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:	An Teaghlach Uilinn Nursing Home
Name of provider:	Knegare Nursing Home Holdings Ltd
Address of centre:	Kilrainey, Moycullen, Galway
Type of inspection:	Unannounced
Date of inspection:	03 April 2023
Centre ID:	OSV-0000309
Fieldwork ID:	MON-0039756

About the designated centre

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

An Teaghlach Uilinn Nursing Home is a purpose-built designated centre for older people. Residents are accommodated in single and twin bedrooms. A variety of communal rooms are provided for residents' use, including sitting, dining and recreational facilities. The centre is located close to Moycullen village, Galway. Residents have access to a secure enclosed courtyard. The centre provides accommodation for a maximum of 75 male and female residents, over 18 years of age. The service provides care to residents with conditions that affect their physical and psychological function. Each resident's dependency needs are regularly assessed to ensure their care needs are met.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	43

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Monday 3 April 2023	07:30hrs to 17:40hrs	Sean Ryan	Lead
Monday 3 April 2023	07:30hrs to 17:40hrs	Brid McGoldrick	Support

What residents told us and what inspectors observed

Residents living in An Teaghlach Uilinn Nursing Home told inspectors that they felt safe living in the centre and that staff were kind and polite to them. Staff were observed to be respectful and courteous towards residents. Overall, the feedback from residents was that, while there was some improvement in the availability of staff, they continued to experience extended waiting times to receive assistance and support from staff. Residents told the inspectors that the quality of the food they received had improved in the context of 'flavour and taste', however, residents continued to express dissatisfaction with the quantity of food they received.

Inspectors arrived unannounced at the centre and were met by night staff, and later by a clinical nurse manager. Following a brief introductory meeting, inspectors walked through the centre and spent time observing the care provided to residents, talking to residents and staff, and observing the care environment. There was a calm, but busy atmosphere in the centre as staff were observed responding to residents' requests for assistance.

Residents informed inspectors that a new chef had joined the service and explained that the chef engaged with them for feedback on their dining experience. Inspectors observed a pleasant and social meal-time experience for residents in the dining room. There was adequate staff to support and supervise residents with their nutritional care needs within the dining room, however, inspectors did not observe the same level of supervision and support being provided to residents who had their meals in their bedrooms. Residents who required supervision during mealtimes were observed to be eating their meals unaided and unsupervised. In addition, a resident who required a modified consistency diet was not served food that was in line with their dietary requirements.

Inspectors spoke with a number of residents in their bedrooms, and in the communal areas. Residents told inspectors that staffing levels had improved since the last inspection and that there were a number of new staff who they were getting to know. One resident told the inspectors that they often experienced difficulty in 'getting the attention of staff', either through using their call bell or calling out for assistance. The resident told the inspector that when the staff responded to their request for assistance, the care they received was 'kind and patient'. Another resident told inspectors that they would have to shout for assistance, particularly when they were in bed, as the call bell was not securely placed in close proximity to them. Inspectors observed that a significant number of residents did not have their call bell within their reach while in bed or when sitting out on a chair in their bedroom. Some residents were observed to wait extended periods of time for staff to respond to their call bells. On two occasions during the inspection, inspectors were required to locate staff on behalf of residents who required assistance.

Some residents preferred to remain in their bedroom throughout the day. Residents reported that they were satisfied with their bedroom accommodation, and further

satisfied with the storage facilities for their personal possessions. Residents were provided with supportive equipment such as specialised seating, and wider beds, to safely and comfortably accommodate residents with complex care needs.

Inspectors observed that the kitchen and catering areas were not cleaned to an acceptable standard. Utensils, cooking equipment, food storage areas, and food preparation areas were visibly unclean on inspection. Floor coverings were in a poor state of repair, with liquid observed to be penetrating from underneath areas of damaged floor coverings. This was a repeated finding that had been brought to the attention of the provider during the previous inspections of the centre.

Areas of the premises occupied by residents, such as communal dayrooms and the dining rooms, were observed to be clean. However, a number of vacant and occupied bedrooms were not clean. Communal bathrooms and toilets were visibly unclean.

The management of clean and dirty linen had improved. New linen trolley's had been provided to segregate clean and dirty linen. However, linen trolley's were observed to be stored in communal bathrooms, when not in use. The laundry areas were not managed in a manner that promoted effective infection prevention and control. A large quantity of soiled linen, awaiting laundry, occupied both the dirty and clean areas of the laundry area. This is further detailed under Regulation 27, Infection control.

Inspectors observed that urinals and contents were not disposed of appropriately. This practice impacted in the quality and safety of the care environment.

Inspectors observed that the premises was bright, spacious, and warm. The centre provides accommodation over two floors, and comprised of both single and shared bedroom accommodation. The first floor of the premises was accessible to residents through a passenger lift and stairs. The provider had redecorated some areas of the premises, including the main reception area. However, inspectors observed a number of areas of the premises that were in a poor state of repair. While some corridors walls had been prepped for painting since October 2022, the provider had not progressed to redecorate those areas of the premises. In addition, there were areas of the premises where walls, skirting boards, handrails, and doors were visibly stained and chipped. Inspectors observed that some new chairs had been sourced since the last inspection. However, there were several pieces of equipment were not maintained in a satisfactory state of repair, such as shower chairs that were visibly rusted and unclean.

While corridors were wide and facilitated the safe mobility of residents with appropriately placed hand rails, inspectors observed that bedroom door widths were not sufficient in size to allow adequate access and egress by some residents with complex needs in the event of a fire emergency. In addition, inspectors observed a number of fire doors that were damaged or impaired. This included the doors separating the dining room from the kitchen area, where there were large gaps between the hinges and the door frame. This compromised the function of the doors to contain the spread of smoke and fire, in the event of an emergency. Inspectors

also observed a lack of fire detection devices in some areas of the centre and emergency escapes that were obstructed by a trolley and furniture.

Residents told the inspector that they were consulted about the quality of the service frequently through scheduled resident committee meetings and explained how they used this forum to express their views about issues such as the activities programme, and the quality of the food. There were some activities taking place during the inspection, facilitated by one staff member. Inspectors observed residents spending long periods of time in their bedrooms without social engagement or appropriate access to meaningful activities. While residents were supervised by staff in the communal day rooms, there was limited engagement between residents and staff observed.

Capacity and capability

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

- monitor compliance with the Health Act 2007 (Care and welfare of residents in designated centre for older people) Regulation 2013 (as amended).
- follow up on the actions taken by the provider to address significant issues of non-compliance identified during a series of poor inspections of the centre on 11 January, 27 January and the 22 and 23 February 2023.
- review the detail of representation, submitted by the provider following the issuing of a notice of proposed decision to refuse the application to renew the registration of the designated centre.

The findings of this inspection were that the provider had failed to implement their compliance plans following the previous inspections of the centre, and significant urgent action continued to be required with regard to the governance and management of An Teaghlach Uilinn Nursing Home. The impact of a weak organisational structure, and ineffective management systems of monitoring and oversight, continued to impact on the quality and safety of the care provided to residents. Inspectors found that, where the provider had implemented some systems to monitor aspects of the service, such as the monitoring of residents nutritional care needs, and the systems in place to monitor the quality of environmental hygiene, the provider had failed to ensure that the implementation of those systems were consistent and sustained. This resulted in repeated regulatory non-compliance under the following regulations;

- Regulation 5; Individual assessments and care plan,
- Regulation 6; Health care,
- Regulation 15; Staffing,
- Regulation 16; Training and staff development,
- Regulation 21; Records,
- Regulation 23; Governance and management,

- Regulation 27; Infection control.

In addition, the provider was found to be non-compliant with Regulation 28; Fire precautions on this inspection.

Significant regulatory non-compliance's were found during a series of poor inspections of the centre since June 2022. On each individual inspection, inspectors found that the provider had failed to take appropriate and timely action to ensure the safety of residents, and to address the findings of the previous inspections.

The provider had submitted an application to renew the registration of the centre. As a consequence of identified repeated non-compliance and their impact on resident's safety and well being, the Chief Inspector issued a notice of proposed decision to refuse the provider's application to renew the registration of An Teaghlach Uilinn Nursing Home. The provider made representation within 28 days of the notice being issued, the detail of which was reviewed on this inspection. The representation outlined a revised organisational structure, and the action being taken to bring the centre into compliance with the regulations. Inspectors found that the proposed organisational structure had not been fully established, and the actions taken to comply with the regulations were not sufficient to meet the requirements of the regulations. The persistent failings had significant impact on the safety and quality of life for residents.

Knegare Nursing Home Holdings Limited, a company comprised of five directors, is the registered provider of An Teaghlach Uilinn Nursing Home. The company is represented in the centre by one director, who is also the clinical director. Since the previous inspection, the registered provider had increased their presence in the centre with the additional attendance of a group operations director. The operations director was responsible for monitoring non-clinical aspects of the service including compliance with record keeping and staff training. However, the increased presence of the senior management team in the centre was not found to be associated with improvements in the governance and management of the designated centre or resident care.

Within the centre, the clinical management structure consisted of a person in charge, supported by a clinical nurse manager team. The position of assistant director of nursing remained vacant since August 2022. An additional clinical nurse manager had been recruited and two clinical nurse managers worked in a supervisory capacity. However, the post of assistant director of nursing, a key role in the clinical governance of the centre, remained vacant. An additional supervisory role had been established in the centre in the form of health care assistant team leaders. Their role included supervising and co-ordinating the care provided to residents by the staff team. On the day of the inspection, the organisational structure was not clearly defined. The person in charge was on leave and the deputising arrangements for the duration of their leave had not been established.

Inspectors found that the provider had failed to organise and manage the staffing resource effectively within the centre. Consequently, the provider had failed to ensure that the designated centre had sufficient resources to ensure that care and

services were provided, in accordance with the centre's statement of purpose. For example, a review of the staffing rosters found that staffing resources were not available to cover planned and unplanned staff leave, particularly in housekeeping, laundry and the catering departments. This resulted in those areas of the service being under-resourced. The centre was visibly unclean on inspection.

The provider had an on-going recruitment programme in place, however, the number of staff leaving the service remained high. While 13 staff had been recruited since February 2023, six staff had left the service, and a further four staff were leaving the service in the weeks following the inspection.

A review of staffing rosters found that staffing levels were inadequate to meet the needs of residents in the centre, and for the size and layout of the building. The staffing levels detailed on the staffing rosters were not reflective of the staffing levels present in the centre, or aligned with the staffing levels described to inspectors on arrival at the centre. A review of rosters found multiple gaps in the planned roster over the previous two week period, where vacant shifts had not been covered within the housekeeping and catering departments. This resulted in staff being redirected from caring duties to support other aspects of the service. This is discussed further under Regulation 15; Staffing.

The provider had committed to implementing systems to ensure that the service provided was safe, appropriate, consistent and effectively monitored. While a schedule of audits was in place to evaluate the quality of some aspects of the service, the systems in place to monitor, improve, and sustain improvement actions were ineffective in areas of the service such as clinical documentation, infection prevention and control, and the hygiene of the kitchen environment and equipment.

Risk management systems were guided by the risk management policy. This policy detailed the systems that were in place to identify, monitor and respond to risks in the centre that may impact on the safety and welfare of residents. A review of the risk register evidenced that some clinical and environmental risks were assessed and had been categorised according to their level of risk to residents. However, the provider had failed to ensure that known risks in the centre, such as risks identified in a fire safety risk assessment completed in December 2021, were included in the risk register. The exclusion of known risks from the centre's active risk register impacted on the centre's ability to minimise and appropriately manage risk.

Inspectors reviewed the system of record management in the centre. The provider had taken action to ensure staff personnel files contained the information required by Schedule 2 of the regulations. However, inspectors found that the systems of record management, and oversight of clinical records, remained poor. Records were not securely stored, or maintained as required by Schedule 3 and 4 of the regulations. This included records with regard to incidents involving residents, and the nursing care provided to a resident following an incident in the centre.

Inspectors found that an incident involving a resident had not been notified to the Office of the Chief Inspector, within the required time-frame.

The provider had taken some action to facilitate staff to attend mandatory training

in safeguarding of vulnerable people, and infection prevention and control. However, a significant number of staff had not completed fire safety training. Staff spoken with did not demonstrate appropriate levels of knowledge, commensurate to their role, with regard to fire safety.

In addition, staff also demonstrated poor knowledge in relation to the nutritional care needs of the residents. Inspectors found that the provider had failed to ensure that arrangements were in place to appropriately allocate and supervise staff. For example, staff were not appropriately supervised to ensure residents were supported and supervised with their nutritional care needs.

Regulation 15: Staffing

The provider had failed to sustain sufficient staffing levels in the centre to meet the needs of the residents, and for the size and layout of the centre. The impact of inadequate staffing was evidenced by;

- On the day of inspection, a vacant shift in the laundry department resulted in senior member of the healthcare staff being redirected from their caring duties to carry out laundry duties. This impacted on the number of staff available to respond to residents requests for assistance, and to supervise the quality of care provided to residents.
- Residents reported, and were observed, waiting long periods of time to receive assistance and support from staff with their personal care needs.
- A review of the staffing rosters for the previous two weeks showed that there were seven occasions where planned staffing levels were not maintained within the kitchen and catering department.
- The centre did not have adequate numbers of cleaning staff to ensure the centre was clean. There were five occasions, within the previous two weeks, where there was one housekeeper on duty to clean the centre, where two were required. On the day of inspection, there was one housekeeper on duty to clean the centre. This impacted on effective infection prevention and control and quality of environmental hygiene.
- There was insufficient staff on night duty to ensure the safe and timely evacuation of residents in the event of a fire emergency.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff did not have access to appropriate training. Staff spoken with did not demonstrate the required knowledge to deliver effective and safe services to the residents. This was evidenced by:

- Some staff did not have the required knowledge to ensure residents received meals, in modified textures, in line with their dietary requirements.
- A number of staff had not completed fire safety training. Staff demonstrated a poor awareness of the centre's fire evacuation procedure, and the arrangements in place for the safe and timely evacuation of residents with complex care needs in the event of a fire emergency.

In addition, the inspectors found that staff supervision arrangements were not appropriate to protect and promote the care and welfare of residents. This was evidenced by:

- Inadequate supervision of staff allocated to the cleaning process in the centre, and infection prevention and control practices.
- Poor supervision of staff to ensure residents received care and support in line with their assessed care needs.
- Poor supervision of additional resources provided to improve the standards of hygiene and cleanliness in the kitchen and catering areas.

Judgment: Not compliant

Regulation 21: Records

The management of records was not in line with the regulatory requirements, and records were not kept in a manner that was safe or accessible. For example;

- Staff rosters did not reflect the staffing levels on the day of inspection and staff rosters for the week prior to the inspection were not reflective of the roster that was actually worked by staff. Staff that were on unplanned leave from the centre were not identified as such on the planned or worked rosters provided to inspectors on the morning of the inspection.
- Residents records were not securely stored. For example, repositioning charts from October and November 2022 had not been removed from a vacant bedroom when the resident relocated to another bedroom in the centre.
- While nursing care records were completed daily with regard to the health, condition and treatment provided to residents, the records did not detail or identify the nurse on duty who had completed the record, in line with the requirements of Schedule 3 of the regulations, and relevant professional guidelines.

Judgment: Not compliant

Regulation 23: Governance and management

The registered provider had failed to ensure that resources in the centre were planned and managed to ensure person-centred, effective and safe services. The provider had failed to ensure the service had sufficient staffing resources to;

- ensure the management structure was maintained in line with the centre's statement of purpose. This impacted on effective governance and oversight of the service.
- maintain housekeeping, laundry and catering staffing resources to ensure a quality and consistent service was provided.

The registered provider failed to ensure there was an effective management structure in place, with clear lines of accountability and responsibility. For example, deputising arrangements for the person in charge were not established, and accountability for the management of the staffing resources were not clear.

Inspectors found repeated failings in the governance arrangements and ineffective management systems to ensure a safe, monitored and consistent service was provided. This was evidenced by;

- compliance plans submitted following the previous inspections were not fully implemented, some were found to be ineffective, and others not sustained. This resulted in repeated non-compliance in multiple regulations including nutrition, governance and management, and infection prevention and control.
- risk management systems were not effectively implemented to manage risks in the centre. Risks that had been assessed by the provider were not managed in line with the centre's own risk management policy. For example, fire safety risks.
- ineffective systems to evaluate and improve the quality of the service. For example, audit findings were not effectively used to implement and sustain quality improvement actions.
- poor oversight of record-keeping systems to ensure compliance with the regulations.
- ineffective communication systems to ensure key clinical information regarding residents care needs were effectively communicated to staff. For example, staff were not informed of incidents involving residents, or when the residents had acquired an infection.
- ineffective systems in place to monitor and promote the well-being of residents through providing timely and appropriate referral to medical and health care services.
- poor oversight of the submission of statutory notifications to the Chief Inspector.

Judgment: Not compliant

Quality and safety

While the day-to-day interaction between residents and staff was kind and respectful throughout the inspection, inspectors found that the quality and safety of care provided to residents was compromised as a result of ineffective systems of governance and management described in the capacity and capability section of this report. The continued failure of the provider to implement effective quality assurance and clinical oversight posed an ongoing risk to residents in the centre, with regard to resident's nutritional care needs, their individual assessments and care plan, timely access to health care, and infection prevention and control. Furthermore, action was required to ensure compliance with Regulation 28; Fire precautions.

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

A review of residents' records found that there was regular communication with some residents' general practitioners (GP) regarding their health care needs. However, some residents were not provided with appropriate access to medical and health care professionals, despite showing signs and symptoms of physical deterioration. In addition, some residents were not provided with timely referral and access to specialist health care services for further assessment, despite this being indicated within their medical, and nursing notes.

A review of the food and nutritional aspects of the service found that the provider had taken some action to improve the quality of the dining experience for residents. Arrangements were in place for the monitoring of residents weights and nutritional intake. However, the provider had failed to take appropriate action to ensure residents nutritional care needs were met, in line with their assessed nutritional care needs. For example, residents were observed to be served food that was not properly or safely prepared, in line with their modified consistency diet prescribed by health care professionals, due to swallowing difficulties.

A review of the care environment found that the provider had failed to take action to maintain an appropriate standard of environmental and equipment hygiene. While there was a cleaning schedule in place, inspectors observed that some areas of the centre were not clean. For example, areas of the kitchen that had been documented as clean were visibly unclean on inspection. Inspectors observed personal care equipment which was visibly unclean, and this posed a risk of cross contamination, and therefore risk of infection to residents. The ineffective decontamination of resident's toileting aids and equipment, and waste management, further compounded the risk of infection to residents. The findings identified a repeated failure by the provider to establish a robust infection prevention and control monitoring system. This issue is discussed further under Regulation 27; Infection Control.

The registered provider did not have adequate arrangements in place to ensure residents were protected from the risk of fire. Inspectors identified deficits in the system of fire detection, containment and management of fire safety. In addition, staff demonstrated a lack of awareness of the fire risks in the centre and the procedure to be followed in the event that a fire required the evacuation of residents. Further findings are discussed under Regulation 28; Fire Precautions.

Regulation 18: Food and nutrition

The provider had failed to ensure that food and nutrition was delivered in line with the regulatory requirements. This was evidenced by;

- Residents were not provided with adequate qualities of food and drink. Some residents continued to express dissatisfaction with the quantity of food they received.
- The food served to residents was not properly and safely prepared. The catering environment and equipment was visibly unclean on inspection. Food was not prepared, or provided to residents, in line with their assessed dietary needs. For example, a residents who was prescribed a modified consistency diet was served an inappropriate diet.
- Residents were not appropriately supervised during mealtimes. For example, two residents required the supervision of staff when eating and drinking. Inspectors observed those residents to be unsupervised during meal-times.

Judgment: Not compliant

Regulation 27: Infection control

The provider had failed to take action to ensure that infection prevention and control procedures were consistent with the National Standards for Infection Prevention and Control (IPC) in community settings published by HIQA. This was evidenced by repeated findings of:

- Poor oversight of the cleaning procedure and the quality of environmental hygiene. For example, cleaning records for the kitchen indicated that specific pieces of equipment had been cleaned. However, the equipment was visibly unclean on inspection.
- Daily cleaning records were not consistently signed. This meant that the provider could not be assured that all areas had been cleaned.

The environment and equipment was not managed in a way that minimised the risk of transmitting a healthcare-associated infection. This was evidenced by;

- The centre did not have a dedicated room for the storage of cleaning

equipment or preparation of cleaning chemicals. Cleaning equipment continued to be stored inappropriately in the dirty utility. This posed a risk of cross contamination, and risk of infection to residents.
- The centre was visibly unclean on inspection, including both occupied and vacant bedrooms, en-suites, storage rooms, and communal bathrooms.
- The kitchen, catering areas and equipment had not been cleaned to an acceptable standard. This posed a significant risk to residents and necessitated a referral to an external agency for further assessment.
- Several pieces of equipment used by residents, such as shower chairs, specialised chairs, and soft furnishings were visibly damaged and in a poor state of repair. This compromised effective cleaning of those items and increased the risk of cross infection.
- The bedpan washer was functioning intermittently, and consequently, there was a significant number of toilet aids, urinals and commode basins that had not been decontaminated after use.
- The management of storage areas was not effective to minimise the risk of cross infection. For example, linen skips and mobility aids continued to be stored in a communal bathroom. This increased the risk of cross infection.
- The laundry areas was not managed in a way that reduced the risk of cross infection. The system in place to ensure that items for laundering moved from the dirty area to the clean area was not implemented as evidenced by the storage of linen bags containing soiled linen, and awaiting laundering, stored in the clean linen area of the laundry.

Judgment: Not compliant

Regulation 28: Fire precautions

Action was required by the provider in order to comply with the requirements of Regulation 28: Fire precautions.

Arrangements for providing adequate means of escape including emergency lighting required action. For example:

- Emergency exits were obstructed by trolleys' and pieces of equipment and furniture.
- Emergency lighting was not functioning in some areas of the centre.
- There was a lack of directional signage to identify the appropriate fire evacuation route and which direction of travel to take in order to access a designated fire exit. This posed a risk as it may cause confusion in the event of an evacuation.

Arrangements for detecting and containing fire in the designated centre required action. For example:

- A number of fire doors contained visible gaps when released and closed. The

doors separating the kitchen from the dining room had a significant gap between the door and door frame. This compromised the effectiveness of the fire door to contain the spread of smoke and fire.
- There was a lack of fire detection in some areas of the premises such as the cleaners cupboard on the ground floor.

The inspectors were not assured that adequate arrangements had been made for evacuating all persons from the centre in a timely manner with staff, and equipment resources available. For example,

- There was no record of simulated compartment evacuation of the largest compartment.
- The assessed evacuation requirements for some residents were not known to staff. Therefore inspectors were not assured that robust systems were in place to ensure the safe evacuation of all residents.
- There was no documented plan in place to ensure the safe and timely evacuation of residents with complex care needs. This was compounded by the inconsistent staff responses with regard to the fire evacuation procedure.
- Evacuation aids, such as ski sheets (to allow non-ambulant residents to be quickly and safely evacuated in an emergency) were not correctly fitted to the residents bed. This could cause a delay in the timely and safe evacuation of residents in the event of an emergency.
- The effectiveness of some evacuation plans had not been tested and the provider failed to recognise that plans could not be executed to ensure the safe evacuation of residents from the centre.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

A review of the residents assessments and care plans found that care plans had not been reviewed as required under Regulation 5. This was evidenced by;

- Residents assessed as being at high risk of falling were not identified as such within their individual care plan, as evidenced in two care plans reviewed. These care plans were therefore not informed by an accurate assessment of the fall prevention care needs of the residents.

Judgment: Substantially compliant

Regulation 6: Health care

The registered provider failed to ensure that resident had appropriate access to

medical and health care. This was evidenced by failure to provide;

- appropriate health care to a resident with a history of falls.
- access to appropriate medical care for a residents with re-occuring and persistent symptoms, in line with the directive of medical professionals.
- appropriate access to general practitioner services, and referral to health care professionals for further professional assessment and expertise.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 18: Food and nutrition	Not compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Not compliant

Compliance Plan for An Teaghlach Uilinn Nursing Home OSV-0000309

Inspection ID: MON-0039756

Date of inspection: 03/04/2023

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing: 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.

The centre currently has 40 residents residing in it.
Staffing levels in the centre have remained constant despite the decision to cease admissions for a period. Currently the Nursing Home roster has staffing in place to manage the care needs of the 40 residents residing within it. Staffing levels are supplemented with agency usage. Agency staff used within the Nursing Home are where possible, regular staff who have been inducted into the centre and are familiar with the Nursing Home and its residents. Staffing within the centre daily is as follows:

Day staffing: 2 x Staff nurses and 7 HCAs. 1 x CNM with support from management, activity, catering, housekeeping and administration staff.

Night Staffing: 2 x staff nurses and 4 x HCAs with support from on call manager.

Post inspection

· A part-time laundry assistant has received their induction and is available as an additional support in the event of unforeseen absences. Care Staff are not required to support laundry. There are two housekeeping staff rostered daily in the centre. In the event of any unforeseen absence there are supports in place through an external agency to assist with the cleaning of the centre. Currently we are using the assistance of this agency to ensure appropriate staffing levels are maintained.
· Two additional part-time catering staff have received their induction and are available to support the catering team with rostered hours.
· Call bell audit updated to include residents access to the call bell is in place in addition to monitoring of the response times.
· An additional Night HCA has been put in place to ensure the safe and timely evacuation

of residents. This position will be reviewed on an ongoing basis to ensure it addresses the assessed needs of residents at night in the event of an evacuation being required.
· Staffing is reviewed daily by the PiC or CNM to ensure appropriate cover for the next 24 hours. Where deficits exist due to unforeseen sickness etc they are covered internally where possible, in the event, they cannot be covered, support is sought from the relief panel and then a recognised agency.
· Feedback is sought from the residents in respect of care delivery and service provided through a series of questionnaires, audits and the residents forum. All concerns raised are logged in the complaints log and attended to through appropriate channels/policies. All suggestions for improvements are noted and addressed where appropriate and possible.
· Staffing levels within the centre remain above the required assessed dependencies to enable residents and staff adjust to management structures, improved processes and changes.
· Recruitment within the centre is ongoing to ensure appropriate staffing levels are in place across all departments when the centre is in a position to re-open to admissions.
· Four Nursing staff are planned to arrive to the centre throughout the remainder of 2023.
· A recruitment drive is ongoing for healthcare assistants and auxiliary staff to ensure resources are readily available to meet the needs of both current and future residents. Two HCAs are due to commence employment in the centre on 29-05-2023. Three HCAs are due to travel from abroad (one of which was employed previously earlier this year) to commence employment from 07-06-2023 for a period of 4 months. An additional HCA is returning to employment, on 13-06-2023, who has been employed in the Nursing Home earlier this year. One new catering support has been employed and is due to commence in the centre by end of June.
· Admissions to the Nursing Home will only be re-commenced when the structures are in place to support the needs of residents. The reopening of the Nursing Home to admissions will be planned, phased and risk assessed to ensure the resources are in place to support the needs of residents with provision for unexpected shift cover.
· Handovers take place each morning and evening during change of shift and are led by the CNM and/or PiC. One member of staff is appointed to the supervision of residents during handover time so that call bells are answered promptly. Handover sheets have been updated with greater detail and these provide a clear indication of resident's needs. This assists the clinical team in identifying and understanding residents' care needs.
· The onsite inspection visits with the Compliance and Quality Manager (CQM) will include review of the staffing requirements/compliance and the outcomes will be shared with the CEO/RPR at least once monthly and/or sooner if any high risks are identified. Staffing is reviewed on a weekly basis and dependent on progress, it is our intention to adjust the staffing to levels in line with the SoP, taking into consideration the residents care needs and the QIP in the home.

The inspector has reviewed the provider compliance plan. This action proposed to address the regulatory non-compliance does not adequately assure the chief inspector that the actions will result in compliance with the regulations.

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
Regulation 16(1)(a) The person in charge shall ensure that staff have access to appropriate training.

Training needs analysis has been completed by the HR Manager and PiC. Staff training are being addressed and training remains ongoing in the centre. Staff receiving training have competency tested through staff huddles, audits on the floors and on site by the PiC, Regional Manager and (CQM). Competency issues are addressed immediately, and additional support and training provided where required. The PiC reviews training needs weekly with the administrator to identify gaps, to ensure appropriate training is booked and in place. As part of the annual training plan all staff will complete IDDSI training to ensure staff are competent in providing residents with their appropriate prescribed diet. This is supervised on a daily basis by the allocated Nurse and CNM at each mealtime.

Staff are currently receiving refresher fire training by an external provider. All new staff within the centre receive fire induction and training post commencement.
Staff participate in drills and evacuation procedures to ensure their competence and understanding of the fire procedures. Currently within the centre evacuation drills occur monthly to ensure competency of all staff.

Regulation 16(1)(b) The person in charge shall ensure that staff are appropriately supervised.

There are 2 nursing staff and one CNM on site daily. Staff are supervised by both the CNM and PiC. Additional support is provided on site with the nurses and team leaders. The catering team and household staff are supervised by the CNM on a daily basis with support and oversight by the PiC.

Oversight of care delivery is overseen by the CNM and staff nurses. Escalation pathways are known by staff and communication occurs daily at handover between the team and the CNM/PiC.

Additional oversight of the centre is provided by the Regional Manager and CQM.

At present the RM is on site 2-3 days weekly and the CQM is on site at least 1-2 days per fortnight. This will be reviewed on a monthly basis going forward.

Resources are available within the centre to ensure adequate cover in all departments including but not limited to housekeeping, catering and laundry. Where unexpected vacancies arise outside of the rostered hours, there is support available through external agencies and the home has in place incentives for regular staff to take additional hours. It would always be the policy of the Nursing Home to cover unexpected vacancies within the roster with staff employed and/or staff from the relief panel. However, in the event that this is not always possible arrangements are in place to ensure appropriate cover

can be sourced elsewhere.

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
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.
Records relating to Schedules 2,3 and 4 are available in the centre. The PiC has implemented a revised process to ensure that all Agency nurses have their own identified log in details for all computerised systems required to document information. The process has been communicated to the nursing team to ensure that all nurses are aware of the need for individual log ins and the nurse in charge provides an individual log in for any agency nurse. The CNM will review that this process is completed as part of their role and responsibilities.

Regulation 21(6) Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.
Records pertaining to residents are removed daily by the nursing staff and filed appropriately. This is overseen by the CNM and Team Leader. Thirty Two staff have received training from the HR Manager in respect of confidentiality and the appropriate maintenance of records pertaining to residents.

The management of rosters and allocations have been reviewed and a system implemented to include easy access to rosters whereby the roster is printed weekly, and the electronic roster cross referenced for payroll purposes The PiC produces the roster which is maintained locally and includes those staff on leave and the hours allocated to staff with changes documented to ensure an actual worked roster is available. Staff roster is currently completed on excel and maintained manually and the previous system reviewed by the inspector is maintained for payroll purposes.

Rosters are completed by the PiC and daily allocations by CNM's, taking into consideration the number of staff required based on occupancy and dependency, the skill mix of staff and training needs in the home. The PiC reviews the rosters on a weekly basis to verify their accuracy.

The roster is now available in a printed format and accessible to the staff and management in the home at all times. These records will be retained weekly and available for review.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Regulation 23 (a) The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.

The centre currently has 40 residents residing in it all of which reside on the ground floor.

Staffing levels currently in the centre are as follows:

Day staffing: 2 x Staff Nurse and 7 HCAs. 1 x CNM with support from management, activity, catering, housekeeping and administration staff.

Night Staffing: 2 x Staff nurses and 4 x HCAs with support from on call manager. Staffing is reviewed weekly with the PiC and Regional Manager to ensure there is appropriate staffing on-site to meet the assessed needs of the residents living in the centre. Currently the centre is being staffed daily with additional hours for all departments to provide staff with support and supervision to ensure new practices are embedded. This will allow both staff and residents time to adjust to new management and oversight structures in place. Staffing levels will be risk assessed prior to any reduction to ensure the residents' needs are fully accommodated.

In addition to the 180 hours allocated per week to the Kitchen, since 24-03-23, there has been an average of 24 hrs per week allocated to assist in compliance with this regulation and the cleanliness of the service provided. Additional temporary chef hours have been allocated to the centre. The catering team hours will continue to be reviewed as part of the PiC weekly review and dependent on the need, it is our intention to adjust the staffing to levels within the catering team in line with the SoP.

There are two housekeeping staff rostered daily within the centre to ensure appropriate cleanliness levels are maintained. Currently all residents reside on the ground floor. Support from agency housekeeping staff are available to ensure appropriate staffing levels are maintained in the event of unexpected staff absences.

Regulation 23 (b)The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.

There is a PIC present in the centre supported by 2 x CNMs. An additional CNM was put in place in the absence of an ADoN to ensure cover across 7 days in the centre.

The PiC is supported by the Regional Manager at least 2-3 days weekly and the CQM attends the centre at least 1-2 days fortnightly. These new roles have commenced post

the last inspection and provide an enhanced governance and management structure to the centre, providing a further layer of oversight support and governance to the Nursing Home. Ongoing and continued observation and monitoring of the practices within the centre will continue with the Regional Manager and CQM to ensure that the new practices commenced are continued within the centre. Practices will be overseen and reviewed monthly. Through on-site audit and analysis of the findings, quality improvement plans will be initiated and implemented to ensure any areas of learning are utilised to improve the lived experiences of residents in our care.

Staff roles and responsibilities have been reiterated with staff through a series of department meetings. Escalation pathways are clearly defined within each team and all staff have access to the structure of both the centre and the group at large.

Members of the team are clearly evident in the centre and reporting structures are discussed with both staff and residents at meetings within the centre. The resident's forum details are displayed in the centre in a central place and additional information is distributed to residents independently. Posters displaying information for residents and staff is displayed within the centre.

Communication with all staff throughout the centre is recorded and documented. Communication takes place both formally and informally through team meetings and staff huddles.

Communication between the CNMs and other departments is also recorded and documented.

When a new PIC is appointed to the centre, they will be fully inducted and supported by the Senior Management Team to ensure they are aware of the processes in place to monitor and oversee the care of the residents in the centre. The support currently in place will remain in situ until the Board of Management is assured that the incoming PiC has the ability to maintain and sustain changes implemented across the centre. Roles and responsibilities will be clearly defined within the new management team for the centre. Escalation pathways and communication will also be outlined with specific KPIs being reported on monthly to the Board of Management. These KPIs will include but not be limited to such items as complaints, risk management, wound management, infection control etc. The analysis of these KPIs will be used to identify and trends and areas for learning which will form part of the agenda items for discussion at the monthly governance meetings due to commence in June 2023. Any agenda items that require a quality improvement plan will be implemented, documented and actioned. A new weekly clinical report was implemented on 21-05-2023 which tracks key KPIs and is shared with the Regional Manager and CQM.

Internal compliance monitoring by the CQM will continue with monthly inspections for the next 3 months and going forward future frequency will be reviewed based on risk assessment.

Regular feedback is sought from residents and all concerns raised are documented and followed up as part of the complaints process. The complaints log is reviewed with PiC and RM weekly. The CQM will audit the complaints during internal inspection and report

any findings to the CEO/RPR.

The results of actions plan outcomes and improvements are communicated to staff and residents as part of the meeting schedule during staff huddles, resident forums and heads of department meetings.

Regulation 23©The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

The Regional Manager and CQM are responsible for the review of all practices in the Nursing Home to ensure they meet with the regulatory requirement and local policy and procedure.

These new positions within the company allow for additional support to the PiC and increased oversight on the management systems in place. All findings from these reviews and internal audits are shared with the Operations Director, CEO/RPR respectively.

The PiC and Regional Manager have reviewed all the previous compliance plans to ensure identified issues have a quality improvement plan in place to ensure the service provided meets the assessed needs of the residents and is consistent.

An external provider reviewed the risk register for the centre and provided feedback and training to the Management Team. The register is currently under review to reflect the recommendations noted.

Internal compliance monitoring by the CQM will continue with monthly inspections for the next 3 months and going forward future frequency will be reviewed based on Risk assessment.

The inspector has reviewed the provider compliance plan. This action proposed to address the regulatory non-compliance does not adequately assure the chief inspector that the actions will result in compliance with the regulations.

Regulation 18: Food and nutrition	Not Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
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.

The kitchen within the centre is cleaned daily by both the chef and the catering assistant.

Additional supports for cleaning are in place and the kitchen is reviewed daily by the incoming chef to ensure it is clean. Daily checklists are in place to ensure all equipment is cleaned and maintained to an appropriate standard. The CNM and PiC meet with the Catering Team and the cleanliness of the kitchen is audited weekly.

Residents are reviewed by the dietitian and SALT. The dietician attended the nursing Home on 02-05-2023 and the SALT reviewed residents on 16-03-2023. Residents' needs are discussed at handover and any changes are communicated to both the clinical and catering team.

All recommendations are noted in care plans and communicated to both the care staff and catering team by the CNM. Mealtimes are audited and residents are requested to provide feedback on the mealtime experience through resident forums and mealtime questionnaires. The findings of these questionnaires and any concerns raised at the resident forum are acted upon by the PiC with changes implemented as required. Audits conducted are reviewed by the Regional Manager to ensure compliance. Further review will be conducted by the CQM to ensure adherence with policies and procedures. IDDSI refresher training has commenced within the centre.

Regulation 18(1)(c)(iii) The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional assessment in accordance with the individual care plan of the resident concerned.

All residents have access to the dietitian who attends the Nursing Home when required. Residents' MUST assessments and weights are taken monthly. Any weight loss noted is reported to both the GP and Dietician and any recommendations noted are followed through.

The CNM/Nurse on duty monitors the mealtimes in the centre to ensure that all residents are receiving adequate and appropriate dietary intake. The catering team are aware and advised of all dietary requirements and the information pertaining to diet is maintained and updated within the kitchen weekly or sooner if changes are implemented. The Chef is actively engaging with resident's during and after meals to determine satisfaction and any issues noted are addressed immediately.

All residents' nutritional needs are care planned for and documented. The CNM and Staff Nurse attends the dining room daily and ensures all residents needs are appropriately met. The daily allocations listing identifies staff responsible for the nutritional needs of residents. All staff document intake of residents and nurses are responsible for ensuring this is reviewed and actioned where required. Residents' nutritional needs are discussed daily at handover.

Regulation 18(3) A person in charge shall ensure that an adequate number of staff are available to assist residents at meals and when other refreshments are served.

Staffing levels are reviewed weekly by the PiC and Regional Manager. The daily allocations are discussed at handover and all staff have very clear guidance in respect of

their assigned roles for the shift. All residents receive the assistance they require at mealtimes through these allocations and mealtimes are supervised by the nurse on duty and the CNM.

Those residents that wish to eat in the rooms have a nominated staff to cater for their needs at mealtimes.

In addition to the 180 hours allocated per week to the Kitchen, since 24-03-23, there has been an average of 24 hrs per week allocated to assist in compliance with this regulation and the cleanliness of the service provided. Additional temporary chef hours have been allocated to the centre. The catering team hours will continue to be reviewed as part of the PiC weekly review and dependent on the need, it is our intention to adjust the staffing to levels within the catering team in line with the SoP.

The inspector has reviewed the provider compliance plan. This action proposed to address the regulatory non-compliance does not adequately assure the chief inspector that the actions will result in compliance with the regulations.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
Regulation 27: The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.
The allocation of a CNM working daily in a supervisory capacity assumes responsibility of verifying that kitchen, cleaning records and Team leader checklists are complied with.

The kitchen and catering area is cleaned daily and has been reviewed by an external governing agency on 2 occasions post inspection and found to have only minor non compliances which were addressed.

A cleaner's room has been identified within the centre and these IPC works are currently ongoing to ensure it meets the regulated guidance. These works are scheduled to be completed on 26-05-2023.
Three linen cupboards have been identified across the centre and are currently in use.

The laundry area has been reviewed on 27-04-2023 by an external contractor, the Group Facilities Manager and the PiC, to review the system in place and recommend changes to the BoM. We are currently awaiting costings on these works and guidance in relation to the movement of laundry machines from the manufacturers.

The bedpan washer is functioning properly and in use. There is service history in place for the bed pan washer and should an unforeseen error occur there is a process in place

to access prompt attendance of a relevant engineer.

Daily cleaning records for all equipment are in place and are monitored by the Nurse on duty and CNM.
A review of the wheelchairs and shower chairs was undertaken, and the home has purchased 6 new shower chair and 6 new wheelchairs which have arrived on site and are in use.

A review of soft furnishings has taken place and any soft furnishings that were visibly damaged have been removed.

The home continues to review suitable storage solutions with a view to ensuring equipment is not stored in bathrooms.

A schedule of works as part of the annual capex programme has been defined by the Director of Operations in conjunction with the Board of Management to ensure that areas of the premises identified for improvement including redecorating of walls, skirting boards, handrails and doors.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: Regulation 28(1)(b) The registered provider shall provide adequate means of escape, including emergency lighting.

All emergency lighting and directional signage has been reviewed by the preventative maintenance team. All staff have received training on the appropriate fitting of the ski sheets. Appropriately fitting ski sheets is monitored daily by the Team Leaders and supervised by the Nursing Team.

Emergency exits are checked daily by the Nursing Team and Maintenance Officer. Staff have been tutored on the need to ensure emergency exits are free from clutter and accessible. The nurses and CNMs supervise the staff daily and monitor the exits.

Staff have been involved in simulated evacuations in the centre and PEEPs have been updated and displayed for all residents to ensure all staff have the knowledge they require for the safe and timely evacuation of residents in the centre.

Regulation 28(1)(c)(ii) The registered provider shall make adequate arrangements for reviewing fire precautions.

An audit of the fire systems has taken place over two days from 16-05-2023 to 17-05-2023. We are currently awaiting the report and findings of this audit. Once a report has been furnished to the Registered Provider, it will be reviewed and added to the capital

improvement plan as a priority item.

Regulation 28(2)(i) The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.

Twenty-seven staff have received fire training to date in 2023 with further training due to take place on 23-05-2023. Fire drills and simulated evacuations were conducted and are ongoing within the centre. Staff from both day and night shifts have been involved in these simulated events.

The fire doors noted between the kitchen and dining area have been ordered and are due to be replaced.

Regulation 28(2)(iv) The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.

Post-inspection all residents within the centre have had their needs in the event of a fire reassessed. In some instances, residents have had to be moved to alternative rooms to accommodate them safely and ensure appropriate evacuations can be undertaken.

Regulation 28 (3) The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place in the designated centre.

All PEEPS have been reviewed and are displayed within the centre to ensure staff are aware of the needs of each resident in the event of an emergency.

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:
Regulation 5(4) The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.

Post inspection the PiC and CNM have commenced internal care planning review meetings with residents and their families (where appropriate) to ensure consultation in respect of the care plans prepared and the plan of care for the future.

All Nursing Staff are reviewing care plans with daily tutoring and prompting by the PiC. Care plans are reviewed monthly by the PiC and improvements required are noted and returned to the named nurse for further information. The CQMhas commenced a review

of the quality-of-care plans in the centre to ensure they are reflective of assessed care needs and reflective of the residents' current situation.

Where a resident has returned from hospital the PiC /CNM will continue to review all discharge paperwork to ensure all recommendations from the hospital are put in place, disclosed to the resident and family (where appropriate) and informed to the GP.

Once informed to the GP and the appropriate referral made the CNM will monitor the response time and make contact directly with the MDT member to ensure receipt of the referral and a timeframe to expect intervention will be sought. These referrals will be tracked by the CNM to ensure the expected attention is received by the resident. Where appointment times may be delayed due to waiting lists, the CNM will discuss options with the resident and/or their family to determine if an alternative route can be explored with positive outcomes for residents with support from the Nursing Home and GP.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care: Regulation 6(1) The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time.

All residents have access to GP and Multi-Disciplinary Team (MDT) services. All staff are trained to ensure residents needs are monitored and systematically accessed. Recommendations by the GP are adhered to in consultation with the resident and their families. The PiC ensures that residents assessed needs are met and that their wishes relating to care where known are documented and upheld. The Regional Manager and CQM will audit and review referrals and updates to ensure residents are receiving care as directed.

Where a resident has returned from hospital the PiC /CNM will continue to review all discharge paperwork to ensure all recommendations from the hospital are put in place, disclosed to the resident and family (where appropriate) and informed to the GP.

During April 6 residents returned from hospital and were reviewed by their GP and/or a member of the MDT as clinically indicated.

Regulation 6(2)(b) The person in charge shall, in so far as is reasonably practical, make available to a resident where the resident agrees to medical treatment recommended by the medical practitioner concerned, the recommended treatment.

All residents have in place a GP that will attend the Nursing Home to meet with, review and provide medical attention to Residents under their care. Where Residents decline

care and/or medical attention this will be clearly documented. The PiC has reviewed with all residents their preferred GP. Where Residents decline an alternative GP and state satisfaction with their current arrangements this decision is upheld, and residents are encouraged/facilitated to attend their preferred GPs surgery where reasonable and practical.

When residents are reviewed or attend appointments and require referral to the MDT this is logged and documented by the Nurse. The CNM reviews all referrals weekly to ensure appropriate communication has taken place and the referral sought is in process. Where issues arise with referrals and/or residents' access to appropriate treatment by medical professionals this will be discussed with the resident and their family (where appropriate) to ensure they are aware of alternative options available to them such as private providers/consultants. Where residents and families determine they are not accessing services as recommended and sourced this will be documented and the resident's decision upheld. The management within the centre always ensure residents medical needs, as recommended by their practitioners are sourced, however, if a resident and their family decline the services available or are not prepared to engage with healthcare professionals or avail of the treatment provided then the management will document all attempts made to secure the appointment as evidence to support their involvement.

Regulation 6(2)(c) The person in charge shall, in so far as is reasonably practical, make available to a resident where the care referred to in paragraph (1) or other health care service requires additional professional expertise, access to such treatment.

All residents have access to members of the Multi-Disciplinary Team. Where access is not directly available on site the resident and their family are supported in so far as is reasonably practical to avail of the services externally. All decisions relating to a resident's choice surrounding their medical treatment is recorded and documented.

Residents currently have access to a physiotherapist weekly and dietitian every 2 months. SALT, Optical, Dental and Tissue Viability are accessed as and when required and referral is based on clinical need and/or residents changing health needs. A readmission checklist is in place for all residents who have attended hospital and return to the Nursing Home. This readmission checklist tracks all recommendations and ensures any necessary referrals, appointments and follow-ups with the MDT are documented, sourced and attended.

The frequency of these services will be reviewed on a monthly basis as part of the governance and management meeting of the centre.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	30/06/2023
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	30/06/2023
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/06/2023
Regulation 18(1)(c)(i)	The person in charge shall ensure that each resident is provided with adequate quantities of food	Not Compliant	Orange	31/05/2023

	and drink which are properly and safely prepared, cooked and served.			
Regulation 18(1)(c)(iii)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional assessment in accordance with the individual care plan of the resident concerned.	Not Compliant	Orange	31/05/2023
Regulation 18(3)	A person in charge shall ensure that an adequate number of staff are available to assist residents at meals and when other refreshments are served.	Not Compliant	Orange	31/05/2023
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Not Compliant	Orange	30/06/2023
Regulation 21(6)	Records specified in paragraph (1) shall be kept in	Substantially Compliant	Yellow	17/05/2023

	such manner as to be safe and accessible.			
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	30/06/2023
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Substantially Compliant	Yellow	31/05/2023
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	31/05/2023
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of	Not Compliant	Orange	31/05/2023

	healthcare associated infections published by the Authority are implemented by staff.			
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Substantially Compliant	Yellow	30/06/2023
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	30/06/2023
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	30/06/2023
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.	Not Compliant	Orange	30/06/2023
Regulation 28(3)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place in the designated centre.	Not Compliant	Orange	30/06/2023

Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Substantially Compliant	Yellow	30/06/2023
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.	Not Compliant	Orange	30/06/2023
Regulation 6(2)(b)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the resident agrees to medical treatment recommended by the medical practitioner	Substantially Compliant	Yellow	30/06/2023

	concerned, the recommended treatment.			
Regulation 6(2)(c)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the care referred to in paragraph (1) or other health care service requires additional professional expertise, access to such treatment.	Not Compliant	Orange	30/06/2023