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:	Our Lady of Lourdes Care Facility
Name of provider:	Melbourne Health Care Limited
Address of centre:	Kilcummin Village, Killarney, Kerry
Type of inspection:	Unannounced
Date of inspection:	27 July 2022
Centre ID:	OSV-0000265
Fieldwork ID:	MON-0036481

About the designated centre

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

Our Lady of Lourdes Care Facility is a designated centre located within the rural setting of the village of Kilcummin and a short distance from the town of Killarney, Co. Kerry. It is registered to accommodate a maximum of 68 residents. It is a two-storey facility with lift and stairs to enable access to the upstairs accommodation. It is set out in three wings: Dun Beag is a dementia-focused unit accommodating 18 residents; Tus Nua on the first floor 28 residents; and Deenagh on the ground floor with 22 residents. Communal areas downstairs in Deenagh comprise a large comfortable sitting area, dining room area, prayer room and hairdressers' room. Residents have direct access to a secure, paved, outside area with seating. Upstairs in Tus Nua there is a large lounge with access to the enclosed outdoor balcony seating area, dining room, main kitchen, coffee dock and seating by the nurses' station. In Dun beg, there is a kitchenette, small dining room and small sitting room with open access to the main lounge in Tus Nua. Our Lady of Lourdes Care Facility provides 24-hour nursing care to both male and female residents whose dependency range from low to maximum care needs. Long-term care, dementia care, convalescence, respite and palliative care is provided.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	60

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 27 July 2022	09:20hrs to 17:00hrs	Breeda Desmond	Lead

What residents told us and what inspectors observed

Overall, the inspector found that the person in charge and staff were working to improve the quality of life and promote the rights and choices of residents in the centre. The inspector met with many residents during the inspection and spoke with five residents in more detail. The inspector met one relative during the inspection and she spoke very highly of the care and attention their relative received along with the valuable information-sharing about their relatives condition, progress and medical needs, and were very grateful to be able to ask anything. She spoke of the kindness shown to her as well as her relative and she said she was very grateful for this. Residents spoken with gave positive feedback and were complimentary about the staff and the care provided in the centre.

There were 60 residents residing in Our Lady of Lourdes Facility at the time of inspection. On arrival for this unannounced inspection, the inspector was guided through the centre's infection prevention and control (IPC) procedures by a member of staff, which included a signing in process, disclosure of medical wellness or otherwise, hand hygiene, face covering, and temperature check. An opening meeting was held with the person in charge and Clinical Nurse Manager (CNM) which was followed by a walk-about the centre.

This was a two-storey building, with resident accommodation on both floors and set out in three units: Deenagh (22 beds) on the ground floor, Tus Nua (28 beds) and Dun Beg (18) upstairs. Dun Beg was specifically designated to care for residents with a diagnosis of dementia. While some bedrooms were twin rooms they remained single occupancy as part of their COVID-19 precautions.

There was a large welcome sign at reception welcoming visitors to the centre. The main entrance was wheelchair accessible and led to the main reception and main day space downstairs. The oratory, hairdressers' room and bedrooms were located to the right of main reception; nursing and administration offices, dining area for Deenagh, and residents bedroom accommodation were located to the left of main reception. Additional toilet and bath facilities were available here. The laundry and storage facilities were accessible via a secure corridor on the ground floor.

Upstairs was accessed via a lift and stairs, and these opened into the expansive day room on Tua Nua. The day room had glass frontage which opened into a large secure patio area with garden furniture with tables, chairs and raised flower boxes and potted plants. The day room itself had ample room for specialist chairs, expansive table which was seen to be used for activities and some resident chose to have their meals and snacks there. The coffee doc was a lovely quiet room found off the day room, where residents and visitors could meet in private. On the day of inspection, a birthday party was held in this room with a resident and her family. Staff had decorated the room with birthday banners and balloons. A beautiful birthday cake and plated sandwiches were served as part of the celebrations. There

were water dispensers available on both floors.

Dunbeg was partially secure in that the main entrance to it was keypad access, nonetheless, there was an archway access between the day room in Tus Nua and Dunbeg for residents to move around independently. While there were shower and toilet facilities in both units, some wall and floor tile coverings were miss-matched and not in keeping with a home-like environment.

Call bells were fitted in bedrooms, bathrooms and communal rooms. Most bedrooms were of adequate size and layout and could accommodate a bedside locker and armchair. Flat-screen televisions were wall-mounted in bedrooms. Low low beds, mattresses, specialised pressure relieving mattress, and specialist wheelchairs were seen to be used by residents. Residents had good wardrobe space for storage and hanging clothes, however, due to the layout of some twin occupancy bedrooms, both residents did not have free access to their wardrobe space, for example room 109, 110 and 114. Twin bedroom 114 did not allow unobstructed access by both residents to the en suite facilities. Twin bedrooms did not have storage units in en suites for residents to store their toiletries separately. Bedroom 167 had been reduced from twin occupancy to single occupancy, however, the space had not been re-allocated as the bed remained in the corner of the room. Many bedrooms were decorated in a homely manner and were very personalised, however, some bedrooms were devoid of personalisation and bedside lockers were seen to be located away from the resident's bedside and not accessible.

During the walkabout, the inspector observed that staff knocked on residents' bedroom doors before entering, then greeted the resident by name in a respectful manner, and asked residents how they were. Lovely conversation and interaction was heard throughout the day between staff and residents.

Mealtimes were observed. Medications were administered either before or after meals to ensure meals were protected. Staff providing assistance to residents in dining rooms and bedrooms actively engaged with people chatting as they were assisting with mealtime. Breakfast was seen to be served throughout the morning with residents having their breakfast in the dining rooms up until 11:00hrs. There were two sitting for the main meal, and the first sitting was 12 mid-day and was provided to residents who required full assistance. The dining room upstairs was a lovely bright room with a long display table with flowers and potted plants displayed. The inspector spoke with residents downstairs while they were waiting for their meal to be served. Tables had been set for residents with their drink of choice and their desert of ice-cream, jelly or trifle. Dinner was later served and while it was well presented and appetising, deserts were on the table for a protracted period of time.

Photographs were displayed of resident enjoying parties, birthdays and celebrations. There were two resident cats, Twinkle and Ginger and some residents had feeding bowls and bedding for them in their bedroom for the pets. Misty was the name of the donkey in the paddock alongside the centre which residents could access from the side of the building. There was an outdoor garden area where one resident had developed a vegetable garden which had an array of vegetables such as lettuce, onions, kale, potatoes and carrots. The resident was also involved in the local

community and flower displays decorating the village. Aside from this, the outdoor space downstairs was not developed. While there was an expansive veranda upstairs where several bedrooms had patio-door access, this was not developed to facilitate residents using it. In addition, the balcony wall was not of sufficient height to be assured that it was safe, unlike the secure patio area off the lounge in Tua Nua which had additional clear re-enforced perspex on top of the wall ensuring the area was safe.

Two activities staff provided activation for residents, one on each floor on the day of inspection. Residents were seen to enjoy arts, bingo and a sing-song where they were given sheets with printed words of songs and sang along with the activities person.

Orientation signage was displayed around units to ally confusion and disorientation. Information displayed at reception included the statement of purpose, residents' guide, health and safety statement, inspection reports, complaints policy, advocacy services and the local GAA weekly lottery numbers and winners. The day's menu choice was displayed as well as the activities programme. Murals and words of inspiration were painted on walls throughout the building to brighten and uplift passers-by.

Visiting had resumed in line with the HSE 'COVID-19 Normalising Visiting in Long-term Residential Care Facilities' of July 2022. Visitors were known to staff who welcomed them and actively engaged with them.

Hand-wash hubs were available on both floors. Wall-mounted hand sanitisers were available throughout the centre and staff were observed to comply with best practice hand hygiene. New dani centres were available throughout the centre which stored personal protective equipment (PPE). Laundry was seen to be segregated at source.

Emergency evacuation plans were displayed in the centre with accessible information. Additional evacuation notices were displayed opposite three bedrooms reminding staff of the evacuation route for those particular beds. Appropriate signage was displayed on rooms where oxygen was stored.

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

Capacity and capability

This was a good service with a clear governance structure with good oversight and monitoring of the service that promoted a rights-based approach to care delivery.

Our Lady of Lourdes Facility was a residential care setting operated by Melbourne

Health Care Limited. It was registered to accommodate 68 residents. The governance structure of Our Lady of Lourdes comprised the board of directors with one of the board members nominated as the person representing the registered provider. The person in charge reported to the nominated person. The person in charge was supported on site by the clinical nurse manager 2 (CNM2), CNM1s (Deenagh and Dun Beg), administration, clinical, and maintenance staff. The CNM2 deputised for the person in charge when absent from the centre.

There was generally evidence of good governance and oversight of the centre with monthly clinical governance meetings, where issues such as human resources, complaints, incidents, audits, and key performance indicators were discussed and monitored. Improvements identified had associated action plans with responsibilities assigned and the progress status relating to the actions. However further managerial oversight was required of residents rights and food and nutrition as identified under the relevant regulations.

The audit schedule for 2022 was evidenced with clinical, observational and work practices audited. Daily observational audits were introduced since the last inspection and these included areas such as communication with residents and communication between staff, infection control precautions, data protection and access to computer records, cleaning practices and medication rounds for example. Feedback was given to staff during the daily audit and learning was fed back to the CNM on each unit as part of their overall learning and quality improvement. The provider nominee and maintenance person had completed an audit of the premises which highlighted areas to be upgraded; this report was with the management for costing and procurement.

The incidents register was part of their quality and safety management. This was an excellent document which detailed information on the incident, care planning status, whether an action or intervention was required, and controls put in place to mitigate recurrences of such incidents, such as referrals to the physiotherapist. Clinical observations were completed at the time of the incident in line with a high standard of nursing care providing assurances that all due care and attention was provided at the time of the accident or incident.

Up-to-date service records and periodic reports were seen for water supply, environmental health and microbiological food surveillance and were seen to be complaint. The statement of purpose was updated at the time of inspection to include additional services available to residents.

There was adequate staff to the size and layout of the centre. The person in charge explained that many of the staff were recently recruited and the culture and ethos of the centre would take time to embed. Duty rosters viewed showed staff allocation per unit and this included care and household staff. The training matrix was examined and showed that mandatory training was up to date for all staff.

In conclusion, this was a good service where a rights-based approach to care delivery was promoted. The person in charge was aware of the issues identified and had put initiatives in place to address these to enable quality improvement and

quality of life of residents.

Regulation 14: Persons in charge

The person in charge was a registered nurse, working full time in post and had the necessary experience and qualifications as required in the regulations. She actively engaged in the governance and operational management of the service.

Judgment: Compliant

Regulation 15: Staffing

The staff roster showed that the number and skill mix of care staff was appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the centre.

Judgment: Compliant

Regulation 16: Training and staff development

Mandatory training was up to date for all staff. The training schedule was seen and this showed ongoing staff training booked to ensure training remained current.

There was a full-time maintenance person on site. He had completed fire safety training course and following from this, he undertook regular fire safety training, fire drills and evacuations with staff.

Judgment: Compliant

Regulation 23: Governance and management

While there was a clear governance structure with clear lines of accountability and responsibility for the service, better monitoring systems were necessary to ensure the service was appropriate, as described in further detail under Regulation 18, Food and Nutrition, and Regulation 9, Residents' Rights.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The statement of purpose was updated on inspection to reflect the current layout and floor plans of the centre, and information on the Kerry 'Integrated Care Pathway for Older People' (Kerry ICPOP) service available to residents.

Judgment: Compliant

Regulation 31: Notification of incidents

Notifications submitted to the Chief Inspector correlated with the incident and accident log examined. They were timely submitted in line with regulatory requirements.

Judgment: Compliant

Regulation 34: Complaints procedure

The complaints procedure was implemented in practice and complaints were maintained in line with regulatory requirements. The person in charge maintained robust oversight of complaints and followed up with complainants to ensure they were happy with the outcome. Comprehensive investigations were seen to be assured that due process was followed.

Judgment: Compliant

Regulation 4: Written policies and procedures

Schedule 5 policies and procedures were available on each unit and were up to date.

Judgment: Compliant

Quality and safety

The inspector observed that, in general, care and support given to residents was respectful; staff were kind and facilitated care in a friendly manner.

Visiting was in line with current HPSC guidance of July 2022 and visitors were seen throughout the day in various locations such as bedrooms and day rooms. Appropriate IPC precautions were adhered with coming and going from the centre.

Residents had regular access to on-site GP consultation. Residents medications were reviewed as part of consultation with their GP and ongoing monitoring; the CNM2 outlined that there was ongoing monitoring of and responses to medication to ensure best outcomes for residents. Residents had access to specialist services such as psychiatry of old age, palliative care, speech and language, physiotherapy, occupational therapy, dietitian and optician. The 'Kerry Integrated Care Pathway for Older People (Kerry ICPOP) team included speech and language therapy (and associated dysphagia training for staff) and access to consultant geriatrician. This scheme mitigated the need for some residents to attend the accident and emergency services as consultation enabled better outcomes for residents. The physiotherapist was on site every Monday and Thursday afternoons providing assessment and healthy living exercise programmes.

Pre-admission assessments were undertaken by the person in charge to ensure that the service could provide appropriate care to the person being admitted. Care plan documentation reviewed showed mixed findings. Care plans were person-centred with resident-specific information to guide and inform individualised care, however, assessment to inform the care planning process were not completed in some cases or did not have sufficient detail.

Copies of transfer records for times when residents were temporarily absent from the centre were not maintained on site. Following discharge back to the centre, comprehensive information was available when the resident returned to the centre. Good clinical oversight with monthly records of restraint including chemical restraint was maintained and this information fed into their clinical governance meetings.

The inspector accompanied a nurse during a medication round and best practice medication management was demonstrated by the nurse administering medications. In the sample of medication documentation examined, medication administration records were comprehensively maintained. While transcribing of medication was an exceptional practice, the medication charts included space for two staff to co-sign transcribed medication in line with best practice. Controlled drug register was examined in the morning and it was seen that the drug check was input for the evening change-over which was not in keeping with safe practice.

Residents' meetings were held every three months. The person in charge facilitated these and there were lots of discussion and information sharing including the provision of current COVID-19 guidance.

Laundry was segregated at source. Sluice rooms were secure access to prevent unauthorised access to hazardous waste and clinical products, however, many

inappropriate items were seen partially obstructing hand-wash sinks.

Good oversight of fire safety precautions was demonstrated. This included drills and simulated evacuations along with ongoing staff training. The maintencance person had completed further training regarding fire safety and provided training as part of inducting all new staff. He also facilitated fire drills on a monthly basis and full compartment evacuations on a quarterly basis.

Regulation 11: Visits

Visiting was facilitated in line with July 2022 HPSC guidance. Measures were taken to protect residents and staff regarding visitors to the centre with hand sanitising gels and advisory signage available throughout the centre. Updates relating to visiting in the centre were provided as the guidance changed or in line with the local COVID-19 numbers. Residents spoken with were familiar with the current visiting regimes and understood the rationale for mask-wearing. They said that staff kept them fully informed of the pandemic precautions.

Judgment: Compliant

Regulation 12: Personal possessions

Storage for personal possessions included a double wardrobe and bedside locker for each resident. A lockable unit formed part of the storage available to residents. However, in some twin rooms, residents did not have easy access to their wardrobe due to the layout of the bedroom as the wardrobe was located within the bed space of one resident which did not protect the privacy and dignity of either resident. This was a repeat finding.

Judgment: Substantially compliant

Regulation 13: End of life

Assessments relating to spirituality were based on the 'HOPE' approach, however, some staff appeared not to understand the assessment as many questions were answered with 'not applicable', such as 'what are your sources of hope and comfort', or 'what helps you during difficult times'? Consequently, individualised care could not be provided to residents that addressed their social, psychological and spiritual needs.

Judgment: Substantially compliant

Regulation 17: Premises

Some shower rooms required upgrading to ensure they were suitably decorated and in line with the ethos of their statement of purpose.

While there was outdoor space available to residents including the outdoor patio off Tus Nua, the veranda upstairs and the garden were not adequately maintained to enable residents to access them independently or safely. These were repeat findings.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

A review of meal-times was required as:

- breakfast were served from 07:00hrs to residents requiring full assistance; this was too early for breakfast for residents unable to make the decision regarding their breakfast time, and facilitated the staff roster
- while meals were well presented, residents were served their desert before their main course, and as it was a very hot day, deserts of ice-cream, jelly and trifle would not be maintained at their optimum.

Judgment: Substantially compliant

Regulation 25: Temporary absence or discharge of residents

While the national transfer template was used when residents were being transferred out of the centre, copies of the transfer letters were not maintained on-site. Therefore it was not possible to be assured that comprehensive information was sent to enable residents to be cared for in line with their assessed needs.

Judgment: Substantially compliant

Regulation 26: Risk management

A current risk management policy and safety statement were available. The risk management policy had the specified risks as detailed in Regulation 26.

Judgment: Compliant

Regulation 27: Infection control

Management of the environment required action to minimise the risk of transmitting a healthcare-associated infection. This was evidenced by:

- clinical hand hygiene sinks were not kept clear of items such as clinical equipment
- not all clinical hand wash sinks were complaint as some had metal outlets and taps did not have hands-free mechanism
- one shower bathroom had a broken laundry bin stored in it; a clinical waste bag with items in it and a urinal was found underneath it. This area had not been cleaned as the floor was unclean when these items were removed,
- the large domestic waste bin in the shower room was partially obstructing the hand-wash sink making it difficult for people to access it to use
- one bedroom had several boxes of equipment stored on the ground; another bedroom had several packages of incontinence wear stored on the ground which impeded cleaning of the floor.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Fire training, drills and evacuation of compartments occurred on a routine basis to ensure staff were familiar with fire safety and could undertake an evacuation in a timely manner. Servicing of fire safety equipment was available and up-to-date. Daily fire safety checks were comprehensively maintained.

Emergency floor plans and evacuation routes comprehensively displayed the escape routes available. In addition, there was additional signage for three bedrooms indicating the escape route for that particular bed. Personal emergency evacuation plans were available and the folder was set out per zone per unit with the evacuation type and assistance needed per individual resident along with their photograph for easy identification.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Care plan documentation reviewed showed mixed findings. While care plans were person-centred with resident-specific information to guide and inform individualised care, the corresponding assessments were not sufficiently robust and did not have the equivalent details, so it was unclear where the information was obtained.

Judgment: Substantially compliant

Regulation 6: Health care

Better oversight of medication management practices were required to be compliant with a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais, this was evidenced by:

- the controlled drug register was examined in the morning and it was seen that the drug check was input by the morning staff for the evening change-over, which was not in keeping with guidelines issued by An Bord Altranais agus Cnáimhseachais. Should there be a discrepancy in the controlled drug count it would be difficult to establish when a drug went missing or who was accountable,
- while the temperature of the medication fridge was recorded on a daily basis, a corresponding check was not completed of the inside of the fridge. When the inspector examined the medication fridge, there was a pool of water seen which was encroaching the boxes stored on the bottom of the fridge, so it could not assured that medications were not contaminated,
- some medications in the medication fridge were not dated at the time of opening so it could not be assured that open medications were being used within their optimum time.

Judgment: Substantially compliant

Regulation 9: Residents' rights

In the dementia-focused unit, one resident's bedroom had several boxes of equipment stored on the ground; another bedroom had several packages of incontinence wear stored on the ground which was not in keeping with a rights-based approach to care and respecting people’s privacy and dignity.

While most bedrooms were personalised and set out to maximise residents' independence and comfort, the layout of other bedrooms did not facilitate this as bedside lockers were in the opposite corner of the room away from the resident and

some residents wardrobes were within other residents bed spaces.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Substantially compliant
Regulation 13: End of life	Substantially compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 25: Temporary absence or discharge of residents	Substantially compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Substantially compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Our Lady of Lourdes Care Facility OSV-0000265

Inspection ID: MON-0036481

Date of inspection: 27/07/2022

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 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
To comply with regulation 23 and in conjunction with regulation 18, regulation 9, & regulation 12, Our Lady of Lourdes has set out the following action plan.

Supervision:
As part of the daily routine, management already do spot checks around the Facility. These are recorded and action planned when a deficit is apparent. Different areas of work, practices & regulatory requirements are checked.
To further improve on supervision by management, it has been decided that:
• The CNMs will have a dedicated administration day re-introduced on a weekly basis.
• This will give CNMs time to audit their work practices within their own units
• This, in turn, will free up DON & CNM2 to increase their supervision of various activities throughout the Facility.
• DON &/or CNM2 already do daily spot checks on different areas of the Facility, however, these will be conducted in an orderly fashion going forward. Each day will have a dedicated area to be spot checked.

Mealtime experience:
• Staff have been informed of the issues with the dining experience and the action plan required to improve this situation.
• Our Lady of Lourdes has arranged specific training on Food Service for Nurses & Health Care Assistants of each unit. While these staff have completed their HACCP training, it was decided that training on the proper serving of meals to residents was required to enhance the mealtime experience for residents and to maintain their dignity, and uphold their rights. This training will take place on 20 September 2022 & facilitated by The Food Safety Company.
• Already commenced, Nurses on duty are supervising mealtimes
• DON /CNM2 will spot check mealtimes
• Nutrition & Hydration, and Dignity policies have been reviewed by DON & CNM2 and

information updated encompassing the above Regulations
• These updated policies have been emailed to each staff member.
• Once service training is completed, a Resident survey will follow as a means of feedback on the expected improvement in the Dining Experience.

Early serving of breakfasts:
• Staff input was sought on this issue and an action plan was developed.
• It has been agreed there will be times when residents should have their breakfasts served before 8am, namely
o An early hospital appointment or similar event, which requires the resident to dine earlier than usual
o The resident has always had their breakfasts early. This will be recorded in their care plan and reviewed not less than 4 monthly
o When a resident awakens early, they will be served their breakfasts appropriately
o Any other time that a resident may require their meal early. This will be documented in the resident’s daily progress notes.
o When a resident is served their breakfasts early, at their requests, the option to have lunch and evening tea earlier will be an option for the resident.
• The Nurse on duty in each unit will be responsible for ensuring meals are served at an appropriate time, according to resident wishes.
• DON/CNM2 will audit the mealtime experience in all units
• The practice of serving breakfasts from 0700 hrs has now changed to 0800 hrs.
• The Nutrition & Hydration Policy & the Dignity Policy have been reviewed and updated. Staff are aware of the updates and action plan.

Too many continence packs stored in wardrobe, leading to other medical equipment being stored on the floor of 1 bedroom:
• Effective immediately, only 1 weeks supply (2-3 packs) of continence wear to be stored in the resident’s wardrobe. This allows for other medical equipment to be stored safely within the same wardrobe if needed.
• This has been agreed for all units
• Maintenance staff have arranged for a weekly supply of continence wear to be sent around all units, and are willing to supply more during the week, if needed.
• The Lead Carer of each unit will be responsible for ordering the continence wear, and for checking that there isn’t an over-supply of packs in the resident’s wardrobe.
• The Nurse on duty will be responsible for storage of any medical kits etc within the unit.
• The Infection Prevention & Control Policy has been reviewed and updated
• DON/CNM2 will spot check each unit for correct storage of equipment.

Bedroom layouts:
Noted that some bedrooms, especially those which had been converted from twin to single rooms, required a better layout, to give a homely feeling.
• Meeting held with Housekeeping & Maintenance staff re: room layouts.
• Housekeeping, Maintenance Manager and DON/CNM2 have inspected each room & layouts of rooms changed to suit resident needs.
• Rooms to be spot checked by Housekeeping staff for appropriate layout. Housekeeping will report to DON/CNM2

Wardrobe access in twin bedrooms • Purchasing of new wardrobes has commenced • The new wardrobe in each of the twin bedrooms will allow the occupants to access the wardrobes without impinging on the other resident's private space. • The policy on Privacy, Dignity, Independence & Choice has been reviewed by DON/CNM2 & updated with relevant information. • The updates have been disseminated to staff.	
Regulation 12: Personal possessions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 12: Personal possessions: Our Lady of Lourdes acknowledges that the original layout of wardrobes in twin rooms, no longer suffices at this time. The privacy & dignity of each resident is paramount and the Board of Directors have issued funding to purchase a new wardrobe for each of these rooms, thereby, abiding by regulation 12, regulation 17 & regulation 9. Wardrobe access in twin bedrooms • Purchasing of new wardrobes has commenced since 15.08.22 • The new wardrobe in each of the twin bedrooms will allow the occupants to access the wardrobes without impinging on the other resident's private space. • The policy on Privacy, Dignity, Independence & Choice has been reviewed by DON/CNM2 & updated with relevant information. • The updates have been disseminated to staff.	
Regulation 13: End of life	Substantially Compliant
Outline how you are going to come into compliance with Regulation 13: End of life: Our Lady of Lourdes has always been proud of its reputation in dealing with palliative care residents and their families. This excellent reputation continues as expressed by the Palliative Care Team. • To ascertain the root cause of why this assessment had not been completed correctly, a meeting was held with the Nurses. Those whose 1st language was not English found this particular assessment difficult to interpret. Tuition given and assessment completed throughout the house. • Care plans updated accordingly.	

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Our Lady of Lourdes takes these issues seriously and has actioned the following:
• Shower rooms revamp has already commenced & expected to complete by December 31 2022

• Veranda in Tus Nua: While the handrail (glass wall) is at required level as per Building regulations 2014, a risk assessment has determined that it would be safer if the handrail was higher to protect vulnerable adults and children.
• Each resident has a key to access the veranda from their bedrooms, however, they rarely avail of access to the veranda.
• As assessed by the Architect, raising the existing handrail will be very costly and time consuming, & Our Lady of Lourdes has not budgeted for this in the financial year of 2022.
• The Registered Provider has spoken with the residents of Tus Nua and discussed the safety issues & potential changes to the veranda which may lead to safer & increased use of the area. The Nominated Representatives of those unable to participate in this discussion have been emailed for their input and suggestion.
• Following this discussion, the residents are happy to continue with the current supervised access to the veranda. While one resident stated he did not want to see any changes, the remainder expressed that they are looking forward to having free access to the veranda when it is completed.
• Residents were assured that independent access to the large balcony area in Tus Nua Unit will continue & will not be impacted during upgrading of the veranda
• Residents are aware this may take 18-24 months to complete.
• Gardens in Tus Nua unit and Deenagh have been reviewed by a gardener/landscaper and both these areas will be completed by the end of 2022

Policies on Health & Safety, Restrictive practice, Privacy, Dignity, Independence & Choice have been reviewed and updated accordingly.

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
With regards to Regulation 18, and in conjunction with regulations 23 & 9, Our Lady of Lourdes has reviewed their practices and have actioned new plans.

Mealtime experience:
• Staff have been informed of the issues with the dining experience and the action plan

required to improve this situation.
• Our Lady of Lourdes has arranged specific training on Food service for Nurses & Health Care Assistants of each unit. While these staff have completed their HACCP training, it was decided that training on the proper serving of meals to residents was required to enhance the mealtime experience for residents and to maintain their dignity, and uphold their rights. This training will take place on 20 September 2022 & facilitated by CO'S of The Food Safety Company.
• Already commenced, Nurses on duty are supervising mealtimes
• DON /CNM2 will spot check mealtimes
• Nutrition & Hydration, and Dignity policies have been reviewed by DON & CNM2 and information updated encompassing the above Regulations
• These updated policies have been emailed to each staff member.
• Once service training is completed, a Resident survey will follow as a means of feedback on the expected improvement in the Dining Experience.

Early serving of breakfasts:
• Staff input was sought on this issue and an action plan was developed.
• It has been agreed there will be times when residents should have their breakfasts served before 8am, namely
o An early hospital appointment or similar event, which requires the resident to dine earlier than usual
o The resident has always had their breakfasts early. This will be recorded in their care plan and reviewed not less than 4 monthly
o When a resident awakens early, they will be served their breakfasts appropriately
o Any other time that a resident may require their meal early. This will be documented in the resident's daily progress notes.
o When a resident is served their breakfasts early, at their requests, the option to have lunch and evening tea earlier will be an option for the resident.
• The Nurse on duty in each unit will be responsible for ensuring meals are served at an appropriate time, according to resident wishes.
• DON/CNM2 will audit the mealtime experience in all units
• The practice of serving breakfasts from 0700 hrs has now changed to 0800 hrs.
• The Nutrition & Hydration Policy & the Dignity Policy have been reviewed and updated. Staff are aware of the updates and action plan.

Regulation 25: Temporary absence or discharge of residents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 25: Temporary absence or discharge of residents:
To comply with regulation 25 & Schedule 3(6), OLOL has set the following action plan.

• DON has contacted EpicCare to help with this situation. Prior to the introduction of the National Transfer document, EpicCare had its own transfer document which was stored

electronically. However, the new National transfer document does not save onto EpicCare, therefore, staff had to print the document and send it with the resident, in paper format. Copies of the paper format had not been made, therefore, OLOL was unable to prove the level of information sent with a resident during transfer.

• DON has also contacted EpicCare to see if this document can be saved electronically for future transfers.

• All Nurses are now aware that if a transfer document cannot be stored electronically, then the paper format of the same document must be copied and stored in the resident's personal file.

• DON / CNM2 have reviewed the Transfer, Discharge & Overnight Leave of a Resident policy & updated it. This has been informed to the staff.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
Our Lady of Lourdes acknowledges the deficits found in the inspection. To comply with regulation 27 an action plan was developed.

• Meetings were held with Nurses, HCAs and Housekeeping staff. Staff were informed of the deficits and the actions required to comply with regulation 27.
• The Board of Management was notified of the need to change any sinks which did not comply with regulation 27 and a plan to change these sinks has commenced.
• The Board of Management has sourced a new laundry bin and the broken one has been disposed.
• Maintenance staff have been reminded to store their equipment in the appropriate place and to check that equipment is not left behind when maintenance work has been completed
• Housekeeping have been instructed to clean all areas, including areas that may be under equipment
• The large domestic waste bin has been relocated so as not to partially block access to the sink
• Boxes / equipment packages are no longer stored on the ground.
o Effective immediately, only 1 weeks supply (2-3 packs) of continence wear to be stored in the resident's wardrobe. This allows for other medical equipment to be stored safely within the same wardrobe if needed.
o This has been agreed for all units
o Maintenance staff have arranged for a weekly supply of continence wear to be sent around all units, and are willing to supply more during the week, if needed.
o The Lead Carer of each unit will be responsible for ordering the continence wear, and

for checking that there isn't an over-supply of packs in the resident's wardrobe.
o The Nurse on duty will be responsible for storage of any medical kits etc within the unit.
o The Infection Prevention & Control Policy has been reviewed and updated
o DON/CNM2 will spot check each unit for correct storage of equipment

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:
To comply with regulation 5, a plan has been actioned.

During inspection, it was found that a resident had been transferred to hospital. The Care Plans for this resident had been reviewed and updated, over the course of the acute illness, and were resident specific and person – centred. However, the Clinical Risk Assessments, while they were in date, did not reflect a review and update during the period of acute illness, prior to transfer to hospital.

· Met with Nurses and reminded them that the Clinical Risk Assessments guided the Care Plan, and going forward, during any change in the resident's being, should trigger a review, update & evaluation of Clinical Risk Assessments as well as Care Plans.
· A re-introduction of an administration day for CNMs has been discussed with and sanctioned by the Board of Management.
· CNMs will be responsible for monitoring these assessments & care plans going forward
· DON / CNM 2 will spot check this area

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
To comply with regulation 6, Our Lady of Lourdes has developed an action plan.

While the count in the MDA book was correct, Nurses may only sign the MDA check log, to reflect a correct count, at the beginning/end of each shift.

· This occurred in 1 of 3 units, and is not the usual practice at Our Lady of Lourdes.
· All Nurses in each unit were reminded of the correct procedure for recording a count check of MDA drugs
· All Nurses have completed their Medicines Management Training

· The Medication policy was reviewed and update not required.
· CNMs to monitor compliance with this regulation
· DON/CNM2 will complete spot checks

A pool of water was found on medication fridge base
· Fridge temperatures are checked on a daily basis in all units
· The long-standing practice at Our Lady of Lourdes is that all medication fridges are cleaned /cleared /inspected every Tuesday and Friday by night duty staff.
· All Nurses have been reminded that this practice is to continue in all units
· It will be the responsibility of the CNMs to monitor this practice
· DON / CNM 2 will spot check also.

Opened medications not labelled while being stored in the medication fridge.
· All Nurses were reminded that any ointments, creams, liquids, gels, eye drops must all be labelled with an open date, as many of these products expired within a short period of time, once opened.
· A spot check of the fridges and medicine trolleys on the other 2 units showed labelling was in place.
· It will be the responsibility of the CNMs to monitor this practice
· DON / CNM 2 will spot also check.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Our Lady of Lourdes takes the rights of the resident very seriously. To comply with regulation 9, the following action plan is in place.

Too many continence packs stored in wardrobe, leading to other medical equipment being stored on the floor of 1 bedroom:
• Effective immediately, only 1 weeks supply (2-3 packs) of continence wear to be stored in the resident’s wardrobe. This allows for other medical equipment to be stored safely within the same wardrobe if needed.
• This has been agreed for all units
• Maintenance staff have arranged for a weekly supply of continence wear to be sent around all units, and are willing to supply more during the week, if needed.
• The Lead Carer of each unit will be responsible for ordering the continence wear, and for checking that there isn’t an over-supply of packs in the resident’s wardrobe.
• The Nurse on duty will be responsible for storage of any medical kits etc within the unit.
• The Infection Prevention & Control Policy has been reviewed and updated
• DON/CNM2 will spot check each unit for correct storage of equipment.

Bedroom layouts:
Noted that some bedrooms, especially those which had been converted from twin to

single rooms, required a better layout, to give a homely feeling.
• Meeting held with Housekeeping & Maintenance staff re: room layouts.
• Housekeeping, Maintenance Manager and DON/CNM2 have inspected each room & layouts of rooms changed to suit resident needs.
• Rooms to be spot checked by Housekeeping staff for appropriate layout. Housekeeping will report to DON/CNM2

Wardrobe access in twin bedrooms
• Purchasing of new wardrobes has commenced
• The new wardrobe in each of the twin bedrooms will allow the occupants to access the wardrobes without impinging on the other resident's private space.
• The policy on Privacy, Dignity, Independence & Choice has been reviewed by DON/CNM2 & updated with relevant information.
• The updates have been disseminated to staff.

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 12(a)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that a resident uses and retains control over his or her clothes.	Substantially Compliant	Yellow	31/12/2022
Regulation 13(1)(a)	Where a resident is approaching the end of his or her life, the person in charge shall ensure that appropriate care and comfort, which addresses the physical, emotional, social, psychological and spiritual needs of the resident concerned are provided.	Substantially Compliant	Yellow	15/08/2022

Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	30/09/2022
Regulation 18(1)(c)(i)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are properly and safely prepared, cooked and served.	Substantially Compliant	Yellow	31/10/2022
Regulation 18(2)	The person in charge shall provide meals, refreshments and snacks at all reasonable times.	Substantially Compliant	Yellow	01/08/2022
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.	Substantially Compliant	Yellow	31/10/2022
Regulation 25(1)	When a resident is temporarily absent from a designated centre for treatment at another designated centre, hospital or elsewhere, the	Substantially Compliant	Yellow	01/08/2022

	person in charge of the designated centre from which the resident is temporarily absent shall ensure that all relevant information about the resident is provided to the receiving designated centre, hospital or place.			
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Substantially Compliant	Yellow	31/10/2022
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.	Substantially Compliant	Yellow	10/08/2022
Regulation 6(1)	The registered provider shall, having regard to	Substantially Compliant	Yellow	01/08/2022

	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.			
Regulation 9(1)	The registered provider shall carry on the business of the designated centre concerned so as to have regard for the sex, religious persuasion, racial origin, cultural and linguistic background and ability of each resident.	Substantially Compliant	Yellow	01/08/2022