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:	Cois Abhainn Residential Centre
Name of provider:	Health Service Executive
Address of centre:	Greencloyne, Youghal, Cork
Type of inspection:	Unannounced
Date of inspection:	22 January 2025
Centre ID:	OSV-0000583
Fieldwork ID:	MON-0044249

About the designated centre

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

Cois Abhainn Residential Care is a designated centre operated by the Health Service Executive (HSE) and is located within the outskirts of Youghal town with nearby amenities of shops, banks, churches and walkways. It is registered to accommodate a maximum of 26 residents. It is a single storey building configured in a rectangle which encloses a large garden with walkways, shrubberies and flower beds. The enclosed garden can be viewed from many of the bedrooms. Bedroom accommodation comprises single and twin bedrooms, all with wash-hand basins. There are six communal toilet facilities; two twin bedrooms have en suite toilet and wash-hand basins; two twin bedrooms share toilet and wash-hand basin facilities. There are two showers and one bathroom facilities available. Communal areas comprise a day area to the left of reception and the dining area located to the right of main reception; there are two other smaller sitting rooms and an oratory for quiet reflection. Cois Abhainn Residential Care provides 24-hour nursing care to both male and female residents whose dependency range from low to medium care needs. Long-term care, convalescence, transitional care and respite care is provided.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	20

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 22 January 2025	09:00hrs to 17:15hrs	Breeda Desmond	Lead

What residents told us and what inspectors observed

There were 20 residents residing in Cois Abhainn at the time of inspection. The inspector met with many residents during the inspection to gain insight into their experience of living in Cois Abhainn. Residents spoken with gave positive feedback and were complimentary about staff, their friendliness and helpfulness, and they reported that the quality of food was excellent. The inspector met three visitors and they said that this service was excellent and that 'you couldn't ask for better'.

Cois Abhainn is a single-storey building laid out in a rectangle which enclosed a large garden. The main entrance is wheelchair accessible and leads to a small enclosed porch with hand hygiene sanitiser. Beyond this was a foyer with comfortable seating by a dresser for residents to sit and enjoy the comings and goings of the centre; the sign-in register is on the dresser for visitors to record their entry. A 'no smoking campus' sign was displayed at the main entrance; as this was not implemented into practice the person in charge removed the sign.

Directional signage was displayed throughout the building to orientate residents and visitors to the centre. The main fire alarm system, registration certification, suggestion box and complaints procedure are displayed in the foyer; the complaints procedure was updated on inspection to enable easier access to information. The governance structure was displayed but this did not reflect the current governance structure in place. There is a large white board with information for residents such as the activities programme, meal times, information on SAGE advocacy and bus times.

From the foyer, the dining area was on the right and the main day room area to the left. Handrails were on both sides of corridors. Call bells were fitted in bedrooms, bathrooms and communal rooms. Emergency call bells were located along corridors and in the garden should residents or staff require urgent attention. The garden was seen to be well maintained and one resident loved keeping the garden in 'good shape'. During the inspection a large bronze deer was delivered for the garden; the resident had seen a similar statue when out traveling, found it on line, and ordered it for the garden. He explained that he would chat with the person in charge following the inspection and decide where it would be best placed in the garden.

The dining room was a lovely bright space with views of the main entrance on one side and the garden on the other side. Most residents were in the dining room for breakfast when the inspector started the inspection. They were seen to have choice for breakfast including boiled eggs, a variety of cereals and porridge. Residents explained that they liked to get up reasonably early. The menu on display did not correspond to the day's menu choice and the chef explained that residents asked of lamb rather than beef and this was facilitated. The menu board was updated immediately and the set menu of 'week 1' was removed from display as the choice for the week was changed in accordance with residents' preferences.

The inspector chatted with residents at breakfast and dinner time. During the morning the chef was observed to go around to residents explaining the menu choices for their dinner and again in the afternoon for their supper. Snacks and beverages were offered at 11:00hrs,15:00hrs and again at 20:30hrs. Tables were seen to be appropriately set with glasses, cutlery, napkins and condiments prior to residents coming to the dining room. The dining room was full at dinner time and meals were seen to be served appropriately and staff chatted with residents during their meal to ensure they were happy with their food. Mealtime was relaxed and was seen to be a social affair where residents met up with their friends and chatted. Some residents chose to have their meal in their bedrooms and this was facilitated.

The main day area was a bright space with similar views as the dining room. There was ample space and comfortable seating and foot rests for residents to enjoy and relax. Alexa was seen to be used by residents to play their favourite music and songs. Other communal space included the small sitting room with flat screen TV, comfortable seating and book shelves with a variety of books. There was a larger sitting room on the back corridor with flat screen TV, comfortable seating, a computer for residents and a specialist magnifying viewing screen to enable residents' with very poor eyesight to read. The oratory for residents to enjoy peace and reflection was also located on the back corridor. The hairdressers room was along the corridor to the right and the hair dresser visited the centre on request.

Residents' bedroom accommodation comprised 18 single and four twin rooms. The twin bedrooms had shared facilities of toilet and wash-hand basin; single rooms had a wash-hand basin in their bedrooms. There were two shower rooms and one assisted bathroom with specialist bath available to residents. Toilet facilities were located near communal areas and residents' bedrooms. Bedrooms could accommodate a bedside locker and armchair; bedrooms had large TV's enabling residents to enjoy their programmes in private when they chose. Residents had double wardrobes and cupboards for storage and hanging their clothes; bedrooms were seen to be decorated in accordance with residents' preferences. Profiling and low low beds with specialist pressure relieving mattress were seen in residents' bedrooms. There were privacy screens in twin bedrooms and residents could use them independently. Appropriate signage was displayed on room doors where oxygen was stored and used.

The schedule of activity for the week was displayed on the notice board by the day room and on the second notice board on the back corridor. Residents spoken with told the inspector of the activities facilitated on a daily basis such as the external activities company visited the centre twice a week on Tuesdays and Fridays; there was live music twice a week. Designated staff were allocated to activities at other times such as the afternoon of the inspection where a member of staff sat and chatting with residents about current affairs and local news. Residents listened to mass on the radio every morning and had their morning coffee following this. Visitors were seen coming and going throughout the day and visited residents in the day room area as well as their bedrooms.

Wall-mounted hand sanitisers were available throughout the centre along with advisory signage showing appropriate usage. The centre was visibly clean and tidy;

there was a daily cleaning schedule and a deep cleaning schedule as well with additional staff rostered on to facilitate this. The laundry room and cleaners' room had inappropriate storage and mops on the floor. Cleaning trolleys facilitated the storage of cloths to enable household staff to change cleaning cloths and floor mop-heads between rooms.

Emergency evacuation plans were displayed in the centre and orientated appropriately so they correlated with their relevant position in the building. The area designated as a smoking area was a space outside one of the fire exit doors; there was a fire extinguisher mounted on the wall here; there was no call bell available should residents require assistance. This area was not a sheltered space to protect residents during inclement weather.

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 an unannounced monitoring inspection carried out by an inspector of social services to monitor compliance with the Health Act 2007 (Care and welfare of residents in designated centre for older people) Regulation 2013 (as amended). Due to ongoing non compliance with Regulation 8 over the course of the last number of inspections conducted, the provider had a restrictive condition attached to the registration of the centre, Condition 4, that required '*By 31 August 2024 the Registered Provider will review their governance and oversight of all safeguarding issues to ensure that they are appropriately addressed and escalated within the organisation'.* The provider had applied to remove this condition from their registration and this inspection assessed the progress made to address the non-compliance's that led to the requirement for the restrictive condition.

While there was a governance structure in place for Cois Abhainn, the roles and responsibilities of the person in charge and director of nursing were ill-defined in the statement of purpose as responsibility for the service was attributed to the director of nursing and not the person in charge, as required in legislation; deputising arrangement were delegated to the clinical nurse manager (CNM3) who is the person in charge in this centre but not acknowledged as such in the statement of purpose.

Senior manager with responsibility for the centre were not named as persons participating in management on the centre's registration. The provider was required to review these arrangements and a restrictive condition was placed on the centres registration giving the provider until 31st October 2024 to submit to the Chief Inspector the information and documentation set out in Schedule 2 of the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 as amended, in relation to any person who participates or will participate in the

management of the designated centre. This had not been actioned on the day of this inspection.

The inspector reviewed the actions from the previous inspection and found that the following regulations were addressed: some Schedule 5 policies were updated and wound care management was in line with evidence based best practice professional guidelines; issues identified regarding other Schedule 5 policies and procedures and safeguarding remained outstanding. On this inspection, further action was necessary regarding regulations pertaining to resident care documentation of assessment and care planning, infection control, management of complaints, records maintained and the statement of purpose.

Cois Abhainn Residential Centre is a residential care setting operated by the Health Services Executive (HSE) providing accommodation to low to medium dependency residents. It is registered to accommodate 26 residents. The organisational structure comprises the general manager who is the liaison person between the registered provider and the regulator. The director of nursing reports into the general manager; the person in charge reports into the director of nursing.

While all staff had additional safeguarding training, and mentoring was facilitated for other staff with ongoing supervision and support meetings to enhance the management of the service, some incidents were not recognised as safeguarding concerns and consequently not followed up appropriately or notified to the Chief Inspector, to ensure the safety of residents.

Schedule 5 policies and procedures available on site were examined and these required review to ensure they complied with the specified regulatory requirement. This was a repeat finding and are further detailed under Regulation 4: Policies and procedures. Following review of the incident and accident records, some incidents were not recognised as safeguarding concerns and consequently not followed up as such; this is a repeat finding. This is further discussed under Regulation 8: Protection. The statement of purpose required updating to ensure it complied with the requirements of Schedule 1 of the regulations. This is further detailed under Regulation 4: Statement of Purpose.

Regulation 14: Persons in charge

The person in charge was full time and had the necessary experience and qualifications as required in the regulations.

Judgment: Compliant

Regulation 15: Staffing

On the day of inspection there were 20 low-to-medium dependency residents in Cois Abhainn.

The staff roster for 26 residents comprised:

- director of nursing, Monday - Friday
- person in charge, Monday - Friday
- registered nurses, 8am – 8:15pm x 1, 8 – 18:45hrs
- chef x 1, 8am – 8pm
- administration x 1, 9 – 5
- multi-task attendants x 2 x 8am – 8pm, 8 – 4 x 1 [MTAs role and responsibilities included personal care delivery, assistance with meals and snacks, and household cleaning duties].

Judgment: Compliant

Regulation 21: Records

Records were not maintained in line with Schedule 3 of the regulations as follows:

- there were gaps in drug administration records so it could not be assured that residents received their prescribed medications
- medications were withheld for unknown reasons as the legend included in the administration chart was not consistently used to inform the rationale for withholding the medications.

Judgment: Substantially compliant

Regulation 23: Governance and management

Senior managers with responsibility for the centre were not named as persons participating in management on the centre's registration. Consequently a restrictive condition was placed on the centre's registration giving the provider until 31st October 2024 to submit to the Chief Inspector the information and documentation set out in Schedule 2 of the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 as amended, in relation to any person who participates or will participate in the management of the designated centre. This had not been actioned to date.

A second restrictive condition was applied to the registration, Condition 4, that required 'By 31 August 2024 the Registered Provider will review their governance and oversight of all safeguarding issues to ensure that they are appropriately addressed and escalated within the organisation'. The inspection findings did not

assure that sufficient progress was made to comply with this condition. The provider had applied to remove this condition from their registration, however, evidence on inspection could not support this application, as further outlined under Regulation: 8 Protection.

The registered provider did not have an appropriate governance and management structure in place as described in the regulations to ensure the service provided to residents was safe, appropriate, consistent and effectively monitored. The management systems in place to ensure quality and safety of the care delivered to residents remained inadequate and assurance was not provided regarding safeguarding:

- roles and responsibilities of the person in charge and director of nursing set out in the statement of purpose did not comply with regulatory requirements as responsibility for the service was attributed to the director of nursing and not the person in charge; deputising arrangement were delegated to the CNM3 (who is the person notified under the regulations as the person in charge)
- further oversight of incidents was required: although incidents were recorded, actions taken as described by the person in charge were not recorded, and were not followed up to ensure the protection of residents, this is further discussed under Regulation 8, Protection,
- 3-day notifications as required under Regulation 31 were not submitted to the office of the Chief inspector
- while medication errors were recorded, records did not detail the follow-up described by the person in charge, to be assured that medication management, in particular, administration practices, were compliant with professional guidelines.

Regarding risk:

- residents did not have access to a safe smoking area. The smoking facilities comprised a designated area outside a side door with a fire extinguisher and seating was provided from one of the day rooms. The area was not sheltered and there was no call bell available to enable someone to call for help should they require assistance. This continued to be a repeat finding.

Judgment: Not compliant

Regulation 3: Statement of purpose

The following required action to ensure the statement of purpose contained all the requirements as listed in Schedule 1 of the regulations, as follows:

- the information set out in the certificate of registration was incomplete as two of the conditions of registration were not listed – Condition 4 and 5 were missing
- floor plans detailed in Condition 1 were 24/02/21, however, the current registration floor plans are dated 29/02/24
- roles and responsibilities did not include those of the person in charge; responsibility of the centre was reported as that of the registered provider and the director of nursing with deputising arrangement devolved to the CNM3; the role of person in charge was not included in the document,
- room descriptors do not correlate with rooms on site
- the document states that Cois Abhainn is a 'no smoking' campus since 2016, however, this has not been implemented in practice
- regarding the complaints procedure, the centre was called Cois Abhainn Community Nursing Unit rather than Cois Abhainn Residential Care.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Some notifications relating to allegations of deficits of protection/safeguarding issues were not submitted in line with regulatory requirements.

Judgment: Not compliant

Regulation 34: Complaints procedure

Action was required to ensure the complaints procedure was accessible and complaints were recorded appropriately:

- a complaints officer was named, however, this person was on leave for several months and the procedure was not updated to detail a current complaints office with whom people could consult should they have feedback,
- complaints were seen to be recorded, however, one was seen to be closed out even though it was an ongoing issue. This was actioned on inspection to ensure the records were a true reflection of the current status of the complaint.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

Action was required to ensure the most up-to-date policies were available to staff; that Schedule 5 policies and procedures were updated in line with changes to legislation; and implemented into practice to ensure care was delivered in line with current best practice:

- the complaints policy was not centre specific and did not reflect the current governance structure regarding line manager reporting details
- the policy relating to the temporary absence of a resident did not have required information as detailed in the regulations
- the safeguarding policy required implementation as some issues were not followed and acted upon to ensure the safety of residents in line with their safeguarding policy
- there is a 'no smoking' policy for this service and signage displayed statement that Cois Abhainn was a 'smoke-free campus', however, one resident is a smoker and a second resident uses vapes
- the policy relating to the management of records had units from a different designated centre detailed.

Judgment: Substantially compliant

Quality and safety

On the day of inspection, the inspector observed that the care and support given to residents was respectful; staff were kind and were familiar with residents preferences and choices and facilitated these in a friendly manner. There was a relaxed atmosphere and a social model of care was promoted.

Residents had access to advocacy and care documentation showed that people were supported to access this service in accordance with their choice. Residents had access to a variety of activities on a daily basis. A named staff was allocated to activities on days when the external activities company was not on site. The activities notice included detail of the activities programme throughout the day. As previously outlined staff had undertaken additional safeguarding training, and mentoring was facilitated for other staff with ongoing supervision and support meetings to enhance the management of the service. However some incidents were not recognised as safeguarding concerns and consequently not followed up to ensure the safety of residents and this is further outlined under Regulation: 8 Protection.

Consent was routinely obtained from residents for interventions and care documentation, in line with a rights-based approach to care. The daily narrative to provide updates on the resident's status gave good detail on the resident's well-being, their responses to interventions including pain management, supports and care provided. 'Differentiating Characteristics of Delirium, Dementia and

Depressions' was available to staff as an easy reference guide in assisting with assessment should a resident exhibit specific presentations. A sample of residents' care plans and assessments were reviewed which showed mixed findings. While some had comprehensive assessments to inform the care planning process, other assessments were incomplete and were not updated with the changing needs of a residents. These and other issues identified regarding assessment and care planning will be further discussed under Regulation 5: Individual assessment and care plan.

The GP attended the centre twice a week routinely as well as residents visiting the GP in their surgery in accordance with their preference and choice. Records demonstrated that there was ongoing review of prescriptions along with residents' responses to medication to ensure best outcomes for residents. An antibiotic log was maintained as part of medication records which enabled ease of access to history of treatments for infection along with the type of infection and the resident's response to treatment.

The physiotherapist was on-site during the inspection and provided one-to-one assessment and education for residents; this information was relayed to staff to ensure exercise programmes would be followed up to enable best outcomes for residents.

A new controlled drug recording book was delivered during the inspection and put into practice immediately. This was welcomed as it would facilitate discarded medications to be recorded for example. It also facilitated each drug to be recorded individually when checked; this would enable easy identification of possible mis-counts or medication errors. A sample of medication administration records were examined and issues identified regarding these records are detailed under Regulation 21: Records.

Regarding the premises, painting and re-decorating was necessary to ensure the premise was compliant with Schedule 6 of the regulations; this work was due to commence following the inspection.

Regulation 11: Visits

Visitors were seen coming and going to the centre throughout the day. Visitors spoken with said they were very happy with the care their relative received.

Judgment: Compliant

Regulation 12: Personal possessions

Residents had access to a minimum of double wardrobes and bedside locker, some residents had an additional single wardrobe with shelving as personal storage for their belongings.

Residents' personal laundry was completed on site and arrangements were in place for collection and return of bed linen; there was a good supply of bed linen seen in designated linen storage presses in the centre.There were no concerns raised by residents regarding their personal laundry.

Judgment: Compliant

Regulation 17: Premises

While assurances were provided that premises upgrade works were due to commence in Cois Abhainn the week following the inspection, the following remained outstanding:

- the building was in need of painting and redecorating as many surfaces to walls were damaged following fire safety works and other works
- door frames and architraves were damaged from general wear and tear
- some flooring was damaged.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Mealtimes were observed and seen to be a very positive and social experience. There was lots of chat and conversation at tables and between tables as people caught up with their friends to chat. Meals were pleasantly presented and looked appealing and people sitting together at tables were served together. The inspector saw that residents had lots of choice for each meal; residents reported that they could get 'anything they fancy' and were not confined to the menu choice if you didn't feel like the choice offered. The chef was seen going around to chat with residents asking them their menu choice for the evening meal and dinner for the following day.

A list of residents, their personal menu choices, dietary requirements (such as diabetic, low salt and gluten free), and relevant textures were discretely displayed in the kitchen for ease of access to kitchen staff to ensure residents received meals in accordance with their preferences.

Judgment: Compliant

Regulation 27: Infection control

The provider did not ensure that infection prevention and control procedures were consistent with National Standards for Infection Prevention and Control in Community Services published by the Health Information and Quality Authority (HIQA). This was evidenced by:

- lack of oversight of multi-drug resistant organism (MDROs); the MDRO list available was incomplete and did not reflect the current status of residents in the centre; while the inspector was informed that the MDRO list was part of the daily safety huddle, this list was not comprehensive
- there was no shelving to enable containers dispensing chemicals to the dishwasher to be maintained off the floor (repeat finding)
- floor mops and brushes were stored on the floor in the laundry and household cleaners' room preventing adequate cleaning of floors in these rooms (repeat finding)
- while there was a separate hand wash sink in the sluice room, this was not compliant with current national standards as the outlet was metal and the water flow was directly over the metal outlet; the tap mechanism was not stable and swivelled when used
- shampoo and two razors were seen on the shower tray shelf in one of the communal showers this could lead to cross contamination.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Action was necessary regarding assessments and care planning to ensure they were maintained in line with regulatory requirements, as follows:

- as the MDRO history was not recorded on a resident's admission notes, comprehensive information could not be included when a resident was being referred to or temporarily transferred to another health care setting to ensure appropriate arrangements would be put in place to safeguard both the resident and other residents and staff in the receiving centre
- a resident's assessment regarding breathing and circulation stated the resident had oedema, however, the location of the oedema was not detailed; when the inspector asked regarding this she was informed that the resident no longer had this concern
- obsolete wound care notes were automatically included when the resident (previously admitted for respite care) was admitted for long-term care; this information was not relevant to this admission and the resident's care needs, as the wound had heeled on the previous admission

- a resident's end of life care wishes were not recorded. All of the residents the inspector spoke with on inspection were well able to articulate their thoughts and views, so it would be an opportune time to seek out their wishes and preferences regarding their care should they become unwell.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had good access to GP services. The GP was on site twice a week as well as coming on site when required. Medical notes demonstrated that medications were reviewed as part of the review process. Referrals to allied health professionals and specialist services such as the diabetic retinopathy clinic were facilitated in a timely manner. The physiotherapist was on site during the inspection providing one-to-one care to residents.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

While a responsive behaviour was reported to the inspector, there was no evidence that this behaviour was assessed or recorded appropriately to enable learning, and preventative actions were not recorded to mitigate recurrence.

Judgment: Substantially compliant

Regulation 8: Protection

The inspector found that comprehensive measures were not taken in the centre to safeguard residents:

- a review of the incidents records showed some safeguarding concerns were not recognised as such by the management team, and consequently not appropriately followed up and investigated to mitigate recurrence and ensure the safety of residents. This was a repeat finding,
- a reported incident was not recognised as a resident's right to autonomy, and a possible inappropriate staff interaction was not investigated as part of safeguarding residents.

Judgment: Not compliant

Regulation 9: Residents' rights

Residents' activities programme showed that residents had access to activities over seven days a week. An external activities company provided activities two days a week, live music was held twice a week, and the priest said mass on site on a weekly basis. A member of staff was assigned to activities on days when the external activities facilitators were not on site.

The person in charge facilitated residents' meetings and lots of items were discussed with residents including raising concerns, variety of activities and also reminding residents of the option of completing the satisfaction surveys. Residents' notes showed that advocacy services were availed of and the person in charge ensured residents understanding of advocacy as part of residents' meetings.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Cois Abhainn Residential Centre OSV-0000583

Inspection ID: MON-0044249

Date of inspection: 22/01/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: • A staff meeting was held on 12th February, 2025, the Medication Management Policy was discussed and the importance of maintaining the Medication administration record without gaps to ensure the safe administration of drugs to residents was reiterated. • All nurses will complete additional medication management training- "Medication without harm" on HSE Land, by end of Q2. • Nurses were informed to use the correct indicators in the medication administration record to explain the rationale for withheld or refused medications. • The PIC will be conducting additional audits twice monthly using the Medication Administration audit tool No 6. • All nurses will complete the Medication Management Competency Assessment by end of March 2025-to ensure all are competent, supervisory practices will be put in place in the event of non-competencies being identified. • The Clinical Development Coordinator will support the PIC in conducting audits on site, on a monthly basis.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • Roles and responsibilities of PIC and DON in Statement of Purpose, this has been amended to reflect the current position. • Recording of incidents-as the incidents noted by HIQA were missing items, as directed by the Inspector, in the future such incidents will be reported as an NF06. Information on investigations re missing items will be referenced in the NIMs, as an update.	

• Medication errors- additional audits and additional support will be available to the PIC re medication management. The Clinical Development Coordinator will support the PIC in conducting audits on site, on a monthly basis.
• Information re medication errors will be referenced in the NIMs, as an update.
• Smoking shed- Work to install smoking shelter is in progress. Meanwhile a call bell, Fire extinguishers and a fire blanket are available in the current designated smoking area. Aim to have same completed by the end of May 2025.
• Ongoing support is available to the PIC through the office of the GM.
• As an interim measure in order to bolster the governance in Cois Abhainn Residential Centre, the PIC will have the support of a CNM2, 3 x days per week for 2-3 months. The role of the CNM2 will be to focus on the quality and patient safety aspects of the Senior Enhanced Nurse duties and improve compliance with medication errors and reporting of incidents.

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

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
• Roles and responsibilities of PIC and DON in Statement of Purpose, this has been amended to reflect the current position.
• Recording of incidents-as the incidents noted by HIQA were missing items, as directed by the Inspector, in the future such incidents will be reported as an NF06. Information on investigations re missing items will be referenced in the NIMs, as an update.
• Medication errors- additional audits and additional support will be available to the PIC re medication management. The Clinical Development Coordinator will support the PIC in conducting audits on site, on a monthly basis.
• Information re medication errors will be referenced in the NIMs, as an update.
• Smoking shed- Work to install smoking shelter is in progress. Meanwhile a call bell, Fire extinguishers and a fire blanket are available in the current designated smoking area. Aim to have same completed by the end of May 2025.
• Ongoing support is available to the PIC through the office of the GM.
• As an interim measure in order to bolster the governance in Cois Abhainn Residential Centre, the PIC will have the support of a CNM2, 3 x days per week for 2-3 months. The role of the CNM2 will be to focus on the quality and patient safety aspects of the Senior Enhanced Nurse duties and improve compliance with medication errors and reporting of incidents.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
• PIC to discuss the incidents at local QPS meeting and with senior management and ensure that all notifications are submitted as per the time line.
• Recording of incidents-as the incidents noted by HIQA were missing items, as directed by the Inspector, in the future such incidents will be reported as an NF06. Information on investigations re missing items will be referenced in the NIMs, as an update.
• The Clinical Development Coordinator will support the PIC on site on a monthly basis and participate in the local QPS meeting with the PIC where feedback and follow up regarding recent incidents and reporting will be discussed.
• Ongoing support is available to the PIC in relation to the reporting of incidents through the office of the GM.

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

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
• Complaint procedure was reviewed with current Complaint Officer's name and was communicated to residents at resident's meeting.

• Complaints procedure was displayed in the display board for easy access of residents and visitors and the name of the complaints officer has been updated

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
• Complaint policy was updated with current governance structure on 17/2/2025
• Awaiting ratification of the newly updated Admissions Policy which includes Temporary Absence policy. In the absence of the new policy a local review is taking place.

• PIC to ensure that Safeguarding Policy is implemented to ensure the safety of residents. PIC will liaise with safeguarding and protection team if there is any concerns. The Clinical Development Coordinator will support the PIC on site on a monthly basis and participate in the local QPS meeting.
• Smoking policy was reviewed on 17/2/2025 and the campus is no longer noted as being a tobacco free campus.
• Policy on the management of records was updated on 17/2/25 and other the units details were removed.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• Painting of building was completed in February 2025.
• Floor near to the fire exits were repaired to ease the evacuation of residents on wheelchair in February 2025.
• All architraves and door frames have been repaired and painted- maintenance will address any areas identified as requiring repair when reported.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
• MDRO is included in the weekly statistics and will be discussed on daily safety pause. Resident's care record updated with MDRO.
• Chemicals dispensers are stored off the floor to facilitate proper cleaning of floor.
• Wall mounted brush holders have been installed in the cleaner's room and laundry room. Staff members were informed to keep the brushes on the holder to facilitate cleaning.

• The Health and Safety section of our daily safety pause is used as a reminder to staff re appropriate storage of cleaning equipment.

• Audit on Environmental hygiene will be conducted as per Viclarity Audit Schedule and the findings will be followed up and actioned by PIC. A staff nurse has been identified to complete an additional environmental audit for the next 3 months.

• The tap of hand wash basin in the sluice room was repaired by maintenance team on 24/2/25.

• While there was a separate hand wash sink in the sluice room, this meets the standard HBN 00-10 part C sanitary assemblies for hand wash basins, confirmed by IPC.

• Shower room check list was introduced on 24/2/25 to ensure that the personal items of residents were removed from common shower room and returned to residents appropriately.

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:

• The care plan highlighted on the day of inspection has been updated with current care needs of resident on 31/1/2025 and their EOL wishes are now reflected in the care plan. A complete audit of all care plans is currently being undertaken and all areas of non-compliance will be addressed by end of April 2025. In addition to scheduled monthly documentation audits Cois Abhainn will undertake further audits to include every care plan. All areas of non-compliance will be addressed urgently.
Monthly documentation audits for review by PIC and areas of non-compliance will be discussed and actioned by lead nurse. The Care Plan in question was updated.
• The PIC, who has the responsibility, will oversee that the transfer form is completed with all relevant information required to meet the care needs and safety of residents in other health care settings.
• A staff meeting held on 12th February 2025 and focused on all findings of inspection.

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

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

• The care plan was reviewed with triggering factors and appropriate interventions to manage the behaviours which challenge in order to prevent a reoccurrence.
• The majority of staff have completed managing responsive behaviour training completed as per the training matrix.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• Recording of incidents-as the incidents noted by HIQA were missing items, as directed by the Inspector, in the future such incidents will be reported as an NF06. Information on investigations re missing items will be referenced in the NIMs, as an update.
The PIC as Designated officer will attend upcoming training, on 03.04.2025 and has undertaken to participate in a Safeguarding Forum with a view to gaining awareness of the new Safeguarding case management system and to increase skills in identifying safeguarding issues. The Safeguarding Team have been approached to provide bespoke training to all staff by end of Q3. The PIC has been using the Safeguarding helpline to assist them in recognising any safeguarding concerns. Risk assessments have been completed on previous incidents related to missing items and control measures have been put in place to prevent a reoccurrence.
• A bimonthly meeting has commenced from 20.03.2025 in which the PIC, CNM2 and Clinical Development Coordinator will review all NIMS, safeguarding plans and concerns. Any identified areas of concern will be escalated to the safeguarding team.

• Previous incidents have been followed up with staff members and residents and all have been followed up and concluded with the respect of resident's autonomy and rights. Previous incidents were discussed at resident's meeting to alert the residents about the safe keeping of their belongings.
• PIC will liaise with safeguarding and protection team, if there is any clarification required. Ongoing support is available to the PIC in relation to the reporting of incidents through the office of the GM.

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

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 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	24/02/2025
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Substantially Compliant	Yellow	31/03/2025
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and	Not Compliant	Orange	03/03/2025

	details responsibilities for all areas of care provision.			
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	31/05/2025
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.	Substantially Compliant	Yellow	27/03/2025
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose relating to the designated centre concerned and containing the information set out in Schedule 1.	Substantially Compliant	Yellow	03/03/2025
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	Not Compliant	Orange	03/03/2025

	notice in writing of the incident within 3 working days of its occurrence.			
Regulation 34(2)(a)	The registered provider shall ensure that the complaints procedure provides for the nomination of a complaints officer to investigate complaints.	Substantially Compliant	Yellow	17/02/2025
Regulation 34(6)(a)	The registered provider shall ensure that all complaints received, the outcomes of any investigations into complaints, any actions taken on foot of a complaint, any reviews requested and the outcomes of any reviews are fully and properly recorded and that such records are in addition to and distinct from a resident's individual care plan.	Substantially Compliant	Yellow	24/02/2025
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review	Substantially Compliant	Yellow	31/03/2025

	and update them in accordance with best practice.			
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	30/04/2025
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Substantially Compliant	Yellow	12/03/2025
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.	Substantially Compliant	Yellow	31/03/2025
Regulation 8(1)	The registered provider shall take all reasonable measures to	Not Compliant	Orange	24/03/2025

	protect residents from abuse.			
Regulation 8(3)	The person in charge shall investigate any incident or allegation of abuse.	Not Compliant	Orange	24/03/2025