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:	Aisling House Nursing Home
Name of provider:	Hussein & Jeanette Ali Limited
Address of centre:	Sea Bank, Arklow, Wicklow
Type of inspection:	Unannounced
Date of inspection:	21 November 2023
Centre ID:	OSV-0000003
Fieldwork ID:	MON-0040463

About the designated centre

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

Aisling House Nursing home is a single-storey centre, which provides residential care for 50 people. It provides care for both male and female adults with general care needs within the low, medium, high and maximum dependency categories. A pre-admission assessment is completed in order to determine whether or not the service can meet the potential resident's needs. Twenty-four-hour nursing care is provided. There were 34 single bedrooms, 23 of which had en-suite facilities and eight twin bedrooms, five of which had en-suite facilities. Each bedroom was appropriately decorated and contained personal items such as family photographs, posters and pictures. Communal space included a day room, three sitting rooms and two dining rooms. There was a well maintained internal courtyard. Adequate parking was available at the front of the building. According to their statement of purpose, the centre strives to deliver resident focused care packages tailored to meet the individual needs. The centre aims to promote the quality of life and independence of residents through professional and friendly services.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	44

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
Tuesday 21 November 2023	08:45hrs to 18:15hrs	Bairbre Moynihan	Lead

What residents told us and what inspectors observed

The inspector arrived to the centre in the morning to conduct an unannounced inspection to monitor ongoing regulatory compliance against the regulations and national standards. The inspector spoke to a number of residents during the day of inspection. Residents were complimentary about the staff and the care provided.

On arrival the inspector was greeted by the person in charge and following an introductory meeting the inspector was guided on a walk around of the centre. The centre is registered to accommodate 50 residents with 44 residents on the day of inspection. The centre had two units, Mountainview and Seaview. Seaview is purpose built, built to modern specifications and contained all single en-suite bedrooms. In addition, Seaview had a bright sitting room with a view of the sea and a dining room. In contrast, Mountainview was located in the original part of the building and required ongoing maintenance and upkeep in order to maintain it. It contained a mixture of twin and single rooms with some en-suite facilities. Shared showering and bathing facilities were available for those residents who required them. Mountainview had an open plan day and dining room and a sitting room. The sitting room was a thoroughfare to rooms 1-4 in the centre. Aisling House Nursing Home had an internal courtyard, the doors to which were open during the day of inspection. Seating and chairs were available for residents. Since the last inspection the registered provider had landscaped an area at the back of the centre with paving and grass. The inspector was informed that it was completed two months ago and tables and chairs were due to be purchased for it. This area provides an unobstructed view of the land and sea. A ramp connected the landscaped garden and the internal courtyard and centre.

The registered provider had employed an activities co-ordinator since the inspection in December 2022. A resident informed the inspector about the activities available and how this was a big improvement for residents since the inspector met the resident last year. The activities staff member was on leave on the day of inspection and healthcare assistants were providing activities for residents, however, other than a game with a ball, residents were observed listening to music. There were two residents' notice boards, one in each unit. The activities timetable was on display. Live music was provided on Saturdays. Residents had access to televisions and radios in their room. The WiFi code was on display on both notice boards. In addition, residents had access to a voice promoted music streaming service and could request what song they wanted played through the service.

Residents were consulted about the service through residents meetings and a satisfaction survey. Residents meetings were due to take place quarterly, however, only two meetings had taken place since the inspection in December 2022. The inspector was informed that meetings were cancelled due to infection outbreaks. A time bound action plan accompanied the satisfaction survey and at the time of inspection all areas for action had been actioned.

The dining experience was observed in both dining rooms. Tables were decorated with Christmas themed table cloths. The menu was on display. Residents who required less assistance were in the dining room in Seaview. This was a social occasion and residents were chatting amongst themselves. However, no staff member was present supervising residents while eating. The inspector was informed that the staff member had gone to the kitchen to get some food however, during the intervening period no staff member was around if an incident was to occur. Residents on all levels of diet were provided with a choice of main course, however, on the day of inspection the choice was limited. The inspector was informed that residents could have something else if they would prefer. A resident informed the inspector that if they did not like the choice, the resident was provided with an alternative. The inspector observed a small number of residents not eating their lunch and staff offered the residents a sandwich. Staff were available in the dining and day room in Mountainview to provide assistance where required.

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

Capacity and capability

This was an unannounced inspection to assess the overall governance of Aisling House Nursing Home and to identify if actions outlined in the compliance plan from the inspection in December 2022 were completed and sustained. Overall, the inspector identified that the registered provider had rectified the gaps in the directory of residents and this was sustained. All staff and management meeting minutes contained time bound action plans. However, the inspector was informed at the beginning of the inspection that all actions were completed from the compliance plan, however, recurring issues were identified in staff personnel files, trending of incidents and not all residents had their personal storage within their bed space. Non compliances were identified on this inspection in Regulations: 15: Staffing, 21 Records, 23: Governance and Management, 31: Notification of incidents, 17 :Premises and 27: Infection control.

The registered provider was Hussein and Jeanette Ali Limited. The company had three directors. The registered provider was not involved in the running of any other designated centres. The person in charge, reported to one director who was on site every day for a number of hours and attended the feedback meeting at the end of the inspection. The person in charge worked alongside the operations manager who was also a company director. In addition, the person in charge was supported by staff nurses, healthcare assistants, catering, household, activities and maintenance staff

The inspector identified a number of gaps between the actual staffing level and the statement of purpose. The inspector was informed that two staff nurse vacancies

were vacated the week prior to inspection, one of those unexpectedly. Management stated that interviews had taken place for the replacement staff nurses but it would take time to recruit and onboard staff. In the intervening period current staff were providing extra shifts. When the inspector arrived the person in charge was doing a medication round. The inspector was informed that this was to provide assistance and the person in charge confirmed that they always worked in a supervisory capacity. However, on the last two inspections it was identified that there was over reliance on the person in charge. This was unchanged on this inspection and while there were two nurses on at the weekend, only one nurse was on duty during the week and the person in charge provided assistance as the second nurse. Staff informed the inspector that when all staff were at work they had enough staff to attend to residents, however, if any staff member is on leave it can be difficult for staff to attend to residents' needs in a timely manner.

The registered provider had a training matrix in place. Staff had access to mandatory training, for example; fire and safeguarding training. Oversight of staff training was provided by the operations manager and the majority of staff had completed mandatory training with minimal gaps identified.

The inspector reviewed a sample of personnel files. Garda vetting was in place in all staff files reviewed however, the inspector identified that one staff member had commenced employment shortly before Garda vetting was completed. The professional registration of staff who required it was in place and up to date.

A sample of contracts of care were reviewed. These had been reviewed by management since the inspection in December 2022 and now included the terms relating to the bedroom to be provided to the resident. Additional fees payable were listed in the contract, however, in two out of the four contracts of care reviewed they did not contain the weekly fee.

The annual review of quality and safety of care was completed for 2022 aligned to the National Standards for Residential Care Settings for Older People in Ireland. Systems of communication were in place. Quarterly clinical governance meetings took place between a director and the person in charge, as well as monthly management meetings with the registered provider representative, person in charge and operations manager and quarterly staff meetings. Meeting minutes generally contained time bound action plans. No issues were documented as having been raised by staff in the meeting minutes reviewed. Audits were completed on; medications, falls and the physical environment. Audits identified issues and contained a time bound action plan, however, some areas for action identified in audits were also identified on inspection. The registered provider maintained a log of all risk assessments. The registered provider had completed a risk assessment on the lack of available hand hygiene sinks since the last inspection. The incident log was reviewed. The majority of incidents reported were falls related. While a falls audit was completed, it was not comprehensive enough to identify trends. Notwithstanding this, all incidents that required reporting within three days of the incident occurring were notified to the Office of the Chief Inspector within the timeline and in line with the regulation. However, not all restraint was identified in

the centre and notified quarterly. This is discussed under the regulation.

The registered provider had received a small number of complaints since the inspection in December 2022. These were investigated, included the outcome and the satisfaction or otherwise of the complaint was documented. The complaints procedure was on display at the entrance to the centre. This along with the policy required review to ensure it was in line with Regulation 34.

Regulation 15: Staffing

The registered provider did not ensure that the number and skill mix of staff was appropriate having regard to the needs of the residents assessed in accordance with Regulation 5. Staffing was discussed at management meetings and the reduced staffing levels had not been identified.

On the day of inspection the centre was at 88% occupancy. Gaps between actual staffing levels and what the centre was registered against in the statement of purpose included:

- The centre had employed four staff nurses at the time of inspection. A gap of approximately 3 WTE (Wholetime equivalent) vacancies of staff nurses for 88% occupancy was identified. The inspector was informed that two posts were vacated the previous week and interviews had taken place to replace the vacancies.
- The person in charge was providing assistance to staff which limited the time available to dedicate to oversight which is a key aspect of the person in charge role.
- Approximately, three healthcare assistant roles were vacant.
- Two catering assistant posts were vacant.

On review of the staffing rosters, it was identified that staff nurses were working 96 hours over a two week period to cover the vacancies with one nurse working 102 hours. This is not sustainable.

Judgment: Not compliant

Regulation 16: Training and staff development

The inspector reviewed the training matrix. The majority of staff had completed mandatory training including safeguarding and fire training with minimal gaps identified.

Judgment: Compliant

Regulation 19: Directory of residents

The directory of residents met the requirements of the regulation.

Judgment: Compliant

Regulation 21: Records

Actions were followed up from the previous inspection in relation to schedule 2 documents. The following had not been actioned:

- Three out of the four employment histories reviewed had gaps in their employment history.
- One staff member had commenced employment two weeks prior to the staff member's garda vetting being received.
- One staff member had a reference for an employment that was not outlined in the staff members employment history.

In addition, the inspector identified that the restraint register did not identify all forms of restraint in the centre.

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 23: Governance and management

The registered provider did not ensure that staffing resources in the centre were in accordance with the centre's statement of purpose, as discussed under regulation 15: Staffing.

The management systems in the centre required strengthening to ensure that the service provided was safe, appropriate, consistent and effectively monitored. For example:

- Areas for action identified on the inspection in December 2022 had not been actioned, for example; staff personnel files, resident's storage, infection control and premises.
- Audits of falls were taking place but the audit did not include an analysis of

the falls to identify if there were any trends for example; time of the fall, staffing levels at the time of the fall and actions that could be implemented to reduce the risk of falls.
- Issues identified on audits were identified on inspection and while a time bound action plan was devised the issue had not been actioned.
- Residents were not supervised at all times at lunch-time. For example; no staff member was present in Seaview dining room at lunch-time for a period of time.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

The inspector reviewed a sample of contracts. In line with findings from the last inspection in December 2022, two residents' contracts of care did not contain the fees payable.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

While the quarterly notification on restraint was submitted to the Chief Inspector, not all restraint identified on inspection was notified in line with the requirements of schedule 4 of the regulations. For example; sensor mats, locked doors to exits, and cigarettes and lighters that were being held by nursing staff for residents were not reported.

Judgment: Not compliant

Regulation 34: Complaints procedure

While the complaints procedure was on display in a prominent location it, along with the policy were not in line with the changes of S.I. 628 of 2022. Specifically, the procedure and policy did not indicate the correct time lines or identify an appeals officer or procedure for an appeal.

Judgment: Substantially compliant

Quality and safety

Overall, while the centre was working to sustain a good level of person-centred care provision, deficits in the governance and management of the centre were impacting on key areas such as infection control, care planning and premises. Improved oversight of these areas is required to ensure a consistent safe service which supports best outcomes for residents.

The inspector found that the healthcare needs of the residents were met through good access to medical and other healthcare services if required. Residents' assessments were undertaken using a variety of validated tools and these were updated every four months or more regularly if required. Care plans were developed following these assessments. Care plans viewed by the inspector were updated four monthly in line with regulations, however, they required review so that they were individualised and person centred and could guide staff on residents' care.

Seaview was bright and airy and well maintained. In contrast, Mountainview required ongoing maintenance and general wear and tear was noted throughout this area. Notwithstanding this, since the inspection in December 2022, the registered provider had replaced the flooring and ceiling in the dining room in Mountainview. Actions completed included household staff had received training in the principles and practices of cleaning and no personal protective equipment was observed to be out of date in the centre. At the time of inspection the laundry was outsourced to a private provider. Due to unforeseen circumstances residents' laundry was laundered on site on the day of inspection. Management stated that they were recruiting for a staff member for laundry and this was ongoing at the time of inspection, however, the laundry was to remain outsourced. Infection control and premises are interdependent and deficits in the maintenance of areas of the premises were providing a challenging environment for staff to maintain effective infection control practices. The inspector identified a number of issues identified on the last inspection in relation to infection control that had not been addressed or were not sustained. These are detailed under the regulation.

The inspector observed staff interaction with residents' with communication difficulties. It was evident that staff knew the residents well and could identify a residents' need through non-verbal communication. However, improvement was required in the documentation of communication cues and aides that could guide staff in communicating with residents.

The registered provider had purchased single wardrobes for residents following the inspection in December 2022. However, the layout of twin rooms required further review to ensure that residents' storage was within the residents' bedspace. Furthermore, it was identified that a small number of residents were sharing chest of drawers.

The risk management policy was reviewed and contained the five specified risks along with the measures to control the risks, however, the policy required further

review in order to come into compliance with the regulation.

A fire safety management policy and strategy was available and up to date. Engineering reports were available to provide evidence that the fire detection and alarm systems and emergency lighting had preventative maintenance completed at recommended intervals, however, certificates of completion were not available. The inspector was informed that they have been requested from the fire company. Fire extinguisher servicing was completed yearly and certification was available for this. Signage to guide staff on the evacuation routes was on display in a number of locations throughout the centre, however, these could be difficult to read for staff or residents with reduced vision. Each resident had a personal emergency evacuation plan in place which was located in the staff office. The registered provider had devised a colour coding system to guide staff on the evacuation needs of residents, however, staff were not clear on what each colour represented. Daily, weekly and monthly checks of means of escape were generally completed within the time frames. Smoking assessments and care plans were in place for residents that smoked. A sample of fire doors were checked and gaps were noted in a small number. Fire drills were completed in April, July and August 2023. Evacuation of the largest compartment with night time staffing levels was completed and evacuation aides used.

The registered provider had an up-to-date policy on managing behaviours that challenge. Overall there was a person-centred approach to managing responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). Staff were knowledgeable and skilled at identifying and preventing episodes of responsive behaviours and behavioural assessments were regularly carried out. While there was a low use of bed rails, not all forms of restraint were identified.

Improvements were identified in the activities programme since the inspection in December 2022. Activities were evolving at the time of inspection. It was evident from information provided to the inspector that residents were consulted about their likes and interests and this information was being used to guide the activities programme. A newspaper was provided daily and residents had access to radios and televisions in their rooms. Details of access to independent advocacy services were on display in the centre.

Regulation 10: Communication difficulties

The centre had a small number of residents with communication difficulties. Staff were able to describe the cues they observed if the residents required something however, the care plans were not comprehensive enough to guide the care of a resident with a communication difficulty.

Judgment: Substantially compliant

Regulation 17: Premises

Parts of the premises did not conform to the matters set out in schedule 6 of the regulations, for example;

- The registered provider had endeavoured to address the issues identified on the last inspection with regards to residents' storage within the residents' bed space by purchasing single wardrobes. However, in rooms 7, 12 and 14 the residents' wardrobes were in the bedspace of another resident. In one instance the wardrobe was at the end of another resident's bed and the door of the wardrobe could not be fully opened so the resident could access their personal belongings. A review of all twin rooms in the centre is required so the registered provider is assured that they are meeting the requirements of the regulation.
- General wear and tear was noted throughout Mountainview. For example; the doors leading from the dining room to a sitting room were chipped and damaged. In addition, the skirting board in the day room was in a state of disrepair and was covered with tape. This did not aide effective cleaning.
- Wall tiles in a communal bathroom were chipped and damaged and excessive damage was identified around a toilet bowl in an en-suite bathroom in Mountainview.
- The sitting room in Mountainview was a thoroughfare to access bedrooms 1 to 4. While only a small number of residents were observed using the sitting room, it did not provide a quiet and relaxing environment for residents. Furthermore, the dining room and day room in Mountainview were thoroughfares from one side of the centre to the other. The registered provider stated that it is not used as such however, further assurances are required to ensure that residents can relax while eating, socialising and taking part in activities.
- No call bell was available in the designated smoking area.
- A staff members' work bench containing tools was stored in a store room in Seaview which was also a storage area for incontinence wear. This was also a finding on the inspection in December 2022 and had not been actioned.

Judgment: Not compliant

Regulation 26: Risk management

The risk management policy was reviewed by the registered provider since the last inspection, however, the arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents was not

included in the policy.

Judgment: Substantially compliant

Regulation 27: Infection control

Inspectors observed that the centre was generally clean on the day of inspection, however, improvements were required in order to ensure procedures are consistent with the national standards for infection prevention control in community services. For example;

- Household staff were using disinfectant spray and wipes to clean residents' rooms and bathrooms. This is not in line with the guidance provided to staff within the home which advises cleaning with detergent for the majority of items.
- The household trolley was unclean with dirt and debris. The inspector was informed that the trolley was cleaned when staff had time and that there was no regular rota for cleaning.
- The household cleaning trolley was stored in a store room with clean stock. This posed a risk of cross contamination. Furthermore, the room did not contain a janitorial sink and clinical hand wash sink.
- Hand gel receptacles were observed to be stained and contained excess amount of dried hand gel. This was identified in an infection control audit but had not been actioned.
- A resident's chair in room 28 was torn and chipped and required replacement or repair.
- Mop heads were not changed between the cleaning of residents' bedrooms and their en-suites.

Actions were identified that had not been completed or sustained since the inspection in December 2022. For example;

- Staff had access to two clinical hand hygiene sinks. Neither of these met the required specifications. The clinical hand hygiene sinks were located in the sluice room and laundry. Both doors were locked and not easily accessible. The lack of hand hygiene sinks is a concern in relation to good infection prevention and control practices.
- The sluice room did not contain a clinical waste bin.

Judgment: Not compliant

Regulation 28: Fire precautions

Action was required in relation to fire safety management systems in the centre. For example:

- A small number of doors were identified on the walk around with the person in charge as not fully engaging. Deficits to fire doors mean that fire doors are not capable of restricting the spread of smoke and fire in the event of a fire. The inspector was informed at the end of the inspection that the doors that were affected were rectified.
- Staff knowledge of evacuation procedures required strengthening. Furthermore, the registered provider had introduced a colour coding system on the back of residents doors to identify the mode of evacuation for the resident. All staff spoken to were unable to inform the inspector what the different colours meant.
- Fire alarm and emergency lighting certificates were not available for the inspector to review. Engineering reports were completed, however, they did not provide assurance that the emergency lighting and fire alarm were free of fault or deviation.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Care plans required review to ensure they were person centred and could guide care. For example; three residents had the same care plan in place with no adjustments made to individualise the care plan. Furthermore, one care plan contained another person's name within it.

Judgment: Substantially compliant

Regulation 6: Health care

Residents retained their own general practitioner on admission. The inspector was informed that general practitioners attend as required but carried out a three monthly review on the residents. An out of hours service was accessed outside of regular working hours. A physiotherpist attended as required to review residents following a fall at a cost to the resident per session. Residents had access to speech and language therapy, dietitian and tissue viability advice through a private company at no cost to the resident. Residents who were eligible for national screening services were referred as required.

Observations and weights were completed monthly. The registered provider had good oversight of residents' weights and there was evidence that residents were

referred and reviewed by a dietitian in a timely manner.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Some residents had responsive behaviours. Behavioural assessments were completed and informed an holistic approach to managing residents' responsive behaviours.

The centre had a low use of bed rails. It was evident that alternatives were trialled and least restrictive options were used. The restraint register is discussed under Regulation 21: Records.

Judgment: Compliant

Regulation 9: Residents' rights

Residents' were provided with a limited choice of meals at lunchtime. For example; residents could chose from chicken cooked in two different ways. Residents who did not like the choice were provided with the option of a sandwich and not the option of an alternative cooked meal.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 10: Communication difficulties	Substantially compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management	Substantially compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Aisling House Nursing Home OSV-0000003

Inspection ID: MON-0040463

Date of inspection: 21/11/2023

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

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

Outline how you are going to come into compliance with Regulation 15: Staffing:
The WTE (Wholetime equivalent) noted for Nursing Staff in the Statement of Purpose is 8 Nurses for 50 Residents. At present, our requirements for Staff Nurses with an occupancy of 40 Residents is 6 Nurses, a current shortfall of 2 Nurses.

Interviews for a Senior Nursing position commenced throughout November 2023. On 13 December 2023, the centre appointed a Clinical Nurse Manager (CNM).

Our Nursing continuity plan had made provisions for a new Nurse to join the centre in January 2024. We await the imminent arrival of a Nurse this month which will fulfil our WTE compliment of 6 Nurses based on current occupany of 40 Residents for LTC.

Further to this, an additional complement of Nurses were interviewed during October 2023, offered contracts and will commence in February and April 2024, further strengthening our Nursing Team at the centre, in line with our continuity plan for Nurses.

The recently appointed CNM position and incoming Nurses will alleviate any requirement from the Person in Charge to assist staff, allowing the Person in Charge further time available to dedicate to oversight which is a key aspect of the person in charge role.

Healthcare Assistant roles, as per previous years remain an ever present challenge in this sector. Nonetheless, three new Healthcare Assistants were employed in December 2023 and have commenced in January 2024 and we are ever committed to providing numbers of Healthcare Assistant Staff to ensure a safe and sustainable service.

Catering Assistant posts will be advertised and the recruitment of any vacant posts will be addressed, in line with the staffing levels of the Statement of Purpose.

An additional Activities Assistant is being sought in the first quarter of 2024 to assist with the Centre's new Programme of Activities.

The compliance plan response from the registered provider does not adequately assure the chief inspector that the actions will result in compliance with the regulations.

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
Gaps in the employment histories were reviewed and addressed shortly after the Inspection.

As per FAQs on NHI Garda Vetting website, an individual should not engage with or have any contact with vulnerable persons pending vetting, however, training or induction can take place in this time. The Staff Member in question had an application for Garda Vetting made by the Centre on 24 May 2023. The Staff Member in question attended supervised induction training on 26 May 2023 and 30 May 2023. Garda Vetting applications typically take 10 days to be returned. In this case, it took 15 days due to the volume of applications being processed by the National Vetting Bureau, hence the Staff Member commenced two shifts (4 June 2023 & 6 June 2023) without the appropriate vetting in place. This was an oversight an our part and we will make the necessary adjustment to our processes to ensure that this does not happen again, including engaging with NHI and the Garda Vetting team to assess typical waiting times for applications as they have been demonstrated to be seasonal.

Staff References were reviewed and addressed shortly after the Inspection.

The Restraint Register was reviewed and addressed shortly after the Inspection.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Areas for action identified on the inspection in December 2022 along with areas for action has been added to a new timebound action Action Plan to commence in January 2024.

Analysis of Falls through either software or other instrument(s) are currently being investigated in order to identify if there were any trends associated with any falls and actions that could be implemented to reduce the risk of falls.

Audits and time bound action plans were reviewed to ensure that the appropriate level of response has been actioned to each identified issue.

Supervision of Residents during meals times is of paramount importance and all Staff were reminded of this along with the process of highlighting an event such as communication to the Kitchen during meal times. The Centre will continue to monitor and ensure the supervision of Residents during meal times.

Regulation 24: Contract for the provision of services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 24: Contract for the provision of services:
Since 2019, Fair Deal Contracts of Care utilised by the Centre, authored by Nursing Home Ireland only state the agreed Fee between the Centre and the NTPF, as the Client Contribution (Resident Rate) is subject to review and is a covenant between the Resident and the Nursing Home Support Scheme Office. Following the Inspection of December 2022, all contracts were reviewed to include the observations of the Inspector at that time.

In November 2023, The Centre received new sample Fair Deal Contracts of Care from Nursing Home Ireland which has provisions and illustrations for the NTPF Rate, Client Contribution (Resident Rate) and HSE Contribution (HSE funded Rate). These Contracts are now in use to ensure compliance with Regulation 24. A review of all Fair Deal Contracts of Care took place shortly after the inspection to ensure the fees payable by Residents are correctly noted.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
Quarterly notifications on restraint has been reviewed to ensure that the reporting of all restraints in use in the designated centre will be appropriately reported in line with the requirements of Schedule 4 of the regulations.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
This was discussed during the time of Inspection and the complaints procedure was amended for the following; display in a prominent location, the Schedule 5, Policy 20 "The Handling and Investigation of Complaints from any Person about any aspects of Service, Care and Treatment provided in, or on behalf of a Designated Centre" and the Statement of Purpose.

Regulation 10: Communication difficulties	Substantially Compliant

Outline how you are going to come into compliance with Regulation 10: Communication difficulties:
Care Plans were reviewed for the small number of Residents with communication difficulties to ensure that they are comprehensive enough to guide the care of a Resident with a communication difficulty.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
A comprehensive review and remodel of the identified twin rooms has commenced in January 2024 in order to meet the requirements of the regulation.

Additions will be made to the Maintenance Program to include a focused program to address the noted wear and tear throughout Mountainview, to commence in January 2024. This will focus on areas identified during the inspection with provisions for bi-annual checks on each area of the designated centre to ensure compliance with Schedule 6 of the regulation.

The Wall tile in a communal bathroom which was recently chipped and any damage damage that was identified around the toilet bowl in an en-suite bathroom in Mountanview was addressed shortly after the inspection.

The Sitting Room is an additional communal space in conjunction with the large conservatory, two Dining Rooms and Seaview Sitting Room where Residents can dine or relax. In the summer months, the two large courtyards and newly completed back

garden will be further utilised as communal spaces.

Activities and the location of such are always under review and discussed with the Activities coordinator, Residents and relevant Staff.

A Call Bell for the designated smoking area is under review and is being discussed with the Call Bell Maintenance Provider.

The identified work bench containing tools has been relocated.

Regulation 26: Risk management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management:
The arrangement for the identification, recording, investigation and learning from serious incidents or adverse events involving Residents will be reviewed and added to the Risk Management Policy.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
Staff were reminded of the guidance provided by HSE Guidelines on Infection Prevention & Control along with the Cleaning Schedule and recent Effective Cleaning and Disinfection Skills for the Nursing Home Sector training provided on 20 April 2023. All Cleaning Schedules will be revised in January 2024 to account for this.

The Household trolley should be cleaned daily after each use. The Cleaning Schedule has now been amended to reflect this assumed task.

The items within the store room that houses the household cleaning trolley will be revised to ensure there is no risk of cross contamination. The Cleaning Team utilises Hot Water from the janitorial sink and hand washing facilities in the Laundry Room. The Centre will consult with Nursing Home Ireland and seek an external audit by an Infection Prevention and Control Professional. Any such findings from these consultations will inform and identify any required improvements in regard to Regulation 27.

The cleaning and maintenance of Hand gel receptacles was added to Cleaning Schedule, shortly after the Inspection.

Residents Chair in Room 28 was identified to replaced during the inspection.

Additional Mop Heads were sourced to ensure that Mop Heads are changed between bedroom and en-suites. This will also be added to the Cleaning Schedule.

In regard to the observation of Clinical Hand Hygiene Sinks, the Centre will consult with Nursing Home Ireland and seek an external audit by an Infection Prevention and Control Professional. Any such findings from these consultations will inform and identify any required improvements in regard to Regulation 27.

A Clinical Waste Bin was placed in the Sluice Room shortly after the Inspection.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The small number of doors that were identified on the walk around with the Person in Charge that did not fully engage were rectified during the Inspection.

The Ready Reckoner Evacuation Requirements utilising a colour coding system as provided by our Fire Safety Specialists was introduced in 2023. The Centre will ensure that all Staff knowledge is strengthened with posters of the colour coded system in offices, staff communal areas and during our Annual Fire Safety Training and Fire Drills.

Fire Alarm and Emergency Lighting Certificates, including Annex D2 & Annex F Documentation are available in the Fire Alarm and Emergency Lighting Servicing Contractor's bespoke Maintenance Books in the Centre. A variation to the decibel levels as instructed by the Fire Safety Specialists is planned in the first quarter of 2024 and a new Design Certificate to illustrate this variation has been received. Any further required certification will be received following this variation.

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:
All Care Plans will be reviewed to ensure that they are person centred and can guide care.

Regulation 9: Residents' rights	Substantially Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: Residents choice and wishes inform the service provided by the Centre. This includes the food on offer and Menus within the Centre. Of the three weekly menus that alternate every week; the identified protein prepared in two ways is the only same protein lunchtime option out of 21 meals, and these are vastly different meals. This matter will be raised with the Residents at the next Resident Meeting to assess whether or not a change is required to this lunchtime option. All menus and variations to menus are checked with the Centre's nominated dietician.	

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 10(2)	The person in charge shall ensure that where a resident has specialist communication requirements, such requirements are recorded in the resident's care plan prepared under Regulation 5.	Substantially Compliant	Yellow	01/01/2024
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	01/02/2024
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a	Not Compliant	Orange	01/03/2024

	particular designated centre, provide premises which conform to the matters set out in Schedule 6.			
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	01/12/2023
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 the statement of purpose.	Not Compliant	Orange	01/02/2024
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	01/02/2024
Regulation 24(2)(b)	The agreement referred to in paragraph (1) shall relate to the care and welfare of the resident in the designated centre concerned and	Substantially Compliant	Yellow	01/01/2024

	include details of the fees, if any, to be charged for such services.			
Regulation 26(1)(d)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.	Substantially Compliant	Yellow	01/02/2024
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	01/03/2024
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Substantially Compliant	Yellow	01/01/2024
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at	Substantially Compliant	Yellow	01/03/2024

	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.			
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	01/02/2024
Regulation 34(2)(b)	The registered provider shall ensure that the complaints procedure provides that complaints are investigated and concluded, as soon as possible and in any case no later than 30 working days after the receipt of the complaint.	Substantially Compliant	Yellow	01/01/2024
Regulation 34(2)(c)	The registered provider shall ensure that the complaints procedure provides for the provision of a written response informing the complainant whether or not their complaint has	Substantially Compliant	Yellow	01/01/2024

	been upheld, the reasons for that decision, any improvements recommended and details of the review process.			
Regulation 34(2)(d)	The registered provider shall ensure that the complaints procedure provides for the nomination of a review officer to review, at the request of a complainant, the decision referred to at paragraph (c).	Substantially Compliant	Yellow	01/01/2024
Regulation 34(2)(e)	The registered provider shall ensure that the complaints procedure provides that a review is conducted and concluded, as soon as possible and no later than 20 working days after the receipt of the request for review.	Substantially Compliant	Yellow	01/01/2024
Regulation 34(2)(f)	The registered provider shall ensure that the complaints procedure provides for the provision of a written response informing the complainant of the outcome of the review.	Substantially Compliant	Yellow	01/01/2024
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an	Substantially Compliant	Yellow	01/02/2024

	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 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Substantially Compliant	Yellow	01/02/2024