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:	AbbeyBreaffy Nursing Home
Name of provider:	Knegare Nursing Home Holdings Ltd
Address of centre:	Dublin Road (N5), Castlebar, Mayo
Type of inspection:	Unannounced
Date of inspection:	11 January 2023
Centre ID:	OSV-0000308
Fieldwork ID:	MON-0038978

About the designated centre

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

AbbeyBreaffy Nursing Home is a purpose-built facility that provides care for 55 male and female residents who require long-term care or who require short periods of care due to respite, convalescence, dementia or palliative care needs. Care is provided for people with a range of needs: low, medium, high and maximum dependency.

The centre is located in a countryside setting a short drive from the town of Castlebar just off the N5. The atmosphere created is comfortable and there is plenty of natural light in communal areas and in bedrooms. Bedroom accommodation consists of four double rooms and 47 single rooms of which 50 have ensuite facilities. There are toilets including wheelchair accessible toilets located at intervals around the centre and close to communal rooms. There are several sitting areas where residents can spend time during the day. There were dementia friendly features in place to support residents' orientation and memory and this included signage and items of memorabilia that included displays of china and old style equipment. An accessible and safe courtyard garden is centrally located and has been well cultivated to provide interest for residents.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	49

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 11 January 2023	09:35hrs to 18:35hrs	Rachel Seoighthe	Lead

What residents told us and what inspectors observed

On the day of inspection, the inspector observed that residents were supported to enjoy a satisfactory quality of life, supported by a team of staff who were kind and responsive to their needs. The overall feedback from residents was that they were happy with the care they received and their life in the centre.

The inspector was met by the person in charge upon arrival to the centre. Following an introductory meeting, the inspector walked through the centre with the person in charge and met with a number of residents in communal areas and in their bedrooms.

There was a calm and relaxed atmosphere for residents in the centre and the inspector overheard polite conversation between residents and staff. The inspector spoke with six residents and those who could express a view told the inspector that staff were kind and they were satisfied with the service they received. One resident told the inspector of their worries about moving into a nursing home, but expressed that they were no longer worried as 'they are all so nice here'.

Located a short drive from the town of Castlebar in County Mayo, AbbeyBreaffy Nursing Home provides respite care and long-term care for both male and female adults with a range of dependencies and needs. There were 48 residents living in the centre on the day of the inspection and one resident was in hospital.

The centre is single storey building which was bright and spacious, with easy access to a variety of communal rooms and secure outdoor area. The inspector observed that resident bedrooms appeared to be personalised with items of personal significance such as photographs, ornaments and soft furnishings. Residents had access to television and call bell bells in their bedrooms. Residents privacy and dignity was maintained in bedrooms by use of door signage to alert if care was in progress. Staff were also observed knocking on doors and seeking permission before entering residents bedrooms.

For the most part, staff were observed to follow infection control guidelines in relation to the use of personal protective equipment (PPE) and hand hygiene.

There are a variety of communal areas for residents to use consisting of a vast reception area, two sitting rooms, a visitors room, a family room and an oratory. The dining room was bright and spacious and had adequate seating for residents use. The inspector observed residents spending most of their day in one of two sitting rooms or in the reception area. Residents with higher support needs were observed to spend their time in the Summer brook sitting room.

The corridors in the centre were long and wide and provided adequate space for walking. Handrails were available along all the corridors to maintain residents' safety

and independence.

Although it was not in use during the inspection, the inspector observed that residents had unrestricted access to a large communal garden area, which was decorated with flowers and shrubs. The area had sufficient seating for residents comfort.

Overall, the premises was clean and well maintained. However, the inspector found that some floor surfaces were in need of repair. Additionally, the organisation of storage space required improvement as the inspector observed that a number of storage rooms were very cluttered and resident equipment was not segregated from general supplies.

The inspector observed the staff interacting with residents during the inspection. Residents were seen to be relaxed and comfortable in their company. Staff were observed assisting residents with their care needs, as well as supporting them to mobilise to different communal areas within the building. Some residents required greater time and support to mobilise and overall staff provided this support in a gentle and unhurried manner. Staff were observed to respond promptly to residents' needs.

The provider had taken steps to enhance the activities programme since the previous inspection, the inspector viewed the activities schedule which included regular live music sessions, baking and exercise classes. One resident told the inspector how much they enjoyed the weekly music session. Another resident told the inspector about an outing to Breaffy house and they expressed their wish to attend another outing in the coming weeks. The inspector found that the provider had recruited an activities coordinator since the last inspection. The rosters showed that the activities coordinator worked four days per week in the centre. A health care assistant was assigned to the provision of activities in the absence of the activities coordinator. Notwithstanding these improvements, the inspector found that further action was required to ensure that the arrangements that were in place catered for all residents' capacities, capabilities and preferences.

On the day of the inspection one health care assistant was assigned to the provision of activities for 49 residents.This staff member was required to provide one-to-one and group activities, which took place in communal rooms and in resident bedrooms. The inspector observed that a number of more able and active residents were engaging in activities such as exercises and group reminiscence therapy in one sitting room. While there was a lively atmosphere observed in this room, the inspector observed that there was much less activity occurring in the Summer brook sitting room. The activities schedule showed that tactile activity and reminiscence chat was scheduled to take place from 11:20 -12.00 in the Summer brook sitting room, led by a health care assistant. When the inspector entered the room they observed that there was no staff member present and a number of residents were observed to be asleep. One resident was seated at a table with a tactile activity device placed in front of them but there was no staff present to assist or interact with them. The schedule for the remainder of the day showed that there was only one other activity planned for the residents using the Summer brook day, from

14.30-15.00. The inspector noted that more focus and effort was required in relation to the frequency and quality of activities scheduled to take place in this day room, to ensure that residents spending their time there were afforded the opportunity to engage in activities that met their abilities and preferences.

There was sufficient space for residents to meet with visitors in private.The inspector observed a number of residents receiving visitors during the inspection and found that appropriate measures were in place to ensure that visits were managed in a safe manner.

The next two sections of the report describe the provider's levels of compliance with the Health Act 2007 and the Care and Welfare Regulations 2013. The findings in relation to compliance with the regulations are set out under each section.

Capacity and capability

Although the inspector found that some improvements had been implemented since the last inspection, further actions were needed by the provider to ensure that the management and oversight systems in place in the centre were effective in bringing the designated centre into compliance with the Health Act 2007 (Care and Welfare of resident in Designated centers for Older People) Regulations 2013 and to ensure that residents received a safe and appropriate service.

This inspection was a one day unannounced risk-based inspection to monitor ongoing compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and to follow up on unsolicited information that had been received. The information was partially validated on this inspection and improvements were required in order to bring the centre into compliance with these regulations.

During the service's previous inspection in June 2022, a number of non-compliances had been identified. The compliance plan submitted by the provider to address these findings was assessed at this inspection to determine whether all actions had been effectively carried out.The inspector found that some of these actions were completed but other actions remained outstanding in relation to; care planning, governance and management, staffing, premises, and residents' rights . At this inspection, additional areas of non-compliance were identified in relation to infection control and protection. Therefore, despite the efforts since the previous inspection, the inspector was not assured that the management team had sufficient oversight of the service or could ensure the service was safe and appropriately monitored.

Knegare Nursing Home Holdings limited is the registered provider for AbbeyBreaffy Nursing Home. The provider is involved in the operation of three other designated centres for older persons. The registered provider is represented by one of the company directors.

The inspector found that the clinical management support for the person in charge was not in place as described in the centre's statement of purpose, which detailed the management structure to include an assistant director of nursing and a general manager. The inspector found that the positions of assistant director of nursing and general manager were vacant. Although the inspector was assured that recruitment was in progress to fill the assistant director of nursing role, there were no clear time-lines for when an assistant director of nursing would be in post. The person in charge oversees a team of nurses, health care assistants, activity, administration, maintenance, domestic and catering staff.

The centre had experienced a high turnover of staff in 2022 and not all staff vacancies were filled to ensure there was sufficient staff to meet the needs of 55 residents in accordance with the statement of purpose and function. While the person in charge was working hard to recruit staff and to ensure sufficient staff were on duty to meet the needs of the residents, a review of the completed and planned rosters for the weeks before and after the inspection indicated that this could not always be achieved. The inspector was informed that the provider had an ongoing recruitment programme in place. At the time of this inspection nurse staffing levels were consistent with the statement of purpose, however a number of posts for health care assistants, house-keeping, laundry and activities staff were vacant.

There was good oversight of staff training and records showed that all staff had received mandatory training within the required time frames. A system of annual performance appraisals was in place and records of appraisals were viewed by the inspector.

There were management systems in place to oversee the service and the quality of care, which included a comprehensive programme of auditing in clinical care and environmental safety. The inspector viewed a sample of audits and found they effectively identified areas for improvement and had detailed quality improvement plans. However, the progress of the quality improvement action plans could not be measured for a number of audits. For example, the quality improvement plan which was developed following an audit of call bell response times included additional staff training as a corrective action. However, there was no evidence that this training took place or that the status of those actions had been reviewed. Furthermore, while a number of the inspector's findings in relation to medication management had already been identified through the centre's quality and safety monitoring systems as needing further improvement, these improvements had not been implemented by the provider and centre's management team.

In addition, a number of risks identified by the inspector had not been identified by the provider and appropriate actions had not been put into place to mitigate those risks.

There was evidence of regular meetings with heads of department within the centre, to review key clinical and operational aspects of the service. Records of these meetings were maintained and detailed the attendees, the agenda items discussed and the actions that were agreed. The inspector also reviewed evidence of senior

management team meetings. Agenda items included staffing, human resources issues and clinical topics such as infection control. However the inspector found that these senior management meetings did not contain time bound action plans and there were no meetings records available to view from June 2022 to January 2023.

Residents' views on the quality of the service provided were sought through satisfaction surveys, feedback events and through resident meetings.

An annual report on the quality of the service had been completed for 2022 which had been done in consultation with residents and set out the service's level of compliance as assessed by the management team.

The inspector reviewed a sample of staff personnel files and found that they contained all the information as required by Schedule 2 of the regulations. There was evidence that all staff had been appropriately vetted prior to commencing their respective role in the centre. The provider was not an agent for any residents' social welfare pensions.

An electronic record of all accidents and incidents involving residents that occurred in the centre was maintained. The majority of notifications required to be submitted to the Chief Inspector were done so in accordance with regulatory requirements. However, the of the use of a restrictive practice and a safe-guarding incident had not been notified to the Chief Inspector in the required time-frame, as required by Regulation 31.

A review of the complaints records found that complaints and concerns were responded to promptly and managed in line with the requirements of Regulation 34. A review of the records evidenced that there was a comprehensive record kept, both for complaints resolved locally and complaints which were investigated through the formal process.

Regulation 15: Staffing

The number and skill mix of staff was not adequate to meet the needs of the residents taking into account the size and layout of the designated centre . This was evidenced as follows;

- The provider had identified the need for two house-keeping staff to be on duty daily to ensure that the house-keeping duties were carried out to the required standard. However, rosters showed that there was only one housekeeping staff rostered on 1 and 8 January 2023. This did not assure the inspector that the centre was cleaned on a regular basis and to the required standards to ensure residents were protected from infection.
- The provider had identified the need for 6 health care assistants to be rostered daily to assist residents with personal care needs. However rosters showed that there was only 5 health care assistants rostered on the 3rd and 7th of January 2023.

- The registered provider had recruited an activity co-ordinator since the last inspection,in order to manage the delivery of activities to residents. However resident numbers had increased by a further 36% since June 2022 and the inspector was not assured that the staffing resources available were adequate to ensure that all residents were provided with regular opportunities to participate in activities in line with their preferences and ability to participate.

Judgment: Substantially compliant

Regulation 16: Training and staff development

A review of the training records of staff found that all staff had completed mandatory training in infection prevention and control, manual handling and safeguarding.

Judgment: Compliant

Regulation 23: Governance and management

The registered provider did not ensure that the service had sufficient resources to;

- Ensure the management structure, and support for the person in charge, was maintained in line with the centre's statement of purpose. This impacted on effective oversight of the service.
- Maintain health care, house-keeping and activities staffing resources in line with the centre's statement of purpose.

Risks found on the day of inspection in relation to protection as detailed under Regulation 8 had not been satisfactorily addressed and residents continued to be at risk. For example;

- During an investigation into an alleged safe-guarding incident which occurred in the centre in September 2022, the management team identified that one circuit television (CCTV) camera was out of order in an area of the centre. This meant that the camera could not be relied upon as part of the investigation. Although assurances were given that the fault was repaired, records viewed on this inspection found that the camera was out of order, 14 weeks after the incident was alleged to have taken place.

Judgment: Not compliant

Regulation 31: Notification of incidents

Whilst the majority of notifications were submitted within the time-frames, the centre had not notified the Chief Inspector of a safe-guarding incident as required by the regulations.

The inspector found that not all restrictive practices were being reported on a quarterly basis to the Office of the Chief Inspector, as required by Regulation 31, for example the use of sensor mats and bed sensors which had the potential to impact on residents' free movement when activated.

Judgment: Not compliant

Regulation 34: Complaints procedure

There was a complaints policy in place and this was updated in line with regulatory requirements.The complaints procedure was displayed throughout the centre. Records of complaints were maintained in the centre.There were two complaints recorded for 2022 .The inspector observed that these were acknowledged and investigated promptly and detailed the resolution and whether or not the complainant was satisfied.

Judgment: Compliant

Quality and safety

The findings on the day of inspection were that, for the most part, the provider was delivering good quality clinical care to residents, in line with their assessed needs. Residents had good access to health care services, including general practitioners (GP), dietitian, speech and language and tissue viability services. Clinical risks such as falls and weight loss or gain were regularly monitored. While assessments were completed in a timely manner care planning documentation was not always reflective of residents' needs.

The centre had an electronic resident care record system. Pre-admission assessments were undertaken by the person in charge to ensure that the centre could provide appropriate care and services to the person being admitted. A range of validated nursing tools were in use to identify residents' care needs. The inspector viewed a sample of files of residents with a range of needs and found that

while the care plans viewed were generally informative, some lacked sufficient detail to guide staff in the delivery of care. For example; the inspector found that some care plans did not set out all of the interventions required to effectively guide and direct the care of residents known to be carriers of multi-drug resistant bacteria and there was a risk that their care needs would not be met. Further action was also required to ensure that care plans relating to the management of wound care adequately described the care interventions to be completed, in order to direct staff. This is detailed further under Regulation 5, Assessment and Care Planning.

A small number of residents experienced responsive behaviours (how residents who are living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). Although, these residents were well supported, their care planning documentation required improvement to ensure the levels of care and support required were effectively communicated among the staff team.

Although residents received the correct medications, the inspector's observation of nursing practices were that the administration of residents' medicines was not in line with professional standards and required improvement. This finding is discussed under Regulation 29, Medicines Management.

Residents had access to an independent advocacy service and details regarding this service were advertised on the resident information board, displayed in the reception area of the centre. Residents' meetings were convened regularly to ensure residents had an opportunity to express their concerns or wishes. Minutes of residents meetings indicated that residents were consulted about the quality of activities and planned outings. Residents' feedback was also sought with regard to the quality and safety of the service, the quality of the food, laundry services and the staffing. Residents had access to television, radio, newspapers and books. Internet and telephones for private usage were also readily available. Residents had access to religious services and resources and were supported to practice their religious faiths in the centre.

There was an activities programme in place however the current programme did not ensure that all residents had equal opportunities to participate in meaningful social activities and engagement in line with their preferences and abilities. This will be discussed further under Regulation 9: Resident's rights.

The provider did not act as pension-agent for any resident, but had a procedure in place for the management of residents' petty cash. The inspector reviewed a sample of these transactions and found that they were accurate and reflected the balances, which were stored securely.

Overall, the design and layout of the premises was suitable for its stated purpose and met the residents' individual and collective needs. The centre was found to be well-lit and warm. Resident's accommodation was individually personalised. Inspectors noted that while the dimensions of the twin bedrooms met the minimum requirements of the regulations, the layout of some of these bedrooms required review to ensure they met residents' needs. This finding is discussed further under

Regulation 17: Premises.

Infection prevention and control measures were in place and monitored by the person in charge. There was evidence of good practices in relation to infection control, for example the inspector viewed an effective system to ensure that communal mobility equipment such as wheelchairs and mobility aids were cleaned in between resident use. Further oversight was required in relation to cleaning and maintenance of some parts of the premises. This is discussed further under Regulation 27: Infection Control.

Measures were in place to safeguard residents from abuse, however significant improvements were required to be made to the safeguarding processes that were in place to ensure that any concerns were investigated thoroughly and followed up appropriately and that residents were kept safe. This is discussed further under Regulation 8: Protection.

The inspector found that the registered provider had ensured that visiting arrangements were in place for residents to meet with their visitors as they wished. Visitors were observed attending the centre on the day of inspection. Visits were encouraged with appropriate precautions to manage and mitigate the risk of introduction of COVID-19 infection.

Regulation 11: Visits

The inspector found that the registered provider had ensured that visiting arrangements were in place for residents to meet with their visitors as they wished. Visits were encouraged with appropriate precautions to manage and mitigate the risk of introduction of COVID-19 infection.

Judgment: Compliant

Regulation 17: Premises

The following areas of the premises did not ensure that they were appropriate to the number and needs of the residents:

- Some residents did not have sufficient space around their bed to have bedside storage or a comfortable chair in which they could sit out , for example bedroom 15 and bedroom 55, this is a repeated finding.
- While this room was occupied by one resident only on the day of inspection, the layout of twin bedroom 55 did not ensure that a resident could access the en-suite facilities without encroaching on the space surrounding the second resident's bed space. Furthermore, the layout of the bedroom did not allow for ease of access by staff to both sides of the bed positioned nearest the en-

suite, in order to carry out care and transfer procedures. This meant that residents could not carry out personal activities such as personal care in private.
- A new bath and showering facility for residents had been provided for residents along one corridor who would otherwise have to travel a long distance to access these facilities. However, the inspector found that this facility was unavailable for resident use as a call bell system had not been installed**.**

A review of the premises confirmed that the following areas were not kept in a good state of repair as required under Schedule 6 of the regulations:

- Floor covering in several bedrooms and the sluice room was damaged and in need of repair or replacement. This finding did did not ensure these surfaces were adequately maintained or that effective cleaning procedures could be completed.This was a repeated finding from the previous inspection.

Judgment: Substantially compliant

Regulation 27: Infection control

Further actions were required to ensure that the designated centre fully met the requirements of Regulation 27 Infection Control and the National Standards for Infection Prevention and Control in Community Services (2018). Some aspects of equipment or the environment was not consistently managed to minimise the risk of transmitting a health care-associated infection. For example:

- The hand wash sinks in the sluice room and laundry room did not comply with the current recommended specifications.
- The absence of a hand hygiene sink in the cleaner's room did not support effective hand hygiene procedures.
- The floor surface of the housekeeping room was visibly unclean and items of equipment and boxes of supplies were inappropriately stored on floor. This hindered effective floor cleaning and posed a risk that items stored on the floor would become contaminated.
- One large storage room was very cluttered and many items were stored on the floor of this room, preventing it from being appropriately cleaned.
- While residents had individual hoist slings, a number of slings were being stored together in a storeroom along with resident equipment and were found to be overlapping,which increased the risk of cross-contamination.
- Paint was damaged or missing on a number of wall and door surfaces. This meant that these surfaces could not be effectively cleaned.
- Linen trolleys were observed to be stored in residents communal bathrooms which posed a risk of cross- contamination.
- Residents' toiletries were being stored in a communal bathroom which posed a risk of cross-contamination.

- Residents' incontinence wear was stored loosely in a number of en-suite bathrooms and this did not ensure that the products were kept clean.
- The contents of the bodily fluids spill kit located in the sluice room had expired since November 2022.
- The storage of urine collection bottles for use in communal toilets posed a risk of cross-infection.
- While the majority of staff demonstrated compliance with the use of PPE, a small number of staff were observed using face masks incorrectly or failing to wear one.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The inspector was not assured that medication practices were in line with the safe administration of medicines professional guidance, for example

- Some multi-dose medicines did not have a date of opening marked on them. This meant that staff would not be aware of date of opening and when this posed a risk that recommended manufacturer timescales for safe use would be exceeded.
- Medicinal products such as out-of-date eye-drops, were not segregated from other medicinal products which were in use.
- The inspector found that nursing staff were administering medicines for a number of residents without an up-to-date prescription; this posed a risk of medication error.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Although, improvements were found in relation to care planning since the last inspection, the information contained in some residents' care plans did not clearly reference each resident's health care needs and the care interventions that staff must complete were not clearly described. The inspector reviewed a sample of residents' care documentation and found the following;

- A resident who was admitted to the centre with a pressure wound, did not have a care plan developed within 48 hours of their admission, as required by the regulation. This did not ensure that nursing staff were informed as to what dressings and interventions were required to enable wound healing.
- Although, residents at risk of experiencing responsive behaviours were well supported, behaviour support care plans did not provide sufficient detail to

guide staff. For example, specific responsive behaviours expressed by a resident on seven occasions in a five month period, were not recorded in behaviour support care plan.
- A resident with a multi-drug resistant infection did not have a plan of care in place, this posed a risk that the resident care needs would not be met.
- The regular use of psychotropic medication was not included in a falls prevention care plan for a resident who had sustained seven falls in a six month period.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had access to a general practitioner (GP) of their choice. GPs visited residents in person and were contacted and made aware if there were any changes in the resident's health or well being. Allied health professionals such as dietitian, physiotherapist, occupational therapist, speech and language therapy, and tissue viability nurse were made available to residents, either remotely or on-site, where appropriate.

Judgment: Compliant

Regulation 8: Protection

The inspector found that the systems in place to protect residents from abuse in the centre were not robust and did not ensure that all residents were adequately protected. For example;

- The person in charge had failed to appropriately investigate an incident of peer to peer abuse which had been documented by nursing staff.
- A review of the investigation in relation to a safeguarding incident found that a vulnerable resident did not have a safeguarding plan in place and this did not ensure that staff had adequate knowledge to safeguard the resident from abuse.
- A fault to one close circuit television system camera (cctv) was identified by management as a risk during the investigation of a safe-guarding incident in September 2022. At the time of inspection records showed that the camera was still in need of repair. As a result, the inspector found that the provider needed to take further actions to ensure that all reasonable measures were put in place to protect residents from abuse.

Judgment: Not compliant

Regulation 9: Residents' rights

The inspector carried out observations throughout the day in the main reception area and communal sitting rooms.These observations showed that on the day of the inspection there were some residents sitting in these areas who were not engaged in meaningful activities and had limited access to social interaction with staff or with other residents.

A record of the social activity that each resident attended was available. However, the records available did not give assurances that each resident had opportunities to engage in social activities in line with their interests and capabilities. For example;

- A sample of records reviewed by the inspector indicated that residents did not have any opportunity to participate in social activities in the centre on 29th December 2022.
- A sample of records reviewed by the inspector indicated that some residents did not have any opportunity to participate in social activities for up to four days.
- The inspector viewed the activities schedule and found that one-to-one activities were assigned to take place from 08:30-9.30 in residents' bedrooms at the weekend. However, the rosters viewed indicated that the health care assistant who was assigned to the provision of activities at weekends was allocated to assist residents in the dining room from 08.00-12.00pm.

The daily meal menu was not displayed in the dining room, as a result the inspector was not assured that all residents were informed of the daily menu options.

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 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 27: Infection control	Not compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for AbbeyBreaffy Nursing Home OSV-0000308

Inspection ID: MON-0038978

Date of inspection: 11/01/2023

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing: 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.

An Assistant Director of Nursing commenced within the centre on 22.02.2023. This appointment will provide additional supervision and support to staff.

A Compliance and Quality Manager will commence within the Group on 03-04-2023 and will allow for oversight of the management and consistency of the service within the centre.

Advertisement has been placed both locally, nationally and nationally for staff. The recruitment of staff is ongoing to achieve staffing level as outlined in statement of purpose and function.

Recruitment for additional housekeeping/HCA/Activity Co-Ordinator.

Post inspection the centre has successfully hired:
1 x Housekeeping Staff,
2 x Kitchen Assistants and
2x Health Care Assistants

The centre also has 3 x Health Care Assistants awaiting appropriate Compliance paperwork and Garda Vetting. It is expected these staff will commence employment in the centre on or prior to 20-03-2023

In the absence of an Activity Co-Ordinator a competent Health Care Assistant with particular interest in this area will be allocated for activities.

The Group Recruitment & Administration Manager and the Nursing Home Team currently

reviewing staffing levels weekly to ensure appropriate measures are being taken to recruit and that the Centre is actively planning for any known departures.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Regulation 23(a)The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.

An Assistant Director of Nursing commenced within the centre on 22.02.2023 and this will provide additional supervision and support to the residents and staff in conjunction with the Person in Charge.

A Group Operations Director was appointed from the 20th February 2023 and will co-ordinate and resolve all non-clinical compliance issues including the CCTV.

A Quality and Compliance Manager has been appointed and will commence from 3rd April 2023.

Regulation 23 (b) The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.

The PIC is supported by the ADoN in the center and has support from the Board of Management and the Clinical Director.

The management structure within the Nursing Home is clearly identified with all staff fully aware of the escalation pathways. Escalation pathways are displayed throughout the centre and the lines of authority are discussed at induction.

The CEO and Clinical Director meet with staff quarterly and will continue to do so. Management Structure and lines of accountability and communication are discussed at these meetings.

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.

The Compliance and Quality Manager will be responsible for the auditing and oversight of all clinical systems within the centre.

Currently the centre completes a suite of audits monthly to ensure a safe and consistent service. The Compliance and Quality Manager will review and analyse these audits and their findings to ensure the systems in place are appropriate and any learning or measures required for improvement are implemented and communicated to staff.

Monthly meetings with all Heads of Departments will continue on site to ensure appropriate communication and follow on matters outstanding and/or due for review.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
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.

Post Inspection a review of all incidents will take place and any notifications deemed necessary will be retrospectively submitted.

All incidents/accidents are reviewed on site by the PiC and ADoN and a notification completed if required. The PiC will now discuss all incidents with the Clinical Director to ensure an appropriate decision is made regarding a notification submission.

The PiC will continue to submit all quarterly notifications as required.

Regulation 31(3)The person in charge shall provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of an incident set out in paragraphs 7(2) (k) to (n)

All residents who use a sensor monitor or other falls monitoring equipment have this recorded in their care plan.
Sensor mats/chair alarms are used in centre in conjunction with safety checks and supervision. Residents who use sensor mats have been assessed as high-risk for falls and are unable to use the call bell.
The sensor monitor alerts staff that residents may be attempting to move unassisted and staff are aware of the importance of promptly responding and assisting the residents with their needs. Use of sensor mats/chair alarms is always discussed with the resident/ Next of Kin and their preference is respected and documented in the resident's care plan.

Moving forward these devices will be included in the NF39 notifications quarterly.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Regulation 17(1)The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3

The centre was acquired in 2019 under the understanding that Room 55 was a twin room and had been registered repeatedly as such.

PiC and maintenance staff will review all bedrooms to ensure the layout facilitates bedside storage and a comfortable chair as per residents' preferences.

The works in the communal bathroom were completed in December 2022 and the centre was awaiting a new call bell which had been ordered for the room in question. The required part arrived post the inspection and was installed immediately. The shower facility is functioning and in use by residents since 20-01-2023.

Regulation 17 (2)The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.

Floor covering in bedrooms and sluice room had already been identified as requiring attention during an internal audit. These works have been agreed and are being managed by the Operations Director. The works will be completed on a phased basis to ensure minimum disruption to residents. Post the last inspection priority works on flooring were completed within the centre. A schedule of works is in place to bring all floors to the required standard. This is an ongoing works program.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
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.

Feedback meeting held with staff following HIQA inspection held and finding of reports shared.

PiC and ADON have completed Infection Control Link Practitioner Training and will act as

such in the centre.
PiC/ADON will audit infection control practices formally monthly and will develop and implement action plans with staff.

A revised weekly deep cleaning schedule has commenced within the centre from 22nd February 2023. The weekly deep cleaning schedule will be signed and audited by PiC/ADON and will be forwarded to the Director of Operations on a weekly basis and reviewed when they are on site.

Prior to the inspection the Senior Management Team had completed an audit of the centre and were fully aware of works that required attention. Flooring/ Painting and other cosmetic improvements to the centre are planned in a very comprehensive schedule of works. All minor issues noted and reported within the center are attended to, on site by our maintenance staff. If additional specialist supports are required, they are provided by our external maintenance suppliers.

As all the works in relation to the condition 4 have finally been completed, we are now in a position to repaint all relevant areas across the centre. We are currently seeking quotes in relation to these works.

A Group Operations Director was appointed from the 20th of Feb 2023 and will be co-ordinating all non-clinical compliance issue identified including hand wash sinks in both the sluice room and laundry, the hand washing facility and floor surface in the housekeeping room.

The Group Facilities Manager is currently reviewing storage facility with the view to add external storage.

Staff informed of the IPC risk of storing toiletries, urinals, and linen trolley in communal bathrooms. Practices will be monitored by PiC/ADON daily.

The housekeeping floor looks unclean but unfortunately, we are unable to remove these embedded stains even after deep cleaning this floor on a regular basis. We plan to replace this floor in 2023. All items in the housekeeping room are now stored in secured storage units.

Appropriate use of PPE and Hand hygiene techniques were discussed at handovers and meetings. All staff are up to date on this training. Hand hygiene compliance is audited and where shortcomings are identified, an action plan is followed to address these.

All additional slings which are not in use been removed for storage. Slings in use are kept in residents' bedrooms and are washed when soiled and routinely as per cleaning schedule.

Currently sourcing storage boxes to store incontinence wear in ensuite bathrooms or in bedrooms depending on residents' preference.

Spill kit located in the sluice room were replaced on 12th Jan 2023.

Ongoing education of staff regarding use of PPE. Infection Control and us of PPE will be audited monthly.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
Regulation 29(5)The person in charge shall ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.

Post inspection the PiC has completed Medication Audit and reviewed practices. This review has been used as training for all nursing staff to ensure they are fully aware of the medication management practices in line with safe administration of medicines professional guidance.

All Nursing staff have been requested to refresh Training on HSELand. Due for completion by 05-03-2023

All issues identified in relation to Date of Opening and segregation of medical products were actioned immediately. Ongoing monitoring by PiC/ADON.

The DoN/ADoN will monitor medication management practices and continue to audit monthly to ensure that medication practices are in line with the safe administration of medicine professional guidance.

All Nursing staff will have a medication competency completed by the PiC prior to 15-03-2023

Regulation 29(6)The person in charge shall ensure that a medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident shall be stored in a secure manner, segregated from other medicinal products and disposed of in accordance with national legislation or guidance in a manner that will not cause danger to public health or risk to the environment and will ensure that the product concerned can no longer be used as a medicinal product

Weekly spot checks have been implemented by PiC/ADON to ensure appropriate medication management practices are maintained. These checks will be documented and used as learning for Nursing Staff.

There is a safe system in place to get an up- to -date prescription from GP/ pharmacy and same discussed with nursing staff. PiC/ADON to monitor practices.

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
Regulation 5 (1)The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).

Regulation 5 (3) The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.

Admission checklist for nursing staff developed. Completion of assessment and care plans will be reviewed using Admission checklist.

All Nursing Staff will receive additional support, and where necessary training from the newly appointed PPIM in respect of care planning and assessment.

Each resident has a named nurse in the center. All care plans will be reviewed to ensure that any identified gaps are addressed and to ensure that care plans are in place to support residents assessed needs. This will be completed by 30th March 2023.

Regulation 5 (4)The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.

All care plans are under review as outlined in Regulation.

Post inspection the PIC have completed a review of the care plans identified during the Inspection to ensure they adequately reflect the needs of each individual resident.
This review has been used as training for all nursing staff to ensure they are fully aware of the information required to direct safe and appropriate care for all residents.

All other care plans will be reviewed to ensure that any identified gaps are addressed and to ensure that care plans are in place to support resident's needs.

A monthly Care Plan audit has been devised and implemented in the Nursing Home. This will be reviewed by the PIC/ADON monthly and an action plan devised and reviewed continuously to ensure the care and welfare of residents is appropriately documented.

Admission checklist developed for nursing staff to ensure the admission process is followed and clear. Completion of assessment and care plans will be reviewed using Admission checklist. The checklist will be completed by the admitting nurse and signed off by the PiC or ADoN.

All Nursing Staff will receive additional support, and where necessary training from the newly appointed PPIM in respect of care planning and assessment.

Each resident has a named nurse in the center. All care plans will be reviewed to ensure that any identified gaps are addressed and to ensure that care plans are in place to support residents assessed needs. This will be completed by 30th March 2023.

ADON to provide ongoing training, support, and guidance to nursing staff.

Residents to be reviewed for polypharmacy by GP or discussion of the same to be recorded in residents care plan.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection: Regulation 8(1) The registered provider shall take all reasonable measures to protect residents from abuse.

Post inspection the PiC reviewed care plans identified during the inspection to ensure all vulnerable residents have a safeguarding care plan in place and will be monitored by PiC and ADON.

Regulation 8(3) The person in charge shall investigate any incident or allegation of abuse

Staff training to include documentation of peer-to-peer incidents, the importance of reporting promptly and completing incident report appropriately. PiC/ADON to review all incidents, report as appropriate and to investigate. All learning outcomes to be recorded and actioned and shared with staff. It will be the responsibility of the ADoN to ensure care plans relating to incidents are updated and reflective of learning and updated outcomes. The compliance and Quality Manager will also review incidents monthly to ensure the appropriate measures are being taken to keep residents safe and protected in the centre.

A Group Operations Director was appointed from the 20th Feb 2023 and will co-ordinate and resolve all non-clinical compliance issues including the CCTV.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: Regulation 9(2)(b) The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.

Feedback meeting held with staff following HIQA inspection held and finding of reports discussed. Residents rights reiterated to staff and their roles and responsibilities discussed relating to same.

Full Time Activity Co-Ordinator position is currently advertised, and we are actively looking to recruit an experienced Activity Co-Ordinator.

In the interim and until an activity co Ordinator is appointed then a competent Health Care assistant with a particular interest in this area will be allocated for activities.

The Person in Charge and Activity staff currently reviewing activity schedule. Residents were requested to express opinions in activities they wished to see in the centre and a new activity plan will be developed and implemented in coming weeks. This will be completed by 15th of March 2023.

All activities are recorded, and this include all 1:1 activity within the centre. Discussed with activity staff to record if any resident does not wish to participate in activities.

Care plans are under review by the PPIM and ADON in conjunction with the activity staff to ensure that the activity care plan is an accurate reflection of the residents needs and reflective of their capabilities and interests.

Daily menu will be displayed in the notice board even though menu is discussed with residents daily.

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	15/03/2023
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.	Substantially Compliant	Yellow	15/03/2023
Regulation 17(2)	The registered provider shall, having regard to	Substantially Compliant	Yellow	15/03/2023

	the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.			
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	30/04/2023
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Not Compliant	Orange	15/03/2023
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	30/04/2023
Regulation 27	The registered provider shall ensure that	Not Compliant	Orange	30/04/2023

	procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.			
Regulation 29(5)	The person in charge shall ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.	Substantially Compliant	Yellow	15/03/2023
Regulation 29(6)	The person in charge shall ensure that a medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident shall be stored in a secure manner, segregated from other medicinal products and disposed of in accordance with national legislation or guidance in a	Substantially Compliant	Yellow	15/03/2023

	manner that will not cause danger to public health or risk to the environment and will ensure that the product concerned can no longer be used as a medicinal product.			
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	30/04/2023
Regulation 31(3)	The person in charge shall provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of an incident set out in paragraphs 7(2) (k) to (n) of Schedule 4.	Substantially Compliant	Yellow	20/03/2023
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Substantially Compliant	Yellow	30/03/2023
Regulation 5(4)	The person in charge shall	Substantially Compliant	Yellow	30/03/2023

	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 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Orange	09/03/3023
Regulation 8(3)	The person in charge shall investigate any incident or allegation of abuse.	Not Compliant	Orange	09/03/3023
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	15/03/2023