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:	Sligo Nursing Home
Name of provider:	Mowlam Healthcare Services Unlimited Company
Address of centre:	Ballytivnan, Sligo
Type of inspection:	Unannounced
Date of inspection:	06 October 2022
Centre ID:	OSV-0000363
Fieldwork ID:	MON-0035205

About the designated centre

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

Sligo Nursing Home is a purpose-built facility located a short walking distance of Sligo city. The centre can accommodate a maximum of 62 residents. Residents are accommodated in single and twin bedrooms. The centre is a mixed gender facility catering for dependent persons aged 18 years and over, providing long-term residential care, respite, convalescence, dementia and palliative care. Care is provided for people with a range of needs: low, medium, high and maximum dependency. Resident accommodation is over two floors with a lift facility. There are four corridors. Rosses Corridor and Garavogue corridor are on one level and Yeats corridor and Ben Bulben corridor are on the lower level. A variety of communal rooms are provided on both floors for residents' use, including sitting, dining and recreational facilities.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	55

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 6 October 2022	09:00hrs to 17:00hrs	Leanne Crowe	Lead
Tuesday 11 October 2022	09:30hrs to 16:00hrs	Kathryn Hanly	Support
Thursday 6 October 2022	09:00hrs to 17:00hrs	Rachel Seoighthe	Support

What residents told us and what inspectors observed

This inspection took place over two days. There were 55 residents accommodated in the centre on the first day of the inspection. Overall, residents stated that they were well cared for and the staff treated them with kindness. Inspectors spent time observing the interactions between staff and found that staff were kind and considerate of resident needs.

Upon inspectors' unannounced arrival to the centre on each day of the inspection, they were greeted by a staff member who guided them through the required COVID-19 infection prevention and control measures, including completion of hand hygiene and a temperature check. Following an introductory meeting with person in charge, the inspectors spent time walking through the centre where they also met and spoke with residents in the day rooms and their bedrooms. The inspectors observed that some residents were resting in their bedrooms while other residents were sitting in the communal areas, watching television or engaging with one another. The atmosphere in the centre was bustling and a number of residents greeted inspectors and commented positively about the centre.

Sligo Nursing Home is a two storey premises which can accommodate a maximum of 62 male and female residents with varying medical needs. Residents' accommodation was arranged in twin and single bedrooms on lower and upper ground floor levels. The premises was arranged into four wings; Rosses Point and Garavogue on the ground floor and Ben Bulben and Yeats Country on the lower ground floor. Access between these floors was facilitated by a passenger lift and a stairs. Each floor had a communal dining room and sitting room for residents' use. There was a large reception area which was located at the entrance to the centre. Residents also had access to an enclosed courtyard. Corridors were wide and had sufficient handrails to support residents' mobility.

Many residents' bedroom were observed to be homely and decorated with personal items such as family photos and pieces of furniture. Residents reported finding their rooms comfortable and suitable for their needs. One resident invited inspectors to view their room and stated that they were very happy and comfortable in their own space. The resident had decorated their room with family photographs and a display of birthday cards. The resident took great pride in showing the inspectors around their room and it was evident that that were content with their accommodation.

Inspectors viewed the twin rooms on the Ben Bulben corridor, as findings from previous inspections indicated that due to the limited space in these rooms, they would not be suitable for residents who needed to use assistive equipment such as specialist chairs or hoists. Following the last inspection, the provider had committed to ensuring that only those residents who did not require assistive equipment would be accommodated in these rooms. It was evident on this inspection that the residents who were being accommodated in these rooms did not require assistive equipment. The person in charge explained that as residents' needs changed, they

would endeavour to transfer them to a bedroom that could meet these assessed needs. However, it was noted that despite the additional measures in place, the configuration of these rooms may still negatively impact on the privacy and dignity of residents when occupied by two people, due to the lack of space between one bed and the ensuite doors.

Inspectors also viewed twin rooms on the Rosses Point corridor. These rooms appeared to be more spacious, however the layout of one twin bedroom required reconfiguration to ensure that the residents accommodated in this room could have a comfortable chair and lockable storage within their bed space. Additionally, inspectors observed that another twin bedroom did not have a privacy curtain around a residents' bed space, which did not ensure that residents' dignity or privacy could be maintained.

Residents were observed taking part in activities throughout the day of the inspection. An activity schedule was displayed and residents were facilitated to engage in activities of their choice. Inspectors were informed that the staffing resource to provide activities had been increased since the last inspection. It was evident to inspectors that the activities co-ordinator knew the residents well and was familiar with what they liked to do and how they preferred to spend their day.

Residents had access to local and national newspapers, televisions and radios in their bedrooms and in the communal areas. Information regarding advocacy services was displayed in the centre and inspectors were informed that residents were supported access this service if required.

Visiting was facilitated in line with national guidelines and inspectors observed a number of visitors coming and going throughout the day of the inspection.

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 on the quality and safety of the service being delivered.

Capacity and capability

This was an unannounced risk inspection to monitor compliance with regulations and to follow up on the actions taken to address non-compliances found on the previous inspection in November 2021. The inspection was carried out over two days. While some actions had been addressed in full**,** actions in relation to Regulation 15, Staffing and Regulation 9, Residents' Rights, are repeated at this inspection. The inspectors also followed up on a recent provider assurance report that had been submitted by the provider in relation to the management of falls in the centre.

Overall, this inspection found that there was a clearly defined management structure

in place with effective management systems to ensure the delivery of quality care to residents. However, it was identified on this inspection that some improvements were required to achieve compliance with Regulation 23, Governance and Management, as well as a number of other regulations. These findings are set out throughout the report.

Mowlam Healthcare Services Unlimited Company is the registered provider for Sligo Nursing Home. The Chief Executive Officer (CEO) of the company represents the provider entity. The person in charge is supported in their role by a Regional Healthcare Manager and a Director of Care Services in the senior management team. Within the designated centre, the person in charge is supported by an assistant director of nursing (ADON) and a team of nurses, health care assistants, activity, administration, maintenance, domestic and catering staff. There were clear lines of accountability and staff were knowledgeable about their roles and responsibilities.

The provider had effective management systems in place to monitor the service through regular meetings where key areas of the services were discussed and analysed.

An annual report on the quality of the service had been completed for 2021 which had been done in consultation with residents and clearly set out the service's level of compliance as assessed by the management team. A quality improvement plan had been developed to address any actions that had been identified.

Inspectors reviewed a sample of staff files and found that they contained all of the information required by Schedule 2 of the regulations. All nursing staff had up-to-date registration with the Nursing and Midwifery Board of Ireland. There was evidence that all staff had been appropriately vetted prior to commencing their respective role in the centre.

There was an induction programme in place that included competency assessments and regular reviews by nursing management. Appraisals also took place on an annual basis with all staff.

Regulation 15: Staffing

Inspectors found that on the day of the inspection, staffing levels needed to be reviewed to ensure that there was sufficient staff with the appropriate knowledge and skills to meet the needs of residents. This was evidenced by inspectors observing that on some occasions during the inspection, there wasn't sufficient staff in communal areas to support residents or respond to their needs. On review of feedback from residents' meetings, inspectors noted that residents had expressed dissatisfaction in relation to the time taken by staff members' responding to residents' needs.

Judgment: Substantially compliant

Regulation 16: Training and staff development

There was a training programme in place which included mandatory training as well as areas that would support good provision of care. A review of training records indicated that a small number of staff required refresher training in fire safety, moving and handling practices and safeguarding but there was evidence that this training had already been scheduled to occur in the weeks following the inspection.

Judgment: Compliant

Regulation 22: Insurance

A current insurance certificate was in place and had the necessary insurance coverage as detailed in the regulations.

Judgment: Compliant

Regulation 23: Governance and management

The oversight of staff practices and standards in infection prevention and control was not robust. This was evidenced by:

- An infection prevention and control audit had been carried out by a member of the management team in the days prior to the inspection, but this had not identified the issues described in relation to the storage of cleaning equipment
- The non compliance in relation to storage of equipment in the sluice room was addressed by the person in charge on the first day of the inspection. However on the second day of the inspection the inspectors found that staff had returned a number of items of equipment to be stored in the sluice room in spite of the changes implemented by the senior management team.

Judgment: Substantially compliant

Regulation 24: Contract for the provision of services

A sample of contracts for the provision of services were examined. These included details of the service provided, fees to be charged for such services and detailed the residents room number and occupancy.

Judgment: Compliant

Regulation 3: Statement of purpose

The actions from the previous inspection had been addressed and the Statement of Purpose now contained all of the information required by Schedule 1 of the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

There was a policy and procedure in place to manage complaints, which met the requirements of the regulations.

Judgment: Compliant

Quality and safety

Overall, the inspectors found that residents were looked after by a staff team who knew them well and that care provided was person centred. However, inspectors found that increased oversight was required to ensure that the centre came into compliance with Regulation 27, Infection prevention and control. Additionally some improvements were required to ensure that the quality and safety of care being delivered to residents was consistently managed, to ensure the best possible outcome for residents. In particular, actions were needed to bring Regulation 8, Protection, Regulation 17, Premises, Regulation 5, Assessment and Care Planning and Regulation 9, Residents' Rights into full compliance.

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. However, inspectors found that there were some inconsistencies in the completeness of the assessment and care planning processes. While all residents had comprehensive assessments completed, not all assessments included a comprehensive infection and

multi-drug resistant bacteria assessment. Inspectors found that some care plans viewed did not set out all of the interventions required to effectively guide and direct the care residents known to be carriers of multi-drug resistant bacteria. Additionally, a number of residents with infections did not have any care plans in place, 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 seizures adequately described the care interventions to be completed, in order to direct staff and to ensure resident safety. This is detailed further under Regulation 5, Assessment and Care Planning.

Residents had access to a general practitioner (GP) from the local practices and out-of-hours GP services were available when needed. Residents saw their GP for reviews and if their needs changed. Residents had access to wider health and social care services such as physiotherapy, occupational therapy, dentist and optician. The person in charge had a system in place to monitor access to allied health services, thus ensuring that residents' health care needs would be met in a timely manner.

Residents expressing responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) were well supported by staff. Staff who spoke with inspectors had up-to-date knowledge appropriate to their roles to positively react to responsive behaviours. The staff were familiar with the residents and were knowledgeable on the triggers that may cause distress or anxiety. Referrals were made to specialist services that included a geriatrician and psychiatry of later life.

There were appropriate pension agent arrangements in place for residents that chose to avail of them.

The designated centre was working towards a restraint free environment. There was a total of two residents who had bed rails in use on the day of the inspection. Inspectors found that a comprehensive risk assessment was completed and a plan of care was in place for each resident.There was a restrictive practice register in place, Records within this register demonstrated that there was a low level use of restrictive practice in the centre. Staff demonstrated a commitment to minimal use of restraint and practices and procedures were in line with national restraint policy guidelines. There was a restrictive practice policy in place to guide staff.

Inspectors observed that systems in place for the oversight and review of infection prevention and control practices required further improvement. Inspectors observed that on both floors of the premises, the management of cleaning equipment created a risk of cross contamination. Inspectors found that on both of these floors, some or all of this equipment was being stored in the sluice rooms. While the person in charge acted promptly to address these findings on the first day of the inspection, inspectors found that staff had returned a number of these items to the sluice rooms on the second day of the inspection. This is discussed further under Regulation 27.

The provider had increased staffing in relation to activity provision since the previous inspection, resulting in an increase of ten hours per week and ensuring that activities take place on a daily basis. Further review of the activities programme was

required to ensure resident outings were facilitated as planned.

Regulation 11: Visits

Visiting arrangements were being managed in the least restrictive manner and in line with national guidance. The inspectors saw that residents could receive visitors in their bedrooms or in a number of communal rooms.

Judgment: Compliant

Regulation 12: Personal possessions

Inspectors found that residents had adequate storage in their rooms for their personal possessions. Residents' clothing was laundered regularly and appropriately labelled.

Judgment: Compliant

Regulation 17: Premises

The majority of the premises was in a good state of repair and met the needs of the residents, however the layout of some shared bedroom accommodation did not conform with Schedule 6 of the regulations as some residents did not have sufficient space around their bed to have bedside storage or a comfortable chair in which they could sit out.

In addition the layout of some shared rooms did not ensure that residents could access the ensuite facilities without encroaching on the space surrounding the second resident's bed space. This is addressed under Regulation 9, Residents' Rights.

Judgment: Substantially compliant

Regulation 27: Infection control

The registered provider had not ensured effective governance arrangements were in place to ensure the sustainable delivery of safe and effective infection prevention

and control and antimicrobial stewardship. For example;

- There were no measures in place to improve the quality of antibiotic use within the centre as recommended in the National Standards For example antibiotic use was not tracked or tended to inform quality improvement initiatives, staff were unaware of the community prescribing guidelines and audits of antibiotic use were not undertaken
- The provider had not ensured that results of routine multi-drug resistant bacteria testing done on admission to hospital was communicated to nursing staff in the centre when residents were transferred back from hospital.This meant that appropriate precautions may not have been put in place to prevent the spread of multi-drug resistant bacteria
- Staff and management did not know which residents were carriers of or colonised with multi-drug resistant bacteria. As a result appropriate precautions may not have been in place when caring for these residents
- Admission assessments did not include a comprehensive infection and multi-drug resistant bacteria assessment. Care plans viewed did not set out all of the interventions required to effectively guide and direct the care residents known to be carriers of multi-drug resistant bacteria
- The inspectors identified through speaking with staff that they did not know which infection prevention and control measures were required to be used if caring for a resident that was colonised with Carbapenemase-Producing *Enterobacter* (CPE). Lack of awareness meant that appropriate precautions may not have been in place to prevent the spread of the bacteria if caring for these residents.

The environment and equipment were not managed in a way that minimised the risk of transmitting a healthcare-associated infection. This was evidenced by:

- The sluice room on the upper ground floor was being used to store the cleaning equipment for that floor, including the trolley, mop handles, mop heads and cleaning cloths. These items were being stored openly, which posed a risk of cross contamination
- A cleaning store on the lower ground floor was cluttered, resulting in staff storing this cleaning trolley beside a waste bin in the nearby sluice room
- Cleaning textiles were washed in the sluice on both days of the inspection. Mops were observed to be hung to dry from the shelves and racks in the sluice. This arrangement increased the risk of cross contamination
- Items of equipment including shower chairs, bedpans and a commode basin were visibly unclean. This posed a risk of cross contamination
- Some toiletries were being stored in the assisted bathroom
- The inspectors were informed that a chlorine solution used for cleaning the centre was not mixed newly each day, which may impact its effectiveness.

Judgment: Not compliant

Regulation 28: Fire precautions

While this regulation was not reviewed in its entirety, inspectors noted that a room used to store linens did not contain a smoke detector, which posed a risk to fire safety.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

A review of the quality of the information found in the care plans was required. Inspectors found that the quality of the care plans was inconsistent. Some care plans described resident's care needs and personal preferences in a detailed and person-centred manner, while other care plans lacked the detail required to guide staff to deliver effective, person-centred care. For example,

- A number of residents had multi-drug resistant infections. However, there were no care plans in place to direct staff, which posed a risk that resident care needs would not be met
- A care plan for a resident who experienced seizures lacked sufficient detail to guide staff as to the appropriate management of a seizure
- A resident who expressed responsive behaviours did not have a behaviour support care plan in place.

Judgment: Substantially compliant

Regulation 6: Health care

Inspectors observed that general practitioners made regular visits to review the residents and a full range of other health care-related services were available for the residents in the centre. These included speech and language therapy, physiotherapy, occupational therapy, dietetic services, tissue viability and community mental health services.There was evidence of referrals to the health service executive national screening programme.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

There were systems in place to support residents who expressed responsive behaviours. There was evidence that work was ongoing to keep the use of restraint

at a minimum.

Judgment: Compliant

Regulation 8: Protection

While there were arrangements in place to ensure that residents were safeguarded from abuse, the person in charge had failed to appropriately investigate an allegation of abuse. This was discussed with the management team during the inspection.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Inspectors observed that a resident in a shared bedroom did not have privacy curtain around their bed space. This did not ensure the inspectors that the resident could carry out personal activities in private.

While the majority of the actions in relation to the last inspection had been completed, inspectors noted that the action in relation to the installation of second televisions in shared bedrooms was still in progress and second televisions were not available in some rooms.

Inspectors observed a resident's continence device was exposed on a number of occasions while the resident was seated in a communal area. This did not support the resident's dignity and it was not identified or addressed by staff until it was brought to their attention by inspectors.

The provider had increased activity staff hours following the previous inspection. However on this inspection, inspectors observed that activities were often interrupted because the activities staff had to attend to other resident needs, such as support with mobilising. In addition residents had not been able to access community resources and outings, for example, inspectors noted that an outing planned for this summer had not taken place due to staffing issues and an alternative outing had not been organised for residents. As a result the inspectors found that the current staffing resource did not ensure that residents were able to access meaningful activities in line with their interests and capacities.

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 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Sligo Nursing Home OSV-0000363

Inspection ID: MON-0035205

Date of inspection: 06/10/2022

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: • The Person in Charge (PIC) is supported by a regional Healthcare Manager (HCM) who visits the home regularly. • The HCM and PIC meet at least weekly to discuss the operation of the nursing home, including a review of staffing and deployment of staff within the centre, with consideration given to the dependencies and needs of residents in each area on both floors. • The senior nursing management team includes the PIC and an Assistant Director of Nursing (ADON), supported by three senior staff nurses who provide clinical oversight to Staff Nurses (SNs) and Healthcare Assistants (HCAs). • We will ensure that the staffing establishment reflects the levels outlined in the Statement of Purpose. This will be closely monitored by the HCM and PIC. • The PIC produces the staff roster in advance which sets out the required staffing numbers and skill mix for each unit over a 24-hour period. The roster is based on the number of residents, their dependency levels, care needs and preferences. The PIC and ADON have responsibility for the daily oversight of the rosters. • An additional Healthcare Assistant (HCA) shift has been added to the roster from 10:00hrs to 22:00hrs to enhance support, supervision and skilled safety checks of residents during identified periods. • Rosters are planned to ensure that there are always enough suitably qualified staff available to meet each resident's assessed care needs. • During periods when staff are unavailable to work due to sickness leave, or when a post is vacant, every effort will be made to realign the rosters so that another staff member can cover the shift(s), but if that is not possible, agency staff will be booked to replace the absent staff member.	

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

• There is a clearly defined management structure in the centre, which includes a designated PIC and ADON; they both have extensive experience in caring for older persons.

• The PIC is supported by the regional Healthcare Manager and Director of Care Services. The Healthcare Manager visits the centre regularly and is available for advice, discussion and consultation at all times. A monthly progress review meeting in relation to regulatory compliance is attended by the HCM and the PIC.

• The staffing roster is produced in advance and there are appropriate deputising arrangements in place for the PIC.

• The deployment of nursing and care staff was reviewed and necessary changes to the staff deployment in the centre have been implemented to enhance supervision in all areas of the home, and this is proving to be effective.

• The PIC is aware of all operational issues in the centre, as there are regular communication meetings, mid-shift Safety Pauses and handover meetings held in the centre in order to maintain effective channels of communication with all staff and to give staff an opportunity to provide feedback on any residents who have a change in their needs or health status.

• There is an audit schedule in place to monitor key aspects of care in the centre and appropriate quality improvement plans have been identified and implemented to address any areas of non-compliance. This includes Hand Hygiene audits, IPC audit, Call Bell audit and Falls audit. The HCM has also completed a Falls Analysis and issued a Corrective Action Plan based on the outcome of the audit. The PIC and ADON will continue to monitor the assessment and care planning of residents who have identified falls risks.

• The PIC attends an organisation-wide Falls Committee and participates in a virtual education programme on Falls Management; the learning from this course will be shared with the staff to increase vigilance and improve practice in falls prevention and management.

• There are monthly management team meetings chaired by the PIC and attended by the HCM and representatives of each department. These meetings offer all department representatives the opportunity to discuss issues pertinent to their areas as well as gaining an insight on the overall operation of the nursing home.

• The PIC and ADON (who is the IPC Lead), oversee and monitor Infection Prevention & Control practices in the centre, during daily clinical rounds, ensuring that the most recent Health Protection Surveillance Centre (HPSC) guidelines are available for reference.

• The National Standards for the Prevention and Control of Healthcare Associated Infections are accessible to staff in the home and staff knowledge will be refreshed in respect of the current Standards by regular discussion about the standards during Safety Pauses and IPC Committee meetings.

• The PIC has scheduled CLEAN PASS training for all Senior HCAs and housekeeping staff. A training plan is in place.

• The washing machine that had been used to launder mop heads in the sluice room has been decommissioned and removed.

• A daily check list has been implemented in the sluice rooms and cleaning storeroom to

ensure that expected standards are monitored and maintained.
• The ADON will analyse data and trends in relation to antimicrobial stewardship and present the findings to the IPC Committee. We will be focusing on improving quality of stewardship and awareness as part of a clinical quality improvement programme for 2023.
• The ADON has undertaken a review of care plans with the assistance of the nursing staff, and the necessary updates in respect of infection control measures required for residents with MDRA infection history have been incorporated into the reviews.
• The PIC has scheduled staff training to refresh staff knowledge in respect of MDRA and management, communication of same.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• The Facilities Manager will review the configuration of the twin rooms to ensure they are configured in a manner that maintains residents' privacy and dignity. This includes the layout and position of the privacy curtains.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
• The PIC and the ADON (the IPC lead) oversee and monitor IPC practices in the nursing home during daily rounds.
• The HCM visits regularly and reviews IPC practices and procedures in conjunction with the PIC.
• The PIC will ensure that the National Standards for the Prevention and Control of Healthcare Associated Infections are accessible to staff in the home and will arrange training to refresh staff knowledge in respect of the current Standards.
• The PIC has scheduled CLEAN PASS training for all Senior HCAs and housekeeping staff. A training plan is in place.
• The Facilities Manager has arranged for the washing machine that had been used to launder mop heads in the sluice room to be decommissioned and removed.
• The Housekeeping Supervisor will ensure that a daily check list will be completed in the sluice rooms and cleaning storeroom, to ensure standards are monitored and maintained.
• The PIC has issued the National Antimicrobial Stewardship Guidance to all nurses and will implements improvements to practice based on the guidelines and recommendations in this publication. For example, nurses will routinely dip test urine prior to contacting a GP when a resident is symptomatic for a urinary tract infection (UTI).

• The PIC has scheduled education sessions for all nurses on Antimicrobial Stewardship in January 2023, which will be delivered by a nurse with specialist training in Infection Prevention and Control.
• The PIC will ensure that a written discharge letter/transfer form will be provided by the hospital when residents are transferred back to the nursing home from hospital which will include all relevant clinical information, including infection status. The PIC will also ensure that if residents require transfer to hospital, their transfer letter will include information about MDROs
• The PIC has prepared a master list (line-listing) or register of residents who have colonized Multiple Drug Resistant Organisms (MDROs), identifying the specific organism for each resident as required, and this register will be reviewed regularly to ensure that it is accurate and current. Nursing staff will maintain an up-to-date record of infection status, including MDROs in the care plan of each resident to ensure all staff are aware of specific individual care and protection required. All staff will be made aware of residents who have colonized MDROs, and this will be discussed at handovers and safety pauses; non-clinical staff will also be made aware of affected residents and any specific arrangements in relation to these residents and their accommodation.
• We will enhance the Pre-admission Assessment Form to include a comprehensive assessment of infection status or to record colonisation with specific MDROs.
• The PIC has issued information about specific MDROs, including ESBL, MRSA, VRE, and HPSC Guidance relating to Carbapenemase Producing Enterobacterales1 (CPE) for Long-Term Care Facilities for Older People to all staff providing care to residents.
• . Information leaflets are also on display at reception for staff, residents, and visitors. Residents affected have been provided with information regarding the specific MDRO.
• The PIC has undertaken a supervision with housekeeping staff in relation to specific cleaning requirements of the bedrooms and bathrooms of affected residents.
• A review of monthly assessment process measures (quality indicators) in relation to healthcare associated infection (HCAI) and antimicrobial stewardship, in line with the HSE guidelines on the minimum dataset, has been added to the IPC meeting agenda. This will include a review of all newly acquired infections over the preceding month, the number of urinary catheters, the source of infection, the number of residents on a course of antibiotics (including prophylactic antibiotics), information of residents with CPE, C.Diff and any specific information on infection outbreaks, including Covid-19.
• The ADON has undertaken care plan reviews with the assistance of the nursing staff, and they have completed the necessary updates in respect of infection control measures required for residents with HCAI or MDRO colonisation.
• The IPC Lead Nurse will receive enhanced education on IPC, and will conduct monthly IPC audits, identifying improvements and developing quality improvement plans as required.
• The IPC Lead Nurse will chair monthly IPC Committee meetings, which will be attended by PIC and a representative of all staff grades/departments.
• IPC lead Nurse and Housekeeping Supervisor will complete daily checks and monthly audits with action plans as appropriate to address all areas of non-compliance.
• Daily Safety Pause at handovers gives the PIC an opportunity to discuss relevant IPC issues and maintain staff awareness and vigilance.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• The PIC has oversight of Fire Safety checks and records of these checks are in place.
• The Facilities Manager has arranged for a smoke detector to be fitted in the linen storeroom.

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:
• The PIC or ADON will assess all residents prior to admission to ensure that their care needs can be safely met in the centre.
• The nurses will prepare a care plan within 48 hours of each resident's admission which reflects their assessed care needs, and preferences.
• Care plans will be prepared in consultation with residents and/or their designated representative, and the plans will reflect each individual resident's preferences and choices. A record of consultation will be documented in the electronic care file.
• The PIC and ADON provide clinical oversight to ensure that all resident assessments and care plans have been completed and are individualised and person-centred. They will ensure that the assessment informs the plan of care and considers the resident's current medical, health and lifestyle status.
• Nursing staff will review assessments and care plans at intervals not less than 4 monthly, or as indicated by the resident's condition or circumstances. These reviews will consider all aspects of the residents' physical and mental wellbeing, personal and social care needs and any supports required to meet those needs, as identified by initial and ongoing assessment.
• The Healthcare Manager, Quality & Safety will introduce a Clinical Oversight audit tool. This tool will facilitate the PIC to audit the quality of assessments and care plans and to develop a corrective action plan as required.
• The PIC will discuss any changes to the assessed needs of residents,' post admission with the wider multi agency teams e.g., Mental Health Team and resident's GP, to assist in establishing a plan to move forward with the care of the resident.
• Referrals for specialist additional support required form any member of the multi-agency team will be followed up as required.
• The PIC and the GPs will review pain relief for residents with cognitive impairment, using the PINCH ME assessment to ensure that residents have adequate levels of simple analgesia to reduce Behavioural and Psychological Symptoms of Dementia (BPSD), agitation and sleep disturbance.
• The PIC has added a night duty mid-shift Safety Pause has been added and a record will be maintained of these meetings.

• Staff discuss any residents who have changing needs. Regular safety checks are conducted to ensure that residents are observed and that they have everything they need close by.
• The PIC is available to meet with residents and family members as required and meets residents throughout the day to ensure that they are safe, comfortable and content.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• The PIC has completed all Notifications, Safeguarding Action Plan and referrals to the internal Senior Incident Management Team as per Incident Management Framework for all allegations.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• The Facilities Manager will review the configuration of the twin rooms to ensure they are configured in a manner that maintains residents' privacy and dignity. This includes the layout and position of the privacy curtains.
• Residents with continence devices (indwelling urinary catheter) have appropriate leg strap or catheter stand provided and this is reflected in their individual care plan, with the individuals' preferences recorded.
• A programme of seasonal activities and outings has been planned. An additional HCA has been added to the roster to ensure residents have access to healthcare staff supports, without interrupting the activities coordinator during activities.

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	30/11/2022
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	31/03/2023
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service	Substantially Compliant	Yellow	31/01/2023

	provided is safe, appropriate, consistent and effectively monitored.			
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Not Compliant	Orange	31/01/2023
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	19/12/2022
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	31/12/2022
Regulation 5(4)	The person in charge shall formally review, at intervals not	Substantially Compliant	Yellow	31/12/2022

	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(3)	The person in charge shall investigate any incident or allegation of abuse.	Substantially Compliant	Yellow	31/10/2022
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Substantially Compliant	Yellow	31/10/2022
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	31/10/2022
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities	Not Compliant	Orange	31/03/2023

	in private.			