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:	Darraglynn Nursing Home
Name of provider:	Darraglynn Nursing Home Limited
Address of centre:	Carrigaline Road, Douglas, Cork
Type of inspection:	Unannounced
Date of inspection:	27 July 2021
Centre ID:	OSV-0000220
Fieldwork ID:	MON-0033114

About the designated centre

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

Darraglynn Nursing Home is a family run designated centre and is located within the suburban setting of Douglas, Cork city. It is registered to accommodate a maximum of 25 residents. It is a single storey building with a basement that accommodates the laundry, storage and staff facilities. The centre is set out in two wings named Lucey and Féileacháin (butterfly). Bedroom accommodation comprises 21 single bedrooms and two twin bedrooms; 20 single bedrooms and one twin room have full en suite facilities of shower, toilet and wash-hand basin; one single and one twin room have wash hand basin facilities in their bedroom. Additional shower and toilet facilities are available throughout the centre. Communal areas comprise the sitting room, dining room conservatory and quiet visitors' library room. Darraglynn Nursing Home provides 24-hour nursing care to both male and female residents whose dependency range from low to maximum care needs. Long-term care, convalescence care, respite and palliative care is provided.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	23

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 27 July 2021	09:00hrs to 18:30hrs	Breeda Desmond	Lead

What residents told us and what inspectors observed

There were 23 residents living in Darraglynn Home on the day of inspection. The overall feedback from residents and relatives was that staff were kind and helpful, and this was a good service. The centre was bright and homely with comfortable communal spaces for residents to enjoy.

The inspector arrived to the centre in the morning for an unannounced inspection. Infection prevention and control measures necessary on entering the designated centre included a signing in process, disclosure of medical wellness or otherwise, hand hygiene, face covering, and temperature check.

This centre was on a sloped site with resident accommodation on the ground floor and facilities such as the laundry and storage were in the basement with access to this level to the rear of the building. The main entrance was wheelchair accessible. There was a lovely cosy seating area to the left main of the entrance with comfortable arm chairs, two-seater couch and coffee table. Residents were observed enjoying sitting here throughout the day reading and chatting. Residents' accommodation comprised 21 single and two twin bedrooms; 20 single bedrooms and one twin bedroom had full en suite facilities of shower, toilet and wash-hand basin; the remaining single and twin room had a wash-hand basin in the bedrooms. Additional shower and toilet facilities were available in close proximity to bedrooms and communal spaces.

The centre was recently painted and was bright, clean and well maintained. The day room was bright and homely and had a large flat-screen TV and residents were observed enjoying the Galway races in the afternoon. One resident said she had been there once and loved it, and hoped to get there again sometime. During the walk-about in the morning residents were observed having their breakfast in their bedrooms; trays were set with cereal, toast or bread, tea and juice. Some residents were in the process of getting up and were assisted in accordance with their needs.

Bedrooms were personalised and decorated in accordance with residents wishes. Storage for residents' personal possessions comprised double wardrobes, chest of drawers and bedside lockers, and some residents had two chest of drawers; all bedrooms rooms had lovely mirrors, some were part of the wardrobe doors and others had free-standing full length ornate mirrors. Pressure relieving specialist mattresses, low low beds and other supportive equipment were seen in residents' bedrooms.

Mid morning and afternoon snack rounds were observed where staff offered residents a choice of tea or juices with snacks. Mealtimes were observed and residents were served and assisted in a relaxed and social manner with positive interaction noted. The dining room was a large bright room which opened into a conservatory with views of the enclosed garden. Tables were pleasantly set for residents with cutlery and condiments prior to residents coming to the dining room

for their meal. Residents were offered choice for their meals and gave positive feedback of the quality of the food served and the choice. Meals were well presented including textured meals.

There was a lovely quiet room located opposite the dining room for residents and their visitors. It had bookshelves with an array of books for residents to choose. Ornate advisory signage was displayed throughout the centre to orientate residents to rooms such as the dining room and day room.

The garden was enclosed and could be accessed via the dining room, however the door to the garden was locked and residents were unable to freely access the garden. Residents said they were out in the garden during the hot weather, however, there was no one observed in the garden on the day of the inspection which was a warm dry day.

It was reported that live music sessions were held in the centre twice weekly. An exercise programme was facilitated in the main day room in the afternoon of the inspection and residents actively engaged with the physical therapist. This was an interactive session with chat as well as exercise. In the morning, a member of staff actively engaged with three residents in the seating area by the main entrance, reading the news paper and chatting about events. Nonetheless, there was no activities programme displayed and aside from the aforementioned, the inspector observed long periods where residents were on their own without activation. At the end of the inspection at 18:30hrs, there were three residents in the day room while the remainder were either in their bedroom or in bed.

Visiting had opened up in accordance with HPSC guidance of July 2021. Residents said they were happy with the visiting arrangements and it was lovely to have family and friends back visiting again. The inspector spoke with two family members whose relative was receiving end-of-life care. They said they could not fault the care that their relative received. They were kept up-to-date with their relative's condition and with any changes to their care and well-being. They praised the staff and how attentive they were.

There was COVID-19 advisory signage displayed throughout and wall-mounted hand sanitisers available on each corridor. A personal protective equipment (PPE) station was located at the entrance to Féileacháin wing, however the disposal bin here was not hand-free. The sluice room was key-pad access; there were separate sinks for hand-washing and sluicing purposes. Additional shelving was needed here as disposable bags and alginate bags were stored on the drainage board of the sluicing sink. In some of the en suite rooms seen, wash-basins were stored on the floor.

Catering staff had separate changing facilities to care staff in line with best practice. There was key-pad access to the basement to the laundry, storage, staff dining room and facilities. Appropriate work-flows were seen in the laundry with signage on doors highlighting entry and exit. New washing and drying machines were in place and the old machines were removed at the time of inspection; this enabled additional space for the drying rack for hanging special-care garments. There was a separate hand-wash sink and laundry sink available in line with best practice

guidelines.

Emergency evacuation floor plans were displayed throughout the centre. While they identified escape routes, they did not distinguish between primary and secondary escape routes; the point of orientation was identified on these plans, however, these and all the escape routes were coloured the same so it could be difficult decipher the information.

The treatment room was organised during the inspection to ensure that items were appropriately stored; new signage was placed on the door indication oxygen storage. This room was secured to prevent unauthorised access.

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

Overall, findings on this inspection were that this was a good service where the residents' needs were generally met. Darraglynn Nursing Home was a residential care setting operated by Darraglynn Nursing Home Limited. The organisational structure comprised the registered provider representative, person in charge and assistant person in charge (ADON).

The inspector reviewed the actions from the previous inspection, and found that the following regulations were addressed: vetting disclosures for student placements were in place; the directory of residents was maintained. On this inspection, further attention was necessary regarding regulations relating to staff training records, activities programme, the post COVID-19 outbreak review report, the programme of audit and the annual review. An urgent action plan was issued to the provider relating to fire safety precautions and this was discussed in detail under regulation 28 Fire Safety.

The service was subject to a COVID-19 outbreak which was declared over by Public Health in November 2020. The COVID-19 information was reviewed and included current Health Protection Surveillance Centre (HPSC) guidance, contingency planning and access to support services for example. A chronology of COVID-19 activities, events and undertakings was evidenced. A post COVID-19 outbreak review was discussed and this demonstrated that a review of the management of the outbreak had occurred. However, this needed to be formalised as a report in line with HPSC guidance, to ensure that areas of improvement were documented for reference to inform future outbreak management. The inspector recognised that residents, relatives and staff had come through a difficult and challenging time following the COVID-19 outbreak in the centre. The inspector acknowledged the efforts made by management to ensure that residents, relatives and staff were kept

informed of the changing panorama of service provision due to COVID-19.

The programme of audit for 2021 was examined and this showed mixed findings and required further attention to be assured that the service was effectively monitored. Nonetheless, the incumbent person in charge had introduced daily audits regarding medication management, and gathering of weekly key performance indicators (KPI) of clinical matters such as falls, pressure sores, bed rail usage, infection and antibiotic treatment.

Quality Improvement (QI) meetings were convened on a quarterly basis and attendees included the registered provider representatives and the person in charge. Set agenda items for these meetings included data collected such as clinical (KPIs, COVID-19 precautions, vaccinations) and non clinical matters such as the painting and maintenance of the centre. However, in the minutes seen, results of audits were not included. This would provide assurances regarding the effective monitoring of the service.

A new clinical structure was introduced to provide leadership and responsibility for clinical areas such as infection prevention and control, activities, health and safety, medication management and nutrition, end-of-life care, restrictive practice and falls prevention. Staff were appointed as leads for these clinical areas to provide oversight and promote best practice. This was a new initiative and would take time for staff to become familiar with their new responsibility and for the practice to become embedded.

A sample of staff files were examined and they contained all the requirements as listed in Schedule 2 0f the regulations. Vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 was in place for all staff. A schedule of staff appraisals was in place and these were completed by the person in charge. Staff training matrix was reviewed. While staff confirmed that they had additional training to support them relating to COVID-19 pandemic such as infection prevention and control, hand hygiene, donning and doffing PPE, training records were not comprehensively maintained to be assured that all training was up-to-date. Many certificates of completion of training were seen in staff files and fire training records, and these were added to the training matrix at the time of inspection to provide accurate oversight of the training needs.

While there was adequate care staff to the size and layout of the centre and the assessed needs of residents, during inspection, there was no-one allocate to activities and observation on inspection showed that residents had long periods with little or no meaningful engagement in the day room in the morning and part of the afternoon.

The annual review was available. The reader was introduced to the history of the centre and an explanation of the names of Féileacháin and Lucey wings – Lucey in memory of the owners' mother who started the centre many years ago; and Féileacháin or butterfly and the symbolism of the butterfly. The annual review itself was based on a review of the regulations rather than the national standards, with little information relating to the quality of life of residents.

The incident and accident log was examined and records showed that correlating notifications were submitted. These had thorough documentation including residents' clinical observations, and reviews of occurrences and actions to mitigate recurrences. However, one death notified in the quarterly return should have been notified within the three-day notification, NF01.

The complaints log was examined. While complaints were documented, they were not recorded in line with regulatory requirements. One complaint was not followed up as part of safeguarding, and the appropriate notification was not submitted to Chief Inspector. The appropriate notification was requested to be submitted.

In conclusion, staff positively engaged with residents in a kind, gentle and relaxed manner. The introduction of the clinical structure with responsibility for oversight of specified matters will provide better monitoring of the service, to ensure a rights' based approach to service delivery.

Regulation 14: Persons in charge

The person in charge was a registered nurse who was full time in post and had the necessary experience and qualifications as required in the regulations. He positively engaged with the regulator during the inspection.

Judgment: Compliant

Regulation 15: Staffing

There were no activities staff or staff assigned to activities on the duty roster.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Staff training records were updated at the time of inspection to ensure accurate records and provide oversight of the staff training needs.

Judgment: Compliant

Regulation 21: Records

The sample of staff files showed that they were maintained in line with Schedule 2 of the regulations.

Judgment: Compliant

Regulation 23: Governance and management

The annual review was based on a review of the regulations rather than the national standards, with information relating to clinical key performance indicators such as falls, incidents and accidents and notifications to the Chief Inspector. There was little information relating to the quality of life of residents or that the review was undertaken in consultation with residents and their families.

Most of the audits were comprehensively completed but some were not, for example, the fire management audit. This was significant as an urgent compliance plan was issued to the registered provider to provide assurances associated with night time evacuations. Some auditors synopsised their findings and included actions necessary to remedy deficits, but other audits did not have this detail. Audits of documentation such as staff files and residents showed boxes were ticked to indicate files were checked rather than inputting initials of files examined. Consequently, it could not be determined which files were audited.

Results of audits were not included as part of the Quality Improvement meeting minutes to provide assurances that the service was effectively monitored.

Judgment: Not compliant

Regulation 3: Statement of purpose

Floor plans were updated at the time of inspection to include:

- shower in the bathroom by the day-room
- wash-hand basin in bedroom 17 and 18.

Judgment: Compliant

Regulation 31: Notification of incidents

The appropriate NF06 notification was not submitted to the Office of the Chief

Inspector following a complaint made by a resident.

The death of resident notified to the Chief Inspector in the quarterly notifications should have been notified as an unexpected death (NF01) in line with the guidance issued to providers regarding COVID-related deaths.

Judgment: Not compliant

Regulation 34: Complaints procedure

The complaints records showed that some:

- complaints were not accurately recorded
- complaints were not followed up to be assured that the issues were remedied.

Judgment: Not compliant

Quality and safety

Residents feedback about life in the centre was generally good and residents were happy with the quality of the service. The inspector observed that the care and support given to residents was respectful, relaxed and unhurried; staff were kind and were familiar with residents preferences and choices, and facilitated these in a friendly manner. In general, staff positively and actively engaged with residents including residents with complex communication needs.

Resident care documentation was examined; some records were electronically maintained and others such as consent and resuscitation discussions were paper-based. Pre-admission assessments were undertaken to ensure that the service could provide appropriate care to the person being admitted. However, comprehensive assessment to support holistic care planning to ensure a rights-based approach to care was not in place.

Residents had good access to GP services and medical notes showed regular reviews by their GPs. Multi-disciplinary team inputs were evident in the care documentation reviewed. Timely referrals were requested to specialist services and residents had access to psychiatry of old age, dietitian, tissue viability and palliative care for example. Residents notes included transfer information following a resident's transfer into and out of the service.

Practice observed showed that staff had good insight into residents' specific care needs relating to behaviours and measures put in place to support residents. Bedrail

assessment and usage was discussed with the person in charge. Bedrail use had reduced from 11 residents to five following a review by the person in charge who actively monitored and educated staff regarding restrictive practices. Alternatives such as low low beds were seen in the centre.

Controlled drugs were checked in accordance with professional guidelines; the person in charge had developed a new template to be introduced for recording controlled drugs to enable staff to input comments such as disposal of unused medications when appropriate. The service was liaising with the pharmacy to improve the service. The service was changing over to electronic records and new electronic devices were due within the coming weeks. Scheduled training was being provided by the pharmacy regarding the electronic records. A sample of medication administration records were examined and they were comprehensive and maintained in line with professional guidelines.

While most bedrooms had adequate space for residents and their personal belongings, space in twin bedroom 19 was limited to accommodate maximum dependency residents or residents with mobility aids. The registered provider representative explained that this room was part of their upgrading and refurbishment plan, which was put on hold due to the COVID-19 outbreak.

Laundry was segregated at source and staff described best practice work-flows in the laundry to prevent cross infection. The laundry was neat and tidy and clothes were segregated appropriately. Other precautions in place for infected laundry included the use of alginate bags. There was a sign sheet for staff to indicate they had cleaned the filters of the machines as part of risk management and fire prevention.

The risk registers were examined. There was an extensive register detailing risk associated with COVID-19 with remedial actions completed to safeguard the service. One risk register had risk associated with individual residents and the second had non clinical risk. The register with non clinical risk required review to be assured that the register reflected current risk.

Each resident had a current personal emergency evacuation plan. Appropriate quarterly and annual fire certification was in place. Daily fire safety checks were comprehensively maintained, however, weekly safety checks were not always completed. While staff had up-to-date fire safety training, fire drills and evacuation of a compartment were necessary, cognisant of night duty staffing levels. An urgent compliance plan was issued to the service regarding completing fire drills and evacuation of compartments for both day and night duty staff to be assured that this could be completed in a timely and safe manner.

Regulation 11: Visits

Visiting had recommenced in line with current HPSC guidance. The service was committed to ensuring residents and their families remained in contact and staff

supported residents by means of Skype, WhatsApp, email and other video and telephone calls as appropriate.

Judgment: Compliant

Regulation 12: Personal possessions

Residents' had good personal storage space which comprised double wardrobes, bedside locker and some residents had chest of drawers.

Best practice work-flows were demonstrated regarding laundry services.

Judgment: Compliant

Regulation 13: End of life

Relatives spoken with reported excellent care and attention for their relative receiving end-of-life care.

Judgment: Compliant

Regulation 17: Premises

Twin bedroom 19 had limited space for residents to mobilise around. There was limited access to the internal bed-space for assistive equipment such as hoist or mobility aids.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Residents gave positive feedback regarding the quality and choice of food.

Judgment: Compliant

Regulation 25: Temporary absence or discharge of residents

Copies of information provided when a resident was transferred in or out of the service was available, to be assured that relevant information was provided so the resident could receive appropriate care.

Judgment: Compliant

Regulation 26: Risk management

The register with non clinical risk required review to be assured that the register reflected current risk. Many of the risks recorded were open for several years. While they were regularly reviewed, some required closing-off as issues were addressed; other risk identified during the inspection were not included. For example, storage of oxygen cylinders without the appropriate signage indication hazardous gas (appropriate signage was displayed before the end of the inspection).

Judgment: Substantially compliant

Regulation 27: Infection control

Additional shelving was needed in the sluice room as disposable bags and alginate bags were stored on the drainage board of the sluicing sink.

Residents' wash-basins were stored on the floor in some en suite bathrooms.

Some disposal bins were not hands-free to enable safe disposal of waste.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Fire drills and evacuation of a compartment were necessary, for both day and night duty staff to be assured that this could be completed in a timely and safe manner.

Emergency evacuation floor plans identified escape routes, however, they did not distinguish primary and secondary escape routes. While the point of orientation was identified on the plans, these and all the escape routes were coloured-coded the

same so it was difficult to decipher the information.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Medication administration records were comprehensively maintained in the sample reviewed.

The pharmacy was facilitated to meet their obligations within the centre to provide support to residents and staff.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

While some assessments were completed, a comprehensive assessment was not seen in the four records reviewed, consequently, a holistic picture of the resident and their needs could not be determined. While validated risk assessments were used such as nutritional assessment, this information did not inform care planning. For example, one resident with a nutritional medical history did not have an associated nutritional care plan to inform their care. Some care plans were not updated in line with the requirements of the regulation.

Judgment: Not compliant

Regulation 6: Health care

Residents had regular access to on-site GP consultation. Residents medications were reviewed as part of their consultation with their GP and ongoing monitoring and responses to medication were seen.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Low low beds and crash mats were available to residents; there was good oversight

of bedrail use.

Judgment: Compliant

Regulation 9: Residents' rights

On the day of inspection, residents were observed to spend long periods without meaningful activation.

Access to the garden was restricted and residents were not facilitated to independently access the garden.

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 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 13: End of life	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 26: Risk management	Substantially compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Darraglynn Nursing Home OSV-0000220

Inspection ID: MON-0033114

Date of inspection: 27/07/2021

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: A new activity coordinator has been recruited and commenced employment from 03.09.2021. The new activity coordinator will liaise with our current activity staff to have new revised activity on a weekly basis and a monthly planner. Moreover, a dedicated staff allocation and a revised daily routine management is in place since 03/08/2021 to ensure that all residents receive activation including one to one interaction.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: A revised system for managing audits, residents' meeting, residents' family meeting and staff meeting are in place from 27.08.2021. The risks and deficits identified by the revised audit management system is reflected and acted upon in the action plan register and is communicated across to the staff. A revised schedule is in place for managing both external and internal audit on fire management where the results of it will be discussed in Quality management meetings where it reviews the action plan already set up as a part of providing assurances associated with nighttime evacuations. The newly structured clinical quality improvement committees set up for specific domains are utilized for dissemination of the quality improvement strategies and plans. Records of these meetings including agenda were commenced to record in Quality management meetings and will also be included in the Annual report by the end of 2021. Training session was booked for selected staff members in Audit management on 03.11.2021 to ensure the quality of auditing is achieved for the continuous quality improvement process in the nursing home.	

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
The omission of sending NFO6 was realized on the day of inspection and the notification was send on 10.08.2021.
The death of the resident was notified on NF 39E instead of NFO1 which will be in future avoided by a proper alert system which was commenced 28.07.2021. All relevant staff members were given training on categories of HIQA notification.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
On 24.08.2021, all staff were given training regarding the compliant management policy of Darraglynn nursing home. A monthly checklist is in place since 24.08.2021 to monitor staff compliance and quality of complaints' procedure in the nursing home. All complaints will be discussed in Quality management meetings to evaluate the quality of the compliant management. Complainants' satisfaction regarding the outcome of the compliant will be evaluated directly by the PIC.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Plans were made prior to COVID-19 pandemic to extent the twin room 19. These plans were formulated by our engineers, but unfortunately due to the pandemic the extension plan did not progress. However, our engineers were contacted on 28.07.2021 and a site visit was carried out on 03/08/2021. Revision of plans and planning permission application were discussed and are in progress.

Regulation 26: Risk management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management:
The risk register was reviewed and updated on 03/08/2021with all current identified risks. Audits including walk around audits are used as a source for risk identification. The new risk register covers all clinical and non-clinical risk areas in the nursing home. The new system of risk management identifies the residual risks and proposes additional controls to mitigate them.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
An additional shelf was added to the sluice room for storing different disposal bags including alginate bags on 29/07/2021. New system for storage of wash basins commenced since 29/07/2021. A revision of training in infection prevention and control measures was given to all staff on 24.08.2021. Hands- free disposal bin is in place in the clinical area since 27/07/2021. PIC has started checks for compliance of the renewed policy during walk around audits.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Fire and safety precautions at Darraglynn Nursing home were reviewed with immediate effect on the 28/07/2021. The concerns raised in the urgent compliance plan issued to us was considered and the following actions were undertaken
1. On 03/08/2021,an action plan was compiled by the Clinical governance team which clearly outlined the strategies in place to mitigate the risks identified.
2. A dedicated risk management system for the fire and safety was devised on 03/08/2021 to manage the risks associated with fire and safety.
3. On 28/07/2021 the engineer was contacted to change the update the emergency evacuation floor plan. The revised plan identifies escape routes distinguished as primary and secondary escape routes.
4. As a part of the revised fire evacuation management plan, we have introduced a new fire evacuation training matrix from 28/07/2021. The matrix ensures that every staff member get trained in all compartments with both daytime and night-time fire

evacuation drills and simulations.
5. Review of fire evacuation training and assessment of the existing system was carried out by an external fire and safety agency and urgent Services from Apex fire safety was hired on 29.07. 2021.

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 revised care planning system is in place since 03/08/2021. Nurses meeting was held on 02/08/2021 and the deficit in the existing system of care planning and assessment was discussed. A new staff training, and supervision system is developed for managing care plans. PIC directly supports and supervise the staff nurses in carrying out assessments and developing care plans accordingly. Moreover, plan has been made to source input from the residents, their families and other stake holders. A new care plan and assessment matrix is in situ to alert staff nurses for the timely completion of their allocated residents' assessments and Care Plan. Three level auditing system introduced to ensure the quality-of-care plans by an audit tool where the allocated nurse will do the first check which was followed by peer auditing and a final check by PIC.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
New activity staff has commenced from 03/09/2021 and a new system of activities including 1:1 activities and group activities is in place. The door to the garden was made accessible to the residents since 03/08/2021 and all residents were made aware of this at the residents meeting held on 03/08/2021. There is also a signboard near the door to assist the residents.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Substantially Compliant	Yellow	03/09/2021
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.	Substantially Compliant	Yellow	03/08/2021
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service	Not Compliant	Orange	27/08/2021

	provided is safe, appropriate, consistent and effectively monitored.			
Regulation 23(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.	Substantially Compliant	Yellow	27/08/2021
Regulation 23(e)	The registered provider shall ensure that the review referred to in subparagraph (d) is prepared in consultation with residents and their families.	Substantially Compliant	Yellow	27/08/2021
Regulation 26(1)(d)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.	Substantially Compliant	Yellow	03/08/2021

Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Substantially Compliant	Yellow	24/08/2021
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Substantially Compliant	Yellow	03/08/2021
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	29/07/2021
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.	Not Compliant	Orange	10/08/2021
Regulation 34(1)(f)	The registered provider shall provide an accessible and effective complaints procedure which	Not Compliant	Orange	24/08/2021

	includes an appeals procedure, and shall ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.			
Regulation 34(1)(h)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall put in place any measures required for improvement in response to a complaint.	Not Compliant	Orange	24/08/2021
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.	Not Compliant	Orange	02/08/2021
Regulation 5(4)	The person in	Not Compliant	Orange	03/08/2021

	charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.			
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Not Compliant	Orange	03/09/2021
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Not Compliant	Orange	03/08/2021
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	03/08/2021