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:	09 July 2023
Centre ID:	OSV-0000309
Fieldwork ID:	MON-0040547

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:	38

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
Sunday 9 July 2023	19:00hrs to 22:00hrs	Catherine Sweeney	Lead
Monday 10 July 2023	08:00hrs to 19:00hrs	Catherine Sweeney	Lead
Sunday 9 July 2023	19:00hrs to 22:00hrs	Susan Cliffe	Support
Monday 10 July 2023	07:30hrs to 19:00hrs	Susan Cliffe	Support

What residents told us and what inspectors observed

Inspectors arrived at the centre on a Sunday evening to chat with residents and to observe how they spent this part of their day. The inspection continued the following day, with an opportunity for inspectors to observe what day-to-day life was like for the residents in the centre. Residents shared their experience of living in the centre with the inspectors throughout the two day inspection.

Overall, the feedback from residents was that their quality of life had improved since the last inspection in April 2023. Residents reported that the provider had sought their opinion and feedback on issues such as the dining experience and the staffing levels. Residents reported that both of these issues had improved.

Residents told the inspectors that staff were 'kind and would do anything for them'. One resident explained how they enjoyed spending time with the care staff, and that staff 'seem to have a bit more time to spend with them'. Interactions between staff and residents was observed to be kind and patient, with staff addressing every resident by their preferred title or name. Residents who could not share their experience of living in the centre with the inspectors appeared comfortable and relaxed in their surroundings, and in the company of staff.

A reconfiguration of the bedroom accommodation for residents had occurred since the last inspection. All residents in the centre were now accommodated on the ground floor of the building. Residents spent their day in one of two large day rooms. The day rooms were pleasantly decorated with comfortable furnishings. There was a variety of activities taking place in the centre, from group exercise sessions in the day rooms, to one-to-one time spent with residents in their bedrooms. Residents were observed staying up late to watch a film. Both day rooms were supervised by staff, and an activity coordinator was available on day two of the inspection to facilitate a programme of activity including a religious service. Residents reported being satisfied with the activities on offer and stated that the activity programme 'helped to pass the time'.

Inspectors observed that, in the main, the residents' living environment was visibly clean and the condition of the furnishings had improved since the previous inspection. Residents bedrooms appeared tidy and organised. Many residents had decorated their rooms with items of personal significance, such as photos and ornaments. One resident told the inspectors how they found it hard to move from their home to the nursing home initially, however, they explained that bringing some of their belongings with them and decorating their room in a style that was familiar to them had made a big difference and had helped them settle into the nursing home. However several residents, who had relocated from the first floor to the ground floor, were not clear as to why they had to relocate or how long it was for.

Inspectors observed that some areas of the centre were not cleaned to a high standard and some areas of the centre were malodorous throughout the two days of

inspection. At times a number of domestic and clinical waste bins, which had not been emptied in a timely manner, contributed to the smells, but at other times the odours could not be explained by these issues.

Residents told the inspectors that they were offered a choice at each meal time. Some residents reported that the food was satisfactory, and others explained that the quality of food served had improved over the past month or so. Residents were offered a choice of main course and dessert at meal times. Inspectors observed that staff were attentive to residents during meal times and an allocation system ensured that residents were appropriately supported and supervised during meals. However, the availability of snacks and drinks throughout the day was observed to be limited. Inspectors observed that there was small amount of fresh fruit, bread, biscuits and yogurt available for the residents in between their meal times. Residents reported that only two types of biscuits were offered with tea and expressed a wish for greater variety.

The following sections of this report detail the findings with regard to the capacity and capability of the centre and how this supported the quality and safety of the service provided to residents.

Capacity and capability

This was a two day unannounced risk inspection, 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 carried out on 11 January, 27 January, 22 February and 3 April 2023.
- follow up on information related to notifications received from the provider.
- review the detail of a representation submitted by the provider following the issuing of a notice of proposed decision to cancel the registration of the designated centre.

The findings of this inspection were that some improvements had been made by the provider to improve the quality and safety of care delivered, since the last inspection. Residents feedback in relation to the service received had improved with many residents commenting on the improvement in relation to the availability of staff and the quality of meals. The provider had also updated the policies and procedures for the centre. However, concern remained in relation to the quality of the governance and management systems in place to monitor the service provided and to underpin and sustain the improvements observed. Inspectors found that, despite significant changes in the organisational structure of the centre, the oversight and monitoring of the service remained inadequate. This was evidenced by unclear roles and responsibilities of the management team resulting in poor

oversight of the service. The auditing systems in place to monitor care delivery were ineffective as it did not facilitate the development of any quality improvement plans for the centre. This governance and management issue impacted on the compliance across most of the regulations reviewed on this inspection.

Following significant regulatory action, including four poor inspections, inadequate action taken by the provider to respond to these actions, and a proposed decision to refuse to renewal of the registration of the centre, the Chief Inspector issued a notice of proposed decision to cancel 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 provider of this centre is Knegare Nursing Home Holdings Limited, a company comprised of five directors. The company was represented in the centre by one director, who was also the person in charge at the time of this inspection. The representation detailed a revised organisational structure consisting of a board of directors, an operations director, and a regional manager, all of whom would provide oversight of the service. A compliance and quality manager was also in post to provide an independent line reporting directly to the Chair of the board in relation to the regulatory compliance of the centre. This inspection found that, while the personnel for these positions were in post, there was little evidence that the management systems in the centre had been strengthened. For example, there was no system in place to monitor the regulatory compliance in the centre. In addition, the auditing schedule had not been revised to ensure adequate monitoring of the known risks in the centre.

Within the centre, the person in charge was supported by a clinical nurse manager and a team of nursing, care and support staff. The positions of an assistant director of nursing, and a second clinical nurse manager were vacant. The person in charge facilitated the two days of the inspection. A regional manager and a compliance and quality manager were also in the centre for day two of the inspection. Requests for information were required to be repeated, with the information and documentation provided being poorly organised and not presented in a timely manner.

While the staffing resources available did not reflect the resources committed to by the provider in the statement of purpose, there were adequate levels of staff on the two days of the inspection to meet the needs of the residents and for the size of the centre given that the first floor was closed and all residents were accommodated on the ground floor. The allocation of staff and staff communication had improved since the previous inspections. A shift handover meeting was now attended by all care staff, ensuring that all staff had access to up-to-date information regarding the care of all residents.

A review of the training record for staff found an abundance of different types of training that were labelled as "mandatory HIQA training" reflecting poor insight into what training was a regulatory requirement. That said, the records reflected that a high level of staff had completed training in a broad spectrum of areas.

A review of the record management systems in the centre found continued issues of

non-compliance with the requirements of this regulation. Inspectors requested a copy of the duty roster and a record of whether the duty was worked. An accurate record of the duty roster was not available. The records of duty continued to be documented on three systems and, as a result, a clear record of rostered duty was not made available for inspection. In addition, some records relating to residents finances were not kept in the designated centre, as required under Schedule 3 of the regulations.

Regulation 15: Staffing

The staffing levels in the centre on the two days of inspection, with regard to the low occupancy of the centre, were adequate to meet the needs of the residents and for the size and layout of the centre.

The staffing resources, while adequate for the number of residents accommodated in the centre, would not be appropriate to ensure safe staffing levels if the centre was full. This resource issue will be addressed under Regulation 23(a) Governance and Management.

Judgment: Compliant

Regulation 16: Training and staff development

Arrangements were found to be in place to ensure that staff were trained, however the appropriateness of the training required review. The training schedule would benefit from review to ensure that training provided was targeted and effective rather than focusing on delivering a broad spectrum of training incorrectly described as "mandatory HIQA training". For example, although relevant staff had completed training in infection prevention, practices observed did not reflect national guidance.

In addition inspectors found that there was inadequate supervision of

- cleaning procedures,
- nursing documentation
- oversight of the service at weekends.

Judgment: Substantially compliant

Regulation 21: Records

A review of the duty roster found that it did not accurately identify the people on

duty on the days of inspection, nor did it identify the people who had worked in the centre in the week prior to the inspection. In a compliance plan submitted following an inspection in April 2023, the registered provider committed to reviewing and implementing a system where the roster would be printed weekly and would include all staff on leave, the hours allocated to staff, and any changes documented. This action was not completed.

Paper based records pertaining to residents who no longer resided in the centre were not available for inspection nor were paper based records for staff who no longer worked in the centre. The person-in charge explained that these records had been archived and removed from the centre for filing.

A record of money, received by the provider on a residents behalf, was not kept in the centre, as required by Schedule 3 of the regulations. Ledgers available in the designated centre evidenced good practice but these could not be confirmed by bank records. Monies for a resident for whom there were pension agent arrangements in place was paid into a bank account of the registered provider managed from head office at a Dublin address. These arrangements were not in line with the arrangements set out in the application form for authority to appoint an agent available in the centre for that resident. That form required a named person who was no longer employed in the nursing home to collect the residents pension from a nominated bank account. Records to evidence the change in arrangements could not be provided.

Judgment: Not compliant

Regulation 23: Governance and management

A review of the duty rosters found that staffing resources and structures were not in line with those outlined in the centres statement of purpose. Staff vacancies included an assistant director of nursing and a clinical nurse manager. In the compliance plan submitted by the provider following the inspection in April 2023 a commitment was made to ensure that a clinical nurse manager was rostered daily, including at weekends, to supervise the delivery of care, catering and housekeeping services. This was not in place on the day of the inspection. In addition, the level of available housekeeping staff (cleaning and laundry) was not adequate to ensure that episodes of planned and unplanned leave could be covered.

The registered provider failed to ensure there was an effective management structure, with clear lines of accountability and responsibility in place. The organisational structure, as described in the centre's statement of purpose was not effective. The specific roles of the senior management team were not clearly defined and did not reflect the responsibilities, as set out in the representation submitted by the provider.

This poorly defined organisational structure impacted on the quality of the

management systems in place to ensure that the service was safe and appropriately monitored. Examples included;

- Ineffective risk management systems: a generic risk register was in place supplemented with some centre specific risk assessments. However, the system in place did not ensure effective oversight of the risk of fire
- Ineffective auditing systems. For example, an audit of falls that had occurred in the centre from January to March 2023 did not include an analysis of the findings, no trends or areas of learning had been identified and no quality improvement action plan had been developed to address the identified risks. There was no comprehensive infection prevention and control (IPC) audit in place that provided an overview of the overall IPC standards in the centre. This issue had been identified on previous inspections.
- Poor information governance and record management. The recording of the duty roster did not facilitate appropriate oversight of adequate staffing levels, managerial support or staffing allocation. In addition, paper-based systems used to monitor the service were poorly organised and did not facilitate appropriate governance. For example, environmental and catering audits were filed in clinical care audit folders.
- Poor oversight of nursing documentation. A review of the quality of care plans, committed to by the provider, was not available for review. Care plans, particularly those relating to end of life care, were not based on assessment and lacked the detail required to ensure person-centred care delivery.
- Poor oversight of catering facilities. Inspectors found that the systems of monitoring the cleanliness of the kitchen committed to in the providers compliance plan was not in place. For example, the supervision of the kitchen cleaning duties was allocated to the clinical nurse manager. Due to a staff vacancy, there was no clinical nurse manager on duty on day one of this inspection and there was no member of the management team assigned to complete this role.
- Inadequate oversight of residents finances. The arrangements in place to ensure that residents who require assistance with their pension arrangements were not in line with best practice. Records of residents monies, received by the provider on behalf of the resident, were not kept in the centre and not readily accessible to the resident.

Judgment: Not compliant

Regulation 4: Written policies and procedures

A review of the policies and procedures in the centre found that the provider had up-to-date policies in place, in line with the requirements of Regulation 4. This is an improvement from previous inspections.

Judgment: Compliant

Quality and safety

Some improvements in the quality and the safety of the care were noted over the two days of this inspection. Residents at risk of malnutrition had been appropriately assessed and care plans were in place to ensure the nutritional needs of each resident were in place. Improvement was also noted in relation to the cleanliness of the physical environment, although further action was required to ensure full compliance with the regulations. Residents also reported improvements in relation to care delivery. While the movement towards compliance was acknowledged, the quality and safety of both the resident care delivery and the care environment continued to be significantly impacted by the ineffective management systems, as described in the capacity and capability section of this report.

Some action had been taken to address the issues non-compliance in relation to infection prevention and control since the last inspection. For the most part, the centre was visibly clean and areas such as the sluice rooms were cleared of inappropriate items and reorganised to reduce the risk of cross infection. Resident equipment and furnishings that were damaged and not amenable to cleaning had been removed and replaced. However, a review of the cleanliness of the kitchen and catering areas found that cleaning was not completed to a satisfactory standard. In addition, the cleaning procedures were not known to staff.

The management of fire safety in the centre was not adequate to meet the requirements of Regulation 28: Fire precautions. While some action had been taken since the last inspection such as the clearing of areas around fire escape routes, and improved emergency drill documentation, outstanding issues and assurances in relation to the containment of fire remained to be addressed.

Residents reported improvements in the quality and quantity of food served. There were adequate levels of supervision in place to assist residents with their meals. There was a positive focus on residents nutritional well-being during the nursing and care staff handover meetings. Residents reported having limited access to snacks throughout the day. A review of the food ordering records and the food supplies in the centre supported residents feedback that there was a limited choice of snacks for residents.

The provider had an up-to-date safeguarding policy in place and all staff were trained in recognising and responding to abuse. However, a review of the arrangements in place to safeguard residents finances found that the arrangements for residents who required assistance to access their pensions was not robust.

Access to medical and allied health care was appropriate to meet the health and social care needs of all residents.

A review of a sample of residents care records found that while all residents had an individual assessment and care plan in place the quality of the care plans was

inconsistent. Some care plans reviewed were detailed and person-centred, while others lacked the detail required to deliver high quality care. For example, the end of life care plans for three residents reviewed were generic and did not include the preferences or wishes of the residents in relation to their care. Furthermore, a review of the detail within some care plans, such as those related to medication management, found that they were not aligned with professional and best practice guidelines. In one file reviewed, a risk in relation to a resident's responsive behaviour was not appropriately identified and therefore, effective interventions were not put in place to ensure the residents safety.

Regulation 18: Food and nutrition

The provision on food and the management of nutrition had improved since the last inspection. However, residents reported dissatisfaction with the availability of snacks throughout the day.

In addition, further action was required from the provider to ensure that food served to residents was properly and safely prepared. Inspectors found that the kitchen was not cleaned to an acceptable standard.

Judgment: Substantially compliant

Regulation 27: Infection control

The provider did not take appropriate 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 infection prevention and control practices were observed. For example, bins containing food waste were left full and uncovered overnight causing malodour, and unclean dustpans and brushed were used throughout the centre.
- Cleaning staff demonstrated poor knowledge of cleaning procedures
- The kitchen, catering areas and equipment, while improved since the last inspection, had not been cleaned to an acceptable standard.
- A communal bathroom found to be unclean and not fit for use on the first evening of the inspection were still in the same state the following morning. The issue was not addressed until after 12 midday when the inspector requested a staff member to attend to it.

The oversight of the IPC systems in the centre was impacted by the failure of the provider to ensure that the service was appropriately monitored, as described under Regulation 23(c) Governance and management. There was no comprehensive

environmental audit completed and therefore, no system in place to ensure IPC risks were appropriately identified and addressed. For example, the failure to recognise and address malodours present in one area of the centre was illustrative of the absence of effective environmental auditing.

Judgment: Not compliant

Regulation 28: Fire precautions

A compliance plan, submitted by the provider following an inspection in April 2023 had not been completed. For example;

- Emergency lighting was not functioning in some areas of the centre
- A number of fire doors contained visible gaps when released and closed. This may impact the effectiveness of a door to contain smoke or fire in the event of a fire emergency.
- The provider did not provide assurance that the centre was effectively compartmentalised ensuring that residents could be evacuated to a place of safety in the event of a fire emergency.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

A sample of care plans reviewed were not based on appropriate assessment. For example, end of life care plans were generic and did not guide staff in relation to residents preferences or wishes in relation their care.

Judgment: Substantially compliant

Regulation 6: Health care

A review of the resident's care records found that residents had access to a general practitioner (GP) of their choice. Residents were supported by a team of allied health care professionals including physiotherapists, dietitians, occupational therapists, and community palliative care and mental health teams. The recommendations from these teams were integrated into the residents care plans.

Residents were facilitated to attend outpatient appointments in a timely manner.

Judgment: Compliant

Regulation 8: Protection

The provider did not take all reasonable measures to protect residents from financial abuse. The systems in place to safeguard residents from financial abuse was not robust. The arrangements in place for residents who required a pension agent had not been reviewed and updated when arrangements changed, and were not in line with best practice guidelines.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The provider had implemented systems to ensure that the voice of the resident was listened to; regular resident forum meetings were scheduled and there was evidence that some resident issues and concerns were documented and addressed. However, this was in the early stages and required sustained implementation to ensure that residents feedback was used to improve their quality of life, as the system did not hear or respond to the resident's feedback regarding snacks.

Residents had access to independent advocacy services and referrals to these services were found to be facilitated as required.

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 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 18: Food and nutrition	Substantially 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	Compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for An Teaghlach Uilinn Nursing Home OSV-0000309

Inspection ID: MON-0040547

Date of inspection: 10/07/2023

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 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
Regulation 16 (b): The person in charge shall ensure that staff are appropriately supervised.

• A review of the training matrix has been completed in line with best practice and national guidance. Going forward all scheduled trainings include the relevant policy and application of this policy. Supervision of staff application of the relevant policies and training completed is underway and monitored by the clinical management team. Safety Pause includes updates on training as well as learnings from scenarios. To support assessment of quality improvement plan with clinical nursing documentation, a new daily handover shift to PiC by nurses on duty has been implemented. The induction process is undergoing an overhaul by the HR group manager and the Clinical operations Director to include competency assessment and this will be implemented from October 2023.

• Training plans are reviewed by the PiC to ensure that they meet the needs of the staff in caring for the residents. Some additional training is currently underway in the areas of Complaint Management, Incident reporting, Falls Management, Nursing Accountability, IPC and Nursing Documentation. To support the management & nursing team in the home, on 11-09-23 an ADON was deployed to provide training and development to the nursing team on residents assessment and careplans, recording of incidents and management of residents care needs. The monthly Governance and Management report will include spot checks of the quality and standard of residents records to include review of documentation, communication with resident and staff and observation of practices. This will add to providing oversight and evaluation of the training and development progress.

• All nurses have completed relevant training and receive ongoing supervision on management of residents care through safe and effective assessment and careplanning.

• Documentation will be enhanced to include all areas of the home which are not in daily use. The cleaning procedures in relation to agents and solutions used were reviewed by an external expert on 13/07/23. All housekeeping staff will attend refresher training on cleaning methods on November 1st 2023.

• The PiC has facilitated a number of staff meetings and relayed the importance of supervision of staff and practices by the heads of departments and the nursing team.

• There is a new head chef appointed in who is following HACCP guidelines and detailed cleaning procedures which are recorded in accordance with guidelines. These will be verified by the PiC weekly. The standards of hygiene in the kitchen will be monitored as part of IPC audit and any identified gaps immediately reported to the chef for addressing.

• There is daily supervision in the home on the standard of cleanliness of rooms by the Team leaders and these records are monitored and verified by the PiC weekly. Spot checks of the standard of cleanliness in the home will form part of the checks on the weekly visits by Clinical Operations Director.

• The PiC is currently supported in the supervision of staff by 1 x CNM who is working supernumerary and an additional experienced member of the nursing team who is acting CNM until a second CNM is recruited. This ensures that there is supervision onsite daily.

• Recruitment of ADON is completed and an experienced ADON has been appointed and will commence in this position once all Garda Vetting documentation has been received.

• A new PiC is due to commence in the home on 01/11/2023, this person will be supported onsite by the ADON & CNM. The ADON deployed to support training and development of the clinical team in September will continue to play a role in facilitating quality improvement plans in the center.

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
The compliance plan response from the registered provider does not adequately assure the chief inspector that the action will result in compliance with the regulations.

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.

• The centre retains files on appropriate electronic systems and all files pertaining to residents finances are available as required, available for inspection and at the request of the resident.

• The PiC manages a working printed roster, the electronic version is updated on a daily basis to ensure a true reflection of the working roster for payroll purposes. The PiC has a weekly working roster in place and available at all times. The process of managing the roster in the electronic system is currently under review by the senior management team in the group and once its effectiveness and process is reviewed, determined and defined, the RPR commits to providing an update to the regulator no later than 01-11-2023.

• In the meantime the accuracy of the roster will be checked daily by the PiC to ensure that all planned and unplanned leave if documented and any anomalies are communicated to the support administrator assigned to assist the PiC in maintaining the relevant timesheets and payroll.

• The centre has an electronic system in place for residents' records and this is maintained in line with legislation, It includes retention of records for residents that no longer reside in the centre. In addition the centers administrator will commence scanning all residents paper documentation to a safe and secure electronic system in October 2023, this will improve access by having one point of focus for all records.

• The centre retains all staff files on an electronic system including those who no longer work in the center. These are accessible to authorized persons. All staff inductions will be scanned to the relevant staff files and will be completed by 01-11-23.

• Residents' monies are safeguarded in a secure locked safe in the PiC office. There is a clear checking system in place to record and monitor all activity related to the safe. Residents' finances are stored individually if they wish and statements of these are available to the resident at any time. The overall accounts are managed at group level by a suitably qualified accountant on a secure electronic system and the PiC has access to these accounts in a timely manner for oversight and compliance monitoring.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The compliance plan response from the registered provider does not adequately assure the chief inspector that the action will result in compliance with the regulations.

Regulation 23 (a):
• The Statement of Purpose has been updated in October 2023 to reflect the staffing in the home for current occupancy and WTE of 36 hours per week. The SOP will be reviewed in line with any changes in the center to staffing or occupancy.
• At the time of inspection there was CNM x 1 in position working in a supervisory capacity to monitor and supervise effective delivery of care and interviews were

underway for a second CNM position.
• An experienced ADON in care of the older persons services has been secured and the person is due to commence in Oct 23 once Garda Vetting approval is received.
• The management team within the centre with the support of the HR Manager continue to recruit staff for vacancies to ensure adequate staff numbers are in place to meet the needs of residents when admissions recommence in the centre in consultation with the regulator. The staff workforce plan is tracked weekly by the support HR team, to ensure that staff recruitment requirements are in place as part of any future occupancy rebuild plan with a number of nurses and HCA's currently onboarding and available to work. In October one receptionist returned to work and in addition there is a newly appointed administrator who is due to commence in the center once Garda Vetting documentation is received.
Regulation 23 (b)
• The management of the centre comprises of a PiC supported with CNM x 1 working full time supernumerary. At the time of inspection the registered provider was actively recruiting for ADON and second CNM and recruitment has been successful in recruiting an experienced ADON who is due to commence in October 2023. In addition a new DON will commence as PiC on 01/11/2023. In the interim an experienced ADON from a sister home was deployed on 11-09-23 to support the training and development in clinical practices in the home. This person was subsequently appointed as acting DON on 26-09-23.
• At the time of the inspection, the newly appointed Regional Manager and Compliance and Quality Manager were evident in the centre on the second day of the inspection. Both managers had completed several audits since their commencement in April 2023 and had significant involvement in supporting the center to reach improvement across many areas in the home through enhanced onsite G&M Activity.
• The registered provider has reviewed the management structure which identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision which has been submitted to the regulator in great detail on 10/08/23. The management in the home is supported by the Clinical Operations Director who has specific responsibility for the monitoring of the quality and standard of care provided by the onsite team, as part of monthly review of clinical KPI's, weekly onsite visits and spot check of clinical documentation. This person supports the PiC of the home to meet regulatory compliance and visits the home at a minimum of 6 days per month. The PiC provides a weekly report to the Clinical Operations Director to include clinical KPI's, Incident, complaints and any risks related to day-to-day operations of the home and care, this is discussed in detail with actions identified to be completed as part of quality improvement tool. The RPR continues to monitor the effectiveness of the G&M structure.
• The Clinical Operations Director role also includes responsibility to provide monthly oversight on Clinical Care KPI's, identifying gaps, trending compliance and managing quality improvement plans all detailed in a monthly report provided to the Registered Provider and Group Directors. This report is shared with the PiC who also attends the onsite monthly Governance & Management meeting.
• The Clinical Operations Director will complete a quarterly review of all audit findings for July – Sept 2023 to identify any trends, gaps or areas requiring improvement to meet clinical best practice. These will be presented to the Board of Management and RPR and inform actions and required resources in a defined quality improvement plan. This plan will guide the onsite management team in the center.

• The Group HR manager provides the home with oversight in the compliance of recruitment and staff training. As part of a quality improvement plan on training and development a competency based induction is being rolled out in the center, this will include revisiting induction and related competencies for nursing staff during Oct & Nov 23.
• The Group Facilities manager who reports to the Operations Director has responsibility for monitoring and supporting the compliance related to activity in the area of Premises, Facility Management, Safety Systems and Fire Management Systems. The Group Facilities Manager visits the nursing home every 2 weeks, completes an environmental check of the interior and exterior of the home. Non compliances are referred to the PiC and maintenance person. Identified risks are added to the risk register and the group facility manager supports the onsite maintenance person and provides a monthly update on planned or scheduled works to the PiC.
• Any deficits noted in the area of premises such as the need for repair of wear and tear in bathroom if being addressed by PiC. Risks related to this have been entered into the risk register with internal controls in place and residents are offered to change to alternative room whilst repairs may be required in their allocated rooms.
• A structural engineer visited the home on 10/10/2023 with the Group facilities manager and the Operations Director awaits the report regarding works required.
• The Group Finance department review the processes related to managing the residents' finances and ensure that the related policies and operating procedures are performed in the home in line with best practice and regulation. The process to access residents finances from the electronic system ensure they are available immediately at the time of request. The process of changing the pension agent for residents pension managed by the home is underway and documents were submitted to the Department of Social Protection in October 2023 to meet best practice.
• As part of the G&M structure a weekly meeting takes place to discuss any current risks, complaints, care KPI's from the weekly DON report and the G&M action log. In attendance at this meeting is the RPR, Operations Director, Finance Director, Group HR Manager, Commercial Director and Clinical Operations Director. The defined role of the Clinical Operations Director provides clear reporting structure for the home and responsibility for the oversight on the Governance and Management of provision of care through monitoring and oversight of clinical KPI's, Audit findings and Compliance.
• Monthly G&M onsite meetings attended by the directors is held onsite in the home. The agenda includes discussion and actions post Clinical Care KPI;s: HR items including training/induction/recruitment/vacancies; Financial performance; Commercial and Operational items including Environment & H&S.
Regulation 23 (c):
• A revised suite of audits and audit schedule was devised in the group in May 2023, a number of these had commenced in the center and continued in July in greater detail.
• The centers risk register has been reviewed in October 23 and appropriate changes and adjustments to wording completed.
• There is a suite of audits and checks completed monthly and weekly by the PiC with support from the CNM and compliance and monitoring of these is overseen by the Clinical Operations Director, documented, trended and shared at group level as part of monthly G&M systems. The management of these systems will be enhanced with the commencement of an newly appointed ADON which will strengthen the management team in the home. The center will have a full management team in place from November 1st 2023 to include DON, ADON, & CNM. The Clinical Operations Director is undertaking

a review of the audit systems in place to ensure that the practices in the home are audited against the nursing home policies and clinical best practices. Quality Improvement Plans will include actions following completed audits, trending of non-compliances will be monitored and reported on as part of G&M meetings where actions will be taken to address gaps identified and improve practice e.g. Nursing documentation, IPC, Incident Recording, Assessments and Careplans, Safeguarding, Notification Management and Environment. Areas identified will form part of the annual quality and Safety plan. The group management team will continue to review the effectiveness of the audits in place to ensure all regulations are monitored for compliance.

• However, monitoring of compliance and auditing continues, with the outcomes and review results reported in the monthly G&M meeting. These outcomes and actions are based on gaps identified and shared with the PiC as part of the G&M systems in the home. As above the Clinical Operations Director is completing a review of current audit systems with a view to enhancing their purpose to include increased detail and robust nature of audit.

• The G&M monthly report for July 2023, provided to the regulator on 10/08/23 demonstrates enhanced management systems and monitoring of audit outcomes, Care KPI's and Compliance. A monthly G&M meeting continues to include review of the Clinical Operations Director monthly review report. This monthly report includes checks of the standard of the clinical care provided to residents through spot checks on the relevant documentation as part of monitoring and review of clinical KPI's. Commencing in October the monthly review will take into consideration 10% audit of residents files and documentation per month.

Regulation 18: Food and nutrition	Substantially Compliant

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

Regulation 18 (2): The person in charge shall provide meals, refreshments and snacks at all reasonable times.

• A snack trolley service continues to be provided for residents throughout the home at a minimum 3 times per day between main meals: 11.00, 15.00 & 19.00. In addition there are water stations and drinks available in both day rooms.

• A variety of snacks are provided including yogurts, fruit, homemade cakes, biscuits and drinks. Snacks are fortified and modified as required to meet nutritional needs of residents. The new head chef and support chef are keen bakers and take significant pride in producing homemade cakes and desserts for residents which are presented in a clear display tray on the snack trolley.

• The residents MUST assessment has been reviewed in October, with 3 residents requiring referral to the Dietitian and this was completed. Records of resident intake of

food and fluid is being maintained for per residents needs. The number of residents with a MUST score of ≥2 is now trended as part of the monthly clinical KPI's and discussed as part of the G&M management meeting.

• A review of the snack choices has taken place in the centre and the issue of biscuit choices discussed at the resident's forum meeting.

• The resident mealtime and dining experience survey will form part of the annual resident questionnaire to be launched at the end of October 2023 and the analysis will be included in the annual review of the home.

• As part of the resident committee meeting, the chef attends and mealtimes and nutrition continue on the agenda.

• In addition the PiC has placed a fridge in the dining room area for use by residents only and this facilitates ease of access to snacks throughout the day. This is replenished and managed by the catering team.

• The PiC and Head Chef will commence weekly meetings from October 23 to include review of residents likes/dislikes; concerns/complaints received; observations of dining experience; results of mealtime audit; review of the menu to include provision of variety and suitable modified diets. The rotational menu is due to be reviewed and assessed by external dietician in October 2023.

• The Clinical Management team will reinforce the standard of cleanliness required in the kitchen, the chef has completed all relevant HACCP training and the IPC audit will record findings in the Kitchen area at the time of auditing and immediate actions addressed.

• As part of reviewing the audit system in place, the Clinical Operations Director will device a Food and Nutrition Audit which measures compliance against best practice and also regulation, this will commence November 2023.

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 center has dedicated housekeeping staff rostered daily. Oversight of the cleanliness of the home to include procedures on ensuring bins are emptied in a timely manner is completed by the CNM and/or PiC on a daily basis. There is a monthly IPC and Home presentation audit completed by the PiC and relevant actions plans defined and

delivered on. Outcomes are shared with staff at staff meetings.

• A review has been completed of all brushes and dustpans and any unclean item attended to.

• All staff had received relevant training in housekeeping procedures. Further training is scheduled for November 1st 2023. The housekeeping room has a display of safety data sheets pertaining to all cleaning products in use as part of the dispensing system. Monitoring of compliance of housekeeping standards forms part of the daily PiC, ADON and CNM checks. Review of Compliance in this area has also been added to the nurses daily handover sheet for PiC.

• The commencement of a new Head Chef in August 2023 has assisted in maintaining a high standard of cleaning within the kitchen. This is verified weekly by the PiC and will also be included on the agenda for the PiC/Head chef weekly meeting, commencing in October 2023.

• The CNM or allocated other staff member checks all areas of the home to ensure good housekeeping practices are in place.

• The Clinical Operations Director will complete oversight of an IPC and Home presentation audit on a monthly basis going forward to monitor improvements in IPC, to include the environment and ensure that appropriate quality improvement plans are implemented. The IPC audit is under review to include an increase in the items monitored under IPC environmental compliance, this will be rolled out in October 2023.

• All staff continue to attend training in IPC relevant to their role and compliance to training is supervised by the onsite clinical management team. During 2023 all current staff have completed training in IPC.

• The onsite clinical management team will complete staff huddles on hand hygiene, PPE wearing and IPC practices to ensure all staff understand and can apply the nursing homes IPC policy in line with best clinical practices.

• There is an IPC committee in place and monthly meetings are being completed where audit findings and any identified poor practices are discussed with actions agreed and responsibilities defined.

• The center has purchased a floor washer/dryer to improve the quality of cleaning of the floors.

• The PIC met with the community support team for IPC who visited the home on 10-10-23 and arrangements are in place for a member of the nursing team to complete the IPC Link practitioner programme which will enhance the level of oversight of IPC in the home.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: The compliance plan response from the registered provider does not adequately assure the chief inspector that the action will result in compliance with the regulations.

Regulation 28 (1) (b) The registered provider shall provide adequate means of escape, including emergency lighting.

• The emergency lighting is reviewed by a maintenance contractor on a quarterly basis. Prior to the inspection the emergency lights had been checked in May 2023. There is a weekly schedule in place for the maintenance person onsite to check all emergency lighting.

• Post inspection the emergency lighting has been reviewed within the centre and any faults noted have been attended to. Further upgrade works are required and these will be attended to based on the availability of the contractors.

• Oversight of the fire checks is completed by the Group Facilities Manager during onsite visits every two weeks. The Group Facilities Manager provides a weekly report which include details of communication/actions with the onsite maintenance person to the PiC, Clinical Operations Director and Operations Director in the Group.

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

• Since the inspection in April 2023, the registered provider engaged the services of an external fire consultant. Following thorough of the centre by the consultant the provider was furnished with a comprehensive report and risk assessment. The Risk rating detailed by the consultant on the risk assessment was identified as tolerable, on a scale ranked 1-trivial, 2-tolerable, 3-moderate, 4- substantial and 5-intolerable.

• The provider is currently addressing the actions identified by the external fire consultant. This log of action items was available to the inspectors during the inspection. Some of the identified works need to be completed by an external fire specialist and the provider is actively working to source contractors/ specialists to complete the work. The risks identified in the fire risk assessment has been added to the Risk Register in Oct 23.

• The provider has engaged with a fire engineer to review the compartmentalisation of the home and is awaiting their availability to assess this area. The expert engineer in this area attended the center on 10/10/2023 and the RPR awaits the report. A contractor has been appointed to address repairs in the doors and the RPR awaits a start date.

• As part of manging the risk of Fire in the nursing home there is a robust maintenance system in place which includes: Inspection of the hallway doors twice per year by an external provider; The SCD on the doors are inspected monthly, doors are also observed

during weekly fire alarm testing to ensure they release from the magnetic hold open devices; The Fire Alarm is Tested and inspected 4 times a year and the fire alarm system was upgraded in May/June 2023 including 2 new display panels; Weekly tests are completed to ensure call points operate the alarm, the sounders activate, gas supply is disconnected, all internal doors close and all external doors open; Fire Extinguishers are Inspected and tested yearly. All extinguishers dating 10 years old are replaced, all defects are repaired/replaced. Monthly checks are completed inhouse to ensure all extinguishers are in the correct location, stored correctly, in good condition and have the safety tie in place; the fire hydrants are inspected and tested annually. All defects are reported. Emergency lighting is Tested 4 times per year. All defects reported. The current system has been reviewed and a quote for an upgrade is due. There is a visual inspection of the Fire Management system weekly; Access control to the center is inspected and tested twice per year; and the green BGU's are tested monthly to ensure they operate correctly

• Due to the ongoing demand for remedial fireworks across the nursing home sector, the provider is being advised by fire specialists that there is an extended wait period for contractors to be available to visit the site to assess and commence the works. The Provider is aiming to have all fire related works completed by 10/05/24.

• The management in the home continue to complete simulated fire drills monthly and complete inhouse fire safety checks as part of the fire management safety systems. These are overseen by the PiC and Group Facilities Manager.

• All staff continue to receive training related to Fire Management and in 2023 all current staff have attended appropriate training in Fire Management.

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 (1) The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).

• The onsite clinical management team continue to review the residents careplans to ensure that all information obtained on admission and resident care plan meetings is reflected in a person centered way and individualized within residents careplans. A member of clinical team has been appointed to provide training and development on person centered care plans, completing resident assessment and using the SBAR communication tool in writing progress notes. The nursing team have been provided with a detailed list of recognized nursing assessments which includes the details and description of the assessment and its relevance to residents care. Understanding care

planning leaflet has been provided to the staff and the resident. All staff nurses will have completed additional training in Assessment and Careplan training by 01-12-23. The competency of the nurse in completing the residents assessments and careplans will be monitored by the PiC through individual assessment.

• There is a monthly care plan audit schedule in place, and feedback is provided to the allocated staff member as quality improvement actions. The Standard of the completed actions are reviewed by the PiC and CNM so as to ensure appropriate assessment of residents' end of life needs. A full review of all residents careplans will be completed by 01-11-2023. The Clinical Operations Director will continue to review a sample of the residents files as part of the monthly review and provide detailed actions to the PiC and the clinical team

• As part of the monthly KPI review completed by the Clinical Operations Director, a sample of care plans are spot checked for the standard and compliance of assessments and careplans. Identified actions form part of the monthly report which is shared with the PiC and G&M team. The PiC has responsibility to ensure that these actions are completed by the onsite nursing team in a timely manner.

• Training with nursing staff on the care planning process remains ongoing on site to ensure nursing staff are fully aware of the standard required to meet residents' needs and compliance with regulation. Review of the nurses application of the training provided is forming part of the competency assessment due for commencement in mid October 23.

• The provider of the electronic system in place to manage residents' records has been provided on 16/08/23 to the onsite clinical management team.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection: Regulation 8(1): The registered provider shall take all reasonable measures to protect residents from abuse.

• The center has a locked safe within the center secured in the PiC office. There is a clear process in place with limited access to the safe to ensure protection of residents' belongings.

• In addition, residents may avail themselves of a secure place to store personal items in their room if this is their choice. Residents are offered a safe box in their room should they wish to keep valuable in their room.

• The national patient advocacy service visited the nursing home on 10-10-23 and met with each individual resident to discuss the availability of free, independent advocacy

services and the residents care plans have been updated to reflect this consultation.

• A review of the processes and arrangements related to residents' finances is underway to ensure they are in line with best practice. The pension agents have been reviewed as part of this process and action is in progress to rectify and clarify the name on the pension agent forms to meet best practice.

• The processes related to managing residents' finances will be audited quarterly as part of an improved monitoring system in managing compliance in the center. This will commence in October 2023.

• Residents finances will be managed in line with the nursing home policies on Adult Safeguarding and on Management of Residents' Accounts and Property, including Pension Management.

• All staff have completed safeguarding training to include workshops x 2 facilitated by a dedicated safeguarding officer in August and there is a designated safeguarding officer in the center accessible to staff and residents.

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	01/12/2023
Regulation 18(2)	The person in charge shall provide meals, refreshments and snacks at all reasonable times.	Substantially Compliant	Yellow	08/11/2023
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	08/11/2023
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with	Not Compliant	Orange	20/11/2023

	the statement of purpose.			
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.	Not Compliant	Orange	01/12/2023
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	01/12/2023
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Not Compliant	Orange	08/11/2023
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency	Not Compliant	Orange	10/05/2024

	lighting.			
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	10/05/2024
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Substantially Compliant	Yellow	01/11/2023
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Substantially Compliant	Yellow	01/10/2023