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: | Douglas Nursing and Retirement Home |
| Name of provider: | Golden Nursing Homes Limited |
| Address of centre: | Moneygourney, Douglas, Cork |
| Type of inspection: | Unannounced |
| Date of inspection: | 11 March 2025 |
| Centre ID: | OSV-0000223 |
| Fieldwork ID: | MON-0046651 |

## About the designated centre

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

Douglas Nursing and Retirement Home is a designated centre located within the suburban setting of Douglas, Cork city. It is registered to accommodate a maximum of 58 residents. It is a single storey building set out in six wings. Bedroom accommodation comprises 50 single bedrooms with en-suite facilities of shower, toilet and hand-wash basin, and eight single rooms with wash-hand basins. Additional bath, shower and toilet facilities are available throughout the centre. Communal areas comprise the main day room, conservatory lounge, garden activities room, conservatory smoking room, green quiet room, library and large dining room. Residents have access to three well-maintained gardens with walkways, garden furniture and shrubbery. Douglas Nursing and Retirement Home provides 24-hour nursing care to both male and female residents whose dependency range from low to maximum care needs. Long-term care, convalescence care, respite and palliative care is provided.

**The following information outlines some additional data on this centre.**

| | |
|---|---|
| Number of residents on the date of inspection: | 57 |

## 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 11 March 2025 | 09:30hrs to 18:00hrs | Ella Ferriter | Lead |

## What residents told us and what inspectors observed

There were 57 residents living Douglas Nursing Home and Retirement Home on the day of this inspection. The inspector spoke to nine residents in detail, to obtain feedback in relation to their quality of life in the centre. The majority of feedback from residents was positive. Residents told the inspector the centre was a nice place to live and specifically commented on the kindness of staff, stating that they were approachable and friendly.

On arrival to the centre the inspector entered the reception area which was homely and welcoming with a large desk, pictures and plants. Following an opening meeting with the person in charge the inspector walked around the premises. It was evident that the person in charge knew residents well and vice a verse, as they stopped and chatted along the way and greeted them by name. The inspector observed that the centre was decorated with residents' art work, Irish flags and shamrocks for St. Patrick's Day which would be celebrated the following week.

Douglas Nursing and Retirement Home is a purpose built single storey building located on the outskirts of Douglas in Cork city. The centre is registered to accommodate 58 residents in single bedrooms, fifty of which had ensuite facilities. Some residents told the inspector that the centre was very homely and welcoming and they were happy to be living there. Residents commented with regards the comfortable premises, explaining to the inspector that it had been enhanced and improved over the last year. However, a few residents informed the inspector that staff were very busy and they were sometimes waiting long periods of time for their call bell to be answered. Feedback was also provided with regards to delays in responding to complaints. A review of residents meetings found that residents had brought issues of concern to the attention of management in the last two meetings. This is further detailed under regulation 9.

There was ample communal space for residents to enjoy and to give them choice. These included a library room, the green room, activities/garden room, the rose day room with a connecting conservatory and large spacious dining room. These rooms had comfortable furniture were seen to be bright and warm. They felt like a relaxing place to spend time and residents were seen to be enjoying these areas throughout the day. Many new arm chairs had been purchased and were in use by residents. Residents also had access to a garden to the back of the centre. Paving was being upgraded on the day of the inspection and a mini golf course had recently been installed. The inspector noted it was difficult to access the garden independently for residents as the switch access button was situated at the top of the door frame. The provider put arrangements in place to relocate this on the day of inspection.

The centre had a designated smoking room, to the back of the premises. On the walk around the inspector observed that one exit from this rooms was blocked with building equipment. Discussions with staff with regards the means of escape from this room, in the event of an emergency found that there was conflicting responses

and evacuation strategy was unclear. Call bell facilities in this area were also seen not to be functioning. The provider was requested to address these findings immediately on the day of the inspection which they complied with. This is further discussed under regulation 28.

Residents were observed to be relaxed in the company of staff and staff were seen to actively engage and offer help to residents throughout the day. Some residents the inspector met with were unable to articulate their experience of the quality of the service. The inspector observed that those residents appeared comfortable in their environment. Visitors were seen coming in and out of the centre throughout the day. Four visitors spoken too were very happy with the care and support their loved ones was receiving. It was evident that visiting was encouraged and supported. On the day of the inspection a birthday party was being held for a resident in the Green room, which had been decorated, and a large group of family and friends attended the celebrations.

Residents who communicated with the inspector were positive with regard to the control they had in their daily routine and the choices that they could make. Residents were supported to take weekend leave from the centre and go on trips and days out with their family members. Residents told the inspector about their daily activities. They expressed satisfaction regarding the activities available to them during the week. The inspector noted that there was no planned activities available for residents at weekends. On the day of this inspection the activities coordinator was facilitating an arts and crafts session in the afternoon. An opera singer also attend the centre at 11 am for an hour. However, planned one to one sessions with residents could not take place as the staff member was allocated to alternative duties on the day. These findings are further detailed under regulation 9.

A large proportion of the residents living in the centre attended the dining room at one o clock for their meal. The inspector saw that this was a social experience for residents. The dining room was large, spacious and nicely decorated. The kitchen staff could be seen working through a hatch in the wall. Overall, residents spoke positively about the food, some telling the inspector that they had put in specific requests and suggestions in relation to food choices and quality and felt that the food had improved more recently.

The next two sections of this report will present findings in relation to governance and management in the centre, and how this impacts on the quality and safety of the service being delivered.

## Capacity and capability

This was an unannounced restrictive practice thematic inspection assess compliance against the National Standards for Residential Care Settings for Older People in Ireland. However, due to risk identified on the day the inspector proceeded to a risk-based inspection against the regulations. The provider appropriately engaged in

this process and addressed the inspectors findings, to ensure the safety of residents. Overall, findings of this inspection were that the management oversight of the service required action, to ensure that the service provided to residents was safe, appropriate, consistent and effectively monitored. These findings related to governance and management, incidents, complaints, care planning, healthcare, fire precautions and residents rights.

The registered provider of Douglas Nursing Home is Golden Nursing Homes Limited, which comprises of two directors, appointed in May 2023. There was a clearly defined management structure in place. The person representing the provider was a named person participating in management (PPIM) on the centres registration. The inspector was informed that they were available to the person in charge on a daily basis and attended the centre on the day of this inspection. The provider also employed a Director of Clinical Care Quality and Standards in June 2024, to support the centre. The inspector was informed that relevant statutory notification was in the process of being submitted to the Office of the Chief inspector, to include this person as a PPIM on the centres registration.

From a clinical perspective care is directed via an appropriately qualified person in charge, who was in post since July 2023. They were supported in this role by a clinical nurse manager, who had been newly appointed to a management role, six months prior to this inspection. However, there was a gap in the internal management structure with the absence of a full time assistant director of nursing post, for over a year. This is actioned under regulation 23.

On the day of this inspection the inspector found there were sufficient staff on duty in the centre, to meet the assessed needs of residents, given the size and layout of the centre. Residents spoke very positively about staff reporting they were kind, caring and respectful. There were clear lines of accountability at individual, team and service levels, so that all staff working in the service were aware of their role and responsibilities and to whom they were accountable.

There was evidence of ongoing monitoring and feedback systems in place, which included a schedule of audits for 2025. This formulated part of the centres quality improvement strategy and new systems had recently been developed and implemented. A weekly report was submitted by the person in charge to the senior management team and this provided oversight of incidents, complaints, falls and wounds. However, the inspector found that these systems of monitoring, evaluating and improving the quality and safety of the service were not always effective. For example; a call bell audit in response to residents' feedback regarding delays in care delivery, identified that action was required. However, the issues had not been reviewed and resolved. This is further detailed under regulation 23.

All records as requested during the inspection were made readily available to the inspector. Records were maintained in a neat and orderly manner and stored securely. However, a review of incident records found that these were not always completed in full and there was not appropriate oversight of these by the management team. This finding is actioned under regulation 23.

A record of complaints was maintained in the centre. Complaints were recorded separately to the residents' care plans, as per the requirements of the regulations and the inspector saw that the complaints procedure was clearly displayed in the centre. However, the management of complaints required significant attention as further detailed under regulation 34. A sample of contracts for the provision of care were reviewed and found that the terms relating to the admission of a resident to the centre, including terms relating to the bedroom to be provided and the number of occupants of that bedroom were clearly described, as required by Regulation 24(b).

## Regulation 14: Persons in charge

There was a full-time person in charge employed in the centre with the relevant qualifications and experience, as required by the regulations to undertake the role. They had been employed as person in charge since September 2023 and had a post registration management qualification. The person in charge was knowledgeable of individual residents needs.

Judgment: Compliant

## Regulation 15: Staffing

The staff compliment and skill mix was adequate to meet the care needs of the 57 residents on the day of inspection. Residents spoke very positively about staff reporting they were kind, caring and respectful. The staff allocated to activities in the centre, particularly at weekends required action which is further detailed under regulation 9.

Judgment: Compliant

## Regulation 21: Records

Some records, required to be maintained in respect of Schedule 3 of the regulations, were not appropriately completed. This specifically pertained to adverse incidents involving residents. For example, not all recorded of incidents contained actions taken by staff, contributing factors, a risk assessment, results of an investigation and actions taken.

Judgment: Substantially compliant

## Regulation 23: Governance and management

Management systems required action to ensure that the service provided was safe, appropriate, and consistently monitored, evidenced by the following findings:

- The oversight of incidents occurring in the centre was not robust. This was evidenced by incomplete records and some medication incidents not being thoroughly investigated, to inform quality improvement and delay in reporting one incident. There was also not a robust system in place where incidents were closed off by the management team, as per the centres policy.
- The complaints management system found was not to be effective to ensure that complaints were recorded and acted on in a timely manner, as evidenced under regulation 34.
- Although audits were taking place there was not always evidence that findings of audits were used to inform quality improvement. For example; a detailed call bell audit had been carried out a week prior to this inspection which identified significant delays in response times. However, the system in place did not capture or address the root cause of these delays. Findings of this inspection were that staff practices, where the nursing team did not carry the associated call bell pagers may have contributed to delays. This was due to the fact that nurses were unaware if a resident was calling for assistance. The provider put arrangements in place to change this system following this inspection finding.
- Internal communication systems required action, as on a review of records it was evident that staff meetings in the centre had not taken place since October 2024, five months prior to this inspection.
- Fire precautions in the centre, specifically in relation to the designated smoking room facilities required action and monitoring as detailed under regulation 28.

Although there was a clearly defined management structure in place there was a gap in this structure with the absence of the assistant director of nursing, for over a year. This person was the named person to deputise in the absence of the person in charge, as per the centres statement of purpose. The inspector was informed that the provider was in the process of recruiting an additional manager to cover this absence.

Judgment: Not compliant

## Regulation 24: Contract for the provision of services

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

room to be occupied. The contracts were seen to meet the requirements of legislation.

Judgment: Compliant

## Regulation 31: Notification of incidents

One notification pertaining to a safeguarding incident in the centre had not been reported to the Chief Inspector as required by the regulations. On review of this documentation the inspector was assured that it had been investigated appropriately and all actions had been taken to safeguard the resident. This was submitted following the inspection, however, enhanced oversight of incidents was required as detailed and actioned under regulation 23.

Judgment: Compliant

## Regulation 34: Complaints procedure

Significant action was required in the management of complaints in the centre, evidenced by the following findings:

- From a review of residents meeting records and from speaking to residents the inspector was not assured that residents' complaints were being addressed to a satisfactory standard. Some issues of concern in relation to delays in care and medication management had been brought to the attention of the management team but were not appropriately documented and managed within the centre's complaints register. Consequently, there was no record of how these issues were acknowledged, investigated or resolved to the satisfaction of the complainant.
- A review of complaints records found that the there was not always a provision of a written response to the complainant. This is required to inform the complaint whether or not their complaint had been upheld, the reasons for that decision, any improvements recommended and details of the review process. This is a requirements of the regulation.

Judgment: Not compliant

## Quality and safety

Overall, residents living in Douglas Nursing and Retirement Home were seen to have a good quality of life, which was encouraged by a team of staff who were kind and caring. There was evidence of good access to healthcare services and opportunities for social engagement. However, some action was required in relation to care planning, healthcare, fire precautions and residents rights, as outlined under the relevant regulations

Residents' care plans and daily nursing notes were recorded on an electronic documentation system. An assessment of residents' health and social care needs was completed prior to admission, to ensure the centre could meet the residents' needs. A sample of assessments and care plans were reviewed and found that, while each resident had a care plan in place, care plans were not always informed by an accurate and up-to-date assessment of the resident's needs. Therefore, care plans did not always reflect the current care needs of the resident. Furthermore, care plans were not always reviewed following a change in the residents' condition. These and other findings are further detailed under regulation 5.

The inspector found that residents had access to appropriate medical and allied health and social care professional support to meet their needs. Residents had a choice of general practitioner who attended the centre as required or requested. Residents were also supported with a referral pathways and access to allied health and social care professionals. However, the oversight of wound care practices in the centre required attention which is actioned under regulation 6. Residents were monitored for weight loss and were provided with access to dietetic, and speech and language services when required.

There was an effective mechanism in place for the management of restrictive practice that monitored, recorded and reviewed the use of same. The centre had reduced the number of bedrails in use over the past six months and were focusing on moving towards a restraint free environment. Where restraint was used, such as bedrails and sensor equipment the inspector found residents were assessed appropriately and it was used in line with national policy.

Residents had access to an independent advocacy service and details regarding this service were advertised in the centre. There was evidence that advocacy services had been contacted by the management team to appropriately support residents. Residents' meetings were convened regularly to ensure residents had an opportunity to express their concerns or wishes. However, action was required to ensure that suggestions and requests were addressed. These and other findings are actioned under regulation 9. Residents had access to television, radio, newspapers and books. Residents were supported to continue to practice their religious faiths and had access to newspapers, radios and televisions.

## Regulation 11: Visits

The registered provider had arrangements in place for residents to receive visitors. Those arrangements were found not to be restrictive and there was adequate private space for residents to meet their visitors.

Judgment: Compliant

## Regulation 17: Premises

There was an ongoing programme of upgrades and maintenance to the premises evident. The centre was observed to be clean and overall well maintained. Painting of bedrooms was taking place and scheduled for the months ahead. The layout and design of the premises met residents' individual and collective needs. Residents had free access to the internal gardens.The provider employed a person with responsibility for maintenance of the premises and they worked four days per week in the centre.

Judgment: Compliant

## Regulation 18: Food and nutrition

Residents were provided with wholesome and nutritious food choices for their meals and snacks and refreshments were made available at the residents request. Menus were developed in consideration of residents individual likes, preferences and, where necessary, their specific dietary or therapeutic diet requirements as detailed in the resident's care plan and seen to be implemented.

Judgment: Compliant

## Regulation 28: Fire precautions

While not all aspects of this regulation were assessed immediate action was required on the day of this inspection pertaining to fire precautions. Specifically due to the following findings:

- From discussions with staff the inspector was not assured that the means of escape from the smoking room was clearly understood and which doors were designated fire exits. Information from staff and evacuation drawings displayed were in conflict. The door in the smoking room which exited to the garden was seen to be blocked with equipment as the courtyard was in the process of being repaved.

- Emergency call bell facilities in the smoking area were not functioning.

The manner in which the provider responded to the above findings did provide assurance that these risks were adequately addressed by the end of the inspection. However, further monitoring of fire safety was required as actioned under regulation 23.

Other areas that required action in relation to fire precautions were the following:

- Two fire exits in the dining room were not kept free from obstruction as dining tables and chairs and residents in wheelchairs were placed in front of these exits while they dined.
- Furniture and the carpet in the smoking room had evidence of scorch marks and burns. Therefore, the inspector was not assured that they were made of appropriate fire retardant material.

Judgment: Substantially compliant

## Regulation 5: Individual assessment and care plan

Care plans were recorded on an electronic system. The inspector reviewed a sample of residents care plans and it was evident that action was required to ensure that they clearly detailed residents care requirements and supports required: This was evidenced by the following findings:

- Although validated risk assessments were regularly and routinely completed to assess various clinical risks including risks of malnutrition, pressure ulcers and falls, these were not always used to inform care delivery. Therefore, care plans did not always reflect the risk and care required to address these risks.
- Some Information in care plans was found to be generic and not specific to the named residents care requirements.
- A resident requiring a seizure management care plan did not have this in place.

The management team acknowledged this finding and informed the inspector that there was training planned in the coming weeks to support staff development in this area.

Judgment: Substantially compliant

## Regulation 6: Health care

A review of residents' wound care charts found that nursing care was not always in line with evidence based nursing care. For example; recommended dressing

changes, as indicated via clinical assessments were not always adhered to. Two wound care charts reviewed by the inspector had inconsistent clinical measurements and assessments and dressing changes were not documented in line with the residents care plan.

Judgment: Substantially compliant

## Regulation 7: Managing behaviour that is challenging

There was evidence to show that the centre was working towards a restraint-free environment, in line with local and national policy. The person in charge ensured that staff were provided with up-to-date knowledge and skills to respond and manage responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment). The provider had systems in place to monitor environmental restrictive practices to ensure that they were appropriate. Access release buttons to the gardens were found to be hard to access. The management team addressed this on the evening of the inspection and relocated these switches, to ensure they were easily reachable. This was to ensure that residents were encouraged and supported to optimise their independence where possible, and have free access to safe outdoor space.

Judgment: Compliant

## Regulation 9: Residents' rights

Action was required pertaining to residents rights evidenced by the following findings:

- Residents reported delays in call bells being answered. Staff practices in the centre where registered nurses did not routinely carry call bell pagers, impacted the response time to residents. On the day of inspection there were three registered nurses working and one Clinical Nurse Manager. Responding to residents call bells was delegated to care staff and nurses were not aware that bells were ringing.
- There was not evidence that residents were provided with meaningful activities at the weekend. From a review of records and discussions with residents it was apparent that activities were planned from Monday- Friday. Adding to this on the day of this inspection the person assigned to provide an activities programme for residents was allocated to alternative roles in the morning.

| |
|---|
| • A review of residents meetings and from discussions with residents it was evident that residents suggestions and requests were not always responded to and used to inform quality improvement. |
| Judgment: Not compliant |

**Appendix 1 - Full list of regulations considered under each dimension**

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

| Regulation Title | Judgment |
|---|---|
| **Capacity and capability** | |
| Regulation 14: Persons in charge | Compliant |
| Regulation 15: Staffing | 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 | Compliant |
| Regulation 34: Complaints procedure | Not compliant |
| **Quality and safety** | |
| Regulation 11: Visits | Compliant |
| Regulation 17: Premises | Compliant |
| Regulation 18: Food and nutrition | Compliant |
| Regulation 28: Fire precautions | Substantially compliant |
| Regulation 5: Individual assessment and care plan | Substantially compliant |
| Regulation 6: Health care | Substantially compliant |
| Regulation 7: Managing behaviour that is challenging | Compliant |
| Regulation 9: Residents' rights | Not compliant |

# Compliance Plan for Douglas Nursing and Retirement Home OSV-0000223

## Inspection ID: MON-0046651

## Date of inspection: 11/03/2025

**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 21: Records | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 21: Records:<br><br>To ensure full compliance with Schedule 3, we will endeavour to improve the maintenance of accurate, secure and accessible records.<br>Therefore, to achieve this, by mid-May, 2025, our PIC in collaboration with the Director of Clinical Care Quality and Standards (DOCQS) will carry out a detailed review of Schedule 3 Requirements and a Compliance Checklist will be created accordingly so that specific compliance tasks are now assigned to relevant team members.<br>Furthermore, our DOCQS will conduct regular reviews of records to ensure that they are accurate, secure and accessible, whereas our PIC will be responsible to perform quarterly audit of records based on the Schedule 3 requirements. The outcome of these audits will serve for continuous improvement.<br>Finally, our DOCQS will organise training sessions on maintenance of records for relevant staff by the end of May. | |
| Regulation 23: Governance and management | Not Compliant |
| Outline how you are going to come into compliance with Regulation 23: Governance and management:<br><br>Our aim is to ensure we have a robust governance and management processes in place to enable us to enhance our operational efficiency and risk management.<br>To deliver this we have revised our governance and management processes including the revision and update of our organisational chart, role and responsibilities of all staff with managerial and supervisorial duties which senior management have completed since | |

April 10th.
Furthermore, to ensure the implementation of our clinical governance planner is in line with the requirements of Regulation 23, we have completed a full review of it on April 10th.
We undertook a full review and update of all Schedule 5 policies and procedures which will be completed by May 31st
The PIC in collaboration with the DOCQS will implement a compliance oversight process that will establish required internal controls and monitoring systems which will be in place by May 31st

| Regulation 34: Complaints procedure | Not Compliant |
|---|---|

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:

We are confident that we are maintaining a high standard of care and transparency in handling complaints, however, we acknowledge that it is essential to have a clear and effective complaints procedure that complies with Regulation 34.
Hence, our PIC revised our complaints procedure policy ensuring it is comprehensive and in compliance with Regulation 34, as amended on March, 31st.
All staff, residents and their families will be informed about the complaints procedure changes before the end of April.
Furthermore, by the end of May, our DOCQS will provide specific training on maintaining detailed and accurate records of complaints to be provided to all relevant staff.
To measure the effectiveness of the complaints procedure, we have allocated our DOCQS as the new complaints' reviewer. She will be responsible for carrying out a monthly review of records to identify patterns and areas of improvement. She will also conduct audits every 6 months to ensure that our complaints procedure is following Regulation 34, as amended on March 31st. Findings from these audits will serve for continuous improvement of this regulation.

| Regulation 28: Fire precautions | Substantially Compliant |
|---|---|

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

The safety of our residents is paramount to us, and this year we have allocated and spent a considerable budget on improving our fire safety infrastructure in the home which greatly enhances the safety and wellbeing of our residents.

On the day of the inspection, we demonstrated our commitment to fire safety as immediate remedial actions were taken by us to address issues highlighted to us by the inspector. To date, we can confirm that all issues have been fully resolved.
Continuous efforts in this area will remain and we will continue to carry out Fire safety audits of all safety measures in place in our nursing home on a quarterly basis.
However, to ensure compliance is obtained at all the times, the senior management team nominated a new fire officer that will be supported by the nursing team as all our nurses have now received fire warden training.
Furthermore, a full review of the content of our fire training was undertaken with our training provider.
Our focus now is to conduct regular (on a quarterly basis) and effective fire drills to ensure preparedness.

| | |
|---|---|
| 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:

We will endeavour to develop and implement comprehensive, person-centred care plans that reflect the current needs of each resident as required by regulation 5.
We have already provided further training to all our nurses, on our admission processes, assessment of residents' needs, development and evaluation of care plans while using Epic Care system. This training was provided by our Quality Director in conjunction with our PIC.

We will also put a robust system in place to measure the effectiveness and timeliness of care plan development and updates. Our CNMs will be allocated extra hours to monitor and carry out checks of our residents' care plan. They will provide ongoing support and education to staff that fail to provide individual assessment and care plans in line with regulation 5.

| | |
|---|---|
| Regulation 6: Health care | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 6: Health care:

We aim to ensure that our care practices are in full compliance with Regulation 6 and that each resident receives the highest quality of care.
Since the area of non-compliance was regarding some part of our wound care practices,

our focus is on ensuring that all our nursing staff are knowledgeable about evidence-based wound care practices, and we will provide training on the latest evidence-based guidelines for wound care. Our Quality Director is reviewing our protocols to ensure that they are clear and consistent with the latest clinical guidance and best practices. This will be completed by the end of May.
Furthermore, our PIC will continue to conduct quarterly audits of wound care charts to verify that dressing changes and clinical assessments are performed and documented in line with the residents' care plans.

| | |
|---|---|
| Regulation 9: Residents' rights | Not Compliant |

Outline how you are going to come into compliance with Regulation 9: Residents' rights:

Feedback received from residents on an ongoing basis or during residents' meeting clearly highlights that overall our residents feel that their rights are respected. However, we understand that to enhance even further their quality of life while living in our nursing home, we must ensure consistency in the provision of more planned activities at the weekend, in always answering call bells as promptly as possible and ensuring that all residents suggestions and requests are responded to and used to inform quality improvement.

We have now allocated a staff member for activities on Saturdays and Sundays. An activities schedule has been developed with the residents who wish to partake.

Proactive action was taken on the day of the inspection to ensure that residents' call bells were always attended to in a promptly manner. Nurses now carry pagers to support HCAs in answering call bells. Additionally, the call bells' provider was contacted and was at the nursing home the following morning at 9 am to update the system settings and to address the concern that was observed on the day of the inspection.

In future, a more in-depth review of the minutes of the residents' meeting will be carried out.

## 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 21(1) | The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector. | Substantially Compliant | Yellow | 01/06/2025 |
| Regulation 23(b) | The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision. | Substantially Compliant | Yellow | 01/05/2025 |
| Regulation 23(c) | The registered provider shall ensure that management systems are in place to ensure that the service | Not Compliant | Orange | 01/05/2025 |

| | | | | |
|---|---|---|---|---|
| | provided is safe, appropriate, consistent and effectively monitored. | | | |
| 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. | Not Compliant | Orange | 11/04/2025 |
| Regulation 28(1)(c)(ii) | The registered provider shall make adequate arrangements for reviewing fire precautions. | Substantially Compliant | Yellow | 11/04/2025 |
| Regulation 34(2)(c) | The registered provider shall ensure that the complaints procedure provides for the provision of a written response informing the complainant whether or not their complaint has been upheld, the reasons for that decision, any improvements recommended and details of the review process. | Not Compliant | Orange | 01/05/2025 |
| Regulation 34(6)(a) | The registered provider shall ensure that all complaints received, the outcomes of any investigations into complaints, any actions taken on foot of a complaint, any | Not Compliant | Orange | 01/05/2025 |

| | | | | |
|---|---|---|---|---|
| | reviews requested and the outcomes of any reviews are fully and properly recorded and that such records are in addition to and distinct from a resident's individual care plan. | | | |
| Regulation 5(4) | The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family. | Substantially Compliant | Yellow | 01/06/2025 |
| Regulation 6(1) | The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident. | Substantially Compliant | Yellow | 01/05/2025 |

| | | | | |
|---|---|---|---|---|
| Regulation 9(2)(a) | The registered provider shall provide for residents facilities for occupation and recreation. | Substantially Compliant | Yellow | 11/04/2025 |
| Regulation 9(3)(d) | A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned. | Not Compliant | Orange | 11/04/2025 |
| Regulation 9(3)(e) | A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise their civil, political and religious rights. | Not Compliant | Orange | 11/04/2025 |