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:	Marian House
Name of provider:	Holy Faith Sisters
Address of centre:	Holy Faith Convent, Glasnevin, Dublin 11
Type of inspection:	Unannounced
Date of inspection:	01 June 2023
Centre ID:	OSV-0000693
Fieldwork ID:	MON-0039817

About the designated centre

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

Marian House, Glasnevin, is a Nursing Home run by the Holy Faith Sisters. It is a Holy Faith congregational facility, which seeks to care for Sisters of the Holy Faith and female residents in a comfortable, homely environment supported by qualified nurses and carers. Marian House staff is guided by the current and future best practice guidelines for the care of its residents.
Marian House is purpose designed to provide care for residents with a variety of needs and can accommodate maximum of 26 female residents. There are 24 single rooms and 1 double room in the centre located on two floors. It is surrounded by landscaped gardens with country views. The secure outdoor enclosed courtyard has seating areas for the residents.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	24

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 1 June 2023	09:30hrs to 19:10hrs	Michael Dunne	Lead
Thursday 1 June 2023	09:30hrs to 19:10hrs	Kathryn Hanly	Support

What residents told us and what inspectors observed

There was a relaxed and social atmosphere within the centre. Inspectors observed that staff were aware of residents assessed needs and that residents were comfortable in the company of staff. All residents who expressed a view said that they were content living in the designated centre. They added that staff were kind, caring and respectful. The designated centre provided accommodation to both nuns aligned to a number of different congregations and to lay persons.

Following an introductory meeting with the person in charge, inspectors were guided on a tour of the building. The designated centre was laid out over two floors with accommodation provided in 24 single bedrooms and one twin bedroom. The first floor which was serviced by a lift accommodated 10 residents in single rooms while the remainder of the residents were accommodated downstairs. The twin bedroom was found to have been reconfigured following the last inspection to allow residents access all of their personal storage within their own area.

Communal areas were available on the ground floor and included, a prayer room, a hairdressing salon, large and small sitting rooms and a large dining room. The dining tables were set with decorative tablecloths and floral centre pieces. Mealtimes were observed to be a social occasion. The lunch menu was displayed outside the dining room in pictorial format. Residents confirmed that they enjoyed the meals provided. The meal options available on the day consisted of meatballs, liver and onions, alternative options were available should residents not like what was on the set menu.

Residents could move around the centre freely and inspectors observed a number of residents walking around the centre independently or with the help of staff.

Overall the general environment, residents' bedrooms, communal areas and toilets appeared appeared visibly clean. Access to cleaning resources had improved since the last inspection There was a treatment room for the storage and preparation of medicines, and for clean and sterile supplies. Units also had access to a dedicated housekeeping room for storage and preparation of cleaning trolleys and equipment and a sluice room for the reprocessing of bedpans, urinals and commodes. Equipment and furniture viewed on inspection were generally clean. Fabric seating had been replaced with wipeable alternatives in communal areas following the last inspection. Overall storage space was limited and there was inappropriate storage of residents mobility equipment found in a communal bathroom.

While the centre generally provided a homely environment for residents, improvements were required in respect of premises and infection prevention and control, which are interdependent. For example water damage was observed on the ceiling tiles in several areas, this detracted from the homely environment and was also found during the last inspection in 2022. While the registered provider had plans to upgrade the centre, these upgrades were linked to the upgrade of fire

safety works, however the time frame for these works to commence was not known by the local management team at the time of the inspection.

All residents spoken with on the inspection said they were happy with the support they were getting with their healthcare needs and to attend appointments. Many residents said they felt at home in the centre and were appreciative of the wider support given to them by their respective congregations such as companionship, pastoral care and recreational support.

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 inspection was carried out to monitor compliance with the regulations and to follow up on the findings from the previous inspection of June 2022. A number of repeated non compliance's were found on this inspection in relation to staffing, governance and management, while other repeated non compliance's are discussed in more detail under the relevant Regulations and under the quality and safety theme.

An urgent action was issued by inspectors at the time of the inspection regarding an immediate risk in relation to fire safety concerns, and in particular the ability of the provider to effect a safe evacuation of residents in the event of a fire emergency during the night. Two members of staff were available at night time to provide care and support for 24 residents. A review of resident personal emergency evacuation plans (PEEPS) indicated that four residents required wheelchair assistance to evacuate and a significant number of residents also required the assistance of one to one support to safely evacuate the centre. In order to address the immediate risk identified the provider was required to increase staffing levels at night from two to three staff, this change came into effect on 02 June 2023.

The registered provider for this designated centre is the Holy Faith Sisters which is an unincorporated body consisting of members which form a committee of management. At the time of this inspection the inspectors were informed that there were changes to the make up of the management committee within the provider entity however these changes were not known among the local management team in the designated centre. Neither had the provider informed the Chief Inspector about the changes in line with the requirements of the Registration of Designated Centres for Older People regulations 2015.

The person in charge of the centre was supported in their role, by a person participating in management along with a team of nursing staff which included two clinical nurse managers. The remainder of the team consists of healthcare assistants, household, catering, maintenance, administration and activity staff

members. The inspectors found that there were sufficient numbers of staff available in the designated centre during the day to provide timely support to meet the assessed needs of the residents.

Although, there was commitment on behalf of the provider to ensure the service provided to residents was of a high quality, a number of actions were required to ensure that management systems and levels of oversight were sufficiently robust to ensure the service provided is safe,consistent and effectively monitored.

Management systems which included audit of key performance indicators such as falls, care plans, wound care, infection control,restrictive practice and risk monitoring did not always identify areas of the service that required improvement. While there were a number of local meetings held to provide oversight of the service including clinical governance, health and safety and maintenance meetings, records relating to the provider's attendance at these meetings or evidence of their participation in the oversight of the service were not made available to review.

Furthermore the inspectors were not assured that the necessary information was being captured and recorded by the management team to monitor the service and identify risks and areas for improvements. This is discussed further under Regulation 23.

Records relating to resident contracts required updating to ensure that in instances where additional fees are charged that this is recorded on the contract for provision of services.

Staff were facilitated to attend training in areas such as fire safety, safeguarding, cardiopulmonary resuscitation (CPR) and medication management, There was an ongoing training schedule in place and training had been delivered in responsive behaviors and safeguarding in the week prior to this inspection. However, the training records made available for inspectors to review indicated that a small number of staff did not have all mandatory training in place. A review of staff records confirmed that there was an induction and appraisal system in place to support new staff and to monitor staff performance.

A review of schedule two records confirmed that all the required documentation was in place for new employees prior to commencing employment in the designated centre. All staff had Garda vetting in place before they commenced working in the centre.

Regulation 15: Staffing

The registered provider failed to ensure that there were sufficient numbers of staff having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.

Inspectors found that:

There were only two members of staff, a nurse and a health care assistant rostered during the night to provide care and support for 24 residents on both the ground and first floor. A number of the residents were assessed as maximum dependency and could require both members of staff to provide care and assistance at the same time. This meant that other residents who required support during the night may have to wait until staff were available.

In addition the health care assistant had a number of other duties to perform at night such as laundry and cleaning tasks.

Inspectors were also concerned that low levels of staffing at night may impact on the safe evacuation of residents in the event of a fire emergency, this is discussed further under Regulation 28.

Judgment: Not compliant

Regulation 16: Training and staff development

Records made available for the inspector to review confirmed that not all staff had access to appropriate training, findings on inspection confirmed the following gaps in mandatory training:

- Four staff required safeguarding training.
- Three staff were due fire safety training
- One staff member required manual handling training.

Judgment: Substantially compliant

Regulation 21: Records

There was poor oversight and management of records in the designated centre:

Records relating to simulated fire drills were not always available, the inspectors were informed some fire drills had occurred but there was no record of these in the fire safety file.

Minutes of meetings held between the provider and the management team in the centre were not available for review.

A number of other records were not available at the time of the inspection but were submitted post inspection and included:

Copy of insurance cover for the designated centre
Policy relating to the management of residents accounts and property including pension management policy.

Judgment: Substantially compliant

Regulation 23: Governance and management

The registered provider had failed to ensure that there were adequate resources available to complete the planned fire safety works which were identified in the fire safety risk assessment of 2021 in a timely manner. While some fire safety works had been completed there were a number of improvement works still outstanding which should have been completed by the first quarter of 2023.

Inspectors were not assured that there was a clearly defined management structure in place that identifies the lines of authority and accountability, specific roles and details responsibilities for all areas of care provision. For example;

· Inspectors were informed that there were personnel changes within the provider entity, but these details were not clear at the time of the inspection. The Chief inspector had not been made aware of any changes to the provider entity via the required registration notifications.

· Communications between the provider and the the local management were not robust and did not ensure that the local team were sufficiently informed about the progress of the building upgrades to include the fire safety improvement works that were to be carried out in the centre. As a result they were not able to plan for the works and were not in a position to keep the residents informed about the substantive works that were planned for their home.

· Furthermore there was no evidence that the local management team met with the provider. As a result inspectors were not assured that the the provider was sufficiently informed about what was happening in the centre and had sufficient oversight of the quality and safety of the service.

The registered provider had not ensured effective governance arrangements were in place in the designated centre to ensure services were safe, appropriate and effectively monitored. This was evidenced by:

· Disparities between the finding of local infection prevention and control audits and the inspectors findings on the day of the inspection highlighted that the audit and monitoring process in relation to infection prevention and control were not identifying where improvements were required to ensure compliance with the National Standards for infection prevention and control in community services.

· Risks in relation to low numbers of staff available at night time had not been identified by the provider. Fire safety risks had not been addressed in a timely

manner and had in fact been delayed to align them with premises upgrade works. Furthermore no measures had been put into place to mitigate the known fire safety risks until the works had been completed.

· Monitoring systems did not identify gaps in staff training and care planning found on this inspection and were ineffective in identifying areas that required improvement.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

The inspectors reviewed three contracts for the provision of services. All contracts required amendment to clearly identify if there was a charge for additional services provided in addition to services provided under the Nursing Home Support Scheme.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The registered provider had prepared a statement of purpose dated 18 August 2022 which contained information set out under Schedule 1 of the regulations. However this document did not contain the following information,

- Who was in charge of the centre when the person in charge was absent.
- Information in relation to accessing national screening programmes.

The person in charge agreed to update the statement of purpose prior to the completion of the inspection.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

The policies and procedures required under schedule 5 were available in the designated centre and met the requirements of this regulation. The majority of Schedule 5 policies were scheduled for renewal in 2023.

Judgment: Compliant

Quality and safety

Overall, inspectors were assured that residents living in the centre enjoyed a good quality of life and that there was a rights-based approach to care which was respectful of residents wishes and choices. There was evidence of regular consultation with residents, resident meetings were held on a regular basis and the provider communicated updates on events through a newsletter that was well received by the residents.

Despite these examples good practice, there were a number of repeated non-compliance's found on this inspection which are discussed in more detail under the relevant Regulations relating to fire safety, premises and infection control. The inspectors also found weakness in the provider's identification and management of risk.

Residents had access to a range of health care services and benefited from weekly visits by a GP service. Records confirmed referrals to specialist services such as psychiatry of later life or to allied health care services were made in a timely manner. Resident care plans were accessible on a computer based system. Care plans viewed by the inspectors were personalised and sufficiently detailed to direct care with some exceptions. A review of care plans found that further work was required to ensure that all resident nursing assessments and care plans contained resident's current Multidrug- resistant organism (MDRO) colonisation status. Further improvements were also required to residents wound care plans. This is discussed further under Regulation 5: individual assessment and care planning.

The design and layout of the premises was homely and there was sufficient communal space available for residents to use. There was unrestricted access to a secure communal garden area which was suitable for residents to use. This area contained well-maintained shrubs, plants, flowers and a water fountain feature. There was a range of suitable seating provided for residents using this facility. However there were other areas of the centre which required upgrade such as the replacement of stained ceiling tiles and repair to surfaces to allow for effective cleaning. The areas of the centre which required upgrade were identified in the last inspection held in June 2022 and in the provider's own environmental audit which identified areas requiring upgrade due to general wear and tear. The provider was found to have had reconfigured the twin room to ensure that residents residing in this room had access to storage facilities within their own personal space.

The registered provider had an insurance policy in place to provide cover in the event of injury to residents and to cover other risks such as loss or damage to residents property.

There was a varied programme of activities that was facilitated by an activity co-ordinator's, nursing and care staff and was tailored on a daily basis to suit the expressed preferences of residents. There were good positive interactions between

staff and residents observed during the inspection.

Residents who required support with managing their finances were provided with assistance from a nominated person within the Holy Faith Sisters congregation. There were arrangements in place within the centre for residents to access monies for day to day expenditure. There were records in place which accounted for all monies received and withdrawn.

The centre had effectively managed two small outbreaks and isolated cases of COVID-19 since the onset of the pandemic. The first COVID-19 outbreak occurred in May 2022. A review of notifications submitted to the Health Information and Quality Authority (HIQA) found both outbreaks were generally well managed and contained to limit to spread of infection within the centre.

The provider continued to manage the ongoing risk of infection from COVID-19 and other infections while protecting and respecting the rights of residents to maintain meaningful relationships with people who are important to them. There were no visiting restrictions in place and public health guidelines on visiting were being followed however the universal requirement for staff and visitors to wear surgical masks in designated centres had been removed on the 19 April 2023 but this requirement was still in place in the centre. Inspectors observed that all care staff and nurses were wearing masks during the course of the inspection. A review of correspondence circulated to staff, residents and families found that, contrary to national guidelines, staff were still required to routinely wear masks when delivering care to residents.

This impacted on how effectively staff were able to communicate with some residents, especially residents who had communication needs or had cognitive impairment. Visitors were also encouraged to routinely wear masks when visiting the designated centre. Visitors were reminded not to come to the centre if they were showing signs and symptoms of infection.

Waste and used laundry was observed to be segregated in line with best practice guidelines. However on three occasions bags of used laundry were observed to be transported on top of the used linen skips. A trolley containing stocks of wound dressing was observed to be taken to a residents bedroom and this practice had the potential to lead to cross contamination.

The inspectors found that there were a number of fire safety risks in this centre which were not well controlled. An action plan prepared by the provider to address fire safety risks in August 2022 was not fully completed at the time of this inspection. An immediate risk was identified in relation to low numbers of staff available at night-time to ensure the safe evacuation of residents in the event of a fire. This was addressed on the day of the inspection with the provider increasing staffing levels at night time.

Regulation 11: Visits

There were no visiting restrictions in place. Visits were encouraged and precautions were in place to manage any associated infection risk. As well as visits from relatives, residents also received visits from volunteer sisters of the Holy Faith community which they enjoyed.

Judgment: Compliant

Regulation 12: Personal possessions

Residents had adequate space in their bedrooms to store their clothes and display their possessions. Clothes were marked with resident's details to ensure they were safely returned from the laundry.

Judgment: Compliant

Regulation 17: Premises

A number of actions were required on behalf of the registered provider to ensure compliance with regulation 17 and matters set out under schedule 6 of the regulations, for example:

- A number of areas of the centre required decoration due to wear and tear. Inspectors observed staining to ceiling tiles in multiple areas of the centre, some walls, skirting boards and tiling required upgrade and repair to ensure they could be effectively cleaned to prevent the risk of cross infection.
- A call bell was not accessible in an upstairs communal bathroom.
- The layout of the sluice room in the centre did not support effective infection prevention and control practices. For example the room was small, cluttered and access to the hand washing sink and shelving obstructed.
- Malodours were found in a bathroom.
- A wheelchair was found to be stored in a toilet.

Judgment: Not compliant

Regulation 26: Risk management

There was a risk management policy in place which met the requirements of the

regulations and was due for renewal in June 2023. There was poor oversight and management of risk in this centre which is discussed further under the relevant regulations relating to governance and management, infection prevention and control, fire safety and premises.

Judgment: Compliant

Regulation 27: Infection control

The registered provider had not ensured effective governance arrangements were in place to ensure the sustainable delivery of safe and effective infection prevention and control and antimicrobial stewardship. For example;

- While antibiotic usage was monitored, there was no evidence of multidisciplinary targeted antimicrobial stewardship quality improvement initiatives.
- Surveillance of MDRO colonisation was not undertaken. A small number of staff were unaware of which residents were colonised with MDROs. This meant that appropriate precautions may not have been in place when caring for these residents.
  Inspectors identified through speaking with staff that there was some ambiguity regarding what infection prevention and control measures were required to be used if caring for a resident that was colonised with CRE.

Standard infection prevention and control precautions were not effectively and consistently implemented. This was evidenced by:

- Staff were advised to have a mask "at hand or in their pockets at all times". Inappropriate storage of masks may lead to cross contamination. Inspectors also observed that masks were not worn correctly by all staff during the course of the inspection.
- Cleaning trolleys observed did not have a physical partition between clean and soiled items. Cleaning carts were not equipped with a locked compartment for storage of chemicals. This increased the risk of cross contamination and ingestion of hazardous cleaning products.
- A dedicated specimen fridge was not available for the storage of laboratory samples awaiting collection. Inspectors were informed that samples were stored in a medication fridge. This posed a risk of cross-contamination.
- While the external surfaces of the jacuzzi bath were cleaned after use, the water jets did not receive routine disinfection. This posed a risk of cross infection for residents using the bath.
- Barriers to effective hand hygiene practice were observed during the course of this inspection. For example additional dispensers or individual bottles of alcohol hand gel were required to ensure alcohol hand gel was readily available at point of care. There were a limited number of clinical hand wash sinks available for staff use. There was no hand washing sink in the

housekeeping store.

Judgment: Not compliant

Regulation 28: Fire precautions

The provider had failed to put effective measures in place to identify and address fire safety risks in the designated centre. As a result the inspectors found that the following risks had either not been identified or where identified the mitigating measures to reduce the risk were inadequate. This was evidenced by:

- Holes found in the ceiling of a storage cupboard located in the clean linen room which required fire stopping to stop the spread of smoke and fire.
- There were gaps in the ceiling tiles in a bathroom located on the first floor which prevented effective fire stopping, creating the risk that fire and smoke could spread to other areas.
- Quarterly inspection reports identifying multiple failures in emergency lighting had not been acted upon.
- Actions identified in quarterly fire inspection reports to improve fire detection in the laundry room had not been completed.
- Fire directional signage was in place leading to a fire exit not in use.
- Simulated evacuations did not provide sufficient information to assure inspectors that they were effective, For example: a simulated evacuation carried out with night-time staffing levels in March 2023 was timed as having been completed in 2mins 32sec. This simulated evacuation indicated that 2 residents were transferred to a place of safety on the first floor of the centre, where resident peeps indicated that two residents required the assistance of one staff and two residents required the assistance of two staff while 3 residents were independent. Narrative describing how this evacuation was achieved did not provide the necessary assurances that this simulated evacuation could be performed safely within the time limit indicated on the evacuation record.
- PAT testing(the testing of electrical appliances) had not yet commenced in the centre.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Action was required in individual assessment and care plans to ensure the needs of each resident are assessed and an appropriate care plan is prepared to meet these needs. For example:

- A review of care plans found that not all resident files contained current health-care associated infection status and history. Information was not consistently recorded in one residents care plan to effectively guide and direct the management of an MDRO.
- There was no wound care plan available for one resident. Recent nursing notes had detailed the management of their wound and a photo had been uploaded to their record but the current status of the wound was unclear.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had good access to local general practitioners (GP) as well as specialist treatment and expertise in line with their assessed needs. GPs visited the centre at least once a week or more frequently if required. There was also a system in place to access out of hours medical support. Specialist expertise was available via referral and included access to physiotherapy, occupational therapy, dietetic services, chiropody, and optician care. There was a well-established referral system in place for residents to access psychiatry of later life services.

Judgment: Compliant

Regulation 8: Protection

There was a management of resident accounts and property policy in place which was updated in April 2022 which was made available for inspector's to review post inspection. The inspector's were informed that the provider was not acting in the capacity of a pension agent for any residents living in the centre. There were local arrangements in place to support residents access finances for any day to day expenditure which was effectively monitored by the provider.

Judgment: Compliant

Regulation 9: Residents' rights

Throughout the day the inspector observed residents being offered choice and timely support by the staff team. Staff were observed speaking with and assisting residents in a positive and friendly manner which respected people’s privacy, dignity and independence.

Activity staff were rostered to provide and co-ordinate activity support on a regular basis, however on the day of the inspection this support was provided by care staff and by members of the adjoining convent next door. Residents were observed to enjoy a vibrant music session with many residents joining in on the sing song. An activity schedule was in place and advertised in the centre.

Residents were encouraged to retain their independence as much as possible. All residents rooms viewed on inspection were clean, cosy and well laid out so that residents could access their private belongings. Some residents had access to a kettle, while all residents had access to TV's, radio's and newspapers.

Resident committee meetings were found to be held regularly where residents were kept up to date on news and events related to the designated centre. There was positive resident engagement at these meetings with key service areas discussed such as meals, activities and laundry facilities.

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 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Substantially compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Marian House OSV-0000693

Inspection ID: MON-0039817

Date of inspection: 01/06/2023

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: There were only two members of staff, a nurse and a health care assistant rostered during the night to provide care and support for 24 residents on both the ground and first floor. • Another Healthcare Assistant was added for the night shift from the 2nd of June 2023 up to present. A total of 3 staff at night – 1 staff nurse & 2 HCAs. In addition, the health care assistant had a number of other duties to perform at night such as laundry and cleaning tasks. • Guidelines on tasks to be completed at night are in place and explained to staff. Printed copy available in checklist template for recording and monitoring. TIMEFRAME: Completed in June 2023	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Records made available for the inspector to review confirmed that not all staff had access to appropriate training, findings on inspection confirmed the following gaps in mandatory training: • Four staff required safeguarding training. • Three staff were due fire safety training. • One staff member required manual handling training. • Outstanding training of above staff booked in May 2023 and completed in June 2023.	

TIMEFRAME: Completed in June 2023

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
Records relating to simulated fire drills were not always available, the inspectors were informed some fire drills had occurred but there was no record of these in the fire safety file.
• Record keeping of simulated fire drill reports reviewed and amended as well as fire drill report template. All documents kept in the fire safety folder.
Minutes of meetings held between the provider and the management team in the Centre were not available for review.
• Printed copy of Fire Safety Team Meeting records filed in a folder.

TIMEFRAME: Completed in June 2023

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Inspectors were informed that there were personnel changes within the provider entity, but these details were not clear at the time of the inspection. The Chief inspector had not been made aware of any changes to the provider entity via the required registration notifications.
• NF37 A, B & C were completed and sent to HIQA with the turnover date of 26th June 2023 for the new provider representative and members. Notification Reference: NOT-0802011

TIMEFRAME: Completed in June 2023

Communications between the provider and the local management were not robust and did not ensure that the local team were sufficiently informed about the progress of the building upgrades to include the fire safety improvement works that were to be carried out in the Centre. As a result, they were not able to plan for the works and were not in a position to keep the residents informed about the substantive works that were planned for their home.

Records of provider governance meetings were not available in the Centre on the day of

the inspection. Furthermore, there was no evidence that the local management team met with the provider. As a result, inspectors were not assured that the provider was sufficiently informed about what was happening in the

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Centre and had sufficient oversight of the quality and safety of the service.

• DON/PIC, Designated Proprietor, Provider Representative and/or Member/s of the Congregational Leadership continue to attend the Fire Safety Team meetings; Advisory Board; Clinical Governance
• To maintain circulation of newsletter to the Congregational Leadership, the residents and next-of-kin as a means of information dissemination
• To keep residents informed via the regular Residents' Meeting and/ or thru the residents Spiritual Advisor or sending individual letter or face-to-face.

TIMEFRAME: On-going

The registered provider had not ensured effective governance arrangements were in place in the designated Centre to ensure services were safe, appropriate and effectively monitored. This was evidenced by:
· Disparities between the finding of local infection prevention and control audits and the inspectors' findings on the day of the inspection highlighted that the audit and monitoring process in relation to infection prevention and control were not identifying where improvements were required to ensure compliance with the National Standards for infection prevention and control in community services.
• To contact IPC specialist for support & guidance on audits, quality improvement plan (QIP) & implementation to achieve compliance with the National Standards for infection prevention and control in community services.

TIMEFRAME: IPC specialist visit & audit completed in July 2023 awaiting IPC specialist official audit
report; then to work on QIP and implementation between August & September 2023

· Risks in relation to low numbers of staff available at nighttime had not been identified by the provider. Fire safety risks had not been addressed in a timely manner and had in fact been delayed to align them with premises upgrade works. Furthermore, no measures had been put into place to mitigate the known fire safety risks until the works had been completed.
• Additional night HCA put in place from 2nd June 2023 up to present & is now a permanent complement for night shift.
• Emergency Lighting works commenced on the week of 7th June and works on the fire panel will follow immediately.

TIMEFRAME: Extra Night HCA commenced June 2023
Emergency Lighting + Fire Panel target completion between August & September 2023
· Monitoring systems did not identify gaps in staff training and care planning found on this inspection and were ineffective in identifying areas that required improvement.
• Spreadsheet developed to highlight staff due training or refresher and being

maintained by admin/reception staff as well as record of completion of training.
• Re-education of staff on care planning conducted & audit to continue.

TIMEFRAME: June 2023 & ongoing

Regulation 24: Contract for the provision of services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 24: Contract for the provision of services:
All contracts required amendment to clearly identify if there was a charge for additional services provided in addition to services provided under the Nursing Home Support Scheme.
• Old & new contracts reviewed and updated accordingly with charges for additional services.

TIMEFRAME: June 2023 & ongoing

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
The registered provider had prepared a statement of purpose dated 18 August 2022 which contained information set out under Schedule 1 of the regulations. However, this document did not contain the following information,

• Who was in charge of the Centre when the person in charge was absent.

• Information in relation to accessing national screening programmes.
• Statement of Purpose amended June 2023 included the above information.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
A number of actions were required on behalf of the registered provider to ensure compliance with regulation 17 and matters set out under schedule 6 of the regulations, for example:
· A number of areas of the Centre required decoration due to wear and tear. Inspectors observed staining to ceiling tiles in multiple areas of the Centre, some walls, skirting boards and tiling required upgrade and repair to ensure they could be effectively cleaned to prevent the risk of cross infection.
• Broken & stained ceiling tiles to be replaced; to re-paint walls, skirting boards, etc.; flooring in the staff entrance, staff room and staff kitchenette to be replaced in July 2023.
· The layout of the sluice room in the Centre did not support effective infection prevention and control practices. For example, the room was small, cluttered and access to the hand washing sink and shelving obstructed.
• Sluice room to be expanded, to be rearranged to follow a dirty-to-clean flow, accessible bedpan rack and clinical handwash sink to be installed; flushing unit to be removed and an integrated bedpan washer will replace the existing one.

TIMEFRAME: Replacement of ceiling tiles + re-painting commenced in June 2023 and on-going
Flooring in the staff entrance, staff room & staff kitchenette completed in August 2023
Clinical Handwash sink ordered, delivery in 5 weeks & estimated start date of installation end of October 2023. Site visit from 2 companies for bedpan washer on 14th & 15th September; awaiting final quotes.

· A call bell was not accessible in an upstairs communal bathroom.
· Malodours were found in a bathroom.
• Call bell upstairs in communal bathroom made accessible, and malodours resolved.

TIMEFRAME: Completed June 2023

· A wheelchair was found to be stored in a toilet.
• Storerooms rearranged, all residents' & resident care equipment including wheelchair are now kept in the big storeroom near the dining area on the ground floor.

TIMEFRAME: Completed June 2023

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
The registered provider had not ensured effective governance arrangements were in place to ensure the sustainable delivery of safe and effective infection prevention and control and antimicrobial stewardship. For example;

· While antibiotic usage was monitored, there was no evidence of multidisciplinary targeted antimicrobial stewardship quality improvement initiatives.
· Surveillance of MDRO colonisation was not undertaken. A small number of staff were unaware of which residents were colonised with MDROs. This meant that appropriate precautions may not have been in place when caring for these residents.
Inspectors identified through speaking with staff that there was some ambiguity regarding what infection prevention and control measures were required to be used if caring for a resident that was colonised with CRE.
• Regular staff education to be conducted on:
- antimicrobial stewardship
- MDRO
- IPC control measures & precautions especially for residents with CRE, etc.

• Development of multidisciplinary quality improvements

TIMEFRAME: June, July 2023 & ongoing

Standard infection prevention and control precautions were not effectively and consistently implemented. This was evidenced by:
· Staff were advised to have a mask "at hand or in their pockets at all times." Inappropriate storage of masks may lead to cross contamination. Inspectors also observed that masks were not worn correctly by all staff during the course of the inspection.
• Instructions on use of mask corrected, education sessions conducted, and staff asked to complete IPC course on HSELanD

TIMEFRAME: June, July 2023 & ongoing

· Cleaning trolleys observed did not have a physical partition between clean and soiled items. Cleaning carts were not equipped with a locked compartment for storage of chemicals. This increased the risk of cross contamination and ingestion of hazardous cleaning products.
• Correct trolleys ordered end of July 2023 awaiting delivery.

TIMEFRAME: August 2023

· A dedicated specimen fridge was not available for the storage of laboratory samples awaiting collection. Inspectors were informed that samples were stored in a medication fridge. This posed a risk of cross-contamination.
• Specimen fridge & temperature checker ordered 3rd of August 2023, awaiting delivery.

TIMEFRAME: August 2023

· While the external surfaces of the jacuzzi bath were cleaned after use, the water jets did not receive routine disinfection. This posed a risk of cross infection for residents using the bath.
• Discontinued use from day of inspection up to present. To be replaced with an air jet bath, quotes from 3 different companies received, awaiting product presentations – one scheduled for Thursday 10th August 2023. Installation of purchased bath to be

coordinated with ongoing contractor works.

TIMEFRAME: Between August & September 2023

· Barriers to effective hand hygiene practice were observed during the course of this inspection. For example, additional dispensers or individual bottles of alcohol hand gel were required to ensure alcohol hand gel was readily available at point of care. There were a limited number of clinical hand wash sinks available for staff use. There was no hand washing sink in the
housekeeping store.
• IPC specialist recommended someone to assist in identifying suitable areas for additional dispensers, waiting for availability for a site visit from 8th August 2023
• A clinical handwash sink to be installed on the extension side to cover Rooms 1-7; janitorial sink to be installed in the housekeeping storeroom; both will be part of the upgrade works.

TIMEFRAME: August 2023 for additional alcohol gel at points of care
Estimated start date of major upgrade works October 2023

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: The provider had failed to put effective measures in place to identify and address fire safety risks in the designated Centre. As a result, the inspectors found that the following risks had either not been identified or were identified, the mitigating measures to reduce the risk were inadequate. This was evidenced by:

· Holes found in the ceiling of a storage cupboard located in the clean linen room which required fire stopping to stop the spread of smoke and fire.
· There were gaps in the ceiling tiles in a bathroom located on the first floor which prevented effective fire stopping, creating the risk that fire and smoke could spread to other areas.

• Holes & gaps to be covered.

TIMEFRAME: Holes & gaps covering commenced in June 2023 in the clean linen room storage cupboard, as well as in the identified bathroom on the 1st floor; a fully fire stopped concrete in place above the ceiling tiles which is compliant with fire safety.

Points of clarification from the facility's fire consultant: the suspended ceiling tiles in place are purely for decorative/ cosmetic purposes and make the smoke more visible. They do not contribute and are not relied upon for inhibiting fire spread from storey to storey. Such that fire spread is dealt with by the structural floor plan which are made of

concrete, therefore, not a fire risk issue.

Quarterly inspection reports identifying multiple failures in emergency lighting had not been acted upon.
· Actions identified in quarterly fire inspection reports to improve fire detection in the laundry room had not been completed.

• Emergency Lighting works commenced on the week of 7th June and works on the fire detection/ panel will follow immediately.

TIMEFRAME: New Emergency Lighting system installed & commissioned on the 27th of July 2023 as per IS 3217:2013 + A1:2017; The existing fire alarm/ detection system throughout the building has undergone a complete upgrade to the most recent regulations I.S. 3218:2013 +A1:2019 and will be commissioned on the 26th of September 2023.

· Fire directional signage was in place leading to a fire exit not in use.
• The direction where the arrow is pointing to be changed.

TIMEFRAME: Direction of arrow rectified in July 2023 alongside the emergency lighting works.

A point of clarification from the facility's fire consultant – the existing staircase S2 is always available for ambulant person egressing. There is no situation where a fire exit in the facility is not in use.

· Simulated evacuations did not provide sufficient information to assure inspectors that they were effective.
• Simulated fire drill record reviewed; new template devised.

TIMEFRAME: Completed June 2023; please see below copy of recent fire drill done

·PAT testing (the testing of electrical appliances) has not yet commenced in the Centre.
TIMEFRAME: Completed 19th September 2023

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:
Action was required in individual assessment and care plans to ensure the needs of each

resident are assessed and an appropriate care plan is prepared to meet these needs. For example:

· A review of care plans found that not all resident files contained current healthcare associated infection status and history. Information was not consistently recorded in one residents care plan to effectively guide and direct the management of an MDRO.

· There was no wound care plan available for one resident. Recent nursing notes had detailed the management of their wound and a photo had been uploaded to their record but the current status of the wound was unclear.
• The above were rectified, care plans on residents' HCAIs status & history as well as wound care plan updated accordingly.
• To continue with regular care plan audit and staff re-education.

TIMEFRAME: June/ July 2023 & ongoing

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	02/06/2023
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	30/06/2023
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.	Not Compliant	Orange	31/03/2024
Regulation 21(1)	The registered	Substantially	Yellow	30/06/2023

	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.	Compliant		
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	30/06/2023
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Substantially Compliant	Yellow	25/07/2023
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	30/09/2023
Regulation	The agreement	Substantially	Yellow	30/06/2023

24(2)(b)	referred to in paragraph (1) shall relate to the care and welfare of the resident in the designated centre concerned and include details of the fees, if any, to be charged for such services.	Compliant		
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Not Compliant	Orange	31/01/2024
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	31/03/2024
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	31/10/2023
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire	Not Compliant	Orange	21/06/2023

	prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.			
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Orange	31/07/2023
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	31/12/2023
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where	Not Compliant	Orange	01/02/2023

	necessary in the event of fire, of all persons in the designated centre and safe placement of residents.			
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	19/06/2023
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Substantially Compliant	Yellow	31/07/2023
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Substantially Compliant	Yellow	31/07/2023