staff are informed of the changes and are required to read and sign to confirm they have understood the content of the updated policies.

Time Frame: Completed.

As outlined previously, we have designated the Director of Nursing a senior manager with responsibility and accountability for promoting and managing safeguarding. Investigations of safeguarding incidents will be carried out by the Director of Nursing.

Time Frame: Completed.

CNMs will monitor completion of incident forms related to allegations of abuse on a daily basis.

Time Frame: 31st July 2024

The CNMs will also follow up on documentation related to new admissions, residents whose condition has deteriorated and those who need transfer to hospital.

Time Frame: 31st July 2024

CNMs will also carry out an audit of a random sample of two residents per week and feedback to the appropriate nurse on deficits and in assessments and care plans.

Time Frame: 30th August 2024

Regulation 25: Temporary absence or discharge of residents	Not Compliant

Outline how you are going to come into compliance with Regulation 25: Temporary absence or discharge of residents:
The national transfer document and health profile for residential care facilities will be introduced and used for all resident transfers to hospitals. This document will ensure that all relevant health information is accurately and promptly shared during the transfer process. It will support continuity of care by providing the receiving hospital with a comprehensive understanding of the resident's health status and history. This ensures

residents receive consistent care, particularly during hospital transfers.

Time Frame: 8th July 2024

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
All residents admitted to the center undergo a pre-admission screening assessment conducted by the PIC/DON to identify their care needs and associated risks.

Upon admission, the staff nurse on duty performs a comprehensive assessment.

On day three following admission, the CNM conducts an audit to ensure all required assessments for new residents are completed. The CNM also reviews the care plans to ensure they are person-centered and informed by the comprehensive assessments.

The CNM role will also include a random audit of two care plans on a weekly basis, with provision of feedback to the relevant nurses on any deficits found and the need to make changes as appropriate. The audit tool will include criteria for maintenance of referrals to allied healthcare professionals.

Time Frame: Completed.

Additionally, all nursing staff will be assigned supernumerary time with the Clinical Nurse Managers to review their assigned residents' care plans. This process ensures the care plans accurately reflect the residents' wishes and the findings of their comprehensive assessments.

Time Frame: 30th August 2024

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
We have ensured on-site GP availability by accessing a Locum GP service. This ensures that a GP is available at specified days within the center. Outside regular surgery hours, including nights and weekends, the MIDOC service will provide medical support for all residents and address any urgent health needs promptly.

Time Frame: Completed.

Training for both CNMs and nurses on the use of an evidenced based Transfer Triaging Tool in healthcare has been completed.
Training for both the PIC and Director of Nursing on the implementation of the Transfer Triaging Tool and use of the tool provides staff with direction as to the appropriate pathway of care to access where a resident has either an injury or deterioration in a condition requiring further assessment by their GP or transfer to hospital

Time Frame: 30th September 2024

All residents are referred to the required health care and Multidisciplinary Team services when clinically indicated. The referrals made are documented in the Residents notes and the recommendations placed in the residents plan of care by the Nurse on duty. The PIC will maintain oversight through their review of the weekly KPI Reports.

Time Frame: 30th July 2024

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: To enhance staff development and ensure personalized care, we have scheduled a thorough review of all care plans within our center.

Timeframe: 31st August 2024

In tandem with this review, all nursing staff will complete training on consent and positive risk taking during the month of August to implement these policies and ensure a positive risk taking approach to care in accordance with each resident’s will and preferences

Timeframe: 31st August 2024

Positive risk assessments will be completed with residents or their representatives as appropriate for those who wish to walk around the grounds unaided and unsupervised.

Timeframe: 31st July 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 14(6)(b)	A person who is employed to be a person in charge on or after the day which is 3 years after the day on which these Regulations come into operation shall have a post registration management qualification in health or a related field.	Not Compliant	Orange	15/07/2024
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/09/2024
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Not Compliant	Orange	30/08/2024

Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Substantially Compliant	Yellow	15/08/2024
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Not Compliant	Orange	30/09/2024
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	30/09/2024
Regulation 25(1)	When a resident is temporarily absent from a designated centre for treatment at another designated centre, hospital or elsewhere, the person in charge of the designated centre from which the resident is temporarily absent shall ensure that all relevant information about the resident is	Not Compliant	Orange	08/07/2024

	provided to the receiving designated centre, hospital or place.			
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.	Not Compliant	Orange	31/08/2024
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Not Compliant	Orange	30/08/2024
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	30/08/2024
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide	Not Compliant	Orange	30/09/2024

	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.			
Regulation 6(2)(a)	The person in charge shall, in so far as is reasonably practical, make available to a resident a medical practitioner chosen by or acceptable to that resident.	Substantially Compliant	Yellow	30/09/2024
Regulation 6(2)(b)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the resident agrees to medical treatment recommended by the medical practitioner concerned, the recommended treatment.	Substantially Compliant	Yellow	30/09/2024
Regulation 6(2)(c)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the care referred to in paragraph (1) or other health care service requires additional professional	Substantially Compliant	Yellow	30/09/2024

	expertise, access to such treatment.			
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	31/08/2024