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:	Droimnin Nursing Home
Name of provider:	Droimnin Nursing Home Limited
Address of centre:	Brockley Park, Stradbally, Laois
Type of inspection:	Unannounced
Date of inspection:	11 January 2023
Centre ID:	OSV-0000702
Fieldwork ID:	MON-0038847

About the designated centre

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

Droimnin Nursing Home is a designated centre for older people. The centre has two buildings that are purpose built. The centre provides accommodation for a maximum of 70 male and female residents, over 18 years of age. Residents are admitted on a long-term residential, respite and convalescence basis. The centre is located at the end of a short avenue in from the road and within walking distance to Stradbally, Co Laois. A variety of communal rooms are provided for residents' use including sitting, dining and recreational facilities. Each resident's dependency needs is assessed to ensure their care needs are met.The provider employs a staff team in the centre to meet residents' needs consisting of registered nurses, care assistants, activity, administration, maintenance, housekeeping and catering staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	62

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 11 January 2023	09:30hrs to 17:00hrs	John Greaney	Lead
Thursday 12 January 2023	08:30hrs to 16:00hrs	John Greaney	Lead

What residents told us and what inspectors observed

This inspection was conducted over two days by an inspector of social services. On arrival on day one, the inspector was greeted by a member of staff that assisted the inspector to complete a signing-in process and to ensure adherence with infection control procedures. After an opening meeting with the person in charge and a review of some documentation, the inspector was taken on a tour of the building by the person in charge. The atmosphere in the centre was welcoming, calm and relaxed. Residents were observed enjoying each others' company in the main reception area.

Droimnin Nursing Home is located close to the town of Stradbally, Co. Laois and is registered to accommodate 70 residents. It is a two storey building situated on spacious grounds that contain a number of other private dwellings that were originally designed for independent living purposes. The provider has no involvement in these dwellings. All of the bedrooms are single occupancy and are en- suite with shower, toilet and wash hand basin. Previously the centre comprised two buildings and was registered for 101 beds, however, the second building was vacant at the time of the most recent registration renewal and was not registered as part of the designated centre.

The overall feedback from residents was that Droimnin Nursing Home was a nice place to live. The inspector met briefly with a large number of residents during the walkabout and spoke in more detail with six residents over the course of the inspection. Residents that spoke with the inspector gave positive feedback of their experience of living in the centre. They were complimentary of the food and of the choices available on the menu. Residents confirmed that they had choice over their daily routine, including when to get up in the morning, the clothes to wear and whether or not they wished to partake in the activities scheduled each day.

The ground floor of the centre is called Dunamaise and accommodates 29 residents. Communal space on this floor comprises a large reception area with a variety of comfortable seating and also contains a table and chairs. Over the course of the inspection a number of residents were observed spending a significant part of the day here. These residents told the inspector that they like watching the comings and goings of staff and visitors throughout the day while chatting with each other. Adjacent to the reception area is a secure outdoor space that is landscaped to a good standard with plant beds and also has suitable garden furniture. It is readily accessible to residents from different parts of the centre. The inspector was informed that some residents use this area to smoke. While there were large bucket ash trays immediately outside two of the doors, a large number of cigarette ends were disposed of on the ground. There was a smoking apron, a fire blanket and fire extinguishers located proximal to one of the doors, but there were none of these items at the entrance from the reception area. Additionally, the fire extinguishers were obstructed by a large speciality chair that would impact on the speed at which the extinguishers could be accessed in an emergency situation. There were also no

call bell facilities in either of the smoking areas. Other communal space on the ground floor comprises a day room, a dining room, and an oratory.

The first floor is called Tursalla and accommodates 41 residents. This area is accessible by stairs and a lift. Communal space here comprises a reception area, where most residents spend their day. There are also two day rooms, two dining rooms and an activity room. There is an outdoor area that is mainly used by residents that smoke. This was not suitably equipped as it did not have fire fighting equipment or call bell facilities. This area was very untidy in appearance with wet paper towels and a cloth towel thrown on the ground. The flooring is decking type material that had a green algae like coating. As a result, this area was a potential slip hazard for residents. There was a small ramp leading up to the door to access this area and there were cigarette burn marks on the floor covering immediately inside the door.

The inspector observed that visiting was facilitated and there was a high level of visitor activity over the course of the two days of the inspection. Visitors were observed to meet with residents in the various communal rooms and in their bedrooms. Visitors spoken with by the inspector were complimentary of the care provided to residents and confirmed that there was no restrictions to visiting.

The next two sections of the report describe the provider's levels of compliance with the Health Act 2007 and the Care and Welfare Regulations 2013. The findings in relation to compliance with the regulations are set out under each section.

Capacity and capability

This inspection was conducted over two days by an inspector of social services and was a risk-based inspection to monitor ongoing compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. The inspector also used information received by the office of the Chief Inspector, both solicited and unsolicited, to inform lines of enquiry for the inspection.

Overall, the inspector found that some improvements had been made since the previous inspection in August 2022, however, the finding of this inspection were that current governance and oversight of the centre was not effective and did not ensure that services were provided in line with the centre's statement of purpose. There were repeated non-compliances in the areas of governance and management, the submission of notifications and training and development. Additionally, commitments given in the compliance plan following the most recent inspection in August 2022, particularly in relation to fire safety, were not implemented.

Droimnin Nursing Home Limited, a company comprising three directors, is the registered provider of Droimnin Nursing Home. While the provider is not involved in the operation of any other nursing homes, the company directors are involved in the

operation of four other nursing homes throughout the country. None of the directors attended the centre in person on the days of inspection or for the feedback meeting at the end of the inspection.

Action is required required in relation to governance and management of the centre. A commitment given in the Statement of Purpose of 0.25 whole time equivalent (WTE) for the post of Clinical Director was not fulfilled. While the clinical director was in regular contact with the centre through telephone and email, they did not have a regular presence in the centre. As identified at the last inspection, there have been a number of changes to the person in charge in the recent past, resulting in there being three different people in the role during the 2022 calendar year. The current person in charge was appointed to the role in July 2022. The deputy director of nursing (DDON) had resigned in November 2022 and a new person had been appointed that same month. The post of clinical nurse manager (CNM) remained vacant and has been vacant for some time. Although the inspector was informed that recruitment was underway, assurances were not provided as to a time frame within which a clinical nurse manager would be appointed.

Within the designated centre, in addition to the DDON, the person in charge is supported by a team of nurses, health care assistants, activity, administration, maintenance, domestic and catering staff. There was a comprehensive programme of audits scheduled to take place in 2023. Audits completed in 2022 included falls management, skin care, medication management and the environment. There were action plans associated with the audits to support the implementation of any required improvements. An out-of-hours audit had been completed by the person in charge whereby she visited the centre in the early morning while night staff were still on duty.

Staff were supported and facilitated to attend training. There was a high level of attendance at mandatory training, however, a small number of staff were overdue attendance at training in some of these areas. While the inspector was informed that an induction programme was in place, records were not available to indicate that the induction programme was robust to ensure that management was satisfied that each new member of staff was competent to carry out the role for which they were employed. A system of annual performance appraisals was described to the inspector, however, on the day of the inspection records of a number of these appraisals were not available for review. These issues are addressed in more detail under Regulation 16 of this report.

Residents' views on the quality of the service provided were ascertained through resident meetings. These meetings had only recently recommenced and only a small number of residents had attended. A satisfaction survey involving five residents had recently been completed by the ADON. There was a need to expand the process for obtaining feedback from residents and their families to determine if the centre was meeting the needs of residents.

The inspector reviewed a sample of staff personnel files and found that not all of the information required by Schedule 2 of the regulations was contained in each file.

This is discussed in more detail under Regulation 21 of this report.

A review of the complaints records found that complaints and concerns were responded to promptly and managed in line with the requirements of Regulation 34. A review of the records indicated that there was a comprehensive record kept, both for complaints resolved locally and complaints which were investigated through the formal process. Where it was deemed appropriate for an independent person to investigate a complaint, this was commissioned.

Regulation 15: Staffing

There were adequate numbers and skill mix of staff to meet the needs of residents on the days of the inspection. The need for agency staff to meet the required staffing complement had reduced significantly through successful recruitment campaigns.

Judgment: Compliant

Regulation 16: Training and staff development

Action was required in relation to the induction and training of staff. For example:

- a system was not in place for the sign-off of newly recruited staff by the director of nursing or deputy director of nursing to identify that they had been deemed competent to carry out duties relevant to their role and were no longer required to work in a supernumerary capacity
- a review of training records identified that a small number of staff were overdue attendance at training in the areas of challenging behaviour, safeguarding residents from abuse, manual handling and fire safety

Judgment: Not compliant

Regulation 21: Records

Of the four personnel files reviewed, there were gaps in employment for two staff for which a satisfactory explanation was not recorded.

While there was a system in place for staff appraisal, appraisal records were not accessible on the days of the inspection.

Judgment: Substantially compliant

Regulation 23: Governance and management

Appropriate resources were not in place as the governance and management structures in the centre were not in line with the governance structure as outlined in the statement of purpose and were not implemented in practice. For example, there was a commitment to a 0.25 WTE clinical director post to this centre but records of meetings indicated that the clinical director was only present in the centre intermittently. Additionally, the post of CNM was vacant.

The management systems to ensure that the service provided was safe, appropriate, consistent and effectively monitored, as required under Regulation 23(c), were not sufficiently robust. This was evidenced by:

- induction records identified a general induction to the organisation and to the premises. There was no role specific induction record to ensure all staff were deemed competent to carry out the role for which they were employed
- notifications were not submitted in accordance with the requirements of Schedule 4 of the regulations. For example, quarterly notifications had not been submitted for Quarter 2 and Quarter 3 of 2022
- commitments given in the compliance plan response following the inspection conducted in August 2022 were not implemented. For example, there was a commitment by the Senior Management Team to have weekly meetings with nursing home management. Records available indicate that there were five meetings in the final quarter of 2022. Additionally, there were gaps in cross corridor fire doors, an issue that was also found on the last inspection
- an immediate fire safety risk was identified in respect of bolts present on a cross-corridor fire door. These were removed by the maintenance staff on the day at the request of the inspector.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

Each resident had a written contract of care that included the services to be provided and the fees to be charged, including fees for additional services.

Judgment: Compliant

Regulation 31: Notification of incidents

Notifications were not submitted in accordance with Schedule 4 of the regulations. For example, quarterly notifications were not submitted for Quarter 2 and Quarter 3 of 2022.

Judgment: Not compliant

Regulation 34: Complaints procedure

An accessible and effective complaints procedure was in place. Residents' complaints and concerns were listened to and acted upon in a timely, supported and effective manner. The complaints log was reviewed and showed that formal complaints were recorded in line with the regulations.

Judgment: Compliant

Quality and safety

Overall, residents and visitors expressed satisfaction with the care provided and the quality of life in the centre. Improvements had been noted in the area of residents' rights since the last inspection. Significant action, however, was required in the area of fire safety. While improvements were noted in the areas of infection control and care planning, further improvements were required in these areas.

All residents, except those admitted for respite were under the care of one general practitioner (GP). This GP visited the centre one day each week and was also in regular contact through telephone and email for any medical issues that arose in the interim. Staff informed the inspector that the GP would visit in the event of an emergency. Residents were also provided with access to other health care professionals, in line with their assessed needs. From a review of records it was evident that residents who required assessment were referred to allied health professionals, such as a dietetic and speech and language therapy.

Residents' assessments and care plans were currently paper-based, however, plans were at an advanced stage for the introduction of electronic assessments and care plans. The inspector reviewed a sample of residents' files. Following admission, residents' social and health care needs were assessed using validated tools, to inform care planning. Significant improvements had been noted in care plans since the last inspection. All residents had new care plans put in place since the last inspection. While the majority of care plans were person-centred and provided good guidance on the care to be delivered to each resident, additional detail was required in others. This is discussed in more detail under Regulation 5 of this report.

This is a relatively new purpose-built centre that meets the needs of residents in a homely and comfortable manner. All bedrooms are single occupancy with en-suite bathrooms. Bedrooms were personalised with residents' memorabilia and photographs. There was adequate communal space that was suitably furnished and decorated. Residents had access to outdoor space from both the ground and first floors. The outdoor space on the ground floor was landscaped to a high standard with plant beds and garden furniture. The outdoor space on the first floor, however, was unkempt and required significant attention to make it an inviting and safe place for residents to spend time outside when the weather was suitable. Internally the centre was clean and warm. Housekeeping staff were knowledgeable and maintained appropriate records of what was cleaned, including deep cleaning.

Systems were in place for the maintenance of the fire detection and alarm system, emergency lighting and fire fighting equipment. All fire safety equipment service records were up to date. There was a system for daily and weekly checking of means of escape, fire safety equipment, and fire doors. Based on a review of the records of these checks, there were days when the safety checks were not completed. Each resident had a personal emergency evacuation plan (PEEP) in place that reflected the evacuation needs of each resident in the event of an emergency evacuation. There were fire evacuation maps displayed throughout the centre and staff spoken with were familiar with the centre's evacuation procedure. Action was required in relation to fire containment systems as these were not in accordance with the centre's fire safety policy. While fire drills were conducted, there was a need to increase the frequency of drills based on required improvements identified in the drill records. A number of residents smoked cigarettes. The designated smoking areas were the outdoor areas on both floors. Neither of these areas were suitably equipped due to the absence of call bell facilities and the lack of readily accessible fire fighting equipment in all areas. Fire safety is discussed in more detail under Regulation 28 of this report.

Adequate arrangements were in place for safeguarding residents from abuse. Residents spoken with confirmed that staff were responsive to their needs. The centre was pension agent for two residents and adequate banking arrangements were in place for the management of this money. Residents had access to and control over their monies and adequate records were maintained for small sums of money held by the provider for safekeeping on behalf of residents.

The inspector observed interactions between staff and residents, which were noted to be kind and respectful. The overall atmosphere in the centre on the days of the inspection was relaxed. Improvements were noted in the provision of activities to residents. There were two activity coordinators employed since the last inspection. Residents were complimentary of the improved programme of activities and were observed to be enjoying group activities on both days of the inspection. To enhance the programme of activities musicians visit the centre on alternate Thursdays and every Friday. There was a traditional music group playing in the reception area on the second day of the inspection and a large number of residents had gathered there to enjoy the entertainment. Residents confirmed that their religious and civil rights were supported. There was an oratory in the centre in which mass was held weekly. Recent improvements were noted in the process of involving residents in

the organisation of the centre. A structured agenda had been commenced to ensure that areas of importance were discussed at residents' meetings and any required improvements were addressed. Residents had access to a SAGE advocate should they need assistance.

Regulation 11: Visits

The registered provider had arrangements in place to facilitate visiting in the centre. Residents could meet their relatives and friends in the privacy of their bedrooms or in designated visiting areas in the centre.

Judgment: Compliant

Regulation 17: Premises

Improvements required in relation to the premises included:

- the flooring of the first floor outdoor area a is decking type material that had a green algae like coating. As a result, this area was a potential slip hazard for residents
- the outdoor area on the first floor was littered with paper towels and a cloth towel
- a review was required of windows to ensure that restrictors that prevented the windows from fully opening were operational. The inspector found that a window in the ground floor dining room could open fully and posed a risk for a resident with a cognitive impairment of leaving the centre unaccompanied.

Judgment: Substantially compliant

Regulation 26: Risk management

There was a risk management policy and associated risk register that addressed the items specified in the regulations and is kept under review.

Judgment: Compliant

Regulation 27: Infection control

Action were required to ensure the centre was in compliance with infection prevention and control standards and guidance. For example:

- while there was a programme underway to install wash hand basins throughout the centre this was not yet complete. The wash hand basin in a sluice room did not have hands free taps and there was no wash hand basin in the treatment room
- there was a laundry skip with used laundry stored in a store rooms used for storing clean sanitary items, posing a risk of cross-contamination.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Action was required by the provider to ensure that adequate arrangements were in place to protect residents from the risk of fire. For example:

- there were no door closure devices on bedroom doors. The centre's fire evacuation plan states that all fire doors shall be fitted with a self-closing device capable of closing the door
- there were gaps in cross-corridor fire doors that would impact on their ability to contain fire and smoke in the event of a fire
- one cross-corridor fire door had bolt locks attached. While the inspector was assured that these were never used and management were unaware that these locks were there, they still presented a risk that a resident with a cognitive impairment could bold the doors shut. These were removed immediately by maintenance staff
- the smoking area on the first floor did not contain fire fighting equipment or a call bell for residents to alert staff should they need assistance
- there were marks on the floor covering immediately inside the door from the external smoking area on the first floor suggestive of cigarettes being extinguished on the floor. This is a significant fire safety risk
- there were two doors leading to the external smoking area on the ground floor. There was evidence that residents smoked immediately outside each of these doors but there was only fire fighting equipment proximal to one of the doors. Additionally, the fire extinguishers at one of these doors were obstructed by a large speciality chair that would make it difficult to access the extinguisher and potentially delay the response should the extinguisher be required
- while fire drills had been conducted, the drill records identified that improvements were required in staff response to a fire. There was a need for further drills to ensure that all staff were competent in responding to fire. This was exemplified by some staff describing vertical evacuation of residents from the first floor prior to ensuring that all residents were in a place of relative safety through horizontal evacuation
- while there were daily checks to ensure that evacuation routes were free

from obstruction, there were gaps in the records indicating that the checks were not completed every day.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Action was required in relation to assessment and care planning. For example:

- the care plans for residents with diabetes required additional detail, such as the frequency of blood sugar monitoring and the acceptable range for each resident
- there was a need for a system for monitoring and recording changes to residents' skin condition such as bruising
- not all residents had a risk assessment completed for smoking

Judgment: Substantially compliant

Regulation 6: Health care

All long-term residents were under the care of one GP. Short-term residents retained the services of their own GP while resident in the centre. The GP visited the centre on a weekly basis and was responsive to phone calls and emails for any changes to residents' status in the interim. The GP also visited the centre for residents that required urgent review.

Judgment: Compliant

Regulation 8: Protection

All residents spoken with stated that they felt safe and were complimentary of the care provided by staff. Adequate arrangements were in place for the reporting and investigation of suspicions or allegations of abuse.

The provider is pension agent for two current residents and adequate banking arrangements were in place for the management of this money. For residents that the provider had been pension agent but were now were deceased, efforts were underway for the refund of account balances. The centre held small amounts of money for safekeeping on behalf of residents and there were adequate records were maintained of withdrawals and lodgements of these monies.

Judgment: Compliant

Regulation 9: Residents' rights

Improvements were noted in the provision of activities since the last inspection. Two activity coordinators have been recruited and residents were observed to be enthusiastically participating in activities on both days of the inspection.

Residents were consulted through residents meeting. Records indicated that issues raised at these meetings were brought to the attention of relevant staff to be actioned. A process of consulting residents through surveys had commenced. These, however, were completed by staff on behalf of residents. Management were advised that feedback could also be obtained through relatives surveys, particularly from relatives of residents that may have a cognitive impairment.

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	Not compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Droimnin Nursing Home OSV-0000702

Inspection ID: MON-0038847

Date of inspection: 12/01/2023

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	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.

The Management Team have reviewed the existing training schedule and noted deficits as outlined in the report. Training dates are now in place to ensure all staff have training relevant to their roles. This training will be completed by 30th April 2023.

The PiC has reviewed the continuous training need for the centre for the remainder of 2023 and these trainings will be booked in advance.
The PIC will oversee the training matrix and ensure all staff have received all regulated mandatory and additional training required to support them in their roles.

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

All staff have a formal induction which has now been reviewed and includes a sign off section by the PiC.
The centre has successfully recruited a ADON who commences at the end of April 2023. A CNM has also been appointed and is due to commence at the end of March 2023. These new appointments will further enhance the governance structure and the supervision of staff within the centre. In the interim period, the Operation Director and other members of the Senior Management team visit the centre weekly.

Regulation 21: Records	Substantially 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.

A full review is underway of all staff files by the Senior Administration Team to ensure they contain all the information as laid out in Schedule 2 noted above. The Operations Director has devised and implemented an audit system on 24/02/2023 which will capture all new staff, once an offer of employment is made and track them and their compliance paperwork prior to and post commencement of employment. Audit of staff files will be Completed by 30-03-2023.

Staff File Audits will continue monthly onsite by the Senior Administrator and will be inspected and reviewed by the Operations Director.

All staff appraisal dates will be maintained and evidence of same available for future inspections.

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.

Weekly meetings took place with the centre by the Clinical Director and Other Board Members. These meetings are minuted and recorded, however, the minutes were not maintained in the centre.

Post Inspection the following appointments have been made:

1 x Assistant Director of Nursing
1 x Clinical Nurse Manager
1 x Health Care Assistants
1 x Registered Nurse entered the country to complete aptitude test.
1 x Kitchen Assistant

The centre also has 2 x Healthcare Assistants awaiting Garda Vetting and compliance paperwork. It is anticipated they will commence the week beginning March 20th 2023.

Additional appointed resources include:

Compliance and Quality Manager is appointed and due to commence on 03-04-2023. This appointment will allow for another layer of oversight in the centre to ensure that the systems in place are effectively managed, delivered consistently and monitored to appropriately meet the needs of the resident within the centre.

An Operations Director has been appointed on 20-02-2023 who will assist the center with non-clinical compliance issues.

A Group HR Manager has been appointed and commences on 27-03-2023. This appointment will allow for greater oversight on the recruitment compliance paperwork as well as probations, appraisals and other HR issues.

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.

Currently the Board of Management are reviewing the internal control practice and procedures, including auditing, risk management and health and safety and IPC oversight to ensure that the services provided are safe, appropriate and consistent across the group.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
Regulation 31(3) The person in charge shall provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of an incident set out in paragraphs 7(2) (k) to (n) of Schedule 4.

The Person In Charge has reviewed the notifications required quarterly and those notifications that are required will be submitted retrospectively. This will be completed by 10th of March 2023.

A review has been undertaken of all incidents to ensure that no further submissions are required. The Compliance and Quality Manager will review incidents monthly to ensure the appropriate notifications have been submitted.

The Clinical Director has and will continue to remind the centre of the need for quarterly submissions in advance of the submission dates.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises: Regulation 17(2) The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.

The Operations Director is working with the Group Facilities Manager in compiling a list of all issues that require attention in relation to premises.

The Restrictor noted in the report was attended to immediately. Post inspection a staff debrief took place to share findings in respect of the issues noted. Under Health and safety the restrictor was addressed to all staff and the importance of such issues reiterated. Restrictors within the centre will be monitored weekly by the Maintenance Man.

The first floor decking area has been cleaned and all litter removed. This area is checked daily by the PiC to ensure its cleanliness. The Housekeeping staff maintain responsibility for this area and they are supported by the maintenance team in respect of its upkeep.

Regulation 27: Infection control	Substantially 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 hand washing basin in the treatment room is due for installation and is currently being managed by the Operations Director- due for completion by 30-04-2023

The taps for the sluice room sinks will be installed as per the previous inspection report- due for completion by 30-04-2023

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: Regulation 28(1)(a) The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings. The Operations Director and Facilities Manager have enlisted the assistance of a fire expert to review the centre fire arrangements to include all fire fighting equipment and fire related risks throughout the centre. Regulation 28(1)(c)(ii) The registered provider shall make adequate arrangements for reviewing fire precautions. As part of the fire arrangements review it is expected that a comprehensive set of audit tools will be provided to ensure in the future all fire arrangements in the centre are appropriately reviewed. The Facilities Manager is to attend Fire Safety Specialist Training. Regulation 28(1)(e) The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire. Fire drills will continue on site every 2 months with staff. Fire Training is due to take place with staff on 7th March 2023. All residents have a Personal Emergency Evacuation Plan in place and those residents who are capable of being involved in drills will be included in future. Regulation 28(2)(i) The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires. Appropriate firefighting equipment will be installed in the dedicated smoking area downstairs. The upstairs smoking area is closed due to the ongoing risks identified. All potential new residents that smoke will be advised prior to admission that the dedicated smoking area within the centre is located downstairs. The PiC has reviewed seating arrangements in the reception are of the centre to ensure access to firefighting equipment is not obstructed in any way.	
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(2) The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.

All residents that smoke will have their care plan and risk assessments reviewed by the PiC.
All residents with diabetes have had their care plans reviewed and updated to reflect frequency of blood sugar monitoring and acceptable blood sugar levels documented.

Works have been completed to implement the computerised clinical system. We are currently uploading staff and residents' information to this system so it can become operational. A Key Nurse allocation remains in place and care plans continue to be documented and updated until such time as they can be transferred to the computerised system.

Regulation 5(3) The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.

Post inspection an Admission checklist was developed for nursing staff to ensure the admission process is followed and clear. Completion of assessment and care plans will be reviewed using Admission checklist. The checklist will be completed by the admitting nurse and signed off by the PiC or ADoN.

All Nursing Staff will receive additional support, and where necessary training from the newly appointed ADoN in respect of care planning and assessment.

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)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	30/04/2023
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/04/2023
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	30/03/2023
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	Substantially Compliant	Yellow	30/03/2023

	Inspector.			
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	30/04/2023
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	30/04/2023
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.	Substantially Compliant	Yellow	15/03/2023
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment,	Not Compliant	Orange	30/04/2023

	suitable building services, and suitable bedding and furnishings.			
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	30/04/2023
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Orange	30/04/2023
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	30/04/2023
Regulation 31(3)	The person in charge shall provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of an incident set out in paragraphs 7(2) (k) to (n) of Schedule 4.	Not Compliant	Orange	30/04/2023
Regulation 5(2)	The person in charge shall	Substantially Compliant	Yellow	30/04/2023

	arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.			
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Substantially Compliant	Yellow	30/04/2023