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:	Orwell Private
Name of provider:	MCGA Limited
Address of centre:	112 Orwell Road, Rathgar, Dublin 6
Type of inspection:	Unannounced
Date of inspection:	14 November 2024
Centre ID:	OSV-0000078
Fieldwork ID:	MON-0041160

About the designated centre

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

Orwell Private is located in south Dublin close to local amenities such as bus routes, restaurants, and convenience stores. The centre can accommodate 170 residents, both male and female over the age of 18 years. They provide long term care, short term care, acquired brain injury care, convalescence care, respite and also care for people with dementia. The centre is made up of a period premises that has been adapted and extended to provide nursing care and support through a number of units. The units provide bedroom accommodation alongside communal areas including sitting and dining areas and a kitchenette that are homely in design. Bedroom accommodation is a mix of single and double rooms. The vast majority have en-suite facilities and a small number of bedrooms have shared bathrooms. Additionally on the premises there is a full time hair dressers, cafe, gym, library and training rooms.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	165

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 14 November 2024	08:00hrs to 16:30hrs	Niamh Moore	Lead
Friday 15 November 2024	08:00hrs to 15:55hrs	Niamh Moore	Lead
Thursday 14 November 2024	08:00hrs to 16:30hrs	Aislinn Kenny	Support
Friday 15 November 2024	08:00hrs to 15:55hrs	Aislinn Kenny	Support
Thursday 14 November 2024	08:00hrs to 16:30hrs	Laurena Guinan	Support
Friday 15 November 2024	08:00hrs to 15:55hrs	Laurena Guinan	Support

What residents told us and what inspectors observed

This inspection took place over two days, during which the inspectors spent time in the centre observing the environment and the care provided, and talking to residents, visitors and staff to see what life was like for residents living at Orwell Private. Inspectors met with and spoke with 19 residents and four visitors during the two days. Overall residents and visitors both gave positive feedback about the kindness of staff. The feedback from residents was that they were generally content living in the centre. Visitors spoken with were happy with the care they and their loved ones receive. There was praise provided for the staff team with comments such as they were "kind" and "do anything to help".

Inspectors arrived unannounced at the centre and were permitted entry via a bell system where the front door was opened remotely. Inspectors waited in the reception area for staff to arrive to verify their identity. Inspectors spoke with two staff who were passing who were unaware of who had responded to the bell as all three floors have access to the front door system. One of these staff members informed the deputy director of care who was the senior staff member on duty at that time. Inspectors then held an introductory meeting. At the introductory meeting inspectors were told the access system had been changed the day before and management would follow up to ensure effective measures were in place in respect of safe access to the centre. Management confirmed this was not standard practice.

Following this introductory meeting, inspectors walked through the centre and were met by two members of senior management, the person in charge and a director for the company. Orwell Private is a large nursing home which is registered for 170 residents and consists of three different buildings which contain the residential areas for residents, referred to as Orwell House, The Raglan, and The Elgin.

An area referred to as the Avenue contained additional communal facilities for residents, such as a café which served a variety of hot and cold foods and a small selection of toiletries. It was seen to be a very social area and the staff there created a jovial, familiar environment which was enjoyed by many residents, visitors and staff. The residents could also avail of a hairdressing salon on this level which was finished to a high standard and was seen to be well attended over both days of the inspection. There was an oratory and a well-equipped gym with a treadmill, punch bag, exercise bike and weights that could be used by residents independently or with the assistance of staff. Inspectors observed there were no call bells in two toilets and the oratory located in this area.

The centre was warm and welcoming and furnished to a high standard. Tasteful artwork was on display throughout the centre and many communal rooms were cosy and comfortable with decorative items and furniture providing a homely feel. Some of the residents' bedrooms had identifiers such as photos and information relevant to the resident as a way finder for residents to easily find their own bedroom. Residents' bedrooms were seen to be clean, well-maintained and personalised with

belongings. Residents reported that they were happy with their rooms with one resident stating "the views from my room are just gorgeous". However, during the walk-around, inspectors observed a bedroom without the usual furnishings. Management told inspectors this was due to the management of a resident who had specific needs. These restrictions had not been dealt with in line with the provider's policy.

Inspectors observed there was a calm environment throughout the centre. Residents could avail of many amenities and services that enabled the promotion of a high quality of life. There were communal and quiet areas throughout the centre where residents could meet with their visitors and friends, watch television, read newspapers or listen to the radio. There was an occupational therapy (OT) kitchen where residents were supported to do therapeutic cooking. An activity schedule was on display in all areas. Residents spoken with said they were supported in choosing and accessing the activities. Activities were seen to occur throughout the inspection, such as art, hand massage, relaxation and baking a Christmas cake. There was a monthly "Pub Night" held in the centre's café and residents were also supported to attend external outings. The garden had a men's shed where residents could engage in woodwork and painting, and a putting green. The centre was also home to four chickens. All these provided opportunities to maintain hobbies and stimulate conversation and relationships between residents.

Inspectors observed an excessive amount of inappropriate items, including clinical waste bins, small safes and an ice machine, in the plant room. Staff told inspectors that these items had never been used in this designated centre. An immediate action was issued in this respect and this was responded to and actioned before the end of the inspection. Inspectors also observed inappropriate storage of records and medicines during both days of the inspection. For example, inspectors viewed the mens' shed on the second day of inspection and observed boxes of residents' files being stored in the shed alongside maintenance machinery. There was also a strong smell of solvents in the area and inspectors observed there was no fire detection within this area.

Inspectors observed the lunch-time dining experience. Residents were offered a choice of starter such as soup or melon, main courses such as beef lasagne, cod or chicken and desserts such as profiteroles or fresh fruit salad. Meals appeared wholesome and appetising. Many residents spoken with confirmed they enjoyed the food on offer, with many seen to enjoy the lasagne option on the second day of the inspection. Staff were knowledgeable regarding the different diets each resident was to receive in line with their care plan.

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 inspection to review compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People (Amendment) Regulations 2022). On this inspection, the inspectors also followed up on the compliance plan submitted by the registered provider following the previous inspection in January 2024 and information, both solicited and unsolicited, received since then. The findings of this inspection is that some management systems were not ensuring the service was provided in line with the regulations.

Notwithstanding the overall good level of care provided in the centre and the high satisfaction levels that residents and visitors described, significant concerns in respect of the management and oversight of one resident's care needs led to inspectors issuing an urgent compliance plan under Regulation 5: Individual assessment and care plan and Regulation 8: Protection. The registered provider undertook immediate steps to address this during the inspection, and the response to the urgent compliance plan did provide the required level of assurances and was accepted.

MCGA Limited is the registered provider for Orwell Private. There are five company directors, with three of these directors holding management roles within the designated centre. Two directors of MCGA Limited were present during this inspection. The person in charge was supported in their role by a deputy director of care, a director of nursing, two assistant directors of nursing, clinical nurse managers, a nurse educator, staff nurses, health care assistants, activity staff, catering, household, and administration staff.

The registered provider had a schedule of written policies and procedures which were available to staff and seen to be reviewed within the last three years, however, inspectors saw examples of the provider's policies not being adhered to regarding one resident's care, which had not been identified by the oversight mechanisms put in place by the management team. Examples of which are set out in Regulation 7: Managing behaviours that challenge, and Regulation 8: Protection.

Five staff Schedule 2 files were reviewed and showed that garda vetting was in place prior to the staff member’s commencement of employment. However, the systems in place did not ensure all records, as required by the regulations, were available, and stored securely as further detailed under Regulation 21: Records.

There was evidence of governance and management structures and oversight including management meetings, committees and a schedule of audits in place to evaluate the quality of the service. Inspectors saw that clinical care was discussed in these forums, and there was a comprehensive annual review completed for 2023 which evidenced consultation with residents. However, inspectors found that some of the systems in place to monitor and identify improvement were not fully effective in areas of the service such as documentation, residents' care, managing behaviours that challenge and protection.

A sample of six residents' contracts were reviewed. Inspectors found that for each resident, there was a written contract with the provider. However not all contracts

specified the correct terms for each resident, this will be further discussed under Regulation 24: Contract for the provision of services.

The complaints policy was on display in many areas throughout the centre. Inspectors who spoke with residents and visitors said that they knew who to bring a complaint to. They also said that when they had raised an issue with staff, it had been dealt with promptly. A sample of complaints were looked at by inspectors and they were found to be mostly dealt with within the regulatory timeline. However, inspectors found that although a complaints officer was nominated, complaints were handled by a number of staff. For example, inspectors observed records where three staff were involved in the management of one complaint which was not aligned to local procedure. This will be discussed further under Regulation 34: Complaints Procedures.

Regulation 14: Persons in charge

The person in charge works full-time in the designated centre, and has the relevant experience and qualifications as required by the regulations. For example, they are a registered nurse with experience in the care of older persons and holds a post registration management qualification.

Judgment: Compliant

Regulation 21: Records

Information governance within the centre required overall improvement. For example:

- All records set out in Schedule 3 were not kept in the designated centre or available for inspection by the Chief Inspector.
    - A copy of all correspondence to or from the designated centre relating to each resident, for example inspectors were told documentation on the funding arrangements in respect of one resident was not available. In addition, inspectors requested to see external referral forms for a number of incidents that had been notified to the Chief Inspector in 2023; such copies were not received.
- There was evidence that records were not kept in a manner that was safe and accessible as there were delays to inspectors receiving requested documents. This resulted in delays to accessing key information where documentation had to be requested on multiple occasions.
- Not all records were stored securely. On day one of the inspection, inspectors highlighted to management on numerous occasions that cupboards which contained residents' files were unlocked, this remained a finding on day two.

Judgment: Not compliant

Regulation 23: Governance and management

The governance and oversight arrangements in the centre required strengthening to ensure the service was operated in line with the regulations. For example, this inspection required the issue of an urgent compliance plan to provide assurances due to inspection findings where:

- Inspectors were not assured the provider had effective systems in place to ensure residents were safeguarded from harm at all times; inspectors found this particularly related to one resident where their right to privacy, dignity and autonomy was not upheld.
- Management systems in place had failed to appropriately and comprehensively assess whether the service could meet the needs of one resident with complex needs both in terms of resources and skill-set and take effective steps in ensuring the effective delivery of care in accordance with the statement of purpose.
- Oversight systems for the submission of notifications to the Chief Inspector were not effective.
- Inspectors found that the registered provider had not fully responded to the findings of the inspection of January 2024 under Regulations 9: Residents' rights, specifically the privacy concerns raised for the residents with bedrooms on the Elgin house boardwalk. Inspectors saw that since this inspection, the registered provider had put a film on these windows, however this was not effective as the finding remained that the interior of these bedrooms were still visible to residents, visitors and any contractors accessing these areas.
- As further discussed under Regulation 28: Fire Precautions, the registered provider did not implement their own risk assessment on fire safety. A risk assessment undertaken by the provider had identified a 12 bedded compartment as the highest risk. The provider's action plan stated a commitment to divide the compartment with fire doors and fire wall to make two separate compartments from 12 residents to five and seven, with a date of completion as 31st March 2024. This had not been completed.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

Inspectors reviewed records in relation to contracts for the provision of services and found that these records did not meet the regulatory requirements, for example:

- In two contracts viewed, they recorded each resident's room number, however they did not detail the occupancy of that bedroom.
- In two contracts viewed, the current fees to be charged was not outlined in their contracts. Inspectors were told that fee changes had been made in 2023, however this was not reflected in a contract reviewed.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

From a review of residents' care records and complaints, the person in charge had not submitted all notifiable incidents within three working days of their occurrence as set out under Schedule 4 of the regulations. For example, inspectors saw documentation concerning a physical altercation between two residents which documented that as a result one resident felt unsafe in the presence of the other resident. This incident and others reviewed during the inspection, had not been recognised as abusive interactions and notified to the Chief Inspector.

Judgment: Not compliant

Regulation 34: Complaints procedure

While there was an accessible procedure for dealing with complaints, inspectors found that complaints management within the centre did not meet the requirements of Regulation 34 in the following areas:

- Although the complaints procedure identified a nominated complaints officer to investigate the complaints, this was not implemented in practice. Up to three staff were involved in the investigation of a complaint and the investigation findings were then relayed to the complaints officer who handled communication of these to the resident and families. This was not in line with the centre's own complaints policy.
- Inspectors found that a written response informing the complainant of the outcome was not always furnished. Management informed inspectors that it was standard practice to inform the complainant verbally, and this was seen in two records reviewed.
- Inspectors found that record keeping for complaints was not sufficiently detailed. For example, following review of the complaints log, the details of complaints and the steps taken to resolve them were not clear to inspectors.
- Inspectors saw evidence of training on the management of complaints for the complaints officer. However, training for the review officer was not evidenced

on the day of the inspection. The review officer told inspectors that as the certificate was unavailable for reference, they would re-complete this training.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

The registered provider had policies and procedures as specified in Schedule 5 of the regulations in place which were seen to have been reviewed within the last three years. However, as discussed within this report inspectors were not assured that all of these policies were adopted by staff within the designated centre. Specifically the policies on complaints procedures, record management, the management of admissions, transfers and discharges, behaviours that challenge and safeguarding.

Judgment: Substantially compliant

Quality and safety

Overall, the majority of residents living in Orwell Private received a good standard of care and support to ensure that they could enjoy a good quality of life. However, the registered provider was required to take further significant action in respect of management of individual assessment and care planning, managing behaviours that challenge, protection, residents' rights, premises and fire safety to ensure the service provided was safe and appropriate at all times for all residents.

The majority of care plans reviewed during this inspection showed that residents' needs were in general comprehensively assessed using validated assessment tools and care plans were reviewed at regular intervals. However, inspectors had significant concerns in respect of the care planning arrangements and the care for one resident with complex care needs. An urgent action was issued to the provider following the second day of inspection in relation to this which is further discussed under Regulation 5: Individual assessment and care plan.

A small number of residents experienced intermittent responsive behaviours. Staff were observed to maintain a positive and supportive approach to residents' responsive behaviours and their responses were dignified and person-centred as seen on the day. Inspectors found that restraints use in the centre required review to ensure that as per National Policy, less restrictive alternatives were being trialled and documented.

While training levels were high and staff spoken with on the days of the inspection displayed an understanding and knowledge of safeguarding vulnerable adults, there

was a lack of assurance that staff consistently implemented the principles of training into practice and that there was an effective culture in relation to safeguarding. In addition, inspectors found that the registered provider's policy on safeguarding was not fully adhered to. This is further discussed under Regulation 8: Protection.

Throughout the days of the inspection, inspectors saw residents participating in both group and one- to-one activities which were led by a team of activity staff who were available Monday to Sunday. Inspectors observed staff engaging with residents in a kind and respectful manner at all points of contact. There was evidence of residents meetings being held and attended, however, inspectors found that residents' rights to privacy and the use of advocacy services was limited. This will be dealt with further under Regulation 9: Residents' Rights.

The building was clean, bright and overall the design and layout of the centre met the collective needs of residents. The registered provider had support with maintenance and an ongoing repair programme was in place to ensure the premises was kept in a good state of repair internally and externally. There was adequate communal and private spaces other than bedrooms available. However, some action was required to ensure all areas of the premises conformed to the matters set out in Schedule 6. This is further discussed under Regulation 17: Premises.

Inspectors observed lunch being served on two occasions during the inspection and mealtimes were seen to be a relaxed occasion. Residents could choose to dine in one of the dining rooms or in their bedrooms. Inspectors observed that staff checked the temperature of the meals prior to serving. Modified diets were well-presented and there were staff available to assist at mealtimes and were seen doing so in a calm and appropriate manner.

Since the previous inspection the registered provider had arranged for a fire safety survey of the building and the provider had started to implement some of the actions relating to this. However, concerns regarding the precautions and arrangements in place to reduce the risk of fire are outlined under Regulation 28: Fire Precautions.

Regulation 17: Premises

The registered provider did not ensure that the premises of the designated centre were appropriate to meet the needs of the residents in the centre and equipped and maintained in accordance with the statement of purpose. On the first day of the inspection, inspectors observed one completely unfurnished bedroom which had white-rock walls and no bed, chair, wardrobe or other personal storage space. This was not a homely environment for the resident who lived in that room as outlined in the provider's own statement of purpose. The premises did not conform to the matters set out in Schedule 6, and further action was required to ensure compliance. For example:

- Emergency call facilities were not accessible in every area used by residents. The oratory and three toilets located near to the gym and café did not have an emergency call bell to enable residents to call for support if required.
- There was unsuitable storage seen within the designated centre.
    - Designated storage area for the centre was full with stock items that did not belong to and were not required for the operation of the registered designated centre. In addition, various items were stored inappropriately in the plant room due to a lack of storage internally for maintenance equipment. An immediate action was given during the day one of inspection and these items were removed on the day
    - Medicines were inappropriately stored in a day room and in unlocked presses on corridors which is not safe practice.
    - Residents files were stored unsecurely; a repeated finding on both days of inspection.
- Not all equipment to be used by residents was well-maintained and in good working order. For example the shower and toilet in the en-suite of the unfurnished bedroom was broken, posing a safety risk.

Judgment: Not compliant

Regulation 18: Food and nutrition

The menus on display showed that there was a choice of meals provided, as well as snacks and drinks being available throughout the day. Inspectors observed that the meals served looked nutritious, and were seen to be prepared according to the different dietary requirements of the residents. Residents spoken with were all very complimentary about the food offered.

Judgment: Compliant

Regulation 27: Infection control

Infection control practices were safe. Household staff spoken with had a good knowledge of their role in general cleanliness and in infection control. The cleaning trolleys had a locked compartment to keep cleaning materials secure. Sluices were locked and were seen to be clean and tidy. Hand cleaning and personal protective equipment stations were located throughout the centre to facilitate infection control. There was information recorded for residents with multi-drug resistant organisms (MDROs). Inspectors found that residents' needs in relation to their MDRO was detailed in their care plans, and the infection control outlined were observed to be carried out in practice. Staff spoken with were aware and knowledgeable on the guidance in these care plans.

Judgment: Compliant

Regulation 28: Fire precautions

Arrangements for detecting or containing fires required review. For example:

- Devices to detect fire were not in place in all areas used by the designated centre, such as a medication room.
- A full assessment of the fire doors was required to ensure that they would perform as expected in the event of a fire as some were observed to have damaged smoke seals or did not fully close.

Improvement was required by the registered provider to take adequate precautions against the risk of fire, for example:

- Old electrical items were being stored in a room referred to as a "comms room" that contained an electrical panel and was a high risk area.
- A hoist was being charged in a store room where boxes of files were also being stored.

Improvement was required from the registered provider to ensure, by means of fire safety management and fire drills at suitable intervals, that persons working in the centre and, in so far as is reasonably practicable, residents are aware of the procedure to be followed in the case of a fire. For example:

- While fire safety drills were taking place in the largest compartment and the drills contained good detail, the evacuations that were carried out were on the same three rooms for all drills in this compartment from May 2024 to October 2024 which meant the rest of the compartment did not have a simulated drill. Consequently there was a lack of assurance that all residents could be safely and timely evacuated in the event of fire. This was particularly important as this specific compartment had been identified as a high risk area, and plans to divide the compartment by 31st March 2024 had not been achieved.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Inspectors reviewed the care planning arrangements for nine residents and for the majority of the residents the arrangements were adequate. However significant and urgent concerns relating to the assessment of needs, provision of care and care plans for one resident required urgent review.

- The resident did not have an updated assessment to meaningfully inform their care. This resident had an initial assessment completed upon their admission in 2019, and there was no evidence of any other comprehensive needs assessments completed since then. The information contained within the initial needs assessment in 2019 was not used to meaningfully inform the current care planning arrangements for that resident and there were a number of occasions where the care plans in place contained directions that clearly conflicted with the needs assessment.
- Inspectors were told that the registered provider was having difficulty responding to and managing the resident's changing needs. However, there was no evidence of multidisciplinary assessment, referral and review to inform the care of this resident. For example, inspectors requested copies of the resident's records which showed that the last engagement with psychology occurred in 2019 and occupational therapy (OT) in 2021. In the absence of clinical records, the inspectors could not be assured that the resident's care was underpinned by an accurate diagnosis and assessment of their care needs. Inspectors received conflicting information as to whether the registered provider could meet the needs of the resident, and there was a lack of evidence of referrals to specialist services for appropriate expertise and support. In addition, no advocacy services were involved.
- Inspectors found numerous examples of inappropriate and undignified interventions documented in the resident's care plan which were not evidence-based. Some interventions outlined to guide staff as to how they should respond to communication or behavioral needs posed a safeguarding risk to the care and welfare of this resident. For example, guidance in care plans directed staff to restrict the resident's access to food and communal areas should they not conform with the requests of staff.
- An urgent action plan was issued to the provider to undertake a full review of this resident’s care planning arrangements incorporating a person-centred and human rights-based approach. In addition, the provider was requested to provide assurance of arrangements for ongoing clinical oversight for this resident. The response to the urgent compliance plan received did provide assurances.

Judgment: Not compliant

Regulation 6: Health care

Notwithstanding the overall good healthcare the majority of residents received within the centre, the registered provider had not ensured following a comprehensive assessment the provision of appropriate medical and healthcare to one resident which is reflected under Regulation 5: Individual Assessment and Care plan.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Residents predisposed to episodes of responsive behaviours had a responsive behaviour care plan and other documentation to guide staff. However, inspectors saw one instance where the care plan did not provide effective guidance on how to manage a resident's behaviours in a manner that was not restrictive.

Inspectors found that restraint was not always used in accordance with the registered provider's own policy and the National Policy "*Towards a Restraint Free Environment in Nursing Homes*". For example:

- Not all residents had alternatives documented as having been trialled in advance of implementing a restrictive measure. For example, no evidence was available in two out of eight records reviewed. Therefore there was a lack of evidence that the least restrictive measure was in place for these residents.
- Two residents using bedrails did not have a bedrail assessment in place; this was not evidence-based and was an infringement in residents' right to liberty.
- Not all restrictive practice in place were identified as restraints. For example, eight residents using restraints such as lap belt, bedrails and bed bumpers were recorded as an enabler. There was a lack of understanding in what constituted a restrictive practice.
- The registered provider's policy stated that responsive behaviours should not be managed in a manner that is restrictive, and that intervention is only to be considered as a last resort and for a time limited period. Inspectors found on the first day of the inspection, that a resident's environment had been altered due to responsive behaviours; there had been no reviews to ensure this was for a time limited period or that it was being kept under review.

Judgment: Not compliant

Regulation 8: Protection

The registered provider had not taken all reasonable measures to ensure all residents were safeguarded and protected from abuse, as evidenced by the following:

- There was a failure to recognise and respond appropriately to two incidents of suspected abuse received via the complaint process. This included a confirmed incident of physical abuse between two residents which was not appropriately followed up. There was no investigation into these allegations and, as a result no assurance that the concerns raised were managed according to the centre's safeguarding policy and that appropriate protections were put in place in respect of two residents.

- Arrangements in place for a vulnerable resident did not adequately ensure that they were safeguarded and protected from abuse. Care plans guided staff to take abusive action when the resident did not conform. For example, in care records it stated that if the resident refuses to shower or brush their teeth, they should be informed that they will not receive any food until they comply. Management had not identified these safeguarding concerns and therefore had not appropriately responded to them. These concerns were brought to the attention of the registered provider and person in charge on the day of the inspection. An urgent action plan was issued in respect of these concerns seeking assurance that the resident would be safeguarded and assurances were received following the inspection.
- Further action was required to ensure that staff were skilled and knowledgeable in relation to detection, prevention of and responses to any incidents or allegations of abuse and that they implemented the principles of safeguarding training into practice.

Judgment: Not compliant

Regulation 9: Residents' rights

While the registered provider had many good practices in relation to upholding residents' rights, there were fundamental gaps seen on the inspection in residents' rights to privacy and access to independent advocacy services. For example:

- Inspectors observed a resident's right to privacy was not adhered to. There was a lack of processes in place to support and uphold a resident's privacy and dignity needs and therefore no controls had been put in place to effectively manage the resident's known behaviours and to uphold the resident's rights.
- Residents' rooms were mostly private but those along the outside boardwalks did not have sufficient window screenings to prevent people outside looking in. While inspectors acknowledge that the registered provider had taken measures to address this, the residents inside these rooms remained visible from different points along the boardwalk and particularly when the bedroom light was on. This was a repeat finding from a previous inspection.
- While posters were on display throughout the centre signposting to advocacy services, inspectors found that access to meet and receive support from independent advocacy services was not available to all residents. For example:
    - Inspectors were told that a resident who had a significant number of responsive behaviours since their admission approximately five years ago had been recently referred to advocacy services a few months prior to the inspection, but the centre had received no response. There was no documentary evidence of this provided to inspectors or other evidence to show that staff had followed up on the lack of response or contacted a different service.

- Inspectors were not assured that referrals were made to the most appropriate independent advocacy services as outlined within the registered provider's documentation to enable timely access for residents. For example, inspectors viewed a response to an advocacy referral sent the week prior to the inspection, which detailed the referral was not sent to the relevant service for that particular resident's age profile and ability.

By the end of the second day, inspectors had received assurances that both these residents had been referred to suitable advocacy services.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	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 17: Premises	Not compliant
Regulation 18: Food and nutrition	Compliant
Regulation 27: Infection control	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Orwell Private OSV-0000078

Inspection ID: MON-0041160

Date of inspection: 15/11/2024

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
Regulation 21: Records
Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:

Resident records
The Registered Provider shall put in place measures to:
• Transition to a secure electronic records management system (ERM) to reduce dependency on physical files. Documents for new admissions from hospitals or discharging facilities will be uploaded to resident files in the Care Monitor and stored for easy access and secure archiving.
• Schedule bi-annual internal compliance reviews to assess adherence to record-keeping standards
These will commence in 2025, and the Provider is scheduled to complete these reviews in March and October starting in 2025.
Secure storage
• Install lockable cabinets in all areas containing resident files-Completed
• Conduct daily checks to ensure all cabinets remain locked when not in use-Immediate and ongoing.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The Registered Provider following the Inspection put in place measures to:

• Conduct a comprehensive safeguarding review, focusing on the resident identified in the inspection, to ensure their rights are upheld-Completed and ongoing
• Update the safeguarding policy to ensure clear guidelines on protecting residents' privacy, dignity, and autonomy- Completed
• Continue to provide targeted staff training on safeguarding vulnerable residents, emphasizing practical applications of autonomy and dignity principles.
• Strengthen safeguarding measures and oversight by assigning the designated officer to systematically review complaints, incidents, accidents, and ABC (Antecedent-Behaviour-Consequence) charts to identify potential safeguarding concerns and escalate them for investigation and reporting-Commenced in January 2025.
• Schedule monthly meetings between the Designated Officer and the PIC to review trends, discuss unresolved issues, and update protocols if needed-Commenced in January 2025.
The combination of privacy film, curtains, and blinds effectively addresses the privacy concerns identified during inspections. These measures provide residents with the ability to adjust their environment according to their individual preferences, ensuring their privacy and dignity are upheld at all times. Staff are trained to regularly encourage and support residents in using these privacy-enhancing tools, fostering a comfortable and secure living environment that aligns with the residents' needs and choices. Collect resident feedback from the residents living in the Elgin building through surveys or one-on-one discussions to evaluate their satisfaction with privacy measures which will be incorporated into resident's care plans
Date of completion:30th January 2025
Following the Inspection, the Registered Provider responded to the concerns raised by the Lead Inspector during the Inspection with regard to the needs of a resident with complex care needs by ensuring the statutory notification of specific concerns raised to the Chief Inspector under Regulation 31 and arranging for the investigation of concerns raised pursuant to Regulation 8; by engaging directly with the HSE by specific reference to the resident with a view to seeking to procure State resources to support service delivery to the resident in question

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:
• A comprehensive review of all resident contracts will be carried out by 28th February to identify omissions and inaccuracies. These contracts will be updated with the occupancy status of the resident's bedroom (e.g., single or shared), including specific details of additional funding arrangements, such as one-to-one care.
• The relevant residents and their representatives will be notified about the review of the contracts and be provided with a contract amendment for review and signature by 31st March 2025.
• Assign responsibility to the Contracts Coordinator to update contracts immediately following any changes to fees or funding.
• Perform quarterly audits of resident contracts to verify accuracy and completeness and Chief financial officer to report the audit findings at the Board of Directors meeting.
Date of completion: 28th February 2025

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
The Person in Charge is responsible for notifying the Chief Inspector (and Gardai when applicable) regarding any incidents/accidents, ABC incidents, falls, complaints which result in serious injury or raise an allegation of safeguarding concerns within the regulatory time frame. This is delegated to the Deputy Director of Care in her absence.
A detailed review of all complaints received each week will be conducted by the Person in Charge. The Person in charge will assess each complaint to determine if there are any concerns related to safeguarding or the need for further investigation in accordance with safeguarding procedures
Date of completion: Immediate and ongoing.
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Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
Compliance with Regulation 34
• Complaints requiring investigation will follow the center's formal complaints procedure.
• A single, dedicated complaints officer is appointed to investigate or may establish and direct an investigation team to investigate and manage complaints in line with the center's complaints policy. This will eliminate the practice of multiple staff conducting investigations and ensure consistency.

• Complainants will receive a written response detailing the outcome of their complaint. This will become standard practice and will include:
o A summary of the complaint.
o Actions taken during the investigation.
o The resolution or outcome of the complaint.
o A record of all written responses will be uploaded to the complaints report for auditing purposes.
• Complaints related to safeguarding will be investigated in line with safeguarding policies, and notifications to relevant authorities will be made as required.
• A monthly summary of complaints and their outcomes will be prepared and presented at management meetings to identify trends and areas for improvement.
• Feedback from complainants will be reviewed to assess satisfaction with the resolution process and inform service enhancements.
• All complaints data will be securely stored and regularly audited to ensure compliance with regulations.
• Staff will be encouraged to promote a culture of openness, ensuring residents and their families feel comfortable raising concerns.
• Further training will be provided for key personnel to enhance their skills in complaints management and conduct thorough investigations. This training aims to strengthen the team's capacity to manage complaints transparently and in compliance with regulatory standards.
Date of completion: 30th March 2025

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
To ensure that all policies outlined in Schedule 5 are implemented and adopted by staff within the designated centre, the following measures will be taken:
• All Schedule 5 policies, including those on complaints procedures, record management, management of admissions, transfers and discharges, behaviors that challenge, and safeguarding, are easily accessible to staff in digital formats via Orwell Academy, centres online learning platform.
• The centre has a "Policy of the Month" plan where staff are asked to read, understand and acknowledge policy reading every month.
• Starting in January 2025, the policies highlighted by inspectors during the recent review will be incorporated into the "Policy of the Month" schedule to ensure 100% compliance in policy familiarity.
• The Practice Development nurse will assess staff understanding and knowledge of these policies through regular spot checks and interviews, ensuring practical application in day-to-day activities.
• Staff adherence to mandatory and monthly policy reading will be reviewed during regular performance appraisals.
Date of completion: 30th June 2025

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• Emergency call bells will be installed in the oratory and the identified public toilets: Date of completion 30th January 2025
• Medicines are now stored in the locked cabinet. All staff have been reminded of the medication storage policy: Completed
• The Registered Provider is assured that since the inspection, the single affected bedroom has been appropriately furnished, and the shower/toilet facilities have been fixed and is fully operational. The premises is appropriate to the number and needs of the residents of the Centre and in accordance with the Statement of Purpose.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• Fire detection devices will be installed in the medication room and any other identified areas lacking coverage.
• A comprehensive assessment of all fire doors is scheduled to be carried out by the Fire safety officer. Damaged smoke seals will be replaced, and adjustments will be made to ensure all doors close fully and function as intended.
Date of completion: 28th February 2025
• The coms room has been reorganized to ensure compliance with fire safety standards.
• All resident files from this storage have been removed and the hoists are now charged in this designated area.
• Fire drills now cover all rooms in the largest compartment on a rotational basis to ensure comprehensive testing and staff preparedness-Immediate and ongoing
• Fire drills will be conducted quarterly in all compartments, ensuring all areas are tested within a 12-month period-Commencing January 2025
• The high-risk compartment is planned to be divided by March 2025, with fire-resistant partitions installed to enhance fire containment and safety. This plan includes:
o Engaged with a qualified contractor on 18/11/24
o Installing fire-resistant partitions compliant with relevant fire safety standards.
o Completing construction and testing by March 2025.

Regulation 5: Individual assessment and care plan	Not Compliant

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

• A comprehensive review of the resident's care plan has been undertaken to ensure it is person-centred and incorporates a human rights-based approach .All interventions have been revised to ensure they uphold the dignity, respect, and individual needs of the resident .The electronic copy of this care plan was submitted to the Chief inspector on 25/11/24 along with the urgent compliance plan which was accepted by the Chief Inspector.

• The resident's care plan will be reviewed monthly by the Person in Charge for the next four months to ensure continued adherence to person-centred, human rights-based care and safeguarding principles, a review of resident's care plan was completed on 24/12/24.

Date of next review 24/01/25

Regulation 7: Managing behaviour that is challenging	Not Compliant

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

• DOC and DDOC to review all responsive behaviour care plans to ensure they provide effective, non-restrictive strategies for managing behaviours.

Date of completion 30th March 2025

• Conduct training for staff on non-restrictive interventions and de-escalation techniques tailored to individual residents. A training plan is being developed by the Practice development nurse to include this in the Restrictive practice workshop. Restrictive practice workshop to commence in 2025 and the workshop to include;

o Develop and enforce a documentation protocol requiring clear evidence of alternatives trailed before restrictive measures are implemented.

o Provide staff training on the correct completion of bedrail assessments and alternative safety measures.

o Mandatory training for nursing staff on restraint reduction , alternatives to restraint, and management of responsive behaviours.

Date of completion :30th June 2025

• DOC to conduct a comprehensive bedrail assessment for all residents using bedrails.

• Review and update the care plan to reflect findings from the assessment and justify the use or removal of bedrails.

• Review and update the provider's restraint and responsive behaviour management policies to ensure clarity and alignment with national standards.

Date of completion: 30th March 2025

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• Conduct monthly safeguarding audits commencing January 2025 by the Designated safeguarding officer to review incident reports, investigations, and staff compliance with policies
• The two notifications identified during the inspection were thoroughly investigated in accordance with the complaint's procedure. Actions were taken to resolve the issues to the satisfaction of all parties involved.
• Further, the Registered Provider, following the Inspection, ensured effective engagement with the HSE Safeguarding Team on all safeguarding matters identified by the Inspectors during the Inspection by reference to one particular resident.
• Further strengthening of safeguarding workshops will involve incorporating practical, scenario-based training sessions to enhance staff understanding and ability to apply safeguarding principles effectively in real-life situations. These workshops will include the following components:
o Present real-life case studies and scenarios where safeguarding issues arise and encourage staff to discuss appropriate responses.
o Conduct role-playing exercises to simulate challenging situations, such as identifying signs of abuse, responding to allegations, and reporting concerns.
o Facilitate group discussions where staff collaboratively develop strategies to handle complex safeguarding scenarios.
o Introduce decision-making exercises where staff must prioritize actions based on safeguarding policies and resident safety.
o Provide scenarios that require staff to reference specific safeguarding policies and outline how they would apply these in practice.
o Offer constructive feedback during exercises to reinforce correct practices and address areas of improvement.
o Share best practices and learning points from each activity to enhance collective knowledge.
o Use participant feedback and post-workshop assessments to evaluate the effectiveness of the workshops.
o Regularly update scenarios and content to reflect emerging safeguarding challenges and regulatory changes.

Date of completion: Commence in February 2025 and continue on a monthly basis.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• The DOC contacted the National Safeguarding Team on 19th November 2024 to formally report the incident identified by the inspectors regarding a specific resident, seeking guidance and support to ensure that the situation was addressed comprehensively.
• Develop a directory of advocacy services categorized by age, ability, and other relevant factors to ensure residents are referred to the appropriate service. This would be

communicated to the clinical management team and is also displayed in the DON and CNM office- Date of completion 30th January 2025
• A dedicated advocacy champion will be trained and appointed to ensure timely referrals and services for residents and to follow up on delayed responses -Date of completion:30th June 2025
• Include case studies and practical exercises in the safeguarding workshops to help staff recognize and address privacy breaches and advocate effectively for residents-Date of completion :Immediate and ongoing
• Review the advocacy referral tracking system monthly to ensure all referrals are acted upon promptly and effectively -Date of completion :Immediate and ongoing
• Collect resident feedback from the residents living in the Elgin building through surveys or one-on-one discussions to evaluate their satisfaction with privacy measures.
Date of completion:30th January 2025.

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(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.	Substantially Compliant	Yellow	16/11/2024
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	16/11/2024
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a	Substantially Compliant	Yellow	30/03/2025

	designated centre and are available for inspection by the Chief Inspector.			
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Not Compliant	Orange	30/03/2025
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	30/01/2025
Regulation 24(1)	The registered provider shall agree in writing with each resident, on the admission of that resident to the designated centre concerned, the terms, including terms relating to the bedroom to be provided to the resident and the number of other occupants (if any) of that bedroom, on which that resident shall reside in that centre.	Substantially Compliant	Yellow	30/01/2025
Regulation 24(2)(b)	The agreement referred to in paragraph (1) shall relate to the care and welfare of the	Substantially Compliant	Yellow	30/01/2025

	resident in the designated centre concerned and include details of the fees, if any, to be charged for such services.			
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Substantially Compliant	Yellow	28/02/2025
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.	Substantially Compliant	Yellow	28/02/2025
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	30/03/2025
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (j) of	Not Compliant	Orange	02/01/2025

	Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.			
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	30/03/2025
Regulation 34(2)(f)	The registered provider shall ensure that the complaints procedure provides for the provision of a written response informing the complainant of the outcome of the review.	Substantially Compliant	Yellow	30/03/2025
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	Substantially Compliant	Yellow	30/03/2025

	individual care plan.			
Regulation 34(7)(a)	The registered provider shall ensure that (a) nominated complaints officers and review officers receive suitable training to deal with complaints in accordance with the designated centre's complaints procedures.	Substantially Compliant	Yellow	30/03/2025
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.	Substantially Compliant	Yellow	30/06/2025
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).	Not Compliant	Red	25/11/2024
Regulation 7(2)	Where a resident behaves in a manner that is challenging or poses a risk to the resident concerned or to other persons, the person in charge shall manage and respond to that behaviour, in so far as possible, in a manner that is not restrictive.	Substantially Compliant	Yellow	30/06/2025

Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.	Not Compliant	Orange	30/06/2025
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Red	25/11/2024
Regulation 8(2)	The measures referred to in paragraph (1) shall include staff training in relation to the detection and prevention of and responses to abuse.	Not Compliant	Red	25/11/2024
Regulation 8(3)	The person in charge shall investigate any incident or allegation of abuse.	Not Compliant	Orange	02/01/2025
Regulation 09(5)	The registered provider shall ensure that a resident has access to independent advocacy services, including access to in-person awareness campaigns by independent advocacy services and access to meet and receive	Substantially Compliant	Yellow	30/06/2025

	support from independent advocacy services. These services should be made available to residents in the designated centres and in private, as required.			
Regulation 9(1)	The registered provider shall carry on the business of the designated centre concerned so as to have regard for the sex, religious persuasion, racial origin, cultural and linguistic background and ability of each resident.	Substantially Compliant	Yellow	30/06/2025
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Substantially Compliant	Yellow	30/06/2025
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Substantially Compliant	Yellow	30/06/2025
Regulation 9(3)(b)	A registered provider shall, in so far as is	Not Compliant	Orange	30/06/2025

	reasonably practical, ensure that a resident may undertake personal activities in private.			