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:	Aisling House Nursing Home
Name of provider:	Hussein & Jeanette Ali Limited
Address of centre:	Sea Bank, Arklow, Wicklow
Type of inspection:	Unannounced
Date of inspection:	05 October 2021
Centre ID:	OSV-0000003
Fieldwork ID:	MON-0033443

About the designated centre

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

Aisling House Nursing home is a single-storey centre, which provides residential care for 31 people. It provides care for both male and female adults with general care needs within the low, medium, high and maximum dependency categories. A pre-admission assessment is completed in order to determine whether or not the service can meet the potential resident's needs. Twenty-four-hour nursing care is provided.

There were 15 single bedrooms, four of which had en-suite facilities and eight twin bedrooms, five of which had en-suite facilities. Each bedroom was appropriately decorated and contained personal items such as family photographs, posters and pictures. Communal space included a day room, and two smaller sitting rooms. The laundry and sluice room were situated in an adjacent building.

The environment was bright, clean and well maintained throughout. There was a well maintained internal courtyard. Adequate parking was available at the front of the building.

According to their statement of purpose, the centre strives to deliver resident focused care packages tailored to meet the individual needs. The centre aims to promote the quality of life and independence of residents through professional and friendly services.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	25

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
Tuesday 5 October 2021	09:25hrs to 20:00hrs	Liz Foley	Lead
Tuesday 5 October 2021	11:00hrs to 20:00hrs	Niall Whelton	Support

What residents told us and what inspectors observed

Overall residents received a good standard of health care in this centre. However risks with fire and infection control were impacting on the safety and well-being of all residents and staff. More meaningful activities would enhance the quality of life for all residents living in the centre. Inspectors observed practices, met many residents during the inspection and spoke at length with six residents to gain an insight of the lived experience in the centre.

On arrival inspectors were guided through the centre's infection control procedures before entering the building. The front door, and the external doors in the centre were locked and all staff carried a key to the doors. Residents told inspectors they could not go out alone and that staff had to open the door for them. CCTV cameras monitored all exit doors and the corridors within the centre, there was a sign advising visitors and residents of this. Apart from alcohol hand gel dispensers at the front door there were no other hand gel dispensers and no hand hygiene sinks in the centre and at the point of care for staff to clean their hands. Staff carried individual bottles of alcohol hand gel in their pockets however this was not in line with the national standards and did not support good hand hygiene practices.

The centre was warm throughout and there was a relaxed and homely atmosphere. Residents were observed mobilizing around the centre and relaxing in the day room and sitting room. Residents who smoked were observed frequently enjoying their break in an outside designated smoking area which was in close proximity to the nurse's office. The centre appeared to be clean with the exception of the laundry and sluice rooms. The centre was originally a domestic dwelling which was extended and adapted over time and is a single storey building. The centre can accommodate up to 31 residents at present in a mix of single and twin bedrooms. Some bedrooms had en-suite toilets and showers and the other rooms had a shared bathroom close by. Communal spaces included two sitting rooms, a day room, and a dining room. The centre is built on a long narrow site and overlooks the sea and local landscape at the rear. The most recent extension had 19 single en-suite bedrooms which the provider was hoping to open soon. When the new extension is occupied there will be two court yards which residents can access and a garden is planned at the rear of the centre.

The new extension which was not yet open was almost ready for residents to move into. All bedrooms were single and had en-suite shower and toilets. There was a dining room and a sitting room with a sea view and a kitchenette or tea station for those who could help themselves. The new laundry and sluice rooms were not yet completed. The provider was undertaking to get infection prevention and control advice regarding the layout and working of the laundry. The proposed laundry room only had one door which did not provide a flow from dirty to clean and this created a risk of cross contamination from dirty to clean laundry. Alcohol hand gels were not yet available in this area and would be installed prior to opening. There was a missed opportunity to install hand hygiene sinks for staff at the point of care during

the construction phase. The corridors had assistive hand rails and there was ample space to mobilise throughout the entire centre when in full operation.

A storage room beside the nurses' office had mixed items stored together. This room was cluttered and required review to ensure that there was no risk of cross contamination from the floors and equipment to the supplements and medications stored here.

Some issues with premises were found which the provider was undertaking to address. This included storage space for residents possessions. Cleanliness of high support chairs and staff changing facilities also required improvement.

Some one-to-one activity was observed in the day room in the evening after tea and consisted of hand massage and hand care. Residents told inspectors that not much went on in the centre in terms of activity or entertainment. There were lots of board games, puzzles, books and art supplies in the day room for resident to use if they chose however, no one was observed using any of the items provided. Inspectors observed long periods of inactivity in the day rooms during the inspection. Mostly passive activities were observed, for example, watching TV and listening to the radio. The group activity in the afternoon was praying the rosary which some residents were active in while others remained passively listening. Residents who remained in their bedrooms were not offered an alternative one-to-one activity and their interactions were based on care provision.

Interactions observed between residents and staff were respectful and kind. Residents were complimentary about staff and told inspectors there was always someone available if they required assistance. Residents were complimentary about the food and told inspectors they enjoyed a choice of home cooked meals. One resident explained that he loved pizza and the cook would make sure he had this for tea on a regular basis. Two residents described how they missed going into town since the government restrictions for COVID-19 were put in place and how they are now trying to regain their confidence to socialise outside the centre again. It was evident that staff knew the residents well and that residents were comfortable with staff and interacted positively with them.

The next two sections of the report present the findings of the inspection and give examples of how the provider had been supporting residents to live a good life in this centre. It also describes how the governance arrangements in the centre effect the quality and safety of the service.

Capacity and capability

Poor governance arrangements and poor oversight of risk was impacting on the safety of the service provided. Current systems to monitor the quality and safety of

care were ineffective and there was an over-reliance on the person in charge to manage the service and to provide clinical care, this was unsustainable.

Hussein & Jeanette Ali Limited were the registered provider for Aisling House Nursing Home. The company had two directors, one of whom was the registered provider representative (RPR). The person in charge worked full time and was responsible for the daily operations of the centre. The RPR was also a registered nurse and would deputize for the person in charge for any absences. The staff team consisted of nursing, caring, housekeeping and catering staff. Administrative support was provided remotely.

This was an unannounced risk inspection to monitor ongoing compliance in the centre and to inspect the new extension, which the provider had applied to register. A specialist fire and estates inspector attended on this inspection as there was a particular focus on fire safety management. Risks were identified with fire safety and infection prevention and control and an urgent action plan was issued to the provider following the inspection. The provider took immediate steps during and immediately following the inspection to mitigate the risks identified and to maintain the ongoing safety of residents and staff.

The service lacked expertise in fire safety and in infection prevention and control. For example, environmental hygiene audits did not identify the infection control risks found in the sluice, laundry and the risk caused by lack of access to hand hygiene facilities. These findings were concerning considering the centre had experienced an outbreak of COVID -19 in January this year. While a review of the outbreak had been completed the service had failed to identify these key areas of risk which continued to impact on the welfare of all residents and staff. Fire risks found included a lack of smoke/heat detectors in one part of the centre and lack of fire doors in the same area which combined created a very serious risk to residents and staff. The provider was responsive and immediately took steps to mitigate this risk by installing domestic detectors during the inspection and increasing staff levels by one person at night in order to ensure the detectors would be heard if they were triggered. Additional risks found are discussed under regulations 27 and 28.

Audits did not pick up issues found on inspection, for example, hand hygiene checklists did not identify the dearth of hand hygiene facilities in the centre which are fundamental to promoting good hand hygiene practices. Tools used by the provider to assess staffing needs were poorly understood and did this impacted on the staff resources available to provide meaningful activities.

There had been a high turnover in staffing in the centre over the past year and there were ongoing recruitment efforts in place to maintain safe and consistent staffing levels. The centre were hoping to open 19 new beds and would also be recruiting to find suitable staff to care for the increasing numbers of residents. However assurances were required regarding staffing availability at night to safely evacuate residents and to provide suitable activities.

There was poor oversight of training requirements in the centre. There was an over reliance on on-line training for staff with little evidence of course content or of staff

understanding of the training completed. The centre were looking at re commencing on site training following the easing of restrictions for COVID-19. All staff were due safeguarding training which is mandatory in the centre.

The documentation of complaints required review to ensure that all areas of concern and all types of feedback from residents were recorded. There were no complaints recorded so far this year and only three recorded in 2020 which provided limited opportunity to review quality in the centre.

The provider did not manage any pensions for residents. All staff completed satisfactory Garda Vetting prior to taking up employment and every three years thereafter.

Regulation 15: Staffing

Staffing resources required review to ensure there were sufficient numbers of staff on duty to safely evacuate residents at night and to ensure there were sufficient staff resources to provide suitable activities.

There were two staff rostered on duty at night time, this required review to ensure there were enough staff to safely evacuate and supervise residents in the event of a fire at night. Activities were provided by care staff who were allocated two hours per day, this was not sufficient to meet the needs of all residents in accordance with their needs and preferences.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Staff did not have access to appropriate training in the centre. For example, all staff were overdue or had not completed Safeguarding training which is mandatory training and is essential in maintaining the safety and welfare of vulnerable adults.

Training provided was not always appropriate, for example, some training in the centre consisted of watching a DVD and staff did not have the opportunity to discuss the information or were not assessed for their understanding of the information.

Inspectors were not assured that staff were appropriately trained in relation to infection prevention and control and residents' rights. This is discussed under regulations 9 and 27.

Judgment: Not compliant

Regulation 22: Insurance

There was a valid contract of insurance against injury to residents and additional liabilities.

Judgment: Compliant

Regulation 23: Governance and management

The management structure required review. Lines of authority and accountability were not clearly defined and this resulted in an over reliance on the person in charge for the daily operations of the centre and for clinical care. For example, the person in charge routinely provided nursing care when she was on duty and filled the role of the second nurse. Weekend rosters had two nurses on duty while week day rosters had one nurse and the person in charge. In addition to this, the person in charge was responsible for the daily operations of the centre and monitoring the quality and safety of the service. This was not a sustainable governance structure and resulted in poor oversight of risks and poor management systems.

Management systems in place were ineffective and had not identified the risks found on inspection, for example, risks with fire safety and infection control. Poor oversight and lack of expertise in these areas was impacting on the safety and well-being of residents and staff.

Judgment: Not compliant

Regulation 31: Notification of incidents

Incidents and reports as set out in schedule 4 of the regulations were notified to the Chief Inspector within the required time frames. The inspector followed up on incidents that were notified and found these were managed in accordance with the centre's policies.

Judgment: Compliant

Regulation 34: Complaints procedure

Residents stated they could discuss any concerns with the person in charge or with any staff member and they often did so. However the centre had not recorded any concerns or constructive feedback from residents so far this year which was a lost opportunity to inform quality improvements in the centre.

The centre had a complaints policy and the procedure to follow was displayed in the day room area.

Judgment: Compliant

Quality and safety

The quality and safety of care required improvements. Poor understanding of risks with infection control and fire were impacting on the safety and well-being of residents and staff. Improved access to the physiotherapist and more opportunities to participate in meaningful activities would improve the daily experience for residents in the centre.

An immediate action plan was issued on inspection regarding the absence of fire detection in a section of the centre adjacent to where two residents were residing in a four bedded compartment. The provider took immediate steps to mitigate this risk. Assurance was also sought from the provider in relation to the safe evacuation of residents from the larger fire compartment when staffing levels were lowest. The provider was also requested to submit floor plans, outlining the locations of fire compartment boundaries.

Staff were assigned a copy of the master key for all exits during their shift, and this was managed by the keys being signed in/out at the start and end of their shift. The master key was capable of opening all fire exits and exit gates and this was observed by inspectors. Inspectors saw records for internal fire safety audits, which included prompts to ensure systems were serviced, staff were trained, drills took place, daily inspections of means of escape and random checks of staff knowledge. The frequency of these audits varied. The person in charge had arranged for a comprehensive review of each resident's evacuation requirements. This informed a high level collective summary of residents needs which was kept with an emergency continued care folder in the event of an emergency. The summary document would benefit from further detail.

There were two fire safety registers in place, with relevant information contained in both. There should be one fire safety register and the person in charge confirmed these would be collated into one.

The centre was provided with an L1 type fire detection and alarm system, emergency lighting system and fire fighting equipment and these were all serviced and up to date. However, some aspects of the fire detection system and the

emergency lighting required review. Further improvements were required in relation to fire drills, containment of fire and clarification regarding the exact location of fire. These issues are discussed under regulation 28.

The centre had an outbreak of COVID-19 in January 2021 when 24 residents contracted the virus and sadly six residents who tested positive for COVID-19 passed away. The centre had put in place a contingency plan which assisted them to manage the outbreak. Since then the provider organised a vaccination programme including booster vaccinations for staff and residents in the centre.

Hand hygiene facilities were inadequate. The laundry and sluicing facilities were unclean and and were not fit for purpose. This is discussed under regulation 27.

The premises was generally well maintained throughout with the exception of the existing sluice and laundry rooms. However, some aspects of the premises did not meet regulatory requirements as discussed under regulations 17 and 12.

Care plans were person-centered and based on appropriate assessment of resident's needs. Care plans were routinely reviewed and updated in line with the regulations and in consultation with the resident.

Overall residents received good standards of health care and were supported to access appropriate health care services according to their individual need. There was a choice of GP's and residents could choose to retain the services of their own GP where possible. While there was evidence of referral to allied health professionals, for example, the dietician and occupational therapist, access to the physiotherapist could improve the well being of residents. For example, there was no evidence of reviews by the physiotherapist following a fall and this was a missed opportunity to promote the residents well being and maintain their mobility.

Oversight of risk required improvement, for example, risks already mentioned with fire and infection control. Documentation of incidents required improvements. Incident reports did not always state that neurological observations were monitored following an unwitnessed fall which is best practice in detecting any neurological changes that may indicate the resident needed medical review. Reviews of incidents were not completed and the provider had missed opportunities to promote residents' well-being.

Every external door was locked with a key with the exception of access to an internal courtyard where residents were observed outside smoking. If a resident wanted to go outside, they had to get the assistance of staff to open the door. Residents told inspectors they were not allowed to go out alone. Staff stated that residents may fall or go missing if they were allowed out on their own, and while this may have been a risk for some residents it was not evident in any risk assessment or care plan viewed. There was a poor understanding of the impact of these restrictions on individuals and a reluctance to explore alternatives.

Resident's choices were generally respected. However, activity provision was poor and required review. This is discussed under regulation 9.

Regulation 11: Visits

Indoor visiting had resumed in line with the most up to date guidance for residential centres. The centre had arrangements in place to ensure the ongoing safety of residents. Visitors continued to have temperature checks and screening questions to determine their risk of exposure to COVID-19 on entry to the centre.

Judgment: Compliant

Regulation 12: Personal possessions

Some residents did not have adequate space to store their personal belongings and clothing. Poor organisation of shared wardrobes made it difficult to identify which clothes belonged to individual residents**.** Personal items were observed on top of wardrobes in some bedrooms.

Residents' toiletries were stored on the sink and in some bedrooms it was not obvious who owned the items.

Judgment: Substantially compliant

Regulation 17: Premises

Parts of the premises did not conform to the matters set out in schedule 6 of the regulations, for example;

- Some en-suite and communal bathrooms did not have assistive grabrails to support and maintain the safety of residents.
- The layout of some shared bedrooms required review in order to ensure that all residents could easily access the sink and their personal belongings.
- Catering staff did not have access to separate toilet and changing facilities as required under food hygiene requirements.
- The storage of oxygen cylinders also required review as they were stored on the floor unsecured and could easily fall over and become damaged, making them unsafe.

Judgment: Not compliant

Regulation 26: Risk management

Recording of incidents required improvements. The provider was undertaking to review the documentation of incidents to ensure that actions taken following an incident were comprehensively documented, for example, incident reports did not consistently record neurological observations following an unwitnessed fall. Accurate records are important and help inform quality improvements as part of an audit process.

The controls in place to mitigate the risk posed to residents going outside was disproportionate and impacted on residents right to freedom of movement, this is discussed in detail under regulation 7.

Staff facilities were inadequate. The current staff toilet doubled as a changing room and inspectors noted that facilities for the catering staff were not in line with regulations. The toilet and wash hand basin were small and tiles and grout were stained.

Judgment: Substantially compliant

Regulation 27: Infection control

Systems and resources in place for the oversight and review of infection prevention and control practices required an immediate review. Inspectors observed practices that were not consistent with National Standards for infection, prevention and control in the community services. For example;

- Facilities for hand hygiene required urgent review. In the absence of dedicated clinical hand washing sinks wall mounted alcohol gel dispensers were not accessible throughout the centre. This was a barrier to good hand hygiene practices and was a potential risk to the safety and well being of all residents and staff.
- The laundry room and sluice rooms were unclean and posed risks to the safety and well-being of residents and staff and were not fit for their intended purpose. There was no organisation or flow of dirty to clean laundry within the small room available and there were multiple opportunities for cross contamination from dirty laundry and the environment to clean laundry.
- Responsibility for managing laundry was divided between caring and housekeeping staff. These arrangements were not safe and required urgent review.
- The sluicing facilities were not in line with the regulations or with national standards. The sluice room was visibly dirty on the walls, floors, equipment and all surfaces observed. A hand hygiene sink provided in this area was not in line with the recommended standards and had domestic taps.
- The current system for cleaning floors required improvement. The same mop

head was used for cleaning several rooms in the centre, this posed a risk of cross contamination.
- Some specialist high support chairs and some armchairs were torn and therefore could not be effectively cleaned.
- There was a lot of clutter in storage rooms and items were stored on the floor. This posed a risk of cross contamination and prevented the floors from being effectively cleaned.
- Personal hygiene basins and urinal bottles were observed stored on the floor in bedrooms which posed a risk of cross contamination to residents.
- Waste bins in bathrooms were unclean and were not foot operated which created a risk of cross contamination to those using them.

Judgment: Not compliant

Regulation 28: Fire precautions

At the time of inspection, the registered provider had not taken adequate precautions to ensure that residents were protected from the risk of fire. Improvements were required to comply with the requirements of the regulations. The service was non-compliant with the regulations in the following areas:

The registered provider was not taking adequate precautions against the risk of fire:

- The provider had not arranged for a fire safety risk assessment to identify fire safety risks and ensure they are effectively managed.
- Not all areas in the centre were covered by the fire safety detection system. There was no fire containment between the staff room and the escape corridor serving bedrooms 1-4.
- Some fire doors in the centre were wedged open throughout the inspection.
- Improvements were required regarding the storage of oxygen cylinders. Inspectors noted two loose cylinders within the clinical treatment room, one of which had an expiry date of April 2020.
- The dining room and the front bedroom corridor had ceilings which were lined with timber, assurance was required that they were appropriately treated to prevent the surface spread of fire.
- Not all fire safety checks were recorded.
- Inspectors noted a number of service penetrations through fire resisting construction which required sealing up.

Inspectors were not assured that an adequate means of escape was provided throughout the centre. For example:

- The compartment boundaries used for phased evacuation were not clearly defined or known by staff.

Inspectors were not assured that the emergency escape lighting, and emergency

exit signage provided throughout the centre was adequate. For example:

- A review of the emergency lighting and escape signage was required, to ensure to ensure directions of escape and exits were readily apparent and illuminate the route away from the building.

Adequate arrangements had not been made for containing fires:

- There was uncertainly regarding the locations of, and the integrity of fire compartment boundaries.
- Inspectors noted service penetrations through fire resisting construction which required sealing up to ensure a barrier to the spread of smoke and fire.

Adequate arrangements had not been made for giving warning of fires:

- The fire alarm panel within the nurse office was obstructed by a filing cabinet and a monitor for CCTV.
- There was a new extension to the rear, which was not yet occupied. It was fitted with a separate fire alarm system and at the time of inspection, there was no connection between the two systems, to ensure that staff would be alerted to a fire in the unoccupied extension.
- The evacuation procedure in place as described to inspectors was one of phased evacuation. The fire alarm system was a zoned system comprising four zones. Staff will only know the zone where the detector was activated. A fire alarm zone plan had not been displayed next to the fire alarm panels to assist staff locating the zone activated. The inspectors also found that the boundaries and parameters of the zones did not align with the fire compartment boundaries used for phased evacuation. This could potentially lead to unnecessary delays in identifying the location of the fire resulting in delayed evacuation of residents.

Inspectors were not assured that adequate arrangements had been made for evacuating all persons from the centre in a timely manner. For example:

- Considering the confusion regarding the fire compartment boundaries and the absence of simulated fire evacuation drills, assurances were required from the provider to ensure the safe evacuation of residents from the larger fire compartment when staffing levels were lowest at night time.
- The evacuation procedures to be followed were not prominently displayed in the centre. They were displayed on a notice board in the nurse office.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

The standard of care planning was good and described person-centered care interventions to meet the assessed needs of residents. Validated risk assessments

were regularly and routinely completed to assess various clinical risks including risks of malnutrition, pressure sores and falls.

Based on a sample of care plans viewed appropriate person-centered interventions were in place for residents' assessed needs.

Judgment: Compliant

Regulation 6: Health care

Improved access to appropriate and evidence based health care services would improve the well-being of residents. Residents were not routinely referred to the physiotherapist following a fall. There was no evidence of physiotherapy reviews for resident's particularly those with mobility issues or residents at risk of falling.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The registered provider was not providing opportunities for all residents to participate in meaningful activities in accordance with their assessed needs and preferences. Long periods of inactivity were observed throughout the inspection and residents told inspectors there was often little to do. Care plans were not guiding staff on how to meet each residents' recreational and occupational needs.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

All external doors were locked with a key and residents had to get the assistance of staff in order to go out any of these doors. The provider had these measures in place due to the proximity to the road outside the front of the centre. Residents did have access to internal courtyards.

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	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Substantially compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management	Substantially compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Substantially compliant
Regulation 9: Residents' rights	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Compliant

Compliance Plan for Aisling House Nursing Home OSV-0000003

Inspection ID: MON-0033443

Date of inspection: 05/10/2021

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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Resident Dependency, Bartel Scores and Fire Drills inform the requirement of Staff rostered on duty at night time. As the works to install additional Fire Detection and adequate compartmentation are ongoing, an additional Staff member will be rostered for duty at night time. This is due to be completed on 17 November 2021. The Activities weekly schedule is currently being reviewed to ensure that Residents participate in meaningful activities in accordance with their assessed needs and preferences. Due to the Pandemic, popular activities such as Pet Therapy and Live Music have been unavailable and we have been actively trying to source more meaningful activities. This will be completed on 20 November 2021.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Safeguarding Vulnerable Adults is a theme of the Elderly Abuse training module which all Staff had completed. The Safeguarding Training listed on the Training Matrix related to a standalone training course, undertaken by 3 Staff some years ago. This training is superseded by the Elderly Abuse training. All training now is in the form of blended learning by a provider that can visit for practical courses along with online learning and interactive exams with clear and transparent auditing tools for validation. This has now commenced as of 10 November 2021.	

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The Person in Charge stated during the inspection that they felt supported by the Registered Provider in regard to the daily operations of the centre and monitoring the quality and safety of the service. With the occupancy at the time of inspection, the Person in Charge provides relief Nursing Care for approx. 2 hours in the morning. Weekend rosters are as such due to increased visiting and footfall in the centre due to demand for weekend visits.

Given that the occupancy of the centre will grow in the coming months, an Admission and Staffing Plan was submitted to HIQA on 08 November 2021, detailing how the centre plans to populate and staff the centre safely.

In relation to risks associated with Fire Safety, a competent person to carry out a Fire Risk Assessment was appointed on 09 October 2021 and it is planned that their services will be retained in order to assist with developing more robust documentation and auditing in regard to Fire Safety. This is due to be in place by 26 November 2021.

A Senior Nurse was appointed Infection Prevention & Control Lead to assist the Person in Charge in monitoring the quality and safety of the service on 07 October 2021. Additional training is currently being identified.

There are plans in place to introduce an additional Person Participating in Management in the near future to further aid with supporting the monitoring the quality and safety of the service. This will commence on receiving the outcome of the Application to Vary, submitted 21st July 2021.

Regulation 12: Personal possessions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
Adequate space to store the identified Resident personal belongings and clothing were provided on 25 October 2021.

The identified shared wardrobes are currently being revised and organized to make it easy to identify which clothes belonged to individual Residents. This is due to be

completed by 18 November 2021.

The Personal items observed on top of the Wardrobes in the identified bedrooms have been stored appropriately on 06 October 2021. Resident's toiletries should be kept in the Resident's personal lockers. This has been reiterated to Staff on 06 October 2021.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises: Additional assistive Grabrails in the identified en-suite and communal Bathrooms have been sourced and awaiting installation. This is due to be completed by 18 November 2021.

The layout of the identied shared bedrooms have been reviewed to ensure that the Residents can easily access the sink and their personal belongings. This was completed on 06 October 2021.

The new extension comes complete with a new Staff Room, Changing & Toilet Facilities. It was envisaged that the Catering Staff will retain the current Staff Room, Changing & Toilet Facilities near the Kitchen and that the Care Staff will utilise the Staff Room, Changing & Toilet Facilities in the new extension. We hope to utilise these new facilities on receiving Registration of the new Extension via the Application to Vary, submitted 21 July 2021.

The empty Oxygen Cylinders that were stored have since been removed on 12 October 2021.

Regulation 26: Risk management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management:
A review of the documentation of incidents was carried out on 01 November 2021 to ensure that actions taken following an incident were comprehensively documented.

The Accident / Incident / Near Miss Reporting Form generates an associated Glasgow Coma Scale (GCS) Form which is inserted into the Resident's Care Plan and monitored. This practice has been in place and records of same are available.

"The controls in place to mitigate the risk posed to residents going outside was

disproportionate and impacted on residents right to freedom of movement" is discussed in detail under regulation 7.Staff facilities were addressed in Regulation 17: Premises.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
Additional Wall Mounted Alcohol Gel Dispensers were installed throughout the centre to assist with the current measures in place in regard to Hand Hygiene. This was carried out on 07 October 2021.

On the morning of 05 October 2021, the lint catcher of the Tumble Dryer malfunctioned, dispersing lint into the Laundry Room. This was addressed and the Laundry Room and Sluice Rooms were given a deep clean and additional cleaning is now part of the Cleaning Schedule as of 06 October 2021. The newly completed extension made provisions for a new, fit for purpose Laundry and Sluice Room and we hope to utilise these on receiving Registration of the new Extension via the Application to Vary, submitted 21 July 2021. The current system for cleaning floors has been upgraded to a single use mop system in order to mitigate risks for cross contamination. This was implemented on 15 October 2021.

The specialist high support chairs and the armchairs identified have been placed on a maintenance schedule and works to refabricate same have commenced. It is expected that this maintenance schedule to be completed by 17 December 2021.

The storage rooms layout have been revised to ensure that no items are stored on the floor. This was completed following the inspection on 06 October 2021.

The personal hygiene basins and urinal bottles that were identified have been stored in their correct location. This was completed following the inspection on 06 October 2021.

The Waste Bins in bathrooms identified were clean as they are cleaned after every use. According to several medical supply retailers that we engage with on a weekly basis; these Bins are a standard in incontinence wear disposal with features such as 'antibacterial film' and 'proven to be 25 times more effective at odour prevention than using a plastic bag' and we have strict Infection Prevention & Control procedures in using such bins as to avoid cross contamination.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: On 06 October 2021, Four companies with the competencies to provide a Fire Risk Assessment to the standard of PAS 79 2020 were contacted. On 09 October 2021, a company was appointed to provide a comprehensive Fire Safety Risk Assessment. The company with a competent person are currently advising appointed tradesmen and contractors in regard to the items as detailed in the Aisling House compliance plan dated 11 October 2021, HIQA letter dated 18 October 2021, prior to undertaking a comprehensive Fire Safety Risk Assessment. On Monday 22 November 2021 the competent person arrived at Aisling House Nursing Home to carry out a Fire Safety Risk Assessment. Unfortunately this was not completed on the day and we are awaiting notification of a date where the competent person can return in order to complete this assessment. Additional Fire Detection devices were installed in the Staff Room, the corridor between the Staff Room and Kitchen, and a section of corridor leading to the Bedroom Corridor. This was completed on 17 November 2021. Two additional Fire Doors were sourced for Fire Containment between the Staff Room and the Corridor serving nearby Bedrooms. This was completed on 15 November 2021. The wedges discovered during the inspection have since been removed. In addition, we have re-emphasised the necessity of not propping or wedging open doors to staff on 05 October 2021. The empty Oxygen Cylinders that were stored have since been removed on 12 October 2021. Certificates for the treated ceilings in the areas identified were downloaded and a record of same placed in the Maintenance Log. This was completed on 20 November 2021. The process of recording of Fire Safety Checks was reviewed and updated on 07 October 2021. Service penetrations through Fire Resisting Construction identified have been sealed up on 07 October 2021. This will be reviewed by the competent person and any recommendations for improvement will be implemented following the Fire Safety Risk Assessment as discussed above. Compartment boundaries used for phased evacuation are now clearly defined and known to Staff. This was completed on 06 October 2021. Emergency Lighting is currently being reviewed by the competent person and any recommendations for improvement will be implemented following the Fire Safety Risk Assessment as discussed above. Additional Escape Signage was installed in the areas identified to ensure directions of escape and exits were readily apparent. This was installed on 03 November 2021.	

In regard to Fire Extinguisher Training, this is incorrect as evidence of certification that staff have completed a site specific, theoretical & practical course in the use of portable fire extinguishers was on-site at the time of inspection.

The extent of Fire Compartments were formalised via a new Floor Plan drawing and emailed to HIQA on 11 October 2021. A previous Floor Plan that was submitted contained notable omissions of Fire Doors and their placement, thus confusing matters. Aisling House is actively consulting with the competent person in regard to further compartmentation, prior and pending the outcome of a Fire Risk Assessment. This will be reviewed by the competent person and any recommendations for improvement will be implemented following the Fire Safety Risk Assessment as discussed above.

Works to join the two Fire Alarm systems commenced on 14 October 2021 and was completed on 17 November 2021. A new up to date panel was installed in the Old Extension that was joined to the panel in the New Extension, thus ensuring that Staff would be alerted to a Fire in the unoccupied extension. The Fire Alarm Panel in the Nurses Office was be removed.

A Fire Alarm Zone Plan with an illustration of the boundaries and parameters of the zones was displayed next to the Fire Alarm Panels to assist Staff locating the Zone activated. This was put into place on 06 October 2021.

An additional Staff member was rostered on duty at night time located such that they would be alered to the activation of the domestic smoke detectors and this would remain in place until the additional detectors are installed and commissioned. This was completed on 17 November 2021. Due to present occupancy levels, the additional Staff member will remain on duty at night time to ensure the safe evacuation of residents in the event of fire.

Additional Attic Fire Containment was discussed with the competent person and due to be installed on completion of Fire Alarm and Detection upgrade works completed on 17 November 2021. This will be reviewed by the competent person and any recommendations for improvement will be implemented following the Fire Safety Risk Assessment as discussed above.

Fire evacuation procedures were prominently displayed in the Centre on 06 October 2021.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care: Following a fall, Residents are assessed by their GPs and it is the GP's decision on whether to refer a Resident to a Physiotherapist. We actively monitor the Residents and communicate any change to the GP. Access to further appropropriate and evidence

based health care services is always actively discussed with the Resident families and GPs.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: The current Activities documentation required review as to accurately document all the Resident Theme Nights, Parties and Activities that take place at Aisling House. This was completed on 10 October 2021.

The current Activities weekly schedule is currently being reviewed to ensure that Residents participate in meaningful activities in accordance with their assessed needs and preferences. This will be completed on 20 November 2021.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 12(c)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that he or she has adequate space to store and maintain his or her clothes and other personal possessions.	Substantially Compliant	Yellow	18/11/2021
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.	Substantially Compliant	Yellow	20/11/2021

Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Yellow	10/11/2021
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	Yellow	18/11/2021
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	07/10/2021
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	26/11/2021
Regulation 26(1)(d)	The registered provider shall ensure that the risk management policy set out in Schedule 5	Substantially Compliant	Yellow	01/11/2021

	includes arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.			
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	15/10/2021
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.	Not Compliant	Orange	06/10/2021
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	03/11/2021
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all	Substantially Compliant	Yellow	03/11/2021

	fire equipment, means of escape, building fabric and building services.			
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	22/11/2021
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	06/10/2021
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	17/11/2021
Regulation 28(2)(ii)	The registered provider shall make adequate arrangements for giving warning of fires.	Not Compliant	Orange	17/11/2021
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the	Not Compliant	Orange	06/10/2021

	designated centre and safe placement of residents.			
Regulation 28(3)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place in the designated centre.	Not Compliant	Orange	06/10/2021
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.	Substantially Compliant	Yellow	22/12/2021
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	20/11/2021