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:	The Residence Portlaoise
Name of provider:	The Residence PL Limited
Address of centre:	Block B The Maltings, Harpur's Lane, Portlaoise, Laois
Type of inspection:	Unannounced
Date of inspection:	11 March 2024
Centre ID:	OSV-0008667
Fieldwork ID:	MON-0042325

About the designated centre

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

The Residence Portlaoise is a purpose-built nursing home which consists of 101 single registered bedrooms with en suite bathrooms. The Residence Portlaoise is situated a short distance from the town of Portlaoise, therefore the Nursing Home is serviced by restaurants, public houses, local library, community hall, places of worship and also has easy transport links. The Residence Portlaoise accommodates male and female residents over the age of 18 years for short term and long term care. It provides 24 hour nursing care and caters for older people who require nursing care, dementia care, palliative care, respite and post-operative care. There are a variety of communal day spaces provided including dining rooms, day rooms and visitor rooms available. Residents also have access to a large secure enclosed garden.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	24

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Monday 11 March 2024	09:45hrs to 17:45hrs	Sean Ryan	Lead

What residents told us and what inspectors observed

Residents living in The Residence Portlaoise told the inspector that the quality of care and support they received from staff was of a good quality. Residents told the inspector that they felt respected and supported living in the centre. Residents complimented the staff who they described as kind, caring, and friendly and this made residents feel safe living in the centre.

The inspector was met by the person in charge on arrival at the centre. Following an introductory meeting, the inspector walked through the centre and reviewed the premises. The inspector met with the majority of residents during a walk around the centre and spoke with five residents in detail about their lived experience of the centre.

There was a warm and welcoming atmosphere which was apparent to the inspector on arrival to the centre. During the morning, staff were observed to respond to residents requests for assistance promptly. Staff paced their work so that they had time to engage socially with residents, when providing care. Residents who spoke with the inspector were very complimentary in their feedback about the staff. They described how staff were prompt to answer their call bells. Residents never felt rushed by staff, and they reported that they were always greeted with 'friendliness'. Residents enjoyed engaging with all staff, and spent time chatting with them throughout the day. Residents were familiar with the staff that provided them with care and support and this made them feel safe and comfortable in their care.

This centre was a new purpose-built residential care facility registered to provide care to 27 residents with a range of dependency care needs. The centre had capacity to provide accommodation to 101 residents in single bedroom accommodation over three floors. However, only the ground floor was currently registered to accommodate residents.

The premises was well maintained, bright, clean, spacious and laid out to meet the needs of the residents. There was adequate private and communal space for residents to use and enjoy. There were appropriately placed hand rails to support residents to walk independently around the centre. There was a large enclosed garden accessible to residents. The garden area was appropriately furnished and maintained to a satisfactory standard. There was ample storage facilities for equipment, and corridors were maintained clear of items that could obstruct residents who were observed walking around the centre. The provider had installed guard rails around the majority of the terraced area on the first and second floor, and works were ongoing to complete this renovation on the day of inspection.

Residents were provided with large spacious bedrooms that were personalised, and decorated according to each resident's individual preference. Residents told the inspector they were satisfied with their bedroom accommodation, furnishings and storage facilities for their personal belongings. Each room had lockable storage

facilities for residents to securely store personal belongings. Residents told the inspector they were encouraged to 'make it their own' referring to the personalisation of their bedroom. Residents had accessible en-suite facilities that supported them to move safely and freely to use their bathroom facilities. The inspector observed that residents had pictures of their relatives and friends, and ornaments on display. Call bells were available in all bedrooms and communal areas for residents.

Residents personal clothing was laundered on-site and residents told the inspector they were satisfied with this service. Personal clothing was discretely labeled to minimise the risk of items becoming misplaced or lost.

The residents dining experience was observed to be a pleasant, sociable and relaxed occasion for residents. Residents had a choice of meals from a menu that was updated daily. Meals were served to residents in the main dining room, and were attractively presented. Staff were observed to provide assistance and support to residents in a person-centred manner. The inspector observed that residents were facilitated to attend the dining room at a time of their choosing. Staff were also observed attending to residents in their bedrooms to provide support during mealtimes. Residents expressed a high level of satisfaction with regard to the quality and quantity of food they received, and confirmed the availability of snacks and drinks at their request.

All residents in the centre were seen to be well dressed and it was apparent that staff supported residents to maintain their individual style and appearance.

There was a large notice board at the main reception area that displayed a variety of information for residents. This included information about the complaints procedure, activities, and independent advocacy services. Residents were aware of the procedure to make a complaint and told the inspector that the management were receptive to feedback about the quality of the service.

Residents told the inspector that they looked forward to activities as they were the most enjoyable part of their day and spoke positively about the variety of activities they could choose to attend. This included a discussion on current affairs in the morning, followed by a choice of activities such as arts and crafts, knitting, bingo, and music activities.

The inspector met with two visitors during the inspection. Visitors expressed a high level of satisfaction with the quality of the care provided to their relatives and friends and stated that their interactions with the management and staff were positive. Visitors reported that the management team were approachable and responsive to any questions or concerns they may have.

The following sections of this report detail the findings with regard to the capacity and capability of the centre and how this supports the quality and safety of resident care.

Capacity and capability

This was an unannounced inspection carried out over one day by an inspector of social services to;

- monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended).
- inform a decision in relation to an application to vary conditions of the registration of the centre, to register an additional 74 beds located on the first and second floor of the premises.

The findings of this inspection were that the provider had an established management structure in place that was responsible for the provision of safe and quality care to the residents. However, some action was required with regard to the governance and management of The Residence Portlaoise to ensure full compliance with the regulations. Accountability and responsibility for key aspects of the service were not clearly defined within the management structure and this impacted on the implementation of robust systems to ensure the service provided to residents was safe, consistent and effectively monitored. This included the systems in place to manage risk, and the systems to monitor, evaluate and improve some aspects of the quality and safety of the service. Some action was also required to ensure the service met the needs of the residents living in the centre, particularly in terms of fire safety, individual assessment and care planning, and health care.

The inspector reviewed unsolicited information received by the Office of the Chief Inspector. The information pertained to concerns regarding the assessment of residents care needs and associated care plans, the communication of resident information that is used to plan and deliver person-centred, safe and effective care, and the safe and planned discharge of residents from the designated centre. This information was found to be substantiated on this inspection.

The Residence Portlaoise was first registered in December 2023 by the Chief Inspector to operate as a designated centre for older persons. While the provider had initially applied to register the centre to accommodate 101 residents over three floors, a site visit of the centre in advance of registration identified concerns with regard to the security of the terraced areas on the first and second floor of the centre. Consequently, the Chief Inspector registered the centre with an additional restrictive condition attached to the centre's registration. Condition 4 ensured that the provider admitted residents to the ground floor only. Admissions were restricted to the first and second floor of the designated centre until such time as the terraced outdoor space on the first and the second floor had been renovated to meet the safety needs of residents.

The Residence PL Limited is the registered provider of The Residence Portlaoise. The company has a board of five directors, who are involved in the operation of other

designated centres for older persons. The registered provider was represented by one director in engagement with the Chief Inspector.

The organisational structure supporting the designated centre consisted of a board of directors, chief operating officer, and a regional director who was a person participating in the management of the centre. The regional director was responsible for monitoring clinical and operational aspects of the service, in addition to providing oversight and governance support to the person in charge. Within the centre, the was a person in charge who was supported clinically, and administratively, by an assistant director of nursing, and a clinical nurse manager. Responsibilities for key aspects of the service were delegated to members of the clinical management team to support the person in charge to maintain oversight of the quality and safety of the service provided to residents.

On the day of inspection, the organisational structure was not clearly defined. While accountability and responsibility for monitoring key aspects of the service such as the organisation of the staffing resource and residents clinical records were delegated to the management personnel within the centre, the inspector found that the senior regional management personnel were managing the the day-to-day staffing resources within the centre. Consequently, it was unclear who was responsible for ensuring appropriate staffing levels were maintained on a daily basis.

The centre had sufficient resources to ensure effective delivery of good quality care and support to the current residents. The team providing direct care to residents consisted of a registered nurse, and a team of health care assistants. There were sufficient numbers of housekeeping, catering and maintenance staff in place. There was a system in place to ensure clear and effective communication between the management and staff. The strategy in relation to admission of residents to the centre was organised and planned to allow for recruitment of staff on a phased basis.

The provider had management systems in place to monitor, evaluate and improve the quality and safety of the service provided to residents. This included a variety of clinical and environmental audits, analysis of complaints, weekly monitoring of quality of care indicators and trending of incidents involving residents. However, a review of completed audits found that some audits were not effectively used to identity risks and deficits in the service. For example, completed audits of resident fall incidents assessed the actions taken by staff to support residents following a fall's incident, such as updating fall's risk assessments, care plans and referral of residents for further expert assessment. Each completed audit achieved a high level of compliance with the management of fall incidents, with no quality improvement action plan required. However, a review of residents records found that some assessments, and care plans had not been reviewed following an incident and the residents had not been referred for further expert assessment as required by the centre's fall's prevention policy.

The centres risk management policy detailed the management systems that should be in place for the oversight and monitoring of risk in the centre. As part of the risk management policy, a risk register to record all potential risks to resident’s safety

and welfare was required to be maintained. A review of the risk register found that some known risks were not managed in line with the centre's risk management policy. For example, timely referral of residents to medical professionals was an issue impacting the care of a number of residents. While the provider had assessed this potential risk to residents, the controls in place to manage the risk were incomplete, and there was no evidence that the effectiveness of the risk management plan had been reviewed. In addition, risk management plans were not always implemented. For example, while night time staffing levels were identified as a potential risk to the safe and timely evacuation of residents from the centre in the event of a emergency, the actions that included frequent fire evacuation drills simulating minimum staffing levels were not completed.

Notifiable incidents, as detailed under Schedule 4 of the regulations, were submitted to the Chief Inspector of Social Services within the required time-frame.

Record keeping systems comprised of electronic and paper-based systems. Records were securely stored, accessible, and maintained in line with the requirements of the regulations. Staff personnel files contained the information required under Schedule 2 or the regulation. This included a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2021.

There was a training and development programme in place for all grades of staff. Records showed that all staff had completed training in fire safety, safeguarding of vulnerable people, and supporting residents living with dementia. Staff demonstrated an appropriate awareness of their training with regard to fire safety, and their role and responsibility in recognising and responding to allegations of abuse.

There were systems in place to induct, orientate and support staff. The person in charge, assistant director of nursing, and clinical nurse managers provided clinical supervision and support to all staff.

The policies and procedures, as required by Schedule 5 of the regulations, were reviewed by the inspector. Policies had been reviewed by the provider in September 2023 and were made available to staff. However, the registered provider had failed to ensure that some policies and procedures were implemented. This included the policies and procedures in relation to nutritional care, risk management, and medication management.

Regulation 15: Staffing

On the day of inspection, the staffing numbers and skill mix were appropriate to meet the needs of the current residents, in line with the statement of purpose. There were satisfactory levels of health care staff on duty to support nursing staff.

The staffing compliment included laundry, catering, activities staff and administration staff. There was adequate levels of staff allocated to cleaning of the centre.

Judgment: Compliant

Regulation 16: Training and staff development

Training records reviewed by the inspector evidenced that all staff had up-to-date training in safeguarding of vulnerable people, fire safety, and manual handling. Staff had also completed training in infection prevention and control.

There were arrangements in place for the ongoing supervision of staff through senior management presence, and through formal induction and performance review processes.

Judgment: Compliant

Regulation 19: Directory of residents

The registered provider maintained a directory of residents in the centre. The directory contained the information as specified in paragraph (3) of Schedule 3 of the regulations.

Judgment: Compliant

Regulation 21: Records

Records set out in Schedules 2, 3 and 4 were kept in the centre, stored safely and available for inspection. The inspectors reviewed a sample of four staff files. The files contained the necessary information as required by Schedule 2 of the regulations including evidence of a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012.

Judgment: Compliant

Regulation 22: Insurance

The provider had an up-to-date contract of insurance against injury to residents and protection of residents property.

Judgment: Compliant

Regulation 23: Governance and management

The registered provider had not ensured there was a clearly defined management structure in place, with clear lines of accountability and responsibility. It was unclear who held overall accountability and responsibility for key aspects of the day-to-day service delivery such as the organisation and management of the staffing resource, the management of risk, and the oversight of clinical care records. For example, responsibility for the aforementioned aspects of the service were delegated to the management team within the centre, however, the inspector found that the senior regional management team were completing duties such as updating residents care plans. This had the potential to impact on effective governance and oversight of the service, in addition to creating unclear pathways of escalation to the provider.

The management systems in place to monitor the quality of the service required action to ensure the service provided to residents was safe, appropriate, consistent and effectively monitored. For example;

- Risk management systems were not effectively monitored or implemented. Some documented risks were not appropriately reviewed or updated, in line with the centre's risk management policy. For example, risk management plans developed in response to identified risks such as inadequate access to medical professionals was incomplete and did not appropriately detail the actions in place to ensure residents had timely access to a medical practitioner. In addition, some known risks were not included in the risk register. This included the risk associated with locked fire escape doors that required a key to open the door. Consequently, there was no risk management plan in place to manage the risk.
- 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, completed audits with regard to clinical care records, fall's management, residents assessments and care plans, and nutritional care reflected full compliance and did not identify known risks and areas where improvement was required.
- There were ineffective systems in place to monitor and promote the well-being of residents through providing timely and appropriate referral and access to medical and health care services.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Notifiable events as set out in Schedule 4 of the regulations were submitted to the Chief Inspector of Social Services within the required time frames.

Judgment: Compliant

Regulation 34: Complaints procedure

The centre had a complaints procedure that outlined the management of complaints. A review of the complaints register found that complaints were recorded, acknowledged, investigated and the outcome communicated to the complainant.

Judgment: Compliant

Regulation 4: Written policies and procedures

The registered provider had not adopted and implemented policies and procedures designed to support and protect residents. This included the policies in relation to;

- Risk management,
- Nutrition and hydration,
- Temporary absence and discharge of residents.

Judgment: Substantially compliant

Quality and safety

Residents were satisfied with the quality of the service, and reported feeling safe and content living in the centre. There was a person-centred approach to care, and residents' well-being and independence were promoted. However, the findings of this inspection were that the provider did not ensure that residents received care in an environment that protected them from the risk of fire through appropriate fire containment measures. In addition, the assessment of residents needs was not consistently used to inform the development of care plans, and residents were not always provided with timely access to medical and health care. Action was also

required to ensure that the transfer of residents from the centre was carried out in line with the requirements of the regulations.

Arrangements were in place to carry out comprehensive admission assessments to determine if the centre could meet the needs of prospective residents. A sample of assessments and care plans were reviewed and found that there was evidence that the residents' needs were being assessed using validated assessment tools. However, the care plans were not informed by these assessments and did not reflect person-centred, evidence-based guidance. Furthermore, care plans were not always reviewed following a change in the residents condition.

A review of residents' records found that there was regular communication with some residents' general practitioners (GP) regarding their health care needs. However, a number of residents were not provided with appropriate access to medical and health care professionals, when required or requested by residents. While the provider was aware of this issue and a plan was in place to address it, appropriate interim arrangements were not in place to manage the risk or to ensure residents had an accessible general practitioner.

Arrangements were in place for residents to access the expertise of health and social care professionals such as dietetic services, speech and language, physiotherapy and occupational therapy through a system of referral. Records showed that the majority of residents were appropriately referred to health professionals for further expert assessment when clinically indicated. However, some residents assessed as being at risk of malnutrition, and others at risk of falls had not been referred for further expert assessment in a timely manner to ensure best outcomes for residents.

A safeguarding policy provided guidance to staff with regard to protecting residents from the risk of abuse. Staff demonstrated an appropriate awareness of the centres' safeguarding policy and procedures, and demonstrated awareness of their responsibility in recognising and responding to allegations of abuse. Residents reported that they felt safe living in the centre.

A review of records relating to discharged residents found that some discharges from the centre were not carried out in a manner that was safe or planned. One record reviewed found evidence that the discharge process was not carried out in consultation with the resident, or their representative.

Residents were provided with a guide to the services in the designated centre in an accessible format. The guide contained information about the services and facilities provided in the centre, complaints procedure, arrangements for visits and information regarding advocacy services.

The premises was bright, spacious and decorated to a satisfactory standard throughout. Corridors were wide and fitted with handrails to support residents to mobilise independently and safely and all areas of the centre were wheelchair accessible. There was directional signage to assist residents and visitors to navigate the centre with ease. The communal areas were decorated and furnished to make

them homely in appearance. All equipment used by residents was visibly clean and maintained in a satisfactory state of repair.

The inspector found that the premises, including the bathrooms, bedrooms, communal space and dining room, were clean and well maintained. There were cleaning schedules in place, ensuring consistent cleaning of the centres' living environment, curtains and communal bathrooms. Facilities to support effective infection prevention and control measures such as hand hygiene were in place. There was appropriate storage in the sluice rooms and cleaning rooms.

A review of the fire safety systems in the centre found that there were systems in place to ensure that fire detection and emergency lighting were maintained at scheduled intervals. Arrangements were in place to ensure means of escape were unobstructed. Each resident had a personal emergency evacuation plan (PEEP) in place to support the safe and timely evacuation of residents from the centre in the event of a fire emergency. Staff demonstrated good knowledge of the procedures in place to respond to the fire alarm, or in the event of a fire. The inspector found that further action was required in the containment and management of fire. For example, a number of fire doors located along corridors contained gaps at the base of the door. This potentially compromised the function of the fire door to contain the spread of smoke and fire.

Residents' rights were promoted in the centre. Residents were free to exercise choice in how to spend their day. Activities were observed to be provided by dedicated activities staff. Residents told the inspector that they were satisfied with the activities on offer.

There were opportunities for the residents to meet with the management team and provide feedback on the quality of the service.

Visiting was observed to be unrestricted, and residents could receive visitors in either their private accommodation or a number of designated visitors room, if they wished.

Regulation 11: Visits

The registered provider had arrangements in place for residents to receive visitors. Those arrangements were found not to be restrictive, and there was adequate private space for residents to meet their visitors.

Judgment: Compliant

Regulation 17: Premises

The premises was appropriate to the number and needs of the residents in the centre and in accordance with the statement of purpose. The premises conformed to the matters set out in Schedule 6 of the regulations.

Judgment: Compliant

Regulation 20: Information for residents

The registered provider had prepared and made available to residents a guide in respect of the designated centre. The guide included the information required by the regulations.

Judgment: Compliant

Regulation 25: Temporary absence or discharge of residents

The provider did not always ensure that the discharge of a resident was discussed, planned for and agreed with the resident and, where appropriate, their representative.

Judgment: Substantially compliant

Regulation 27: Infection control

There were appropriate infection prevention and control policies and procedures in place, consistent with the National Standards for Infection Prevention and Control (IPC) in Community Settings published by the Authority.

Staff were appropriately training in infection prevention and control practices and procedures. The environment and equipment was appropriately managed to minimise the risk of transmitting a health care-associated infection.

There were appropriate facilities in place to support effective infection prevention and control. Procedures were in place for the cleaning and decontamination of the physical environment and residents equipment. Cleaning procedures were in line with recommended guidelines.

Judgment: Compliant

Regulation 28: Fire precautions

There was inadequate arrangements for containing fire in the designated centre. For example;

- Some fire doors were found to have a gap at the bottom of the door over the allowable tolerance for a fire door. This could impact on the containment of smoke and fire in the event of an emergency.
- Fire doors fitter to a communal bathroom and a store room were not fitted with a door closer to ensure the containment of fire and smoke in the event of a fire emergency.

There was inadequate arrangements for providing adequate means of escape. For example;

- One fire exit to the outside was fitted with a key locking mechanism. The door was locked and a key to open the door could not be located when requested. This had the potential to impact on the safe and timely evacuation of residents from the centre. The provider took action to address this issue on the day of inspection.

A review of fire drill reports found inadequate arrangements had been made for evacuating residents from the centre in a timely manner with the staff and equipment resources available. The evacuation drills did not evidence;

- if a full compartment evacuation had taken place.
- the number of staff participating in the evacuation drill.
- that an evacuation drill had been practiced in the largest compartment simulating minimum staffing levels.

Judgment: Substantially 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, a resident assessed as being at high risk of falls was 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 and protect the resident from further falls.
- Some residents who were assessed as requiring specific care interventions to manage their responsive behaviours (how residents living with dementia or other conditions may communicate or express their physical discomfort, or

discomfort with their social or physical environment) did not have a care plan in place to guide the appropriate care of the residents.
- Care plans were not reviewed or updated when a resident's care needs and condition changed. For example, the care plan of a resident discharged from hospital had not been reviewed or updated following a significant increase in their personal care and support needs.

Judgment: Substantially compliant

Regulation 6: Health care

The registered provider did not ensure that all resident had appropriate access to medical and health care. This was evidenced by failure to provide;

- timely access to general practitioner services.
- timely referral of a resident assessed as being nutritionally at risk further expert assessment, in line with the centre's policies and associated procedures.

Judgment: Substantially compliant

Regulation 8: Protection

There were systems in place to safeguard residents and protect them from the risk of abuse. Safeguarding training was up-to-date for all staff and a safeguarding policy provided staff with support and guidance in recognising and responding to allegations of abuse. Residents reported that they felt safe living in the centre. The provider did not act as a pension agent for any residents living in the centre.

Judgment: Compliant

Regulation 9: Residents' rights

Staff demonstrated an understanding of residents' rights and supported residents to exercise their rights and choice, and the ethos of care was person-centred. Residents' choice was respected and facilitated in the centre. Residents could retire to bed and get up when they choose.

There were facilities for residents to participate in activities in accordance with their interests and capacities. Residents were consulted about the activity schedule to

ensure it was enjoyable and engaging for all residents. Residents complimented the provision of activities in the centre and the social aspect of the activities on offer.

Residents said that they were kept informed about changes in the centre through monthly resident forum meetings and daily discussions with staff and felt that their feedback was valued and used to improve the quality of the service. This included discussions about the quality of the activities and planned outings. A new meeting agenda was being developed to ensure feedback was sought from residents in relation to all aspects of the service provided.

Residents were provided with access to religious services in the centre.

Residents were provided with information about services available to support them, such as independent advocacy services.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Compliant
Regulation 20: Information for residents	Compliant
Regulation 25: Temporary absence or discharge of residents	Substantially compliant
Regulation 27: Infection control	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for The Residence Portlaoise OSV-0008667

Inspection ID: MON-0042325

Date of inspection: 11/03/2024

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 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: A review of the management structure was completed to ensure there is clear lines of accountability and responsibility.Completed 31/3/2024. By 14/04/2024, a review of risk management will be completed by the Director of Nursing to ensure actions identified will be implemented and training will be provided to ensure that policies are followed. From 14/04/2024, risk management systems will be reviewed at the monthly governance meetings to ensure there is a robust system in place for identifying and managing risks as well as ensuring that all controls are actioned in a timely manor. Training will be provided by the PPIM by 14/4/2024 for all staff completing audits to ensure they identify areas for improvement in the service and to ensure they are actioned appropriately. The Director of Nursing will complete a review of systems in place by the 14/4/2024 to ensure appropriate and timely referral and access to medical and health care services.	
Regulation 4: Written policies and procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 4: Written policies and procedures: Training will be provided to all staff by the 12/4/2024 to ensure that all policies and procedures are understood and implemented including Risk Management,Nutrition and Hydration, and Temporary Absence and Discharge of Residents.	

Regulation 25: Temporary absence or discharge of residents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 25: Temporary absence or discharge of residents:
Training and support will be provided for all nursing staff and nurse managers on the management of discharges to ensure that it is planned and agreed with the resident and, where appropriate, their representative. This will be commpleted by the 14/4/2024.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
All fire doors have been reviewed to ensure they meet manufacturer's guidance and will provide containment in the event of an emergency- complete and ongoing

Fire door closures were fitted to the communal bathroom and the store room on the day of inspection. Completed 11/3/2024

The locked door located on the ground floor has been reviewed. The door required a magnetic lock to be attached which will release in the event of a fire. This has been completed 09/04/24.

The Director of Nursing has completed fire simulation drills of a full compartment with all staff. This includes ensuring they are completed with night time staffing levels. From 12/3/2024, this drill will be completed monthly and reviewed at Governance meetings to ensure all learning and improvement oportunities are identified are addressed.

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
All assessments and care plans have been reviewed to ensure they meet the residents' assessed needs. This includes actions required to reduce risks such as increased falls,

responsive behaviors and safeguarding concerns. Completed 15/3/2024. Training will be delivered to all nursing staff to ensure care plans and assessments guide practice, are person centred and are reviewed and updated when a resident's care needs changes. This will be completed by 30/06/2024

Regulation 6: Health care	Substantially Compliant
Outline how you are going to come into compliance with Regulation 6: Health care: In order to ensure that there is appropriate access to medical and health care within the home, medical cover is in place in advance of the commencement of a formal in-house GP service. This will commence the 1st May 2024. A review of the referral pathway for services such as Dietitian, TVN and SALT services was completed on 31/3/2024 and actions implemented to ensure there is timely referral sent and timely interventions in place. From 14/4/2024, a monthly review of resident access to these services will be conducted to ensure timelines are appropriate	

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 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.	Substantially Compliant	Yellow	31/03/2024
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.	Substantially Compliant	Yellow	14/04/2024
Regulation 25(3)	The person in charge shall ensure that, in so far as practicable, a resident is discharged from	Substantially Compliant	Yellow	14/04/2024

	the designated centre concerned in a planned and safe manner.			
Regulation 25(4)	A discharge shall be discussed, planned for and agreed with a resident and, where appropriate, with their family or carer, and in accordance with the terms and conditions of the contract agreed in accordance with Regulation 24.	Substantially Compliant	Yellow	14/04/2024
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Substantially Compliant	Yellow	30/04/2024
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	12/03/2024
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting,	Substantially Compliant	Yellow	11/03/2024

	containing and extinguishing fires.			
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.	Substantially Compliant	Yellow	12/04/2024
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.	Substantially Compliant	Yellow	15/03/2024
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	15/03/2024
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	01/05/2024

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 expertise, access to such treatment.	Substantially Compliant	Yellow	31/03/2024