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:	Dunshaughlin Care Home
Name of provider:	Dunshaughlin Care Home Limited
Address of centre:	Dublin Road, Dunshaughlin, Meath
Type of inspection:	Unannounced
Date of inspection:	17 July 2024
Centre ID:	OSV-0008713
Fieldwork ID:	MON-0043243

About the designated centre

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

Dunshaughlin Care Home is located in the commuter town of Dunshaughlin, with convenient access to Dublin. It is serviced by nearby restaurants, public houses, library, cinemas, community halls, a large variety of local shops, and historical sites of interest and amenities throughout Co. Meath such as the Boyne Valley as well as ease of access to multiple attractions in Co. Dublin. Dunshaughlin Care Home is made up of 96 beds, all of which are all single rooms with en-suites and in line with regulatory requirements. There are five lounges and five dining room areas and four additional toilets all of which are wheelchair accessible. The designated centre provides care service for residents both male and female over the age of 18 years with the following care needs: Care of the Older Person, End-of-Life Care, Palliative Care and Dementia Care. The home provides nursing care for low, medium, high and maximum dependency residents and it is divided into three floors - ground Floor (Fern Unit) accommodating 20 residents, first floor (Ivy Unit) accommodating 38 residents and second floor (Violet Unit) with 38 residents. The centre was registered for an occupancy of 38 residents only, with accommodation located in level two - Violet Unit.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	35

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 17 July 2024	07:40hrs to 15:40hrs	Helena Budzicz	Lead

What residents told us and what inspectors observed

The inspector observed that staff were working towards improving the quality of life and promoting the rights and choices of residents in the centre. While the centre was comprised of 96 beds, the centre was registered for an occupancy of 38 residents only, with accommodation located on the second floor- the Violet Unit. The inspector spent time observing the residents' daily lives in the centre in order to understand the lived experience of the residents. The inspector spoke in detail with 10 residents and two visitors. For the most part, the inspector heard positive comments about the kindness of staff, and residents reported satisfaction with the service provided. However, some residents said that they have to wait a long time for assistance, which was also observed on the morning of the inspection during breakfast serving.

Throughout the morning of the inspection, the centre appeared to be busy. The staff worked hard to answer the call bells and serve breakfast for the residents in their bedrooms or in the dining room. The feedback from residents having their breakfast in the dining room was positive. They were reading newspapers, chatting to each other and enjoying the sunny, warm morning. The experience for some residents who were in their bedrooms was different. The inspector observed a number of residents shouting to get the attention of the staff as they were waiting a long time for their breakfast. Other residents with high dependency needs were waiting for assistance while their breakfast was getting cold on the bedside table. The inspector observed a resident with severe mobility and cognitive impairment being left uncovered in their bed only in their incontinence wear while the bedroom door was left open. The resident was observed hitting their shins from the bedside table with the breakfast tray above them, and the inspector observed red and purple marks on their skin. This was immediately brought to the attention of the staff and management of the centre. These arrangements were not person-centred and did not support a sociable mealtime experience.

Residents' mealtime experience at lunch time in the dining room had a relaxing atmosphere, and sufficient staff were available in the dining room to assist. Dining room tables were observed to be appropriately laid out for residents with utensils and condiments. Meal times were not rushed, and residents were observed interacting with each other, which was a social occasion for them. Staff were observed to provide assistance and support to residents in the dining room and their bedrooms in a person-centred manner. There was a range of snacks and drinks made available to residents outside of regular mealtimes.

The inspector observed that many residents were getting up and dressed and participating in the activities. Staff were observed attending to some residents' requests for assistance, and it was clear that they were familiar with residents' care needs.

All areas of the centre and the unit were appropriately styled and furnished to create

a comfortable environment for residents. Residents' bedrooms were modernly-styled and furnished, and they provided residents with sufficient space to live comfortably.

Residents had safe, unrestricted access to an outdoor garden that contained suitable seating areas and seasonal plants. Residents were observed spending time with staff or their visitors outside, enjoying the good weather throughout the day. However, the balcony on the Violet Unit was locked with a keypad, and no arrangements were in place to provide residents with unrestricted access to a safe outdoor space on that floor.

The inspector observed that activities were attended to a very good standard. There was a detailed weekly activity schedule on display to support residents in choosing what activities they would like to participate in. The inspector observed the interactions between residents and staff and observed that staff supported residents in enjoying and engaging in activities.

Friends and families were facilitated to visit residents, and there was no restriction on visiting in this centre. Residents have access to television, radio, Wi-Fi and newspapers in this centre.

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

Overall, there was a clear commitment from the provider, regional manager and the clinical management team to promote continual quality improvement. Feedback from residents, relatives and staff was actively sought and used to improve services.

This was an unannounced one-day inspection 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. The inspector also reviewed notifications and unsolicited information received by the office of the Chief Inspector of Social Services in relation to the governance and management oversight of the centre and the quality and safety of care provided to residents. The findings of this inspection were that the management systems in place in the centre were not fully effective and did not provide assurance there was sufficient oversight of the services provided to residents, as further detailed under the relevant regulations of this report.

The registered provider of the centre was Dunshaughlin Care Home Limited. There was a clearly defined management structure in place, with identified lines of authority and accountability. The person in charge was supported in their role by a regional manager, who attended the centre four times a week and locally by an assistant director of nursing (ADON) and clinical nurse manager (CNM). A team of

registered nurses, healthcare assistants, activity, administration, maintenance, domestic and catering staff made up the staffing complement. The assistant director of nursing deputised in the absence of the person in charge. The person in charge had recently resigned from their position and was working on their resignation notice. The inspector was informed that the provider had a recruitment plan in place to fill the position of the person in charge.

Regular meetings took place with staff and management in relation to the operation of the service. Records of these meetings were maintained and detailed the attendees, the agenda items discussed and the actions agreed.

On the day of the inspection, the inspector observed that there were sufficient numbers and skill-mix of staff on duty to meet the needs of the residents. The roster showed that there were at least two registered nurses on duty at all times to oversee the clinical needs of the residents. However, the allocation of nursing staff responsibilities was not appropriate to ensure residents' medication was administered in line with evidence-based practice guidelines, as further detailed under Regulation 23.

While there was a training and development programme in place for all staff and an induction programme for newly recruited staff with a high level of attendance at mandatory training, the supervision of staff practices in respect of the breakfast meal times and the clinical nursing documentation was not adequate.

There were management systems in place to monitor the quality of care and service provided, including an audit schedule. There was evidence that the care plan audit identified shortcomings, and there was an action plan to support improvements. While the registered provider had several assurance systems in place to monitor the quality and safety of the service provided, they were not effective, and actions were required in the areas as outlined under Regulation 23: Governance and management.

Incidents were mostly submitted to the Chief Inspector as required. During the inspection, the inspector identified that a notifiable incident had occurred; however, the appropriate notification was not submitted to the office of the Chief Inspector.

The complaints policy and procedure were in place, with information consistent with the regulation's requirements, and the complaints procedure for residents was on display in the centre. While there was evidence that complaints in the centre were recorded, there were some gaps in complaints management practices where actions were required to comply fully with Regulation 34: Complaints procedure.

Regulation 15: Staffing

There was sufficient staff on duty to meet the needs of the residents, considering the size and layout of the designated centre.

Judgment: Compliant

Regulation 16: Training and staff development

Staff supervision arrangements were not always sufficient to promote the care and welfare of all residents. This was evidenced by insufficient oversight of the residents' clinical documentation to ensure that the assessments, care plans, and documentation regarding newly admitted residents or the use of restraints were completed in a timely and accurate manner and were up to date to reflect the current care needs of the residents.

Judgment: Substantially compliant

Regulation 19: Directory of residents

The directory of residents contained all the information specified in paragraph three of Schedule 3 of the regulations.

Judgment: Compliant

Regulation 23: Governance and management

The allocation of staffing resources was not always appropriate and required review. From speaking with staff, observation on the day of the inspection, and a review of staff allocation and medication records, it was evident that only one staff nurse was administering medication to all the residents both during the day and night. The second staff nurse was allocated to work as a healthcare assistant. Such arrangements led to prolonged medication rounds, which meant that not all residents received their medication at the prescribed times, in line with evidence-based guidelines. In addition, the allocation of resources at breakfast time required review.

The governance and management systems in place required strengthening to ensure the service provided to residents was safe, appropriate, consistent and effectively monitored, in particular;

- The oversight of the complaints management system had not identified that all complaints were not managed in line with local policy and regulatory requirements, as detailed under Regulation 34: Complaints.
- Although a variety of monitoring systems were in place, quality improvement plans were not consistently developed to address known deficits in care

planning arrangements and restrictive practices monitoring, as further identified under Regulation 5: Individual assessment and care plan and Regulation 7: Managing behaviour that is challenging.
- The restrictive practice register was not a live document to inform the oversight. A register was in place but was not updated regularly to reflect the actual number of residents using restrictive practices. For example, residents no longer residing in the centre were still on the register.
- The systems for recognising statutory notifications that need to be notified to the Chief Inspector had not ensured that required notifications had been made.
- The oversight systems to monitor staff practices did not ensure that each resident had a sociable and dignified breakfast experience and timely assistance to meet their identified nutritional needs.
- Management systems had failed to identify that residents' medication was not administered as prescribed and within safe administration times. This posed a risk to residents that had not been picked up by the provider's own auditing systems.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

The provider ensured each resident was provided with a contract for the provision of services that were in line with regulatory requirements.

Judgment: Compliant

Regulation 31: Notification of incidents

The inspector identified that one notifiable incident of allegation of potential safeguarding incident had occurred. However, the Chief Inspector had not received the appropriate notifications. The person in charge submitted the required notification retrospectively.

Judgment: Not compliant

Regulation 34: Complaints procedure

A review of the complaints log in the centre found that complaints were not consistently managed in line with the requirements under Regulation 34. The

inspector was informed that complaints received were dealt with mostly informally, and the outcomes of the conversations or the complaints investigation were not documented appropriately in the complaint log. For example, there was not always evidence that the written response informing the complainant whether or not their complaint had been upheld, the reasons for that decision, improvements recommended, and details of the review process were provided.

Judgment: Substantially compliant

Regulation 21: Records

Copies of transfer letters for occasions when residents were temporarily transferred to the hospital were not maintained in residents' files and were not available on the day of the inspection as required in Schedule 3.

Judgment: Substantially compliant

Quality and safety

Overall, the inspector found that aspects of the quality and safety of care provided to residents were impacted by inadequate governance and management, as described in this report. This was evidenced by findings in key areas fundamental to high-quality care and safe services such as assessments and care plans, managing behaviours that are challenging, food and nutrition, residents' rights, medication management and protection.

A review of a sample of residents' assessments and care plans found that residents' needs were assessed prior to admission to the centre to ensure that their care needs could be met. However, following admission, a nursing assessment was not always completed in a timely manner, and an associated care plan to identify residents' individual support needs, care goals and person-centred guidance was not completed within 48 hours following the admission.

Residents' care plans for responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment) were in place. However, they were not always person-centred and did not guide staff on how to prevent or manage episodes of responsive behaviours. In addition, the oversight and monitoring of the incidence of restrictive practices in the centre were not appropriate, as some of the records reviewed showed that appropriate risk assessments, consents, or care plans did not always actually describe the restrictive practice in place. This is further discussed under Regulation 7: Managing Behaviour that is Challenging.

The inspector observed residents' dining and serving experiences during the inspection. It was found that residents did not have an appropriate serving experience at breakfast time and were not supported to have a dignified meal experience. The findings are detailed under Regulation 18: Food and nutrition.

The inspector saw that the centre used a comprehensive transfer letter on occasions when a resident was transferred to an acute hospital. This letter was generated from the electronic system. However, the letter used on the previous transfers was not saved on the system or in the residents' files. When a resident returned from another designated centre or hospital, evidence was available to show that the designated centre had obtained all the relevant information.

While the provider had systems in place to ensure that residents were protected from the risk of abuse, the inspector found that one allegation of abuse was not addressed and appropriately managed in line with the centre's safeguarding policy.

Medications were stored securely within the designated centre. All medication on the medication trolley was labelled and stored according to the manufacturer's description. However, an area for improvement was identified on the day of the inspection as outlined under Regulation 29.

The overall premises were designed and laid out to meet the needs of the residents. The centre was bright, clean and tidy and well maintained.

The centre had dedicated staff responsible for the provision of activities. There were suitable facilities available for residents to engage in recreational and occupational activities. Advocacy services were available to residents. Residents had access to religious services and resources and were supported in practising their religious faiths in the centre. However, the inspector observed some practices that did not support residents' rights, as discussed under Regulation 9.

Regulation 18: Food and nutrition

The inspector observed that the mealtime experience for residents required review with regard to the following;

- A number of residents who required assistance or were served their breakfast in their bedrooms at the same time as the other residents. This practice led to their breakfasts getting cold while residents waited for staff assistance. The inspector saw delays of more than 45 minutes and one resident voicing their concerns about the delay in getting their breakfast. The staff members informed the inspector that they were first serving meals to independent residents, and then they would assist the residents who were in their bedrooms and residents who required assistance with meals. Such a setup did not allow residents to enjoy their meals fully and disrupted their mealtime experience.

Judgment: Not compliant

Regulation 25: Temporary absence or discharge of residents

The nursing staff ensured that upon residents' return to the designated centre, all relevant information was obtained from the discharge service, hospital and health and social care professionals.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

On the day of the inspection, after observing the staff members, speaking with them, and reviewing the documentation available from the medication management system, it was noted that the medication administration rounds in the morning and at night exceeded the prescribed medication administration time as directed by the general practitioner (GP). The inspector found delays on some occasions exceeding three hours, which posed a safety risk to the residents. In addition, staff nurses were frequently disturbed during medication rounds to assist other staff or residents, which posed an increased risk for medication error.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Care plans were not always completed within 48 hours of admission, guided by a comprehensive assessment of the resident's care needs. For example, assessments such as skin integrity, Braden or care plans for nutrition were completed seven days following the admission, and some, such as the Braden assessment predicting the pressure area risk, were still missing.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

Residents with a history of episodes of responsive behaviours had a responsive behaviour care plan. However, these care plans were not person-centred and did not always describe the behaviours, potential triggers for such behaviours, and de-

escalation techniques to guide staff and residents in safe care delivery. In addition, the Antecedent, Behaviour, and Consequence chart and the Cohen Mansfield assessment were not always in place.

In addition, where bed rails and other restrictive practices were in use, the associated risk assessments and care plans were not accurate or, in some instances, not in place. There was not always a consent form in place, and in other cases where consent had been obtained, it was not updated and was found to be in respect of a different type of restriction no longer in use. In some instances, there was no evidence of alternatives being trialled before considering the use of a restraint. Therefore, the inspector was not assured that these practices were being used as a last restrictive option.

The door leading into the balcony on the unit was locked with a key-pad code, and no additional arrangements were in place to enable residents to attend to this balcony independently. Residents who spoke with the inspector did not know the code and said that they had to ask the staff on duty to open the door for them.

Judgment: Not compliant

Regulation 8: Protection

Inspectors were not assured that a complaint in respect of safeguarding allegations was recognised and appropriately investigated in line with the centre's safeguarding policy and that all reasonable measures were implemented to protect all residents from abuse.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Residents' rights to privacy were not consistently upheld. In the morning, during breakfast time, the inspector observed a resident with severe mobility and cognitive impairment uncovered in their bed, only in their incontinence wear while the bedroom door was left open. Staff were busy serving breakfast to other residents and passed by the door without taking action to ensure residents' privacy and dignity were protected.

The inspector found that not all residents could exercise choice in respect of when they could have their breakfast, as the system in place for serving food in the morning meant that residents requiring assistance were served last. The inspector observed a resident calling for assistance while waiting too long to receive breakfast in their bedroom.

Medication rounds were conducted by nursing staff in the dining room during the lunchtime meal. This did not uphold residents' privacy and impacted the nature of the dining experience for all residents.

Judgment: Not compliant

Regulation 11: Visits

The registered provider had arrangements in place for residents to receive visitors. There were no restrictions on residents' visitors, and visitors were seen visiting their loved ones during the day. There was adequate space for residents to receive their visitors in areas other than their bedrooms if they wished.

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	Substantially compliant
Regulation 19: Directory of residents	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 21: Records	Substantially compliant
Quality and safety	
Regulation 18: Food and nutrition	Not compliant
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Not compliant
Regulation 11: Visits	Compliant

Compliance Plan for Dunshaughlin Care Home OSV-0008713

Inspection ID: MON-0043243

Date of inspection: 18/07/2024

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • All staff have up to date mandatory training • Supervision arrangements have been enhanced with the introduction of Clinical Nurse Manager cover 7 days a week in the centre to support the governance and oversight within the centre. This is in place since 02/09/24 with daily support also provided by the ADON and DON on site Monday to Friday and on call arrangements in place over every weekend. • The centre has 1 ADON who work's supernumerary Monday to Friday. A Supernumerary CNM are on duty 7 days a week. The ADON and CNM attend the daily morning handover. Staff allocation is completed, and duties are assigned. • Any issues, risks are discussed and addressed with the PIC, ADON and CNMS on a daily basis after handover. The ADON and CNM's in line with their roles and responsibilities will be responsible for supervision on the floor will oversee the care delivery. This is in place since 5th August 2024. • Any risks or issues identified or lessons learned will be followed up with staff at a staff meetings which take place weekly and monthly. This commenced August 12th 2024. If a gap in education and training is identified education and training for staff is arranged through formal and informal training, this is reviewed on an ongoing basis. • The ADON and CNMS will also review staff performance and ensure residents needs are met on a daily basis. • An Assigned individual responsibility for each nurse has been put in place for all residents to ensure that assessments and care plans are completed in line with the assessed needs of the residents. This is overseen by the CNM. This was introduced August 12th 2024. • A schedule of meetings with residents and their families commenced in August 2024 to discuss individual assessments and care plans- this will be completed every 4 months this is to ensure person centred care. • All staff have had training on restraint by an external provider which was completed by August 13th 2024. All residents who require any form of restraint have been assessed	

and care plans updated, with ongoing review. This was completed 18th August 2024, with additional review on 3rd of September. Ongoing review of all restrictive practices in the centre is in place, with a commitment to reducing the use of restraint in the centre. Information leaflets on Restrictive practice have been developed and shared with residents and their families. This was completed in August 2024.
• All staff have completed in person safeguarding training.
• The quality of care and experience of residents are monitored, reviewed and improved on an ongoing basis. The management will ensure staff provide person-centred, effective and safe services and supports to residents. This will ensure that staff will be supervised and feel supported in a learning environment.
• Oversight has also been enhanced through the introduction of a detailed audit programme and quality oversight which is overseen by the PIC and reviewed on a regular basis. The findings of all audits and any necessary QIPs are shared with staff at staff meetings to ensure understanding. There are clear governance arrangements now in place in the centre to ensure clear accountability. This was introduced in August 2024 with ongoing review as necessary.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• The centre now has enhanced governance arrangements in place. A Regional Manager has commenced in the role to support the PIC with oversight over the centre. The Regional Manager attends the centre on a regular basis and is part of the local management meeting which is held on a monthly basis to ensure robust governance and oversight.
• The centre has a full time PIC, ADON and 3 CNMs, this ensures there is a management structure in the home 7 days a week.
• A programme of review of all staffing allocations is underway in the centre with weekly review by the PIC and management team to ensure that resources and skill mix are assigned in the most suitable way for the delivery of care to the resident's needs. This was introduced August 12th 2024 with ongoing review.
• Allocations are completed on a daily basis by the CNM with additional oversight by the ADON/PIC as required. Supervision has been enhanced through the introduction of CNM cover 7 days a week with additional support by the ADON and PIC. This was introduced by September 2nd 2024.
• A full review has been undertaken of medication administration processes with a number of quality improvements identified and introduced;
- New trollies have been purchased which ensures that there are now 2 medication trollies, one for each corridor. This was completed by August 12th 2024.
- Both RGNs complete medication rounds now. In the event an RGN is absent, the CNM will complete a drug round to ensure drug rounds are not the sole responsibility of one nurse at any given time. This was completed with ongoing review by August 19th 2024.

- The times of rounds have been reviewed and amended, moving from rounds four times a day to three times a day. Times of rounds have also been adjusted to 10am, 3pm and 9pm which supports the RGNs to have uninterrupted time to administer medications. This was completed by 5th September 2024 with ongoing review.
- Ongoing programme of audits are underway to monitor the effectiveness of such changes and any amendments needed as appropriate. Audits completed on medication rounds have demonstrated that the times for drug rounds have been reduced significantly and is now in line with best practice. This was completed by September 15th 2024 with ongoing review.
- Furthermore, the pharmacy team have been met with by the PIC and they will also support with a programme of external audits which will commence in September 2024.
- The times of drug rounds being altered has also meant that there is an increased allocation of staff to assist with breakfast time and morning care. This was completed 5th September 2024 with ongoing review.
- All staff have received training in complaints and complaints management ensuring that all complaints are managed appropriately and effectively. This was completed by August 12th 2024 with ongoing review.
- All complaints are reviewed by the Person in Charge on a weekly basis to ensure that any required quality improvements or follow up is managed in a timely manner and that any complainant is communicated clearly with and same is well documented. Furthermore, any learning from any complaint is communicated to staff in staff meetings to ensure learning and quality improvement. This is completed and ongoing through September 2024.
- All residents with a history of responsive behaviours have had care plan reviews. The care plans are now person centred which describe the behaviours and potential triggers for such behaviours and suggested techniques to escalation behaviours. As required, there is engagement with other healthcare teams for the management of any behaviours that challenge. This was completed by 30th of August. Training in the management of Actual and Potential aggression has been scheduled for September and October 2024 for all staff.
- On a weekly basis the PIC reviews all incidents with the ADON to ensure all incidents of behaviours have updated appropriate assessments.
- A full review was undertaken of the restraint register and the use of restrictive practice in the centre. This was completed in August 2024. All consent has been updated to ensure that all residents have the use of restraint in place as part of a multidisciplinary decision and that appropriate consent is in place for use of same. The restraint register has been fully reviewed and is now updated and reviewed by the management team on a weekly basis to ensure accuracy. The use of restrictive practice is now monitored on an ongoing basis, with trials ongoing with residents to reduce the use of restraint where possible.
- All incidents are now reviewed by the Director of Nursing on a weekly basis to ensure that any that require formal notification to the inspector is done so within the regulatory timeframes. This process commenced in August 2024

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
• A daily handover is held with the PIC, ADON and CNMs to discuss any incidents, accidents, complaints or concerns as well as clinical and operational issues.
• Any incidents which are identified are reviewed by the manager on duty, and reported to the ADON/ PIC appropriately, ensuring that all incidents which are notifiable to the chief inspector are reported in a timely manner.
• All incidents are now reviewed by the PIC on a weekly basis to ensure that any that require formal notification to the inspector is done so within the regulatory timeframes, furthermore all incidents are discussed at the local management meeting which is attended by the Regional Manager. This process commenced in August 2024.
• Any lessons learned from any incidents will be reported back to staff at staff meetings. These have been introduced in August 2024 and are held by the management team.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
• All staff have received complaints training within the centre to ensure that any complaint is managed and documented appropriately. This was completed by August 12th 2024.
• The PIC completes a review of any incident or complaint on a weekly basis to ensure that it is managed appropriately and that any required follow up or communication with the complainant is clearly documented. This was commenced with ongoing review since August 5th 2024. Furthermore, a review of all complaints will be undertaken on a quarterly basis to ensure ongoing oversight of any recurring themes or issues within the centre. This will be completed by November 30th 2024.
• The findings or outcomes of complaints are now shared with the team to ensure their understanding of any required quality improvements. This commenced in August 2024. This will be overseen on an ongoing basis by the management team.

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
• Transfer documents for all residents that have been transferred are now maintained in resident files and are readily available for review. This is overseen by the CNMs on a weekly basis for any transfer that occurs with additional oversight by the ADON and PIC.

Regulation 18: Food and nutrition	Not Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
Breakfast operations and service has been reviewed with the following actions taken:
- The allocation of staff assisting with mealtimes including breakfast have been fully reviewed. There is now adequate staff to support a pleasant breakfast service for all residents.
- The times of breakfast has been extended to ensure that all residents are provided with adequate time to enjoy meals.
- Training and supervision has been provided by the catering team to support staff understanding of the dining experience for the residents.
- A food satisfaction survey is being undertaken with estimated completion date of September 30th 2024. All findings will be reviewed and shared with the team to promote a quality service in line with resident preferences and needs.
- An audit was completed by Dietician services to ensure the nutrition and hydration needs of residents were being adequately met. This was completed by August 8th 2024 with ongoing action of any quality improvements

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
A full review has been undertaken of medication administration processes with a number of quality improvements identified and introduced;
- New trollies have been purchased which ensures that there are now 2 medication trollies, one for each corridor. This was completed by August 12th 2024.
- Both RGNs complete medication rounds now. In the event an RGN is absent, the CNM will complete a drug round to ensure drug rounds are not the sole responsibility of one nurse at any given time. This was completed with ongoing review by August 19th 2024.
- The times of rounds have been reviewed and amended, moving from rounds four times a day to three times a day. Times of rounds have also been adjusted to 10am, 3pm and 9pm which supports the RGNs to have uninterrupted time to administer medications. This was completed by 5th September 2024 with ongoing review.
- Ongoing programme of audits are underway to monitor the effectiveness of such changes and any amendments needed as appropriate. Audits completed on medication rounds have demonstrated that the times for drug rounds have been reduced

significantly and is now in line with best practice. This was completed by September 15th 2024 with ongoing review.
- Furthermore, the pharmacy team have been met with by the PIC and they will also support with a programme of external audits which will commence in September 2024.
- All RGNs have completed medication management training and also completed a supervised medication administration competency assessment to ensure they understand their role in the correct administration of medications. This was completed in September 2024.

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:
An Assigned individual responsibility for each nurse has been put in place for all residents to ensure that assessments and care plans are completed in line with the assessed needs of the residents. This is overseen by the CNM. This was introduced August 12th 2024.

A schedule of meetings with residents and their families commenced in August 2024 to discuss individual assessments and care plans- this will be completed every 4 months this is to ensure person centred care.

An admission checklist was introduced from August 5th to ensure that assessments and care plans for all new residents are completed within the timeframe as laid out in regulation. This is reviewed by the CNM to ensure completion with further oversight by the PIC who reviews all admissions and their relevant documentation. Any required action is communicated with the team in a timely manner to ensure ongoing compliance.

Audits of care plans are completed by the management team on a regular basis with any quality improvements identified and shared with the team to ensure timely action and follow up. This is overseen by the CNMs with additional oversight by the PIC and ADON. These will be completed by September 30th 2024 with ongoing review.

Regulation 7: Managing behaviour that is challenging	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
All residents with a history of responsive behaviours have had care plan reviews. The

care plans are now person centred which describe the behaviours and potential triggers for such behaviours and suggested techniques to escalation behaviours. As required, there is engagement with other healthcare teams for the management of any behaviours that challenge. This was completed by 30th of August. Training in the management of Actual and Potential aggression has been scheduled for September and October 2024 for all staff.

On a weekly basis the PIC reviews all incidents with the ADON to ensure all incidents of behaviours have updated appropriate assessments.

A full review was undertaken of the restraint register and the use of restrictive practice in the centre. This was completed in August 2024. All consent has been updated to ensure that all residents have the use of restraint in place as part of a multidisciplinary decision and that appropriate consent is in place for use of same. The restraint register has been fully reviewed and is now updated and reviewed by the management team on a weekly basis to ensure accuracy. The use of restrictive practice is now monitored on an ongoing basis, with trials ongoing with residents to reduce the use of restraint where possible.

All doors with keypad locks in the centre accessing the internal gardens now have a butterfly symbol in place to support the use of the keypad lock by any resident able to do so. The use of the butterfly symbol is also communicated and demonstrated to all residents with the support of the activities team. This was completed by August 12th 2024.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
A daily handover is held with the PIC, ADON and CNMs to discuss any incidents, accidents, complaints or concerns as well as clinical and operational issues.

Any incidents which are identified are reviewed by the manager on duty, and reported to the ADON/ PIC appropriately, ensuring that all incidents which are notifiable to the chief inspector are reported in a timely manner.

All incidents are now reviewed by the PIC on a weekly basis to ensure that any that require formal notification to the inspector is done so within the regulatory timeframes, furthermore all incidents are discussed at the local management meeting which is attended by the Regional Manager. This process commenced in August 2024.

Staff have completed in person Safeguarding training, this was completed by 27th of August 2024. This is supported by informal toolbox talk sessions for staff on safeguarding which are completed by the management team in the centre and the development of a one page protocol on safeguarding processes to support staff understanding. This was completed by August 19th 2024 with ongoing review.

The PIC has also completed the Safeguarding Self Assessment and developed a robust quality improvement plan which is currently being actioned in the centre. The estimated date for completion of all actions is November 30th 2024.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
A review has been undertaken of mealtimes and how resident rights can be supported in a more meaningful way.
- The allocation of staff assisting with mealtimes including breakfast have been fully reviewed. There is now adequate staff to support a pleasant breakfast service for all residents.
- The times of breakfast has been extended to ensure that all residents are provided with adequate time to enjoy meals.
- Training and supervision has been provided by the catering team to support staff understanding of the dining experience for the residents.
- A food satisfaction survey is being undertaken with estimated completion date of September 30th 2024. All findings will be reviewed and shared with the team to promote a quality service in line with resident preferences and needs.
- An audit was completed by Dietician services to ensure the nutrition and hydration needs of residents were being adequately met. This was completed by August 8th 2024 with ongoing action of any quality improvements
- Medication rounds no longer take place at mealtimes, and if a resident requires medication with food this is supported in a private and dignified way by staff.
- Regular resident meetings are held on a monthly basis and all residents are supported to voice their concerns, preferences or ideas with the team. These are completed by the Activities team with oversight from the PIC. Any suggestions or actions are reviewed and managed in a timely manner by the management team. This oversight commenced in August 2024 with ongoing review.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/10/2024
Regulation 18(1)(c)(i)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are properly and safely prepared, cooked and served.	Not Compliant	Orange	30/09/2024
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Substantially Compliant	Yellow	27/09/2024
Regulation 23(a)	The registered provider shall ensure that the designated centre	Not Compliant	Yellow	12/08/2024

	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	30/09/2024
Regulation 29(5)	The person in charge shall ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.	Substantially Compliant	Yellow	31/10/2024
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	Not Compliant	Orange	05/08/2024

	its occurrence.			
Regulation 34(1)(b)	The registered provider shall provide an accessible and effective procedure for dealing with complaints, which includes a review process, and shall display a copy of the complaints procedure in a prominent position in the designated centre, and where the provider has a website, on that website.	Substantially Compliant	Yellow	30/11/2024
Regulation 34(2)(c)	The registered provider shall ensure that the complaints procedure provides for the provision of a written response informing the complainant whether or not their complaint has been upheld, the reasons for that decision, any improvements recommended and details of the review process.	Substantially Compliant	Yellow	30/11/2024
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	Substantially Compliant	Yellow	30/10/2024

	concerned.			
Regulation 7(2)	Where a resident behaves in a manner that is challenging or poses a risk to the resident concerned or to other persons, the person in charge shall manage and respond to that behaviour, in so far as possible, in a manner that is not restrictive.	Not Compliant	Yellow	31/10/2024
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.	Not Compliant	Orange	30/08/2024
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Substantially Compliant	Yellow	30/11/2024
Regulation 8(3)	The person in charge shall investigate any incident or allegation of abuse.	Substantially Compliant	Yellow	30/11/2024
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as	Not Compliant	Orange	30/09/2024

	such exercise does not interfere with the rights of other residents.			
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Not Compliant	Orange	30/09/2024