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:	Dundalk Care Centre
Name of provider:	Tempowell Limited
Address of centre:	Inner Relief Road, Marsh South, Haggardstown, Dundalk, Louth
Type of inspection:	Unannounced
Date of inspection:	01 February 2023
Centre ID:	OSV-0008237
Fieldwork ID:	MON-0038787

About the designated centre

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

Dundalk Nursing Home is nestled on the edge of the peaceful townland of Haggardstown.
It is registered to accommodate 130 residents all in single ensuite bedrooms and offers an extensive range of short term, long term and focused care options to residents. The ethos of Dundalk Nursing Home is to provide quality person centred care, where residents are offered choice in their in their way of life and are consulted and participate in decisions regarding their care.

The nursing home is set in landscaped gardens with exceptional views across fields of outstanding beauty. There are a number of enclosed outdoor areas ideal for anyone wishing to spend time in nature, suitable for outdoor pursuits and recreational activities as well as providing tranquil space.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	52

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 1 February 2023	09:30hrs to 18:00hrs	Sheila McKevitt	Lead
Friday 3 February 2023	09:30hrs to 13:00hrs	Sheila McKevitt	Lead
Wednesday 1 February 2023	09:30hrs to 18:00hrs	Geraldine Flannery	Support

What residents told us and what inspectors observed

Inspectors observed that residents were well groomed. Those spoken with said they received the assistance of staff with activities of daily living. However, some residents reported that staff were extremely busy. One resident told the inspectors that it was often nearly lunchtime by the time staff had time to assist them to get washed and dressed and they would prefer to be assisted earlier in the day. Another resident said staffing at night was particularly poor, and said that nursing staff were overheard complaining that there were not enough nurses on duty at night, which was not nice to hear. The resident went on to explain that when the staffing levels were low, the staff on duty were not always in good form, as they were stressed and this was not nice for residents who relied on staff for company.

Staff spoken with confirmed that they were often short of staff. They said there was a high staff turnover and they felt the high level of staff sick leave was due to the high demands of the job. They said that it was always busy and explained that there were constant admissions into the centre, which required a lot of time. On review of the roster on day two of the inspection there was just one staff nurse rostered to work on night duty, however assurances were sought and gained that a second nurse was sought and rostered to work the night shift.

Inspectors observed that the standard of nursing documentation was not of the required standard. There was an absence of appropriate assessments and care plans for residents within 48 hours of admission. The oversight of nursing documentation practices was insufficient.

Residents' rights' were upheld. Residents spoken with said they were given choices in relation to food offered at each mealtime and also what activities they attended.

Residents described the food as excellent, they received a choice of meals and drinks. Inspectors observed the lunchtime dining experience, which appeared to be a relaxed event which residents appeared to be enjoying. There was a lot of chat between residents and in some cases with staff, who were available to residents who required assistance.

Residents' right to privacy was maintained. There were privacy locks on each bedroom, en-suite, communal bathroom and toilet door.

Laundry facilities were available on site. Residents informed inspectors that they sent their laundry for washing and received it back clean and fresh. Clothing was labelled with the resident's name to prevent loss and one resident explained that when they had something go missing it had been returned.

Residents' enjoyed the choice of activities particularly the exercise class which was in full swing on the first day of inspection. Another resident said they really enjoyed

their visit to the hairdresser who attended the centre on a weekly basis.

Inspectors observed that staff did not have access to clinical wash hand basins and that some issues identified under infection prevention and control and under premises remaining outstanding and reappear on this report.

Some staff reported they were cold and therefore were wearing long sleeved tops over their uniform when delivering care, one resident also told inspectors that they found it cold at night. However, the resident said they had not informed staff but would the next time. The temperature dial in a number of communal areas were checked and most read either 21 or 23 degrees centigrade.

The next two sections of this report present the inspection findings in relation to the governance and management in the centre, and how governance and management affects the quality and safety of the service being delivered. The areas identified as requiring improvement are discussed in the report under the relevant regulations.

Capacity and capability

Overall, this was not well-managed at the time of the inspection. There had been 78 residents admitted to the centre since it was registered on 26 August 2022, 33 of whom were admitted in January 2023. The inspectors found that the person in charge did not have adequate support from the wider organisation supporting structures to effectively manage this volume of admissions. In addition, management systems had not been implemented to effectively monitor the quality of care being delivered. Inspectors found that the oversight of clinical care was poor. They also found that staffing levels were not sufficient to meet the needs of residents at all times and staff supervision was lacking in areas which resulted in some staff working without having the required mandatory training in place. Inspectors also found that policies were not implemented in practice.

This was the second risk inspection carried out in Dundalk Nursing Home since it was registered on 26 August 2023. Tempowell Limited is the registered provider of Dundalk Nursing Home. The senior management team included the provider representative, person-in-charge, and an assistant director of nursing. This team was supported by a director of clinical governance and quality, a chief operating officer, a group facilities manager, human resource staff, and administrative supports. However, inspectors found that the level of support provided to the person-in-charge was not adequate and had a negative impact on the quality care delivered to and the quality of life experienced by residents living in the centre.

Inspectors found that adequate resources were not available to ensure the service provided was safe, appropriate, consistent and effectively monitored. There were no systems in place to oversee practices. In the absence of an established system, the areas of non-compliance identified on this inspection had not been identified by the management team and had led to a less then satisfactory quality of care being

delivered to residents. Following the inspection, an urgent compliance plan was issued and a cautionary meeting was held with the governance and management team, where assurance was sought and received from the provider that they would take immediate action to bring the centre into compliance.

Training was not adequately resourced. Staff had not completed mandatory training prior to commencing work in the centre or on induction. Therefore, staff were working with residents without having their mandatory training in place. This was not in-line with the centre's own policy and had the potential to negatively impact the standard of care delivered to residents.

The centre was not appropriately resourced with staff. This had a negative on the quality of care that residents received.

Regulation 15: Staffing

Inspectors found that there were not enough qualified staff nurses employed to work in the centre to ensure that the high volume of residents being admitted to the centre were comprehensively assessed.

Judgment: Not compliant

Regulation 16: Training and staff development

The provider had not ensured that staff had the appropriate training in place:

- All staff did not have the required mandatory training in place prior to commencing work in the centre. Over a quarter of the staff employed since July or August 2022 had not completed training in safeguarding vulnerable adults. A small number had not completed fire safety and/or manual handling training.
- The staff member working in the laundry did not know how to turn off the gas supply in the event of an emergency. This was identified as an issue in the last inspection and despite assurances provided by the provider, staff working in the laundry had not received this training.

Judgment: Not compliant

Regulation 19: Directory of residents

The residents directory was reviewed and it was found to contain all the required

information outlined in part 3 of Schedule 3.

Judgment: Compliant

Regulation 21: Records

The planned and actual rosters provided to inspectors were not accurate. Staff who were scheduled to work as per the roster, were not actually on duty for a variety of reasons outlined by the person in charge. For example, staff nurses and housekeeping staff.

Judgment: Substantially compliant

Regulation 23: Governance and management

The inspector was not assured that the centre was well managed, resourced or monitored:

- the person in charge did not have the appropriate level of support from the senior management team to enable effective management and oversight of service.
- the management structure was not clearly defined and the lines of authority and accountability were not clear. They were not in line with the statement of purpose.
- the specific roles and responsibilities of the management team were not clear.
- the proposed admission schedule submitted to the chief inspector during
- the registration of the centre was not implemented in practice, for example, there had been 78 admissions to the centre since it opened on 26 August 2022, 33 of which had been admitted in January 2023. The inspectors saw evidence that more than nine residents per week were admitted for short stay at times.
- there was an audit schedule available for Jan 2023 only, however all the audits outlined in the schedule had not been completed.
- for those completed, such as the complaints audit, the audit tools used, analysis of findings, action plans, responsible person and time-frames were not available for review.Medication management systems were not robust as further evidence under regulation 29.
- one staff nurse who was rostered to work on the actual roster for the week of the inspection was not registered with Nursing and Midwifery Board of Ireland (NMBI) as a staff nurse. Inspectors noted on day two of this inspection that this staff nurse's name had been removed from the roster.

Judgment: Not compliant

Regulation 31: Notification of incidents

The chief inspector had been informed of all incidents which occurred in the centre within the required timeframe.

Judgment: Compliant

Regulation 34: Complaints procedure

The complaints made to date were being addressed in line with the complaint's policy. There were two opened complaints both of which were being addressed by the person in charge.

Judgment: Compliant

Regulation 4: Written policies and procedures

The registered provider had not ensured that all the policies prepared in writing were detailed enough to guide practice and to ensure they were implemented in practice: For example,

- the medication management policy did not outline the procedure for nurses to follow when checking controlled drugs on a daily basis.
- the medication management policy did not outline the procedure to return medications to pharmacy.
- the staff recruitment, selection and appointment policy stated that "employees will commence employment when a completed garda vetting has been received". This was not being adhered to in practice as per evidence found during this inspection.

Judgment: Not compliant

Quality and safety

Significant improvements to the quality and safety of care provided to residents

were required to ensure residents received a high standard of quality care as stated in the registered provider's statement of purpose and were safeguarded by staff who had the required training and knowledge to effectively identify and meet residents' needs.

Inspectors found that residents were not appropriately assessed on admission to the centre. A comprehensive assessment and other relevant clinical risk assessments were not in place for residents who had been admitted to the centre. In addition, a number of residents did not have care plans in place to reflect their identified care needs and guide staff in the provision of care in line with multidisciplinary assessment. The failure to comprehensively assess a resident on admission and outline the care they required in a person-centred care plan had the potential to negatively impact the quality of care delivered to residents.

Not all residents had a medical review completed within 48 hours of admission. There was evidence that residents had access to all the required allied health professionals services and inspectors saw evidence that a variety of these practitioners were involved in assessing and caring for the residents. However, the poor standard of clinical documentation, showed that specialist's visits were not always recorded. The overall standard of nursing care was not high. This is reflected in the evidence outlined below under the respective regulations.

Premises were clean and uncluttered, all entrances and exits were clear. Residents were receiving visits as and when required and they assured the inspectors their right to visitors was being upheld.

There was a safeguarding policy in place, however all staff had not received the required appropriate training in the protection of vulnerable residents prior to starting work in the centre. An Garda Siochana (police) vetting disclosures had not been secured for two staff prior to commencing employment, and therefore the protection of residents was not assured. The provider was not a pension-agent for any residents. There was a safe system in place to hold petty cash on behalf of the resident.

The medication management management practices were not aligned with best practice guidelines. The administration practices in relation to control drug administration practices, records and the safe storage of medication all required review to ensure that current practices did not pose a risk to residents.

Regulation 17: Premises

Inspectors were informed that the safety risk to residents on the roof terrace in relation to the height of the parapet wall had not been addressed to date . This area remained inaccessible to residents.

The Chief Inspector had been notified of visitors pressing the fire alarm at the front door by accident. Inspectors observed that there was no clear signage at the front

door informing visitors that they had to ask the receptionist to let them out. Inspectors were informed that the maintenance team were to fit a cover over fire alarm button, however at the time of inspection this had not taken place.

A stainless steel folding table for the laundry had not been installed. Inspectors were informed that it had been ordered in January 2023 and it would be installed on delivery.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Water and a glass was available in the residents rooms. Residents informed inspectors that there was a good choice of food available to them and that they could access food and snacks whenever they wanted.

Judgment: Compliant

Regulation 27: Infection control

While a number of alcohol hand gel points were in place, staff did not have access to clinical wash hand sinks throughout the centre.

Inspectors observed inappropriate mask wearing throughout the first day of inspection. Increase mask wearing stewardship was required.

Inspectors observed that staff were not wearing their uniform in-line with best practice or the uniform policy. For example, some staff were seen wearing long chains on their necks and others wore long sleeve tops over their uniform, which did not ensure adherence to bare below elbows infection control standards. When staff were asked why they wore the long sleeve top, they said they were cold.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The two fire doors, one on the dirty side and one on the clean side of the laundry were held open, this was rectified at the time by staff.

Housekeeping staff were not aware of how to turn off the gas supply in the event of

a gas leak.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

The person in charge had not ensured that all medicinal products were administered in accordance with best practice for the administration of medications by nurses:

- The inspector observed that a controlled medication had been administered to a resident, the staff nurse had signed the residents administration chart to state that they had administered the medication, however they had failed to complete the controlled medication book, and therefore there was no evidence that the controlled medication had been checked with a second nurse in line with best practice guidelines.
- Two nurses had checked the controlled drugs at 8 am and 8 pm each day. They had not picked up on this gap/error in the controlled medication book as they were not checking the controlled medication book against the number of controlled medications in the locked cupboard.

The person-in -charge had not ensured that medicinal products dispensed by a pharmacist for administration to residents were stored securely. Inspectors observed:

- An unsealed purple pharmacy box on the outside of the reception desk. It contained two rolls of individual packets of medications dispensed for two residents.
- Four unsealed purple pharmacy box were in an unlocked sitting room that contractors were using throughout the course of the inspection to access the internal courtyard where they were repairing a blocked pipe.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

The person in charge had not arranged for all residents to be comprehensively assessed on admission and had not ensured that each resident had a care plan in place to reflect their assessed needs within 48 hours of their admission|:

- A comprehensive assessment had not been completed for residents immediately before or on admission to the centre. Four residents records were reviewed, and one out of the four had a comprehensive assessment fully completed. The remaining three comprehensive assessments were incomplete and inspectors could not determine the needs of the resident due

to poor standard of nursing documentation.

- Each resident did not have a care plan in place to reflect their care needs. For example, some care plans reviewed were set-up on the computerised documentation system but were not personalised and did not reflect the care required by the resident. For example, inspectors noted from the daily nursing records that one resident was an insulin dependent diabetic. This was not reflected in the residents partially completed comprehensive assessment and the resident did not have a care plan in place reflecting the care they required.
- Where a resident had been identified as approaching the end of their life the person in charge had not ensured that they had their wishes reflected in an end of life care plan. Therefore, inspectors were not assured that the resident would receive the care and comfort that reflected their wishes when they approached the end of their life. Staff spoken with were not aware of residents end-of-life wishes which were recorded on their hospital transfer documents.

Judgment: Not compliant

Regulation 6: Health care

Residents did not have a comprehensive assessment of their medical care needs completed prior to or within 48 hours of their admission to the centre. In the absence of appropriate assessment and regular review, a high standard of evidence-based nursing care was not evident.

Judgment: Not compliant

Regulation 8: Protection

The registered provider had failed to take all reasonable measures to protect residents from abuse:

Two staff members whose names appeared on the staff roster did not have garda vetting in place. One of these, was observed working beside another staff nurse on the orange corridor on the first day of this inspection. This was discussed with the person in charge and the staff member was subsequently moved into an office. On day two of this inspection their names had been removed from the weekly roster and inspectors were assured they were not on duty.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Dundalk Care Centre OSV-0008237

Inspection ID: MON-0038787

Date of inspection: 01/02/2023

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: To ensure compliance the RPR will have the following in place and implemented and actioned as required: • The DCGQR and the COO review on a weekly basis the roster submitted by the PIC. Planned agency is then approved as per process. The roster is reviewed against the dependency of the residents and the size and layout of the home. As this is a new home the Group HR Director also attends this review so future staff requirements are discussed and planned for. • This review will now consider the planned admissions for each roster period to ensure the staff are sufficiently resourced to ensure the admission is safe and is per regulation 5 and 6. • A full review of the roster has taken place with the PIC/ADON and DCGQR. The roster now clearly identifies each department and the homes staff requirements. The roster now endeavours to have 3 nurses day duty and 3 nurses night duty with the addition of 1 CNM/Senior staff nurse daily to support and guide staff. Each Unit has 3 HCA day duty and 1 HCA night duty. • Emergency use of agency is as per process: PIC confirms agency is required to fill the roster and the COO approves.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: To ensure compliance the PIC will have the following in place and implemented and actioned as required:	

• The PIC has completed a full review of the digital HR folders for each staff. All folders now contain and evidence that all staff have had their mandatory training. The Group HR manager will review the Audit report on HR compliance monthly to ensure ongoing training is recorded and staff met the requirements. • The Staff in the laundry have been trained in how to turn off the gas supply in the event of an emergency.

Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: To ensure compliance the RPR will have the following in place and implemented and actioned as required: • The roster format has been changed to better reflect the staffing in the home. The roster is reviewed and agreed weekly with the PIC/ADON and DCGQR. Changes based on day to events are now reflected on the roster.	

Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: To ensure compliance the RPR will have the following in place and implemented and actioned as required: • To ensure the PIC has sufficient and an appropriate level of support the following is in place, Weekly reviews of the planned roster against dependency, size, layout and planned admissions in place to ensure the home has sufficient staff in place to meet the needs of current and planned admissions. A new roster now in place that very clearly identifies the staff required in each area. This will be reviewed weekly by COO and DCGQR and with the PIC/ADON. • All resident's preadmission assessments now will be overseen and reviewed by the DCGQR and PIC to ensure the correct planning is in place to meet the identified care needs. This will be for both short- and long-term residents. • The admission process will be further enhanced by the addition of the CNM/Senior staff nurse daily to support incoming admissions. • A Full care plan review and education and training is underway to ensure care plans meet regulation 5 and 6, with the support of the DCGQR and team. • The Audit schedule is under review at present with the RPR and PIC. The audits will be completed, and an action plan agreed with learning outcomes identified and followed up by the RPR team. The minimum monthly schedule of audits will be completed on Viclarity	

which will allow immediate transparency of actions required to the PIC and RPR team.
• Weekly staff meeting have commenced to ensure staff are aware of the requirements of them to their residents. To ensure they are informed of incoming admissions and how to meet their needs.
• 1-1 session have also commenced with staff to ensure all issues relating to resident wellbeing and care are addressed. This is also an opportunity for staff to discuss any other working concerns they may have. Once feedback is received a plan will be agreed with the PIC and the Group HR Manager.
• A new staff allocation sheet is in the process of being agreed and will support and guide them in care delivery.
• A schedule of training will be agreed and commence this month.
• The Governance support meetings with the PIC are with the DCGQR are as follows - Agenda, Care quality indicator review, Incident/Accident review, Open Complaints, RIP's since previous meeting, HIQA related issues, Facility issues outstanding and AOB.
• The Governance support meetings with the PIC and COO, DCGQR, HR, Agenda- compliance, Quality, Safety, Facilities, Audit updates and Staffing.
• The Governance support meetings with the PIC and the Group HR Manager, Agenda, Recruitment needs, staff issues and staff leavers.
• To ensure 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 the RPR has the following in place: The homes management structure is now clearly defined to show the authority, accountability, specific roles, and details responsibilities for all areas of care provision. The PIC will be supported in their role by the RPR team which consists of their Line Manager COO, DCGWQR, Group HR Director, Clinical Support Nurse and Compliance and Quality Support.
• The admissions schedule is decided by the PIC who ensures that following a preadmission assessment, that the care needs can be met. The admission only takes place if there are sufficient staff rostered to ensure the identified care needs can be met.
• The Audit schedule has been agreed and includes a plan of action, responsibilities and learnings. ViClarity will further enhance this process.
• All nurses on the roster are registered with the Nursing and Midwifery Board of Ireland. No nurse in the future will be rostered as a nurse until registered.

Regulation 4: Written policies and procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
To ensure compliance the RPR will have the following in place and implemented and actioned as required:
• The medication policies have all been reviewed and disseminated to staff to sign off that they understand and will follow the policy. Medication audits continue and finding are reviewed and discussed with staff to ensure learnings. There is a stand-alone policy on the procedure for nurses to follow when checking controlled drug daily.

• The Medication policy reflects the procedure to return medications to the pharmacy. • The policy on staff recruitment, selection and appointment is now fully adhered to. A check takes place with the PIC and homes administrator prior to rostering to ensure all staff have Garda vetting in place.

Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: To ensure compliance the RPR will have the following in place and implemented and actioned as required: • The roof terrace accessibility will be addressed by installing structural glass screens that will allow visibility and ensure safety. • Clear signage is now at the front door to ensure visitors do not press the fire alarm and cover will be fitted. • The stainless-steel folding table for the laundry is in place.	
Regulation 27: Infection control	Substantially Compliant
Outline how you are going to come into compliance with Regulation 27: Infection control: To ensure compliance the RPR will have the following in place and implemented and actioned as required: • Additional Hand gel dispensers have been installed for staff use throughout the centre. • Staff have been reminded in how to wear masks correctly as per IPC policy. • Staff have been instructed on the appropriate uniform wearing to ensure IPC.	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: To ensure compliance the RPR will have the following in place and implemented and actioned as required: • No fire doors will be held open, and staff instructed not the wedge doors open. • All Household trained in how to turn off the gas supply.	

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
To ensure compliance the PIC will have the following in place and implemented and actioned as required:
• The medication policies have all been reviewed and disseminated to staff to sign off that they understand and will follow the policy. Medication audits continue and finding are reviewed and discussed with staff to ensure learnings. There is a stand-alone policy on the procedure for nurses to follow when checking controlled drug daily. The PIC and ADON are ensuring on going compliance and support for staff to ensure adherence to policy.
• The medication audits introduced will ensure compliance and identify gaps and ensure learnings when non conformances found.
• All medicines dispensed by the pharmacy will managed as per policy and reviewed as per Audit.
• All medicines stored as per policy and reviewed as per Audit.

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:
To ensure compliance the RPR and PIC will have the following in place and implemented and actioned as required:
• The introduction of an admission checklist audit is ensuring that all residents admitted into the centre have their comprehensive assessment and care plan are in place. This is being verified by the group clinical governance and compliance team when in the centre
• To ensure each resident has a dedicated care plan to reflect their care needs a weekly review of care Ongoing training with staff to ensure best practice for the resident and ensuring a standard of care is adhered to for the holistic wellbeing of the resident. A comprehensive care plan and assessments as required ensuring care plans are meeting the needs of the residents.
• All residents have had their EOL life wishes reviewed and all staff are aware of the residents status. This is reviewed with the ADON, PIC and GP weekly.

Regulation 6: Health care	Not Compliant
Outline how you are going to come into compliance with Regulation 6: Health care: To ensure compliance the RPR and PIC will have the following in place and implemented and actioned as required: • The introduction of an admission checklist audit is ensuring that all residents admitted into the centre have their comprehensive assessment and care plan are in place. This is being verified by the group clinical governance and compliance team when in the centre.	
Regulation 8: Protection	Not Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: To ensure compliance the PIC will have the following in place and implemented and actioned as required: • Assurance sent to Inspector on the 3rd February to assure that no staff rostered without Garda Vetting in place. Going forward weekly review of the Roster and newly hired staff will take place to ensure no staff are ever rostered without Garda Vetting. This review will be completed by the DCGQR with the PIC/ADON and the Group HR Director	

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 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	10/02/2023
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	24/03/2023
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	07/02/2023
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and	Substantially Compliant	Yellow	30/06/2023

	needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.			
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	30/06/2023
Regulation 21(4)	Records kept in accordance with this section and set out in paragraphs (6), (9), (10), (11) and (12) of Schedule 4, shall be retained for a period of not less than 4 years from the date of their making.	Substantially Compliant	Yellow	07/02/2023
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	10/02/2023
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that	Not Compliant	Orange	10/02/2023

	identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.			
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	10/02/2023
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Substantially Compliant	Yellow	24/03/2023
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Substantially Compliant	Yellow	07/02/2023
Regulation	The registered	Substantially	Yellow	07/02/2023

28(1)(c)(i)	provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Compliant		
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.	Not Compliant	Orange	10/02/2023
Regulation 29(5)	The person in charge shall ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.	Not Compliant	Orange	10/02/2023
Regulation 29(6)	The person in charge shall ensure that a medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident shall be stored in a secure manner, segregated from other medicinal	Not Compliant	Orange	10/02/2023

	products and disposed of in accordance with national legislation or guidance in a manner that will not cause danger to public health or risk to the environment and will ensure that the product concerned can no longer be used as a medicinal product.			
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	10/02/2023
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.	Not Compliant	Orange	10/02/2023
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later	Not Compliant	Orange	10/02/2023

	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	10/02/2023
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Orange	03/02/2023
Regulation 8(2)	The measures referred to in paragraph (1) shall include staff training in relation to the detection and prevention of and responses to abuse.	Not Compliant	Orange	03/02/2023