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:	TLC City West
Name of provider:	Cubedale Limited
Address of centre:	Cooldown Commons, Fortunestown Lane, Citywest, Dublin 24
Type of inspection:	Unannounced
Date of inspection:	25 October 2023
Centre ID:	OSV-0000692
Fieldwork ID:	MON-0041643

About the designated centre

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

TLC City West is a purpose-built nursing home which can accommodate 119 male and female residents over the age of 18. There are 103 en-suite single rooms and 8 en-suite double rooms in the centre over four floors: Ground, 1st, 2nd & 3rd Floor. The building is T shaped which is divided into left, right and middle wing. The details of rooms, sizes and facilities are available in the centres statement of purpose. Each bedroom is fully furnished and has a television and a phone provided. The centre is designed to meet the individual needs of the older person in pleasant surroundings, whilst facilitating freedom and independence. TLC Citywest is ideally located close to the Red Luas line, Citywest Hotel, Citywest shopping centre and Saggart village. It is just off the N7 or the N81 in the other direction and within close proximity to Tallaght Hospital.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	117

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 25 October 2023	09:00hrs to 18:40hrs	Niamh Moore	Lead
Wednesday 25 October 2023	09:00hrs to 18:40hrs	Aislinn Kenny	Support
Wednesday 25 October 2023	09:00hrs to 18:40hrs	Catherine Furey	Support

What residents told us and what inspectors observed

Inspectors spoke with 13 residents and six visitors over the day of the inspection, to elicit their experiences and views of life in TLC City West. Many residents spoken with said they were happy with their bedrooms, the cleanliness of the centre, the laundry service and the mealtime experience provided. Residents said that staff were kind and lovely, however some residents felt there was not enough staff and reported that they found that staff were always very busy. Many visitors spoken with also said that they felt there was staff shortages and sometimes this could result in a lack of attention to detail for their loved one.

On arrival inspectors were met by a member of the centres administration team and signed the visitor's book. Following an opening meeting, inspectors were accompanied on a tour of the premises by two members of management. The centre was built over five floors with stairs and a lift between the floors to ensure that all areas were accessible to residents. Residents' bedroom accommodation was located on the ground, first, second and third floors. Each of these floors had their own dining and sitting rooms which could be used by the residents from that floor. The ground floor also had additional communal areas available to all residents such as a large dining room, hairdresser room, an activity room and an oratory. There was access to the garden from the ground floor where residents could freely enter this area. Inspectors saw that residents spent the majority of their days throughout communal areas taking part in activities, watching television, spending time in the garden and some residents were also seen to use the smoking hut throughout the day.

The registered provider had completed some premises works since the last inspection including works to fire doors which were ongoing on the day of the inspection. Chairs were no longer positioned around nurses stations and instead these areas provided opportunities for residents and staff to participate in recreation such as pool or table tennis. Communal areas were nicely decorated with many seasonal Halloween decorations on display for residents to enjoy.

Bedroom accommodation comprised of 103 single bedrooms and eight twin rooms, all with en-suite toilet facilities**.** Residents' bedrooms were seen to be clean and homely. Many bedrooms had been personalised with items such as family photos, bedding, ornaments, plants, flowers and balloons. All bedrooms provided wardrobes and lockable storage for residents to store their clothes and personal belongings. Residents spoken with said they were satisfied with their bedroom, with many commenting on the cleanliness of their rooms. Since the last inspection, the registered provider had reduced the bedrooms on the first and second floors to all single en-suite rooms. The twin bedrooms on the ground floor had been modified to ensure they were compliant with the regulations affording each resident sufficient privacy. However some staff spoken with informed inspectors that these rooms had insufficient space for residents who required the use of specialised equipment such

as a hoist.

Residents could attend dining rooms or have their meals in their bedroom if they preferred. Residents were provided with tea, coffee, and snacks such as pastries, biscuits, yogurts and fruit outside meal times. Inspectors observed that the meals provided were of a high quality and well presented. Feedback from residents was positive relating to the dining experience they received. However, inspectors noted that residents who required a modified consistency diet, for example pureed or soft diet, were not always offered a choice of menu items which is further discussed under Regulation 18: Food and nutrition within this report.

Activity schedules were displayed throughout the centre which detailed a varied activity programme available to residents. Residents were observed enjoying the music provided by an external musician on the day of the inspection. There was good participation seen with residents engaging with the musician and joining in with the singing. Residents that were spoken with on the day of inspection mentioned they enjoyed the music in particular.

Overall, inspectors saw that the majority of residents appeared relaxed and comfortable in their home. However, there were occasions where inspectors observed that staff were not consistent in their approach to those residents who presented with 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). Inspectors also noted that outside of the group activities provided, there was limited engagement by staff with residents in a meaningful manner rather most engagement was for tasks such as personal care or assistance at meal time. For example, while observing the lunch-time experience, a staff member was observed standing over residents rather than sitting with them at eye level while assisting them with their meal.

There was no restrictions on visiting and visitors were seen coming in and out of the centre throughout the day.The general environment appeared clean with few exceptions, and some premises work was outstanding which impacted on the cleanliness and homely appearance of areas which will be further discussed within this report.

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 impact on the quality and safety of the service being delivered.

Capacity and capability

This was an unannounced inspection to review compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People Regulations 2013). This inspection also followed up on the compliance plan from inspections in 2022 and reviewed information since the last inspection. Inspectors found that the

registered provider had made improvements to the layout of twin bedrooms and communal areas since the last inspection and to the provision of group activities. However, inspectors found there were gaps in management systems and oversight of staff supervision and residents' care.

Cubedale Limited is the registered provider for TLC City West. The governance structure in place is well-established with oversight from the Chief Operating Officer, Regional Director and an Associate Regional Director from Orpea Care Ireland. The person in charge works full time and was supported in their role by a housekeeping and catering manager, three assistant directors of nursing and four clinical nurse managers.

Staff were allocated per floor with the ground and third floor having shared staffing allocations. Nursing staff were supported by senior health care assistants, health care assistants, activity staff, a physiotherapist, household and catering staff. On the day of the inspection, inspectors found that there was sufficient staffing levels within TLC City West.

There was an ongoing mandatory training programme in the centre. The training matrix provided to inspectors found high levels of attendance at mandatory training such as fire safety, manual handling, infection control and safeguarding. In addition, the registered provider had made training on dementia care mandatory for staff within the designated centre. While inspectors noted 98% of staff had up-to-date safeguarding training, two out of three staff spoken with did not have appropriate safeguarding knowledge on the day of the inspection.

The registered provider had a thorough induction programme for new starters and inspectors reviewed supervision processes such as the sign off of induction and probation forms for staff. However, inspectors found that the registered provider's systems of supervision and oversight relating to resident care was not sufficiently robust. This is further discussed under Regulation 23: Governance and Management.

Inspectors were informed that the directory of residents was available for review on the electronic computerised system. However, the directory shown and printed for inspectors did not contain all information as set out and required by the regulations.

The registered provider had a current certificate of insurance which indicated that cover was in place against injury to residents, staff and visitors.

There was evidence of management systems in place such as management forums and auditing. The person in charge reported to the governance forum monthly on areas such as complaints management, safeguarding, activities, audits, occupancy and the resident committee. There was a clinical and corporate monthly governance meeting attended by members of management from the designated centre. Topics discussed at this meeting included human resources, finance, housekeeping and catering, maintenance, and a report from the person in charge relating to the regulations and clinical governance. A resident quality indicator report was also completed monthly which reviewed information relating to occupancy and medical care in areas such as medication, falls, restraints, weight loss and pressure areas. In

addition, there was also more in-depth analysis into incidents, falls, antimicrobial stewardship and a recent COVID-19 outbreak report. However, despite these management systems in place, gaps were found in ensuring all residents received a service that was safe, appropriate, consistent and effectively monitored.

The registered provider had an annual review of the quality and safety of care delivered to residents in 2022 which included consultation with residents and their families. Three main actions for 2023 were identified from this feedback which included to ensure residents' personal care and basic needs are consistently met, improve the garden facilities and to improve communication with residents and families.

There was a complaints procedure in place which complied with the updated regulatory requirements. A summary of this procedure was on display in the reception area for residents and visitors information. The registered provider completed monthly audits and trending of complaints received.

Regulation 15: Staffing

There was a sufficient number and skill mix of staff available on the day of the inspection.

Judgment: Compliant

Regulation 16: Training and staff development

Inspectors found that staff did not have access to effective safeguarding training. Despite a high record of attendance at safeguarding training, two staff spoken with were unable to detail the different types of abuse and the process of reporting abuse.

Judgment: Substantially compliant

Regulation 19: Directory of residents

The directory of residents was in electronic format and did not meet the criteria as set out within Schedule 3 of the regulations. For example, the directory presented to inspectors was not collated into one document and it also did not include information relating to the telephone number of the residents general practitioner.

Judgment: Substantially compliant

Regulation 22: Insurance

There was an appropriate contract of insurance in place that met the regulatory requirements.

Judgment: Compliant

Regulation 23: Governance and management

The oversight and monitoring systems of key areas of the service was not sufficiently robust and did not ensure that care and services were being delivered in line with the centre's own policies and procedures, and the regulations. For example, inspectors were not assured that the registered provider had satisfactory oversight of staff supervision for the following reasons:

- a staff member spoken to was not aware or knowledgeable on a resident's identified need that they were assigned to support
- the assignment of staff duties on one unit on the day of inspection did not follow a contract the registered provider had in place with the Health Service Executive
- there were significant gaps in the documentation of one hour safety checks for residents. In addition, paper work from 30 minute safety checks were not immediately available when requested but provided to inspectors at the end of the inspection.
- call bells working and accessible to residents were due to be checked during safety checks as per a provider assurance report provided to the Chief Inspector. However, four staff spoken with stated that this was not checked during safety checks. In addition, there was no documentation evident to include the accessibility of call bells at safety checks
- staff engagement with a resident displaying responsive behaviour was not in line with the centre's policy on the management of behaviour that is challenging.

While there was auditing of key performance indicators and clinical data occurring regularly, this was insufficient as it had not identified or addressed inspectors findings under Regulations 5 and 6.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The registered provider had an accessible and effective procedure for dealing with complaints. Inspectors reviewed the 2023 complaints log with the person in charge and saw there was evidence of complaints being recorded, investigated and responded to as per policy.

Judgment: Compliant

Quality and safety

Overall, the quality and safety of care provided to residents was of a good standard. However, there was some inconsistencies found and some areas required improvement to ensure all residents received high quality care. These areas included care planning, healthcare, managing behaviours that challenge, meaningful engagement with residents, choice at mealtimes, premises and infection control. These are discussed further under the relevant regulations.

A sample of residents' care plans and nursing assessments were reviewed. Inspectors noted overall improvements in care planning since the previous inspection. Relevant information was seen to have been documented prior to and following admission to the centre. Care plans had been developed with the support of residents and family members. These were seen to contain sufficient information to guide staff in caring for the medical and nursing needs of residents. Validated risk assessment tools were used to identify specific clinical risks, such as risk of falls, pressure-related skin damage and depression. Records showed that assessments were regularly updated in line with residents' changing needs, for example following a fall, or on return from a hospital stay. Nonetheless, the oversight of residents' weights required review to ensure that these were correctly measured. This is particularly important as the residents' weight is used to complete a clinical assessment of the risk of malnutrition. The recorded weights for one resident did not align with the results of the risk assessment and the nutritional status of the resident was unclear. This is discussed further under Regulation 5: Individual assessment and care plan.

Residents had good access to evidence-based health and social care services from a range of health care professionals. General practitioner (GP) services were accessed through regular medical rounds held in the centre. Residents were supported to safely attend out-patient and other appointments. Inspectors saw evidence of appropriate referrals made to specialist services such as psychiatry of older age, community palliative care and speech and language therapy. The centre's management team included a qualified physiotherapist who ensured regular reviews of resident's mobility and dependency requirements. The oversight of wound care

required review, as discussed under Regulation 6: Healthcare.

The provider had systems in place to monitor restrictive practices in the centre and the restraint register identified that all restraints were documented clearly and reviewed regularly. There was good evidence to show that the centre was working towards a restraint-free environment in line with local and national policy. Restraints such as bedrails were appropriately assessed prior to use and there was a procedure in place for their regular review and release, in line with national guidance. There was evidence of discussion with residents and their representative, and consent was obtained for the use of all restrictive equipment. Corresponding individual care plans were in place for residents using bedrails, and other restrictive equipment such as alarms for residents who walk with purpose. Least restrictive restraints were widely used, for example sensor alarms and low profile beds. There was good oversight of this equipment and staff were knowledgeable about the appropriate use of these devices.

There was a small number of residents displaying responsive behaviours and inspectors found that the registered provider continued to actively try to reduce incidents of responsive behaviours. Communal areas in the centre had been reconfigured to reduce the congregation of residents in some key areas where peer to peer incidents were frequently occurring. A dementia care specialist continued to conduct individual assessments of residents' needs and provided recommendations for staff on how to respond to responsive behaviours. The incidence of peer to peer incidents occurring within the centre had reduced since the previous inspection. However, during the inspection, inspectors saw that staff response to some residents displaying responsive behaviours was not consistent, as discussed under Regulation 7: Managing behaviour that is challenging.

An up-to-date, centre-specific safeguarding policy was in place, which outlined the steps to take in the event of an allegation of abuse. When required, residents were supported to access independent advocacy services. The majority of staff had completed training in safeguarding vulnerable persons at risk of abuse. However, a small number of staff spoken with did not display sufficient knowledge regarding this subject. This is detailed under Regulation 16: Training and staff development.

Overall there was some good evidence that residents' rights were mostly upheld in this centre. Residents had access to television, phone and newspapers. The registered provider had information displayed on noticeboards relating to advocacy services available to residents. All residents had individual occupation and social recreation care plans which provided details and interventions to guide staff on how best to support the residents' psychological and social needs. Inspectors observed good participation in group activities on the day of the inspection. There were audits completed of attendance at activities which provided evidence of one to one activities. Feedback from residents and visitors was positive about the activity provision available. This was a noted improvement since the last inspection. In addition, there was a residents meeting where residents had the opportunity to provide feedback which was attended by the person in charge and the household and catering manager. Satisfaction surveys were also carried out and included family input. Nevertheless, despite sufficient staffing levels in place, inspectors noted there

was minimal meaningful engagement with residents and staff were found to be task focused when interacting with residents. This will be further discussed under Regulation 9: Residents' Rights.

Residents had adequate storage space for their personal belongings and clothing. Laundry arrangements were in place in the centre and residents told inspectors that their clothing was returned to them promptly.

Residents were provided with adequate quantities of nutritious food and drinks, which were safely prepared, cooked and served in the centre. Residents could avail of food, drinks and snacks at times outside of regular mealtimes. Support was available from a dietitian for residents who required specialist assessment with regard to their dietary needs. There was adequate numbers of staff available to assist residents with nutritional intake at all times. Nonetheless, it was noted that residents who required a modified diet were not always offered choice at mealtimes.

The registered provider had prepared a residents guide in respect of the designated centre which had recently been updated in October 2023. This guide included the required information in line with regulatory requirements.

The layout of the premises promoted a good quality of life for residents. The centre was maintained by a catering and household manager and a maintenance team. The registered provider had installed clinical hand wash facilities since the last inspection. Good practice was seen with the appropriate isolation of residents based on their diagnosis, use of correct infection control precautions including the correct wearing of PPE. Inspectors observed residents to be supported to maintain good hand hygiene prior to the lunch time meal in the centre. Overall the premises was clean, however there was some wear and tear visible on items of furniture and equipment which may impact on cleaning. In addition, the management of clinical waste required review which is further discussed within this report.

Regulation 12: Personal possessions

Residents were supported to access and retain control over their personal property. There was adequate space to store clothes in resident bedrooms and a laundry system was in place to ensure that clothes were laundered regularly and returned to the resident.

Judgment: Compliant

Regulation 17: Premises

The registered provider had not provided premises which conformed to all matters

set out in Schedule 6 of the regulations. For example:

- emergency call facilities were not accessible in every room used by residents. During the premises walk in the morning, inspectors noted three communal rooms without sufficient call facilities. One of these areas were addressed by the end of the inspection
- some skirting boards, flooring, furniture and equipment were seen to be in a state of poor repair
- there was inappropriate storage of cleaning equipment in a communal bathroom and of linen trolleys in sluice rooms which prevented access to the room
- the ventilation in a dining room was not suitable for residents. For example, when the lunch was served from a bain-marie, this required the window to be open to allow for sufficient air. Feedback from residents stated that it was cold with the window open.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Notwithstanding the high quality of the food served, all residents were not always offered choice at mealtimes. For example:

- there were two choices of main meal at lunch time, turkey and haddock. Inspectors observed that on the first floor, turkey was served to residents who required a modified diet, despite menu sheets indicating that some residents had chosen haddock
- at tea time, the options for residents requiring a modified diet were not the options that were displayed on the menu. No attempt had been made to modify the main tea time meal of chicken curry. Instead, these residents were served modified chicken, mashed potatoes and gravy; a meal very similar to their lunch time meal.

Judgment: Substantially compliant

Regulation 20: Information for residents

A residents' guide was available which included a summary of services and facilities available, terms and conditions with a sample contract available, the complaints procedure and visiting arrangements.

Judgment: Compliant

Regulation 25: Temporary absence or discharge of residents

Records showed that when residents were temporarily discharged to another facility, all pertinent information about the resident was provided to that facility. A detailed transfer letter was used to capture relevant detail. On return to the centre following the temporary absence, medical and nursing transfer letters were reviewed for any changes to the resident's care.

Judgment: Compliant

Regulation 27: Infection control

Some items of furniture and equipment which were seen to be in a poor repair may impact on the effective cleaning of those surfaces. For example, the wooden surround on a clinical hand wash sink was cracked which would not allow for sufficient cleaning.

The management of clinical waste required review. Inspectors saw that residents with a history of multidrug resistant organisms (MDRO's), for example *Meticillin Resistant Staphylococcus Aureus* (MRSA), each had clinical waste bins in their bedrooms. There is no clinical requirement for this. Additionally, during the premises walk inspectors observed there was no clinical waste bins in some of the areas where they were required, for example, three of the four dirty utility "sluice" rooms did not contain a clinical waste bin.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

A validated assessment tool was routinely used to monitor for risk of malnutrition. However, inspectors found that there had been repeated miscalculation of one resident's risk of malnutrition, resulting in an incorrect assessment of their nutritional status. Once the risk was identified, a dietetic review was completed, however the resident's nutritional care plan had not been updated to reflect the recommendations of the review. Additionally, the menu and handover sheets used by staff had not been updated and there was no evidence that the nutritional requirements of the resident had been communicated to nursing, healthcare or catering staff.

Judgment: Substantially compliant

Regulation 6: Health care

Recommended medical treatment and professional advise from health and social care professionals was not consistently followed. This could potentially lead to poor outcomes for residents. For example:

- a recommendation by a tissue viability nurse for a high-risk resident to have regular four-hourly repositioning was not consistently followed, with excessive gaps evident in the repositioning chart
- wound care charts for residents with pressure ulcers were inconsistently completed. On a number occasions a note was made that a dressing had been renewed, but there were no clinical measurements of the wound documented, to show improvement or deterioration of the wound. This is required to demonstrate evidenced based practices
- in one wound care chart, clinical photographs of a different wound were filed. This could cause confusion in relation to the progression of the wound.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

Inspectors observed that one resident displaying responsive behaviours was not consistently responded to in a person-centred manner. On one occasion, the resident was displaying the behaviour for 15 minutes with no interaction or response from staff, who were nearby. A review of this resident's corresponding individual care plan identified duplicate care plans with differing information in relation to the management of these behaviours. The care plans did not sufficiently describe the triggers to the behaviour, and alternative interventions and de-escalation techniques were not fully outlined to direct the care of the resident.

Judgment: Substantially compliant

Regulation 8: Protection

The registered provider had taken reasonable measures to safeguard residents and protect them from abuse. Records showed that all allegations of abuse were investigated, and appropriate actions taken to prevent recurrence.

Judgment: Compliant

Regulation 9: Residents' rights

Inspectors found that residents had good opportunities to participate in group activities in accordance with their interests and capacities. However, inspectors found that for residents who predominantly spent time in their bedrooms, there was inconsistencies in staff attending to those individual resident's social needs for recreation throughout the inspection. Staff interaction was observed to be predominantly task oriented and lacked meaningful engagement. For example, a staff member supporting a resident on a one-to-one basis throughout the day, was observed to seldom interact with the resident despite the resident's care plan referring to activities being a part of their daily life.

Judgment: Substantially 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	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 20: Information for residents	Compliant
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for TLC City West OSV-0000692

Inspection ID: MON-0041643

Date of inspection: 25/10/2023

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: By 31 January 2024, updated safeguarding training will have been provided onsite to all staff. This will be overseen by the PIC and compliance assured by the Regional Director at the February monthly governance meeting.	
Regulation 19: Directory of residents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 19: Directory of residents: EpicCare has been customised to provide a dedicated report of the Directory of Residents containing the information required by regulation and relevant staff have been trained by the PIC on how to correctly export this information to the report (Complete).	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The PIC with oversight from the Regional Director, has revised the systems in place to	

ensure that services are delivered in accordance with regulations and standards, the centre's policies and procedures and the assessed needs and wishes of each resident. This includes the provision of 1:1 support and ensuring that care is delivered in accordance with the level of service to be provided.

The PIC will ensure that QUIS audits are completed on a monthly basis until March 2023 and in conjunction with the Regional Director will ensure compliance and best practice in dementia care. By 30 April 2024, the PIC and management team will have in place a quality improvement plan that encourages meaningful interaction with residents based on the review findings from the audit.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Through daily staff handovers and safety pauses, the PIC or her designate has reinforced in staff the need for ongoing checking of the environment which includes for example call bells, sockets and storage of skips. To assess the impact of daily monitoring, the PIC has introduced an updated weekly safety check form that is completed by staff and reviewed monthly by the Regional Director.

An ongoing capital expenditure programme informed by the PIC will ensure that equipment is replaced and/or refurbished as required during 2024.

Weekly temperature recording of the second floor dining room introduced by the PIC will inform an assessment of the ventilation requirement for this areas and as applicable will be included in the CAPEX programme for 2024.

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
Immediately following the inspection, the PIC in conjunction with the catering and housekeeping supervisor introduced updated menu record sheets and provided update training for staff that ensures all residents are provided with a menu selection fully reflective of their assessed needs and wishes. Ongoing monitoring by the Household & Catering Manager and senior nurse management ensures adherence to choices (Complete).

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
Training and supervision of staff has been enhanced to update staff's understanding of infection prevention and control in relation to clinical waste management. This is assessed by the PIC through ongoing audit and reviewed by the Regional Director at monthly governance meetings (Complete).

Under the oversight of the PIC, the maintenance team addressed the environmental improvements highlighted during the inspection. (Complete).

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:
Immediately following the inspection, the PIC in conjunction with the catering and housekeeping supervisor introduced updated menu record sheets and provided update training for staff that ensures all residents are provided with a menu selection that fully reflects their assessed needs and wishes.

By 31 January 2024, staff nurses will have completed updated MUST training to enhance their understanding of modified diets. Ongoing monitoring by the Household & Catering Manager and senior nurse management will ensure that menu options offered to residents are varied and reflective of resident choice.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
Update training on wound care management will be delivered to all registered nurses by 29 February 2024. Through daily handover meetings, staff are reminded by the PIC or designate on the need to deliver wound care to residents in line with the directions of the tissue viability nurse.

From January 2024, an ADON under the direction of the PIC will review wounds and present an analysis of the findings to the Regional Director at monthly governance meetings.

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
Immediately following the inspection, the PIC reviewed and revised the care plan of the resident identified by inspectors to ensure that care provided reflected the person's assessed care needs and wishes; to remove duplication, to include triggers to the behavior, alternative interventions to be adopted along with de-escalation techniques. Through daily handover meetings, the PIC or designate reminds staff of the care to be provided to this resident.

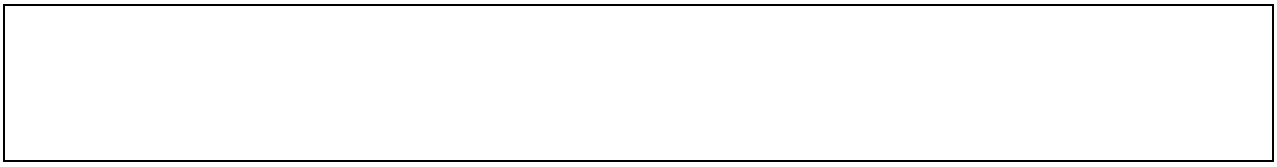
QUIS audits will be completed by the ADONs on a monthly basis for the next three months to review compliance with best practice in dementia care. The PIC and management team will review findings from the audit and develop a quality improvement plan to encourage meaningful interaction with residents. This will be effective from 31 March 2024.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
QUIS audits will be completed on a monthly basis for the next three months to review compliance with best practice in dementia care. The PIC and management team will review findings from the audit and develop a quality improvement plan to encourage meaningful interaction with residents.

The PIC will continue to review and enhance the activity provided to residents with particular focus on those who spend time in their bedrooms. Activity provision will be monitored by the Regional Director at monthly governance meetings.

Under the direction of the PIC or designate the nurse management team continue to ensure that staff assigned to provide 1:1 support are fully briefed and are suitable for the role.



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 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	31/01/2024
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	31/12/2024
Regulation 18(1)(b)	The person in charge shall ensure that each resident is offered choice at mealtimes.	Substantially Compliant	Yellow	31/12/2023
Regulation 19(3)	The directory shall include the information specified in paragraph (3) of Schedule 3.	Substantially Compliant	Yellow	30/11/2023
Regulation 23(c)	The registered provider shall ensure that	Substantially Compliant	Yellow	31/03/2024

	management systems are in place to ensure that the service 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.	Substantially Compliant	Yellow	31/12/2023
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).	Substantially Compliant	Yellow	31/01/2024
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with	Substantially Compliant	Yellow	29/02/2024

	professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.			
Regulation 7(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.	Substantially Compliant	Yellow	31/03/2024
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	31/03/2024