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:	Glendonagh Residential Home
Name of provider:	Glendonagh Residential Home Limited
Address of centre:	Dungourney, Midleton, Cork
Type of inspection:	Unannounced
Date of inspection:	05 December 2024
Centre ID:	OSV-0000229
Fieldwork ID:	MON-0044205

About the designated centre

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

Glendonagh Residential Home is located near the village of Dungourney in East Cork. It is set on well maintained, extensive grounds. The centre is registered as a designated centre under the Health Act 2007 for the care of 42 residents with 24-hour nursing care available. The centre is registered to provide accommodation for 42 residents over two floors. There is a specific nine bedded dementia care unit for residents who required additional support called the Orchard unit. Care is provided by a team of nursing staff who are supported by care, catering, household and activity staff. Medical and allied healthcare professionals provide ongoing healthcare for residents.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	39

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
Thursday 5 December 2024	14:00hrs to 00:10hrs	Siobhan Bourke	Lead
Thursday 5 December 2024	14:00hrs to 00:10hrs	Caroline Connelly	Support

What residents told us and what inspectors observed

This was an unannounced inspection which took place from the afternoon into the night by two inspectors of social services. Over the course of the inspection, the inspectors met with many of the residents, staff and six visitors, to gain insight into what it was like to live in Glendonagh Residential Care home. Inspectors spoke in more detail with six residents. Many of the residents told inspectors that some of the staff were kind and caring to them, however a resident told inspectors that staff were "rushed off their feet" and three residents said that their care often felt rushed. Staff who spoke with inspectors also outlined how they were frequently short staffed and how this impeded their ability to provide residents with the care they required.

On arrival to the centre, the inspectors saw that the centre was beautifully decorated for Christmas and preparations were underway for the festive season. Following a short introductory meeting, with the registered provider representative and the person in charge, the inspectors did a walk around the centre where they met residents, visitors and staff. The inspectors spent time observing the residents' daily life in the centre, in order to understand the lived experience of the residents.

Glendonagh Residential Care Home is located on spacious, well maintained grounds, near the rural village of Dungourney. The centre has three floors, with accommodations for 31 residents on the ground floor and 11 residents on the first floor, in the Manor Wing. The laundry and storage areas are in the basement of the building. Resident accommodation is in three distinct units, namely the Orchard Unit, which is a secure unit for residents living with dementia, or other specific needs. This unit has seven single rooms and one twin room for residents. The Courtyard Unit is on the ground floor and accommodates 14 residents in two twin rooms and 10 single rooms. The Manor Unit is over two floors with one triple room on the ground floor, four twin rooms and eight single bedrooms. The centre had a number of well-maintained communal rooms and private spaces for residents' use, including a large day room and oratory, a large dining room, the Gold Room, used as a visiting room and the Green Room or family room.

The Orchard Unit had a small kitchenette/dining room and cosy day room. The corridors in the Orchard Unit had scenic murals to brighten up the corridors and activity boards, which residents could use as they walked up and down during the day. Bedroom doors in the Orchard Unit were personalised with pictures and displayed residents' names to help them with way finding. The inspectors saw that cupboards storing chemicals, such as mouthwash, creams and other toiletries, in the Orchard Unit were not locked, which was a risk to residents with a dementia diagnosis, who were living there. This was immediately addressed by the person in charge.

The inspectors also observed that sealed boxes of pharmacy supplies that had been delivered the previous day, were stored in the hair salon, while the hairdresser was

in attendance. This was brought to the attention of the person in charge during the inspection.

Notwithstanding, the observations by inspectors, that rooms were generally clean and well maintained; inspectors noted very strong malodours from a number of bedrooms, in two sections of the centre. A number of visitors also commented on the odour to inspectors. While equipment for residents' use was clean in one of the sluice rooms, the inspectors saw that a bedpan that was stored on a rack ready for use was not clean and a urinal was stained. This is further described under Regulation 27; Infection Control.

The inspectors observed the activity in the centre during the early evening and night shift. An inspector attended the handover between day and night shift. Information handed over between day and night staff was observed to be comprehensive.

The inspectors saw that many of the residents either, did not have a call bell in easy reach so that they could call for help, or there was no call bell available. A resident in the upper manor wing of the centre could be heard calling out and distressed; when an inspector entered the room, the resident's call bell was not within reach of the resident. These finding were brought to the attention of the nurse on duty.

An inspector observed care in the secure Orchard Unit and saw that the carer working on the night shift was responsive to residents' needs. Residents who had responsive behaviour were observed to be gently directed and a very person centred approach was taken by the carer. The only nurse rostered for the night shift commenced a medication round following handover. Inspectors observed that the nurse was frequently interrupted during the medication round to attend to residents needs and requests from care staff. The medication round was not completed until after 10.40pm whereby following this, as part of their night allocations, the nurse was required to clean the medication trolley, which meant they were unavailable to supervise care staff or provide care to residents until after 11.00pm.The inspectors saw that there were two care staff available to assist residents to go to bed and the majority of residents required some level of assistance. While care staff were attending to residents' care needs, inspectors saw that residents who remained in the day room were unsupervised and calling out for attention or for assistance to go to the bathroom.This is outlined further under Regulation15; Staffing and Regulation 16 staff training and development.

During the early night, the inspectors saw that the majority of residents had two bed rails raised and a resident was sleeping with their legs out over the side of the bedrails.

There was an activity schedule available for residents that was provided by care staff and external facilitators such as musicians, exercise classes, yoga and therapy dogs. Mass was celebrated in the centre each week. On the day of inspection, a care assistant was assigned to the day room and inspectors saw that they were facilitating a game of skittles with a large group of residents, who spent their day in the day room. One resident told an inspector that they could have "good craic" with the staff and how they loved to go for walks around the grounds on a fine day. The

hairdresser was in the centre's salon during the afternoon of the inspection and many of the residents had their hair styled. Residents appeared well groomed in their own personal style and gave positive feedback regarding the hairdressing service available. Visits were observed to take place in residents' bedrooms and communal areas. Visitors confirmed that they could visit anytime and they were always warmly welcomed to the centre.

Inspectors saw that residents were offered regular drinks and snacks rounds and the inspectors observed the evening supper. There were two sittings for residents in the dining room and residents were offered a hot and cold choice for this meal. The food appeared wholesome and nutritious and there were adequate portions provided. Residents were very complementary regarding the food served to them. Residents who required assistance were provided with this in a respectful manner. Inspectors observed that plastic aprons were used as clothes protectors for residents which did not promote residents' dignity. This is outlined under Regulation 9; Residents' Rights.

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

Capacity and capability

Management oversight of the quality and safety of the service and care provided to residents' required significant action to ensure that the service provided to residents was safe, appropriate, consistent and effectively monitored; in particular the systems in place with regard to staffing and supervision of staff, care planning, managing behaviour that is challenging and upholding residents' rights.

Following the previous inspection, a cautionary meeting was held with the provider where serious concerns were raised regarding the staffing levels at night, supervision of care staff, fire precautions and infection control. The inspectors found that action had been taken by the provider to address some of the findings of the previous inspection such as action required in relation to Regulation 28; Fire precautions. However, significant action was required to ensure the quality and safety of care provided to residents. Repeated non compliance was found with regard to Regulation 15; Staffing, Regulation 23; Governance and management and Regulation 27; Infection control. Additionally, non compliance was found in the following regulations; Regulation 16; Training and staff development, Regulation 31; Notification of incidents, Regulation 5; Individual assessment and care plan, Regulation 7; Managing behaviour that is challenging and Regulation 9; Residents' Rights.

The registered provider for Glendonagh Residential Home is Glendonagh Residential Home Ltd. The registered provider company has two directors, one of whom is actively involved in the management of the centre and is the nominated person

representing the provider. The designated centre also had a full time administration manager and receptionist.

The provider had a full time person in charge who was supported in their role by two clinical nurse managers. A person, who previously worked in the centre as a director of nursing, also provided support to the person in charge, with the administrative function of their role.

There were insufficient resources available to ensure the effective delivery of care to residents. For example, the nursing staff and health care assistant complement in the centre was not adequate to meet the assessed needs of the 39 residents living in the centre, at the time of inspection. There was one whole time equivalent (WTE) nursing shortage and two WTE care staff vacancies at the time of inspection. The provider gave verbal assurances to inspectors that recruitment was ongoing to fill these vacancies. However, the impact of these vacancies are outlined under Regulation 15; Staffing and Regulation 16; Training and staff development.

Staff had access to training appropriate to their role such as fire safety, manual handling, managing behaviour that is challenging and safeguarding. The clinical nurse manager assigned to monitor staff training, was provided with supernumerary hours during weekday mornings, to provide care staff with small group face-to-face training in aspects of care including, personal care and food and nutrition. From a review of the training matrix provided to inspectors, a small number of staff had yet to complete safeguarding training and managing responsive behaviour training. Inspectors found that staff were not always appropriately supervised as detailed under Regulation 16; Training and staff development.

There was a schedule of audits in place to monitor the quality and safety of the service provided whereby aspects of care such as staff compliance with hand hygiene, wound care management, care planning and medication management were monitored. The provider and person in charge had implemented a modified medication administration observation sheet since July 2024 whereby the registered nurse working on the night shift was required to record any disruptions to the night medication round. A monthly review of these sheets was completed by the management team. From a review of the findings of this audit, inspectors noted that frequent interruptions were recorded, yet action had yet to be taken with regard to nursing night time staffing levels. This and other findings are outlined further under Regulation 23; Governance and Management.

The complaints procedure was updated since the previous inspection to meet the requirements of regulation. At the time of inspection, the system of recording complaints was being transferred over from a paper based system to the electronic record system available in the centre.

From a review of recorded incidents in the centre, an inspector saw that while some required notifications were reported to the office of the Chief Inspector in line with regulations, some were not as outlined under Regulation 31; Notification of incidents.

Regulation 15: Staffing

At the time of inspection, there were 15 residents who had been assessed as having maximum needs and nine residents with high care needs, which meant that the majority of residents living in the centre require a high or very high level of care. The inspectors found that the staffing levels and skill mix were not sufficient, taking into account the assessed needs of the residents and the size and layout of the centre as evidenced by the following;

- There was one nurse on duty from 7.30pm to 7.30am with two care assistants for the full night and one twilight care staff. From a review of the rosters and speaking with staff and management, on some evenings, the care staff member allocated to the twilight shift went home at 10.00pm and on others evenings it was 11.30pm.
- The inspectors observed that following the evening handover between day and night nursing staff, the nurse went to prepare the medication trolley and then proceeded to administer the night time medications. At 10.45pm, the nurse was finishing off the medication round and told inspectors that as part of their roles and allocations during the night shift, they were required to clean the trolley so the nurse was not available to provide care until after 11.00pm. This left three care staff on the floor; one in the Orchard Unit and one on each of the other units to assist residents to bed. From a review of staff allocations records for the night shift and speaking with staff, inspectors noted that night care staff were assigned many cleaning tasks such as washing floors in the day room, kitchen and corridors and setting up breakfast trays and trollies which further took from the time they were available to provide care to residents. The inspectors saw on a number of occasions, during the evening and night time, residents looking to go to the bathroom, having to wait long periods of time and two residents in their rooms calling out, without staff available to provide this attention, due to the number of residents in the centre and the layout in three separate units and one upstairs.
- Inspectors observed that the one nurse on night duty was frequently interrupted, while administering medications to residents, which both delayed medication administration and was a risk to safe medication administration and could lead to errors. These interruptions were from residents calling for assistance, care staff calling the nurse to attend to residents and attending to the pharmacy delivery to the centre at 9.30pm.
- The nursing staff levels in the centre were not in line with the centre's statement of purpose against which the centre is registered, whereby the centre was required to have seven whole-time equivalent (WTE) nurses available. At the time of inspection, there were only six WTE nurses available to the roster. Similarly, from a review of staff rosters provided to inspectors and from a review of the statement of purpose, there were two WTE care staff vacancies which impacted the number of staff available to provide care

for residents. Therefore staffing levels had further deteriorated since the previous inspection in April 2024.
- The issue of staffing has been a long term issue in this centre, where the centre used to have four staff at night, but the provider has reduced that to three plus a twilight. The provider had agreed to put on a second nurse at night or minimal of a nurse to cover the twilight shift and yet neither of these are available. This is a repeated non-compliance.

Judgment: Not compliant

Regulation 16: Training and staff development

The inspectors found that training was not appropriate in relation to safeguarding, management of responsive behaviours and care planning as evidenced by the following;

- Inspectors found that staff knowledge on what constituted safeguarding of vulnerable adults was not appropriate to ensure residents were protected at all times. Inspectors found that a small number of incidents with regard to poor care practices had not been actioned or reported as safeguarding incidents.
- Records provided to inspectors indicated that nine staff had not completed safeguarding training and eight staff had not completed training in responsive behaviour. The provider assured inspectors that this training was scheduled in the weeks after the inspection.
- Residents' care plans were not maintained in line with regulations and did not have enough detail to direct care as outlined under Regulation 5; Individual assessment and care plan.

As found on the previous inspection in April 2024, there was a lack of appropriate supervision of care staff in the centre due to staff shortages. Care staff mostly worked alone and there was minimal supervision of their practices. This was especially evident at night, when there was only one nurse on duty. This is a repeat finding.

Judgment: Not compliant

Regulation 23: Governance and management

Management oversight of the quality and safety of the service and care provided to residents required urgent action to ensure that the service provided to residents was safe, appropriate, consistent and effectively monitored;

The inspectors were not satisfied that the centre had sufficient resources to ensure the effective delivery of care;

- The inspectors found that the staffing resources was not sufficient to meet the assessed needs of the residents particularly at night time which is further discussed under Regulation 15 Staffing; this has been a repeat finding over the course of a number of previous inspections and resulted in a cautionary meeting being held with the provider following the previous inspection.
- A review of nurse staffing provision was required to ensure residents had access to adequate nursing supports at all times including from 7.30pm to 7.30am. For example, on some weekdays, there was a supernumerary person in charge, two nurses, a supernumerary clinical nurse manager (CNM) and a nurse completing clinical audits(five nurses) while from 7.30pm, there was only one nurse on duty to provide clinical care for up to 42 residents throughout the night and to provide supervision for care staff.

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

- The system and oversight of training required strengthening in relation to safeguarding, care planning and management of responsive behaviour for residents and staff supervision as detailed under Regulation 16; Training and staff development.
- The system of audit and review required action as while there was an audit schedule in place, good compliance with audit findings was not reflected in the inspection findings as outlined under Regulation 5; Individual assessment and care plan.
- Furthermore, where the provider had identified frequent interruptions to the night time medication round in their monthly audits completed since July 2024, action had yet to be taken in relation to increasing nursing night time staffing levels as outlined under Regulation 15; Staffing.
- The system of oversight of incidents required improvement. Inspectors found that a number of allegations and incidents of abuse that impacted the safety and welfare of residents were not being appropriately investigated and managed, to ensure that residents were protected. As a result, legally mandated notifications were not submitted as required to the Chief inspector with regard to allegations or incidents of abuse of residents as outlined under Regulation 31;Notification of incidents.
- Oversight of risk management systems required action as inspectors observed that pharmacy supplies were inappropriately stored in the hair salon while residents and the hairdresser were using the room on the day of inspection. Furthermore, a press containing chemicals was found to be unlocked in the secure dementia unit which was a risk to residents. This was actioned by the person in charge during the inspection.
- Oversight of the systems in place to ensure compliance with infection control standards required strengthening as evidenced by the findings in relation to Regulation 27 Infection Control.

- Repeated non compliance found in relation to regulations 15; Staffing, 23; Governance and management and 27; Infection control.

Judgment: Not compliant

Regulation 31: Notification of incidents

From a review of the records of incidents and records, maintained in the centre, the inspectors found that not all notifications had been submitted to the Chief inspector as required as evidenced by the following;

- allegations or incidents relating to safeguarding of residents had not been notified to the Chief inspector as required.

Judgment: Not compliant

Regulation 34: Complaints procedure

The registered provider provided an accessible and effective procedure for dealing with complaints, which included a review process. The required time lines for the investigation into, and review of complaints was specified in the procedure. The procedure was prominently displayed in the centre.

Judgment: Compliant

Quality and safety

While a number of residents and their relatives told inspectors that care staff were supportive and caring, a number of residents raised concerns regarding delays in care and response times to call bells in the centre. The levels of non-compliance found on inspection was posing a risk to the safety and well being of residents, particularly with regard to infection control, care planning, managing behaviour that is challenging and ensuring residents' rights were promoted at all times.

The inspectors reviewed a sample of four residents' files and found that each resident had a care plan in place. Validated assessment tools were used to assess risks to residents and to inform care planning. However, inspectors found that these assessments were not always completed and were not sufficiently detailed to direct care as outlined under Regulation 5; Individual assessment and care plan.

It was evident from a review of care records, that residents had good access to GP services and arrangements were in place for residents to access the expertise of health and social care professionals such as speech and language, dietitian and palliative care through a system of referral. Wound care plans were in place for residents with pressure ulcers and wounds. Records indicated that access to tissue viability nursing expertise was sought as required and dressings were changed at the required frequency.

Inspectors saw, that many staff working in the centre, engaged with residents in a respectful and dignified way during the inspection. However, the high usage of bed rails in the centre required action. The inspectors observed that two residents, who were risk assessed as not requiring bed rails, had both bed rails in use during the inspection and residents who had negative outcomes from the use of bed rails did not have these reflected in their assessments as detailed under Regulation 7; Managing behaviour that is challenging.

There was a schedule of daily and deep cleaning of rooms. The inspectors saw that there was an adequate number of housekeeping staff rostered to ensure the centre was clean. The inspectors saw that residents' bedrooms and communal areas were visibly clean and residents who spoke with inspectors reported that their rooms were cleaned on a daily basis. Extra hand gel dispensers had been installed in the centre and there as evidence of improved oversight of hand hygiene practices. However, inspectors were not assured that the contingency plans in place to manage an outbreak were effective from review of the management of a large outbreak of COVID 19 in the centre in September 2024, where 15 residents and 11 staff were impacted. While a staff nurse had been nominated by the provider as the lead for infection prevention and control, they had yet to be enrolled or complete the link nurse infection control course. These and other findings are outlined under Regulation 27; Infection control.

Fire safety training was up-to-date for staff and the provider ensure fire simulation drills of the largest compartment with minimal staffing levels were carried out in the centre at regular intervals.

There was a schedule of activities available for residents which was overseen by one of the clinical nurse managers. A number of external providers such as musicians, exercise instructors and therapy dogs services attended the centre to provide activities for residents. Preparations were underway on the day of inspection for the upcoming family Christmas parties for residents. Residents had access to daily and weekly newspapers and television. However action was required in relation to ensuring residents rights to privacy and dignity were upheld and evidence of consultation with residents with regards to the organisation of the centre was limited. These and other findings are outlined under Regulation 9; Residents' rights.

Regulation 11: Visits

Visitors were welcomed in the centre and inspectors saw several visitors attending the centre during the inspection. Visits were observed to take place in residents' bedrooms and communal areas. Residents who spoke with the inspectors confirmed that their relatives and friends could visit anytime.

Judgment: Compliant

Regulation 27: Infection control

The inspectors found that while the registered provider had actioned the findings from the previous inspection, some procedures were not consistent with the National Standards for infection prevention and control in community services (2018). The following findings required action:

- The inspectors saw that a bedpan was unclean and stored on a rack as ready for use, a urinal was also observed to be stained. This presented a risk of cross contamination.
- While residents bedrooms were visibly clean, inspectors noted strong malodours in a number of residents' bedrooms. Visitors who spoke with inspectors also reported this malodour to the inspectors.
- From review of the management of a large outbreak of COVID-19 in the centre in September where 15 residents and 11 staff were impacted, inspectors were not assured that the contingency plans in place with regard to staffing, availability of testing equipment and PPE were in line with guidance. As four of the six available nursing staff contracted the virus and were unable to work, this left one registered nurse rostered each day and night for two days of the outbreak which was not sufficient to meet residents needs. Swabs to test residents for viral illnesses were not readily available in the centre and at the onset of the outbreak, staff were not using FFP2 masks as recommended in national guidance.

Judgment: Not compliant

Regulation 28: Fire precautions

The inspectors saw records available, indicated that quarterly and annual testing of the fire alarm and emergency lighting was in place. Fire-fighting equipment was serviced annually. Exit routes were observed to be clear of obstructions. Signage to indicate that a resident required oxygen was not evident outside a resident's bedroom, this was addressed by the person in charge on the day of inspection.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

A sample of assessments and care plans were reviewed and these showed mixed findings. Some had personalised information to inform individualised care while others did not have this detail and required action to enable staff provide individualised care. For example:

- the centre was using core care plans and many care plans were not personalised to the residents' needs
- a number of care plans seen contained information that was not relevant to the residents care and had not been removed
- one care plan for a female resident referred to care for a male resident in another unit of the centre
- care plans for residents with responsive behaviours did not contain sufficient information to guide care and inform the staff of triggers to responsive behaviours and of de-escalation methods for staff to use to aid and support the resident.
- some individual assessments were found to be inaccurately recorded or not fully completed, therefore, they could not inform care delivery. For example, while photographs were taken to inform wound care management, the wound care assessment tool available for nurses was not been completed to assess if wounds were deteriorating or improving.

Judgment: Not compliant

Regulation 6: Health care

Residents had good access to general practitioners and allied health care professionals such as dietitian, speech and language therapy as required. There was evidence that residents had regular medical reviews by their GP who attended the centre on a weekly basis or more often if required.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

There was a very high incidence of the use of bed rails in the centre; with over 50% of residents having two bed rails in use. Care documentation evidenced that alternatives to bed rails as a restrictive practice were not implemented such as low-low beds and sensor mats.

Appropriate assessments were not evidenced, to inform the care planning process in line with national policy, for example;

- A resident was assessed as not requiring bed rails, yet the inspectors saw two bed rails were up for this resident during the inspection. These were only removed when brought to the attention of the nurse on duty.
- A review of a post fall risk assessment for a resident, required that bed rails were not to be used. However, inspectors found that bed rails continued to be used, therefore the risk was not reduced.

The inspectors observed that residents were restricted in their movement, with one resident sleeping with their legs out over the bed rails. A resident told inspectors how bed rails had restricted their access to their locker and call bell during the night.

Judgment: Not compliant

Regulation 9: Residents' rights

The inspectors found that action was required to ensure that the rights of residents, who were living in the centre, were upheld at all times as evidenced by the following;

- Inspectors observed that call bells were not within easy reach for residents to call for assistance when required, in some residents' rooms, call bells were not working.
- Residents who spoke with inspectors outlined how there were delays when they did call for assistance.
- Inspectors observed information displayed on sheets in residents' bedrooms, outlining their requirements for continence care, which did not promote residents' privacy and dignity.
- While relatives meetings were held in the centre, the frequency of residents' meetings was not in line with every two months as detailed in the statement of purpose. Records available indicated that the last residents' meetings were held in March 2024, therefore this did not provide residents with an opportunity to be involved in the organisation of the centre.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Glendonagh Residential Home OSV-0000229

Inspection ID: MON-0044205

Date of inspection: 06/12/2024

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:

Glendonagh is committed to the ongoing assessment and care of our residents, as demonstrated by our use of the Barthel Index which we will continue to use to evaluate and adapt to the evolving needs of those in our care, ensuring our staff are equipped to meet the needs of residents at any time, day or night. We take pride in having never fallen short of the Health Act 2007 (S.I. 415/2013 15/2) in ensuring that a qualified staff nurse is on duty 24/7. In alignment with HIQA's core function, we are dedicated to continuous improvement and quality care.

Glendonagh has historically had an on-call system in place to support our night team and ensure that resident safety remains paramount. However, as the importance of protected time during medication rounds evolves we have successfully recruited two new members to meet this need. We have adjusted our nursing roster accordingly, allocating nursing hours to provide a supplementary twilight nurse. The second nurse is in place since the start of January 2025 and provides both a support and oversight function as well as fully protected time during the evening medication round. This additional resource is in place from 7.30pm – 10.30pm every night to ensure consistency.

Our commitment to high-quality staff is reflected in our recruitment process, which is thorough and time-consuming, as we prioritise quality over quantity. Every staff member undergoes a rigorous interview then training programme that not only covers the technical aspects of their role but also emphasises essential skills such as compassion and cultural sensitivity. In addition, staff are supported by continuous on-site learning through dedicated resources to ensure that they remain up to date with the latest care standards and practices.

Consistency in staffing is critical, and we recognise the importance of maintaining a stable team, especially when adjusting staffing levels. While we can make short-term adjustments, we ensure that any long-term changes are carefully considered to

guarantee flexibility across our nursing team. Since our last inspection in April 2024, we have placed a significant focus on recruitment, both nationally and internationally, to strengthen our team further.

If needed, we will consider use of agency staff. When previously used, we found that they did not align with our commitment to delivering the highest level of care to our residents, however we understand and will consider their value should the need arise. We will continue to prioritise permanent, well-trained staff at all times.

Cleaning of medication trolleys is the responsibility of all nurses post every medication round, this follows best practice infection control measures. However, we will ensure that nurses are aware that the daily deep clean and restock should not be given priority over resident care or staff supervision and that same can be done once all residents are settled. This will be monitored on an ongoing basis.

In line with our 3 monthly medication reviews between GP, pharmacists and nursing staff with continually assess nightly medications to ensure only necessary medications are prescribed/administered during this round.

At Glendonagh, we are committed to ensuring that all aspects of our care meet the highest standards, and we will continue to monitor, adjust, and improve our practices to ensure we consistently deliver quality care that supports the needs and rights of our residents.

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:

Glendonagh places significant emphasis on the continuous development and training of all staff, particularly within our Healthcare team, including Nurses and Healthcare Assistants (HCAs). We ensure that all new recruits are qualified to the highest standards in their respective fields, with many of our HCAs holding nursing qualifications from their home countries. All new staff undergo a comprehensive induction program, which lasts a minimum of three days or until they have demonstrated full competency in their role. During this induction, they remain supernumerary to the roster, ensuring that we are confident in their abilities before they are integrated fully into the team.

Mandatory training, as well as supplementary training, is provided to all staff. This includes external training courses and a robust in-house training program that runs weekly. The in-house training, overseen by our Clinical Nurse Manager (CNM), includes both group education sessions and one-to-one training to ensure that all staff receive personalised support and are equipped with the necessary skills to deliver care to the

highest standard. Additionally, staff are encouraged to engage in relevant courses available through HSELand to further enhance their professional development.

At the time of inspection 9 staff members with safe guarding and 8 staff with responsive behaviour training were due for renewal however as noted on the day to HIQA all training was booked. There will always be small training gaps due to factors such as the number of courses which staff need to complete, team sizes and new starts however Glendonagh has given the commitment to further use online training such as HSEland to ensure certificates are in place and bridge this gap whilst waiting for onsite to be completed.

A key part of our training approach is ensuring that Night Team members—both Nurses and HCAs—are fully trained before transitioning to night shifts. This involves a minimum number of months of training during the day to become familiar with our residents, the building, and the care standards we uphold. At the time of inspection, all mandatory training was up to date, and all staff receive specialised manual handling training from an external provider. This is followed by daily oversight to ensure that best practice techniques are consistently followed. Manual handling training and assessments are conducted regularly on-site, with a dedicated resource overseeing the training matrix to ensure that all obligations and best practices are met.

Regarding staff oversight, particularly during the night shifts, a structured handover takes place between the Day and Night Teams, followed by a Night Team huddle to discuss the specific needs of residents for the night ahead. After the medication round and when all residents are settled, a second huddle is held to address any arising issues or additional care needs. A final huddle occurs before the morning handover. Additionally, throughout the night, the nurse receives hourly updates from the HCAs after each resident check to ensure consistent oversight and as any other requirements arise. We will continue to monitor that this system of oversight and liaison between team members continues through feedback from our night nursing staff.

A supplementary nurse has been added to the night shift to further enhanced supervision and support during the busiest hours (7.30 – 10.30). This second nurse's role is to provide support, oversight and ensure the primary nurse on duty has protected time to complete their medication round effectively. The second nurse is in place until all residents are settled and the primary nurse has completed her key roles. Should additional time be required the twilight nurse is aware she is in place until required.

Glendonagh maintains a higher nurse-to-carer ratio during the night shift (2:2.5 (twilight) and 1:2 thereafter) compared to the day shift (1:3.5 morning and 1:3 afternoon), ensuring that there is sufficient supervision and protected time for medication rounds. Despite the higher ratio, we have added an additional team member to support protected medication rounds and provide extra assistance to carers during the busy bedtime period. We ensure that HCAs have clearly defined allocations of responsibilities, allowing the nurse to remain fully aware of care duties throughout the night.

To further enhance the environment for both staff and residents, all nurses are required to wear aprons during medication rounds to indicate their protected time, signalling that they should not be interrupted unless there is an urgent matter.

Glendonagh's commitment to safety is reflected in the use of 32 cameras strategically placed around the facility, with a main overview screen located at the nurses' station. Additionally, phones are available in all rooms and corridors, and nurse call systems are installed at each bedside, where residents are assessed as being able to use them, as well as in all communal spaces. A comprehensive fire alarm system is in place and undergoes quarterly audits by an external company, with weekly tests and daily in-house reviews to ensure operational efficiency. Fire drills are conducted on a weekly basis to ensure staff readiness and safety.

Glendonagh takes great pride in the strong relationships we build with every member of our team, fostering open and honest communication regarding workloads and resident care. As care needs evolve, so too do the challenges within different areas. We collaborate with our team and families to meet these needs and are always open to learning lessons to improve our services.

This commitment to high standards of training, staff development, and oversight is central to ensuring that Glendonagh continues to provide the highest quality of care, aligned with HIQA's expectations and regulatory requirements.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

Governance by definition corresponds to the processes and structures that provide autonomy, control and authority to staff regarding practices within an organisation. High standards of governance are maintained by a clear framework through sharp up to date audits, regular and thorough governance meetings and daily oversight none of which is in question.

After exceptionally challenging years we have stabilised our team and place a huge emphasis on staffing, both recruitment and training, to ensure we have adequate resource at all times. Throughout the many discussions with HIQA we have highlighted our commitment to always ensuring a high quality of care that most importantly is sustainable as a company. We have recruited 2 new nurses to support an additional dedicated twilight shift – 7.30- 10.30 which will further enhance supervision during the busiest part of the night shift as well as ensuring protected time for medications round. We will continue to monitor the effectiveness of this service to ensure it meets the needs of our residents and ensures adequate oversight of our night-time staff.

Also noted under governance is system and oversight of training which at the very core of our company values and as mentioned have a dedicated onsite support. Our training matrix has been reviewed with monthly management checks in place as well as training

updates at governance meetings. Online HSELand certifications will be requested for all new member of staff should there be a small gap between onsite training and their start dates.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:

We acknowledge the important obligations outlined by HIQA under Regulation 31 and endeavour to ensuring that all relevant notifications are submitted within the required timeframe. This includes both formal and informal information that may impact the care we provide.

We have reviewed our concerns/complaints management and put a clear and consistent reporting structure in place. Going forward, any complaints made by residents or families will be reported to the CNM 2 by the nurse on duty. We have implemented a Preliminary Investigation Tool which the CNM/Management will complete. Following this the Director of Nursing will make an informed decision on what is notifiable. This system is now in place and ensures continuity and consistency in our care and ensures all concerns made are addressed and notified where required.

Glendonagh has a diligent framework in place to ensure all quarterly notifications are submitted as well as a clear governance structure to support discussion in regards adhoc notifications. Furthermore, we have added additional support recently with the alliance of a private support body whom we feel comfortable in discussing any issues with to further understand their impacts and resolutions as well as ensuring we are kept abreast of evolving regulations.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:

Infection control is reviewed daily with continual audits and oversight in place. Elevated checks have been added to sluice rooms to ensure best practices with a member of staff accountable each day.

In addition, Glendonagh has a dedicated Link Nurse appointed whom will be overseeing

elevated consistent infection control measures.

Whilst there was no concern in regards the general cleanliness of the facility we have elevated the use of products for those rooms which require daily deep cleans as well as mattress and bedframe audits by housekeeping.

Glendonagh endeavors to keep abreast of evolving requirements for outbreaks such as COVID. With our recent addition of membership with a private support company, we will better be supported in achieving this goal.

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:

We acknowledge the feedback regarding the need for greater personalised information within individual assessments and care plans. We understand the importance of capturing comprehensive and detailed information and are committed to ensuring it is both captured and reviewed on a more comprehensive basis.
We always try to ensure our care plans have consistently followed a person-centered approach and have been designed to meet the specific needs, preferences, and aspirations of each individual in our care. The information included in the care plans is tailored to ensure that high-quality, individualized care is delivered. The areas identified as needing further personalisation are currently being reviewed and updated to ensure that any additional relevant information is fully integrated into the care planning process. It is important to note that while the person-centered focus was maintained, the feedback highlights areas for further enrichment, which we are committed to addressing immediately. We believe this is an opportunity to refine and enhance our processes, ensuring they align even more closely with HIQA's expectations.

To address the concern raised, we are implementing the following actions:
1. Enhanced Staff Training: We are conducting additional training for staff to ensure they fully understand the importance of gathering and documenting all relevant, personalised information. This will help to further enhance the quality and depth of the individual assessments.
2. Review and Update of Care Plan Templates: Our care plan templates are being revised to ensure they include all necessary sections to capture the full scope of personalised information needed for the delivery of high-quality care. In addition, some templates are being removed to ensure no inaccuracies such as the use of he/she incorrectly.
3. Ongoing Monitoring: In addition to our formal 3 monthly audits of Careplans we will implement weekly audits to further ensure that care plans are not only person-centered but also meet the full requirements of Regulation 5 in terms of personalisation and completeness. This will include additional checks to ensure that all relevant details are

captured and appropriately reflected in care plans.
We want to assure HIQA that we remain fully committed to providing care that is both person-centered and responsive to the individual needs of those in our care. We take full responsibility for addressing this matter and are confident that the corrective actions outlined above will further enhance our ability to meet regulatory requirements.
We remain dedicated to continuous improvement and will continue to take all necessary steps to ensure that the highest standards of care planning are maintained.

Regulation 7: Managing behaviour that is challenging	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:

We acknowledge the concern raised regarding the high number of bed rails in use in Glendonagh. We understand the importance of ensuring that restrictive practices are minimised and that care is delivered in a manner that prioritises the dignity, safety, and well-being of our residents.
We have established a robust process for the use of bed rails, ensuring that they are applied only when clinically indicated and with the utmost consideration for the individual's needs. The use of bed rails is regularly audited as part of our ongoing efforts to ensure they are used appropriately and in accordance with best practice guidelines.

Furthermore, residents who are using bed rails are trialed regularly to assess whether their needs can be met without the use of such restrictive measures, all details are available in bedrail folder. This trial process is essential for ensuring that bed rails are not used unnecessarily and that residents are provided with the least restrictive care options available.
To further align our practices with the principles of least restrictive care, we are taking steps to educate both staff and families about the nature of bed rails as a restrictive practice. We will work closely with families to ensure they understand the importance of not relying on bed rails and the necessity of ongoing assessments to determine whether they are required for the safety and well-being of the resident. Furthermore, we have documented this within our newly updated welcome pack for all new residents and their families.
In addition, we will be re-educating our staff on the importance of adhering to individual risk assessments and ensuring that residents who are assessed as not needing bed rails are not subjected to them. This will be reinforced through ongoing training and supervision, emphasising the need to constantly review care practices to ensure they are in line with the least restrictive approach.
We place a significant emphasis on minimising the use of restrictive practices in Glendonagh. In line with this, we conduct monthly falls assessments and bed rail reviews to ensure that all residents are being appropriately supported. These assessments

involve a detailed review of individual care needs, including whether the continued use of bed rails is necessary and appropriate. Our commitment to reducing restrictive practices is reflected in the comprehensive monitoring system we have in place, which includes regular reviews by the multidisciplinary team to ensure residents' needs are being met in the least restrictive manner.
We are confident that our ongoing efforts to audit and review the use of bed rails, along with the education of staff and families, will continue to ensure compliance with Regulation 7. The safety and dignity of our residents remain a priority, and we will continue to make adjustments to our practices as needed to ensure that restrictive practices are used only when absolutely necessary and in the most minimally restrictive manner possible.
We are dedicated to continuous improvement and the highest standards of care delivery. We are committed to reducing the reliance on restrictive practices and ensuring that all care provided is person-centered and in line with regulatory requirements

Regulation 9: Residents' rights	Not Compliant

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

We believe that the most significant issue raised in the report concerning call bells has not been accurately reflected and would like to provide the following clarifications and context:

1. Call Bells:
Resident safety and dignity are our top priorities. Since this inspection, we have upgraded our call bell audits, they are strictly 3 monthly now going forward. In addition, we are auditing whether residents have the cognitive function to use the call bell, whether there is a safety risk involved, considering factors such as the risk of trips or strangulation. In cases where the risks outweigh the benefits, call bells are removed, and this is documented in individual care plans. We are also checking that the call bells are fully functioning. A separate risk assessment form can be found in our call bell audit file documenting the reason why a call bell might not be in place for specific residents. Call bells are also risk-assessed for each resident upon admission. We note that no clarification was sought during the inspection regarding this practice.

Following the inspection, we conducted a comprehensive audit of our call bell practices and functionality. We can confirm that all call bells are in working order, and no equipment broken. We have a robust policy for the review and replacement of equipment, supported by a full-time qualified maintenance personnel who ensures all systems are operational. In addition, we have a long standing service agreement in place with a national provider whom service all call bell equipment quarterly.

Following the audit and advice from the feedback meeting, we are now beginning to audit call bell response times. We will conduct 3 audits every 3 months and put

education measures in place if delayed answering times are observed.

Since our inspection we have implemented a daily review of call bells, as well as weekly reminder to all staff of the importance of the positioning of call bells particularly at night.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	10/01/2025
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	14/02/2025
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	10/01/2025
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the	Not Compliant	Orange	16/12/2024

	effective delivery of care in accordance with the statement of purpose.			
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	10/01/2025
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	09/12/2024
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.	Not Compliant	Orange	14/02/2025
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4	Not Compliant	Orange	11/02/2025

	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.			
Regulation 7(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.	Not Compliant	Orange	14/02/2025
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.	Not Compliant	Orange	06/12/2024
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	23/01/2025
Regulation 9(3)(e)	A registered provider shall, in	Not Compliant	Orange	23/01/2025

	so far as is reasonably practical, ensure that a resident may exercise their civil, political and religious rights.			