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

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| Name of designated centre: | Leopardstown Care Centre |
| Name of provider: | Mowlam Healthcare Services Unlimited Company |
| Address of centre: | Ballyogan Road,<br>Dublin 18 |
| Type of inspection: | Unannounced |
| Date of inspection: | 28 February 2024 |
| Centre ID: | OSV-0008692 |
| Fieldwork ID: | MON-0042892 |

## About the designated centre

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

Leopardstown care centre is situated in south county Dublin and is in close distance to a local shopping area. It is a purpose built facility that is currently registered for 51 beds but can accommodate 150 residents in the future.  It is a mixed gender facility catering for dependent persons aged 18 years and over, providing long-term residential care, respite, convalescence, dementia and palliative care. Care is provided for people with a range of needs: low, medium, high and maximum dependency. The registered provider is Mowlam Healthcare Services Unlimited. The person in charge of the centre works full time and is support by a senior management team and a team of healthcare professionals and care and support staff.

**The following information outlines some additional data on this centre.**

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| Number of residents on the date of inspection: | 33 |

## 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 28 February 2024 | 09:40hrs to 18:35hrs | Karen McMahon | Lead |

## What residents told us and what inspectors observed

The overall feedback from residents' was that they liked living in Leopardstown Care centre. Residents' spoken with were complimentary of the staff and said they were nice but that sometimes they were waiting a while for assistance. The Inspector observed staff showing a kind and caring attitude towards the residents' they cared for on the day of inspection. However, the inspector found that some of the governance and management systems in place needed to be improved to ensure the service was safe and appropriately monitored.

On arrival to the centre the inspector was met by the receptionist and person in charge, who guided them through the sign in procedure. After a brief introductory meeting with the person in charge and the operational manager for the centre, the person in charge escorted the inspector on a tour of the premises. The centre is a purpose built designated centre, based on the outskirts of Dublin city and is closely located to local amenities and serviced by Dublin bus routes. The centre is spread out over three floors but currently 51 beds are registered on the ground floor. The registered provider recently submitted an application to vary their registration to include the 99 beds on the first and second floors.

All bedrooms were single rooms with en-suite facilities and had been decorated and furnished to a high standard. Many residents had personalised their rooms with personal possessions and photographs. On the ground floor, residents had access to a range of communal areas including a choice of sitting rooms and a reflection room. These rooms were seen to be clean, bright, comfortable and tastefully decorated.There were two enclosed courtyard spaces accessible to residents. The enclosed external courtyards were well-maintained with level colorful paving, comfortable seating and shaded areas.

Overall the centre was clean and well maintained.There were suitable ancillary services throughout the building, including appropriate hand washing facilities. However, there had been a significant leak on the first floor which had caused water staining on one wall on this floor.

There was a large dinning room that had an area with armchairs and a TV for resident's to use. The inspector observed that the location of the dinning room served as a through way for different areas of the centre. There were four access points in total. The inspector was informed that these doors were closed at mealtimes to discourage people from walking through while residents are having their meals.The inspector also observed this in practise during the centre's dinnertime. The doors to the dining room, when closed, were heavy to push open. Resident's who were not in the dinning room before these doors were closed were required to ring a doorbell, located to the side of these doors, for staff to assist them in opening the doors.

The inspector observed that dinnertime in the centre's dining room was a relaxed and social occasion for residents. The dining room was large and allowed all residents to dine at the same time. There were two hot options available for dinner and a hot and cold option available for the evening meal.The meals were home cooked on site in the large kitchen. Resident's who required assistance at mealtimes were given it and the staff were observed not to rush residents.

There was an activity programme in place. However, there was limited recreational and occupational opportunities for meaningful activities observed to be provided to residents on the day of the inspection. The inspector observed that there were lengthy periods of time where some residents were observed sitting in communal areas watching television without other meaningful activities being available. One resident reported that while the staff were nice it was very boring in here.

One resident told the inspector how they enjoy the location of the centre for it's proximity to a large supermarket and a coffee shop, as they frequently visit these amenities with their family members when they visit. Some residents told the inspector that while it was nice living in the centre and that the staff were friendly, they were often waiting long periods of time for assistance. On the day of inspection the inspector found one resident, who was not independently mobile, had been left in the centre of their bedroom and did not have their drink, call bell or table within reach. The resident had been watching for staff passing the door to get their attention to pass them their drink as they were thirsty.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted the quality and safety of the service being delivered.

## Capacity and capability

Management systems and clinical oversight required action to ensure the service was safe, consistent and of a good quality. Improvements were required across a number of regulations including: governance and management, staffing, premises, residents rights, protection and notifications.

This was an unannounced inspection conducted over one day to monitor the provider's compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and to inform a response to an application to vary Conditions 1 and 3 attached to the registration of the centre. The provider had applied to open the remaining floors to admissions, increasing their capacity from 51 to 150. The chief inspector had recently received information of concern, regarding care in the centre, which were followed up on this inspection and some areas of the concerns highlighted were upheld during this inspection.

The registered provider was Mowlam Healthcare Services Unlimited company. The management structure in place on the day of inspection was not in line with the statement of purpose, which meant that the lines of responsibility and accountability were not clear.There was a person in charge who worked Monday to Friday. However, there were a number of roles not filled including the assistant director of nursing role and supplementary clinical nurse manager roles. This was resulting in a lack of supervisory and support roles to support staff, which was having a direct impact on the delivery of care to residents. Furthermore, the role of the maintenance person had not yet been filled and this had resulted in maintenance issues that also impacted fire safety in the building. This is further discussed under regulation 23 Governance and Management and regulation 28 Fire safety.

The Inspector reviewed rosters and found that there was an insufficient skill mix to ensure adequate supervision and delivery of safe care. This had resulted in poor care practises including a delay in providing care and responding to the needs of residents. Many staff members had no previous experience of working in older persons services or under the regulations that governed these services. They required direction and guidance from experienced staff members. There was one clinical nurse manager and one senior staff nurse working in the centre. The inspector was informed on the day of the inspection that the clinical nurse manager was working in a part time capacity and that the senior staff nurse had been on leave for the majority of the previous month, with no cover in place. Examination of rosters showed that there had been multiple occasions were there were no senior staff nurses on duty.

There was an accessible complaints policy and procedure in place to facilitate residents and or their family members lodge a formal complaint should they wish to do so. The policy clearly described the steps to be taken in order to register a formal complaint. This policy also identified details of the complaints officer, timescales for a complaint to be investigated and details on the appeal process should the complainant be unhappy with the investigation conclusion.

The complaints log was made available to the inspector for review. There were 9 open complaints logged. A review of these complaints highlighted significant concerns around the care being delivered to residents. Many of these complaints included significant safeguarding concerns including acts of neglect and omission of care. One complaint alleged that a call bell was left unanswered for a significant amount of time. The inspector was informed that a review of the call bell log found this allegation to be true. These allegations had not been recognised by the registered provider or person in charge as safe-guarding concerns. As a result the complaints had not been appropriately investigated and no appropriate learning outcomes had been identified and actioned. As the registered provider had failed to recognise the allegations within the complaints they had not submitted the relevant notifications, as set out in Schedule 4 of the regulations, to the chief inspector.

## Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration

An application for the variation of conditions 1 & 3 of registration of the designated centre had been received by the Chief Inspector and was under review.

Judgment: Compliant

## Regulation 15: Staffing

The registered provider did not ensure that the number and skill mix of staff was appropriate and adequate to meet the needs of residents. There was a significant gap in senior nursing and health care roles which resulted in a lack of supervision. This had had a direct impact on the delivery of care. For example:

- from speaking with residents the inspector found that their assessed care needs such as personal hygiene, assistance with toileting and responding to call bells had not been met.
- a review of the complaints log highlighted significant poor care practises e.g multiple occasions were incontinence wear was not changed in a timely manner, residents been left in nightwear late into the day and residents not being dressed appropriately with one resident been found by their relatives in mis-matched footwear.

Contingency plans to cover staff shortages or leave were inadequate. While the following roles had been recruited: assistant director of nursing, activity cordinator and maintenance staff, they were not yet in place as their employment checks were being completed. An interim maintenance person was available to provide assistance three days a week in the centre but there was no effective contingency plan in place for the other roles. This had resulted in poor care practises and limited opportunity for recreational or occupational activities for residents residing in the centre. Furthermore there had been no contingency plan in place to allow for the absence of the senior staff nurse.

Judgment: Not compliant

## Regulation 23: Governance and management

The registered provider had failed to ensure that the centre had sufficient resources for the effective delivery of care in accordance with the statement of purpose. There was a poor skill mix of staff and contingency plans to cover staff shortages and leave were found to be inadequate, as detailed under Regulation 15: Staffing.

Insufficient staffing levels resulted in poor oversight of staff practices. For example, some dietican assessments did not correlate with care planning information.

Management systems failed to ensure the service provided was safe, consistent and effectively monitored. The inspector identified the following concerns:

- A number of safeguarding allegations, made through the complaints procedure, had not been recognised as safeguarding concerns, so they had not been dealt with accordingly.
- There was a lack of oversight of maintenance in the centre to identify potential risks and ensure the building was well maintained.

Judgment: Not compliant

## Regulation 31: Notification of incidents

The Inspector identified that multiple notifiable safegaurding incidents had occurred; however, the Chief Inspector had not received the appropriate notifications.

Judgment: Not compliant

## Regulation 34: Complaints procedure

There was a policy in place that was reflective of regulatory requirements. There was information about the complaints process displayed on the walls in the centre.

Judgment: Compliant

## Quality and safety

Overall the inspector was not assured that the systems in place, overseeing the quality and safety aspects, ensured that all residents living in the centre were protected by safe practices which promoted a good quality of life. Management systems in place had failed to fully oversee aspects of the care of residents and insufficient staff resources available impacted the provision of care for residents.

Residents had ample storage for their personal possessions and there was an appropriate system in pace to ensure residents retain control over their finances. The registered provider did not act as a pension agent for any resident. Residents clothes were laundered externally by a contracted laundry service and returned to the resident.

Residents had access to a general practitioner (GP) who attended the centre twice weekly. The centre had a referral system in place for health and social care practitioners, such as dieticians, speech and language therapists and tissue viability nurses, for when such services were required.

Residents were offered a varied choice of food throughout the day.There was also access to fresh drinking supplies and snacks. Food was prepared and cooked fresh on-site and resident's were complimentary about the food they received.

A selection of care plans were reviewed on the day of inspection. A pre-assessment was carried out prior to admission to the designated centre and a comprehensive assessment was carried out within 48 hours of admission to the centre. Care plans were individualised and many clearly reflected the health and social needs of the residents. However, care planning in relation to a resident's prescribed nutritional needs required review. This is further discussed under regulation 5 individual assessment and care plan.

There was two conflicting activity schedules displayed throughout the centre, however on the day of inspection no activities were observed taking place, and many residents were sitting in the day rooms watching TV, or in their bedrooms.

Oversight of safeguarding required improvement. During the inspection,the inspector became aware of safeguarding allegations, made through the complaints procedure, which had not been recognised as safeguarding concerns. This meant that they had not been responded to appropriately and no safety improvements had been put in place to reduce further safe-guarding risks from occurring.

Notwithstanding the provider's efforts to ensure fire safety in the designated centre, the inspector found that the registered provider had not maintained fire doors adequately. The inspector observed three double fire doors that had significant gaps in the fire seals in the centre of the doors.

## Regulation 12: Personal possessions

Residents had adequate storage and space for personal possessions and were encouraged to retain control over their personal property, possessions and finances. Appropriate laundry facilities were offered off-site.

Judgment: Compliant

## Regulation 17: Premises

Notwithstanding the overall high standard of the centre, with regards to cleanliness and the overall finish, the oversight systems had failed to identify areas that required attention to ensure all areas of the premises conformed to the matters as set out in schedule 6 of the regulations. for example:

- Multiple ceiling tiles were missing in some areas of the centre, including the kitchen, impacting the hygiene requirements in this area.
- Fire doors had not been maintained as the inspector observed gaps between three fire doors.
- There were water stains on a wall on the first floor following a substantial leak.

Furthermore, the dinning room served as a thoroughfare for various areas of the designated centre. There were four areas of entry to this area and the inspector observed both staff members and visitors walking through here to access other areas of the designated centre, throughout the day,including when residents were using the space to just sit or watch TV. When the doors to this area were closed residents were required to ring a doorbell to gain entry, as the heavy doors posed a risk to residents should they try to open them themselves. As a result this area did not conform to an adequate communal space as set out in schedule 6.

Judgment: Not compliant

## Regulation 18: Food and nutrition

All residents had access to fresh drinking water. Choice was offered at all mealtimes and adequate quantities of food and drink were provided. Food was freshly prepared and cooked on site. The meals were served hot and in the consistency outlined in residents' individualised nutritional care plan. Residents' dietary needs were met. There was adequate supervision and assistance provided to those who required it at mealtimes, however independence was promoted. Regular drinks and snacks were provided throughout the day.

Judgment: Compliant

## Regulation 28: Fire precautions

The registered provider did not take adequate precautions for the maintaining of all fire equipment, means of escape, building fabric and building services. The inspector found three fire doors that had significant gaps in them, making them ineffective for fire compartmentation.

Judgment: Substantially compliant

## Regulation 5: Individual assessment and care plan

Residents' dietary needs were met, but some documentation in relation to this required more frequent review and updating.

The inspector noted recent dietary changes in two resident's records that were not reflected in the residents' personalised nutritional care plan. The care plans had not been updated following a comprehensive assessment by a member of the inter-disciplinary team and therefore did not reflect all the recommendations made.

Judgment: Substantially compliant

## Regulation 6: Health care

There were good standards of evidence based healthcare provided within this centre, with twice weekly oversight by a general practitioner and referrals made to specialist health and social care professionals as required. The inspector was told that eligible residents were facilitated to access the services of the national screening programme.

Judgment: Compliant

## Regulation 8: Protection

The inspector was not assured that the registered provider had taken all reasonable measures to protect residents from abuse. For example:

- The registered provider had not identified five allegations of abuse through acts of neglect and omissions, as defined in their own safe-guarding policy, as safe-guarding issues.
- Allegations of abuse were dealt with through the complaints process and did not have appropriate investigations, actions or learning outcomes in place.

Judgment: Not compliant

## Regulation 9: Residents' rights

The inspector identified that there were no meaningful activities taking place in the centre on the day of inspection and residents also reported that there was a lack of activities in general. One resident told the inspector there were "bored" as nothing was going on in the centre.The inspector reviewed a complaint where the family detailed the fact there were no meaningful activities taking place for their relative to participate in.

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 |
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| **Capacity and capability** | |
| Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration | Compliant |
| Regulation 15: Staffing | Not compliant |
| Regulation 23: Governance and management | Not compliant |
| Regulation 31: Notification of incidents | Not compliant |
| Regulation 34: Complaints procedure | Compliant |
| **Quality and safety** | |
| Regulation 12: Personal possessions | Compliant |
| Regulation 17: Premises | Not compliant |
| Regulation 18: Food and nutrition | Compliant |
| Regulation 28: Fire precautions | Substantially compliant |
| Regulation 5: Individual assessment and care plan | Substantially compliant |
| Regulation 6: Health care | Compliant |
| Regulation 8: Protection | Not compliant |
| Regulation 9: Residents' rights | Not compliant |

# Compliance Plan for Leopardstown Care Centre OSV-0008692

## Inspection ID: MON-0042892

## Date of inspection: 28/02/2024

**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 15: Staffing | Not Compliant |
| Outline how you are going to come into compliance with Regulation 15: Staffing:<br>• We will ensure that there is always a sufficient number of staff on duty to meet the needs of all residents in the centre.<br>• We will ensure that staff are effectively supervised, deployed and allocated to appropriate duties commensurate with their skills and qualifications.<br>• Since the inspection, an experienced Clinical Nurse Manager (CNM) has been deployed to Leopardstown Care Centre from another centre to assist and support the Person in Charge (PIC), providing supervision and oversight to staff, to develop their older persons care skills and to enhance their understanding of best practice in a residential care facility.<br>• An Assistant Director of Nursing (ADON) has commenced in post and is providing additional support and supervision.<br>• There has been a strong focus on local recruitment and since the inspection eleven experienced Healthcare Assistant (HCA) posts have been offered and are currently going through the vetting process.<br>• Overseas recruitment continues and ten HCAs have been recruited from overseas, all of whom are qualified nurses but not registered in Ireland.<br>• Two staff nurses have commenced employment since the inspection.<br>• The PIC and ADON will review care plans and assessments using the communication handover tool (ISBAR) to ensure that staff are informed and aware of the current assessed needs of residents.<br>• The ADON and CNMs will attend handover and mid-shift safety pauses to ensure clear communication using ISBAR format. The safety pause will be used as an opportunity for staff providing care to review the status of residents and ensure that all daily personal care needs are being met.<br>• The PIC and ADON will maintain a visible presence on the floor, observing the response times to residents' call bells and ensuring that residents are dressed in day clothes in a timely manner. Call Bell audits will be conducted monthly to ensure that response times are reasonable and that there are no delays.<br>• The maintenance person is employed on a full-time basis.<br>• We have commenced the recruitment process for a dedicated Patient Flow Manager | |

who will be responsible for assessing referrals to the centre, arranging admissions and liaising with community services regarding discharge plans where appropriate.
• There is an Activities Coordinator (AC) in post, and we will recruit additional ACs. We will ensure that a designated HCA supports the AC, including covering for annual leave.

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| Regulation 23: Governance and management | Not Compliant |

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• A CNM and an ADON have been appointed since the inspection to enhance staff supervision and provide oversight of resident care in accordance with the wills, needs and preferences of residents.
• The appointment of the CNM and ADON has facilitated the improved deployment of staff, ensuring that they are allocated duties commensurate with their skills, abilities and qualifications. Senior staff are available and accessible to support and assist staff in undertaking their duties.
• The ADON and CNMs will oversee resident referrals to Allied Healthcare Professionals, such as Dietitians, Tissue Viability Nurses and Physiotherapists, and will ensure that their recommendations are incorporated into the resident's care plan and communicated to staff during handover and/or safety pauses.
• A twice-weekly management meeting schedule has been implemented, chaired by the Healthcare Manager. In attendance are all Heads of Departments to review, evaluate standards in all departments and monitor compliance with the regulations. Detailed minutes are available for review.
• Clinical Care plan records will be audited every week by the PIC, ADON and CNMs. This will facilitate effective feedback, education and support to the nurses and identify areas of good practice and areas that require further improvement or development. The clinical care audits will be an integral part of the Quality & Safety Management system of auditing.
• Nurses will individually meet with CNM/ADON/PIC each month for Clinical Reflective Practice as part of their development and training. At these meetings, their audited Clinical Care Plans will be discussed with specific actions to be completed within 2 weeks if required. It will also be an opportunity to highlight other elements of clinical care such as incident reports, complaints management, compliments received and ensure mandatory training is up to date.
• Safeguarding workshops will be provided internally by the Quality and Safety Team to all staff, including PIC (DON), ADON, CNM'S. This will be completed by 31/05/2024. The workshops will explore the roles and responsibility of all levels of staff in the event of a safeguarding issue and there will be discussion around how to escalate a concern and foster a safeguarding culture within the centre.
• Safeguarding concerns identified through the complaints procedure have been notified to the Chief Inspector and to the HSE Community Safeguarding Team and followed through accordingly. Families have been made aware. We will ensure that all complaints

will be assessed to ensure that safeguarding issues can be escalated and addressed as required.
• The Regional Healthcare Manager will be in attendance onsite most days to support the PIC in restoring regulatory compliance in the centre.
• There is a maintenance person on site five days per week.

| Regulation 31: Notification of incidents | Not Compliant |
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Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
• The PIC will ensure that all complaints are analysed to determine whether they include any allegations of neglect or abuse, and accordingly submit notifications.
• The Quality & Safety Manager will facilitate a Safeguarding workshop for management and staff in the centre, to assist them in recognising and identifying abuse and to understand each person's individual role in reporting, recording, carrying out a preliminary screening or investigation, notification of the allegation, and resolution. This will support the development of a safeguarding culture in the centre.
• The PIC will attend the Capacity Act training conference on 23/04/24 to further understand legislative responsibilities in relation to advocacy and the co-decision-making process on behalf of residents who lack capacity.
• The Healthcare Manager will review incidents and complaints each week with the PIC to identify any potential concerns of neglect or allegations of abuse.
• The Healthcare Manager will chair a twice-weekly management meeting to provide oversight and monitor progress regarding any clinical concerns that occur in the centre.

| Regulation 17: Premises | Not Compliant |
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Outline how you are going to come into compliance with Regulation 17: Premises:
***The compliance plan response from the registered provider does not adequately assure the chief inspector that the action will result in compliance with the regulations.***

• There is a maintenance person on site five days per week.
• Ceiling Tiles were replaced on the day of inspection 28/02/2024.
• The Facilities team have conducted a full review of all fire doors to ensure any identified gaps are addressed and the three doors in question have been realigned. The fire doors in the centre will continue to be checked on a weekly basis by the maintenance person so that any gaps can be identified and resolved without delay.
• Water stains were caused by a flood on the second-floor terraces and the leaks have

been repaired. Ceilings and walls have been painted.
• The dining area will be maintained as a private area for residents to use for dining. This area is accessed by 4 entrance and exit doors. During mealtimes the doors are closed at the front and open at the rear of the dining area, and staff are always available to assist residents who may need assistance to open the door, as part of the duties of staff allocated to the dining area. At mealtimes, there are always sufficient staff to assist residents to mobilise/transfer to the dining area and return to their bedroom after their meals. Outside of mealtimes the doors will be kept in the open position to allow unrestricted access for residents.
• The layout of the dining area has been revised and all floor space is utilised for dining furniture and there is no obvious access route through the dining area.
• The main corridors are signposted very well to ensure that they are the only route to be used throughout the floor.
• All staff, including members of the multidisciplinary team and Health & Social Care professionals have been instructed to use the main corridors only and not to use the dining room as a thoroughfare to move throughout the building at any time. The PIC will monitor compliance with this instruction.
• Kitchen deliveries are delivered to the rear door of the kitchen adjacent to the dining room, as the kitchen has a rear door entrance for this purpose.

Catering staff returning trays or food trolleys will access the adjacent kitchen via the rear doors of the kitchen and will not need to enter the dining area.

Housekeeping service only bring a cleaning trolley into the area for the sole purpose of cleaning the dining room after mealtimes of breakfast, lunch and tea or if any extra cleaning is required. They access all bedrooms and reception by using the bedroom corridor only.

For visitors, they are now signposted and verbally informed of the route to go to the bedrooms of their relative, and not through the communal space.

The entrance doors to the area are closed at mealtimes, and there is a strict protected mealtimes with no visitors permitted unless certain circumstances such as a person receiving palliative care or other specific personal need.

The entrance doors to the area now have a sign stating for resident access only.

There is oversight by the duty manager (CNM), ADON and DON throughout the day with a focus on mealtimes. Regional manager is in attendance at least twice a week to conduct checks of this area.

Hospitality audits will be conducted by Mowlam Healthcare at a minimum of every 6 months.

• Access to the bedrooms will be via the bedroom corridors only. We will rearrange the furniture in the dining area to maximise the use of the available space and there will be no perception of a thoroughfare in the dining area. We will facilitate ease of access to the dining area for residents by reviewing the doors and this will be completed by 30/04/2024.

| Regulation 28: Fire precautions | Substantially Compliant |
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Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• The three fire doors that had significant gaps identified at the time of inspection were realigned on the day of the inspection.
• There is a need for a weekly audit of all fire doors as the building is new and from time to time there is movement in the doors, so a full inspection of all fire doors will be carried out every week by the maintenance person and recorded. Doors will be realigned as soon as gaps are identified.
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| Regulation 5: Individual assessment and care plan | Substantially Compliant |
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Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
• A selection of Clinical Care plan records will be audited every week by ADON and CNMs. This will provide an opportunity for education, support, feedback and ensure management of any deficits. The audit will be recorded, and a quality improvement plan will be implemented as part of the Quality & Safety Management system of auditing.
• Nurses will individually meet with CNM/ADON/DON each month for Clinical Reflective Practice as part of their development and training. At these meetings, their audited Clinical Care Plans will be discussed with specific actions to be completed within 2 weeks if required and also any other elements of clinical care such as incident reports, complaints received, compliments received and ensure mandatory training is up to date.
• Effective communication workshops have been scheduled for staff for 19/04/2024 and 24/04/2024, and these workshops will provide an overview of verbal, written communication methods, including handovers, safety pauses, meetings and clinical documentation.
• ADON and CNMs will be responsible for all referrals to any member of the MDT, including dietitian reviews or reassessments, Tissue viability or any changes to the residents, and they will ensure that the care plans correlate with the assessments.

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| Regulation 8: Protection | Not Compliant |

Outline how you are going to come into compliance with Regulation 8: Protection:
• The chief inspector has been notified of all allegations of abuse.
• HSE Community Safeguarding Team has been notified of the allegations.
• The centre's Safeguarding policy has been followed and all relevant agencies have been informed of the allegations as appropriate.
• Safeguarding workshops will be provided internally by the Quality and Safety Team and will be attended by all levels of staff including senior management staff.
• Complaints management training for all staff including senior management staff will be scheduled.
• Safeguarding and complaints are both mandatory agenda items for discussion at management meetings. This includes the review of any safeguarding and SIMT referrals.

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| Regulation 9: Residents' rights | Not Compliant |

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• The new Activities Coordinator has commenced employment and will develop a schedule of meaningful activities based on residents' choices and preferences and in accordance with their abilities.
• The weekly activities schedule will be checked to ensure it accurately reflects what is displayed on the larger picture activity board.
• A residents' meeting was held on 12/04/24 to consult residents about activities and what they would like to include in the activities schedule.
• Four bus outings have occurred over the school holidays to maximise the number of residents that could go out if they wished.
• Altra software will be implemented at the beginning of May 2024 to ensure that residents and their families are fully informed of the weekly programme and the choices residents will have on activities. This software includes a comprehensive library of activities that will supplement the current activities program.
• The new Activities Coordinator will have some training in another centre to ensure the expected standards of activities and participation is achieved.
• ADON is taking the lead in residents' rights and restrictive practices, and a meeting will be held for all aspects of residents' rights. This will be completed by 30/04/2024.
• A member of the Healthcare Support Team will conduct a Hospitality and Dining audit to provide an objective review of the residents' dining experience. This is due to take place in the first week in May.

## 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 |
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| 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 | 30/04/2024 |
| Regulation 17(1) | The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3. | Substantially Compliant | Yellow | 30/04/2024 |
| Regulation 23(a) | The registered provider shall ensure that the | Not Compliant | Orange | 31/05/2024 |

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| | designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose. | | | |
| Regulation 23(c) | The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored. | Not Compliant | Orange | 31/05/2024 |
| Regulation 28(1)(c)(i) | The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services. | Substantially Compliant | Yellow | 30/04/2024 |
| Regulation 31(1) | Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence. | Not Compliant | Orange | 30/03/2024 |
| Regulation 5(4) | The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared | Substantially Compliant | Yellow | 31/05/2024 |

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| | under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family. | | | |
| Regulation 8(1) | The registered provider shall take all reasonable measures to protect residents from abuse. | Not Compliant | Orange | 30/04/2024 |
| Regulation 8(3) | The person in charge shall investigate any incident or allegation of abuse. | Not Compliant | Orange | 30/04/2024 |
| Regulation 9(2)(b) | The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities. | Not Compliant | Orange | 31/05/2024 |