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:	Greystones Nursing Home
Name of provider:	Greystones Nursing Home Limited
Address of centre:	Church Road, Greystones, Wicklow
Type of inspection:	Unannounced
Date of inspection:	24 January 2022
Centre ID:	OSV-0000045
Fieldwork ID:	MON-0034867

About the designated centre

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

The centre is based in a town and is close to shops, and local public transport networks. The designated centre provides care and accommodation to male and female residents over the age of 18. It provides a service to residents with a wide range of needs including palliative care, dementia care, acquired brain injury and physical disability. The provider offers long-term and short-term accommodation, respite and convalescence care.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	43

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
Monday 24 January 2022	10:00hrs to 17:00hrs	Liz Foley	Lead
Monday 24 January 2022	10:00hrs to 17:00hrs	Mary Veale	Support

What residents told us and what inspectors observed

There was a welcoming and homely atmosphere in the centre. Resident's rights and dignity were supported and promoted by kind and competent staff. The centre were recovering from an outbreak of COVID-19 which was confined to one part of the building. Residents had finished their periods of isolation and routine was beginning to return to normal. Ongoing issues were found with fire safety and these were being addressed by the provider. Inspectors greeted many residents during the inspection and spoke at length with seven residents to gain an insight into the lived experience in the centre.

On arrival inspectors were guided through the centre's infection control procedures before entering the building. The front door was restricted and only accessible by a key code. Residents could come and go as they pleased but would require the assistance of staff to enter or exit. CCTV cameras monitored all exit doors and the corridors within the centre, there was a sign advising visitors and residents of this. Alcohol hand gel was available on entry at the front door and at regular points throughout the centre. Hand hygiene sinks were limited throughout the centre and were not available at the point of care for staff to clean their hands.

There was scaffolding erected around the perimeter of the main house and inspectors were informed that work would be ongoing in the coming weeks to replace the roof and windows. The centre consisted of two distinct buildings, the original building from the Victorian period which was a former hotel and a three storey modern extension was added in more recent years. The original building had retained many of its Victorian features, for example, high ceilings, coving, ornate plaster work, sash windows with wooden shutters and original fireplaces remained in many bedrooms and communal rooms. Communal rooms in the main building were large and looked out on to the centre's garden and there were additional communal rooms in the extension. Communal areas had seating spaced adequately to allow for social distancing. Some residents remained in their rooms throughout the inspection, while many others were observed using the communal areas to socialise.

The provider was undertaking to redecorate bedrooms, new curtains were being installed in several bedrooms on the first floor. Inspectors noted that many bedrooms were personalised with residents' own furniture and belongings and there was a homely feel throughout the building. Many bedrooms had en-suite bathrooms and some residents shared a bathroom close by. Bedrooms were spacious and in many rooms there was ample space for additional furniture. Overall the centre was homely and decorated appropriately with resident's and original art works throughout.

Inspectors spoke with several of the residents, feedback from residents was that Greystones Nursing Home was a pleasant place to live and that they felt safe and well cared for by staff. Residents stated that staff and management were responsive to their needs and they never waited long for their call bell to be answered.

Residents were highly complementary of all staff in the centre. Inspectors observed a pleasant, relaxed atmosphere throughout the day and saw many examples of kind person centered interactions. One resident who had lived in the centre for a number of years stated how lovely and kind all of the staff were and although they were sorry that some staff had left, they were getting to know the new staff. The quality of food was good and residents had a good choice of home cooked meals and snacks. Some residents routinely walked in to the local town and were supported by staff to continue to do this independently.

Residents stated they had choice within the confines of the centre and that activities provided were fun and enjoyable. Activities staff regularly consulted with residents on what activities and events they would like to celebrate. Residents who could not make decisions about their own care and daily routine had their preferences assessed by a social history with the input of their next of kin, family and friends as appropriate.

Visitors were observed in the centre during the day and one visitor took the time to speak with inspectors. They stated how reassured they were that their loved one was being well cared for and they did not have to worry about them during periods of restriction as they had built up a trusting relationship with the centre.

The next two sections of this report will present findings in relation to governance and management in the centre, and how this impacts on the quality and safety of the service being delivered.

Capacity and capability

Management systems required review as significant risks found with fire had not been identified and were not being managed. The registered provider had taken immediate steps to mitigate these risks and ensure the service was safe. Staff and management had worked hard to keep residents safe during a recent COVID-19 outbreak which they had managed to contain to one side of the centre. Improvements were required with management systems to ensure they were effectively monitoring the quality and safety of the service.

Greystones Nursing Home Limited was the registered provider for Greystones Nursing Home. Ownership of the company had changed since the previous inspection and two new directors were now responsible for the provision of care and services. The nursing home now formed part of the Evergreen care group which had nine designated centres for older persons. The registered provider representative was a company director and was available daily to the management team in the centre. A senior manager who worked on-site further supported the person in charge of the centre and shared group resources were also available, for example, human resources. The person in charge was also new to the role and was

appropriately qualified, experienced and demonstrated a high level of competence during the inspection. The management structure was clear and the person in charge was supported by an assistant director of nursing and a team of nurses, healthcare assistants, activity staff, housekeeping, catering and administration staff.

This was an unannounced inspection to monitor compliance with the regulations and to follow up on the actions from the previous inspection. At the time of the inspection there were 21 vacant beds and the centre were recovering from an outbreak of COVID-19. Improvements required to fire precautions and infection prevention are discussed in the quality and safety section of the report. The systems in place to monitor the quality and safety of the service required improvement. Risks found on inspection in relation to fire safety and infection control had not been identified by the centre's quality systems. This potentially impacted on the safety of all residents and staff should. To date the service has been reactive with managing fire risks. Inspectors reviewed the actions required from the previous inspections in June 2020 and October 2019 which identified ongoing non-compliance with regulation 28 fire precautions.

Lines of authority and accountability were clearly defined however, the person in charge also had responsibility for clinical care and this impacted on the effectiveness of management systems in place. It was evident from the rosters viewed that the person in charge was included in the staffing compliment two to three morning each week. Over reliance on the person in charge to provide routine care to residents and monitor the quality and safety of this service was not effective or sustainable. There was a high turnover of staff in the previous year and the provider had an ongoing recruitment process in place. Inspectors noted staffing levels were lower than normal and not in accordance with the centre's statement of purpose but equally there were 21 vacant beds in the centre. Inspectors were assured there were sufficient staff on duty to meet residents needs on the day of inspection.

There were auditing schedules in place and inspectors viewed samples of clinical audits that had been completed, however, action plans did not inform improvements or learning and there was evidence that poor practices persisted. Audits of behaviours that challenge, medication management and wound management consistently found the same problems over a period of time. Similarly, learning identified in fire drills was not transferred to inform subsequent drills and this was a lost opportunity to improve the effectiveness of the service.

The inspectors reviewed the centre's training matrix. All clinical staff had completed safe-guarding, manual handling, infection control and fire training. All Nursing staff had completed cardio-pulmonary resuscitation training. However, there was no evidence that staff had undertaken training to respond to reducing restrictive practice and managing behaviour that is challenging relative to their role.

There was a good records management system in place, all documents were readily available to inspectors as requested. Appropriate Garda (police) vetting was in place for all staff. Notifications to the chief officer were submitted in compliance with regulatory requirements and the statement of purpose had been amended since the

change of person in charge in August 2021.

The centre had an accessible complaints policy and procedure in place and a small number of complaints were recorded. The inspectors found that complaints were recorded, investigated and responded to in a timely open and transparent manner, by the person in charge who was the designated complaints officer.

The inspectors acknowledge that residents and staff, living and working in centre had been through a challenging time due to a recent outbreak of COVID-19.

Regulation 14: Persons in charge

The person in charge is a registered nurse with experience in the care of older persons in a residential setting. They hold a post-registration management qualification and work full-time in the centre.

Judgment: Compliant

Regulation 15: Staffing

Staffing resources required review. Inspectors found that there were sufficient staff on duty to meet the assessed needs of residents however the person in charge was part of the compliment of rostered staff on duty two to three mornings each week. The major impact of this was on the governance and management of the centre which was found to be not compliant.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Mandatory training for staff in the management of responsive behaviours and restrictive practices had not been provided. This training was important as on the day of inspection 22 residents were living with dementia and several of those residents from time to time presented with responsive behaviours. The lack of training may have been impacting on the high use of restrictive practices in the centre, this is discussed under regulation 7.

Judgment: Substantially compliant

Regulation 21: Records

All records as set out in schedules 2, 3 & 4 were available to inspectors. Retention periods were in line with the centres' policy and records were stored in a safe and accessible manner.

There was evidence that all staff had received Garda Siochana (police) vetting clearance prior to commencing employment in the centre.

Judgment: Compliant

Regulation 23: Governance and management

Staffing resources required review. There was an over reliance on the person in charge who was responsible for the daily operations of the centre and for providing clinical care. The centre's management structure required strengthening to ensure that those with responsibility for the quality and safety of care had sufficient time and support to do so. It was evident from the rosters that the person in charge was included in the staffing compliment two to three morning each week. The major impact of this was on the effective oversight of the quality and safety of care, for example, fire risks identified by inspectors had not been identified and management systems were not effectively informing quality improvements.

Management systems were not effective and ongoing issues were not being addressed. Quality improvement plans following audits did not drive learning or improvements. For example, on three consecutive audits of medication management the same problem was found.

Judgment: Not compliant

Regulation 3: Statement of purpose

The Statement of Purpose had been amended and contained all the required information.

Judgment: Compliant

Regulation 31: Notification of incidents

Incidents and reports as set out in schedule 4 of the regulations were notified to the Chief Inspector within the required time frames.

Judgment: Compliant

Regulation 34: Complaints procedure

An accessible & effective complaints procedure was in place. Records showed that residents and relatives concerns were listened to and acted upon in a timely, supported and effective manner.There was evidence that complainants were satisfied with measures put in place in response to concerns.

Judgment: Compliant

Quality and safety

Residents' rights and dignity were promoted in this centre and they were supported to access high standards of appropriate evidence-based care. However, ongoing risks with regulation 28 Fire precautions were impacting on the safety of residents and staff and required urgent review.

Fire containment risks found on inspection warranted an urgent action plan and the provider had taken immediate steps to ensure that the service was safe. Remedial works were completed on site in the days following the inspection to ensure that existing fire doors were working and as effective as possible. However, assurances around the performance of existing fire compartments and fire doors was not available and the provider was undertaking further fire safety risk assessments by competent persons to ensure the service had suitable arrangements against the risk of fire. A new provider entity had taken over the centre and had a fire safety risk assessment completed in 2020 by a competent person however, this report was not available to inspectors. Inspectors viewed an internal communication which outlined that fire risks had been identified in the centre and a schedule of remedial works was to commence in 2022. However, existing risks with fire containment and evacuation had not been identified and were posing a risk to the safety and welfare of residents and staff. These risks are outlined under regulation 28.

The centre were recovering from a COVID -19 outbreak where 12 residents had contracted the virus. The centre were following the advice of Public Health specialists and had put in place many infection control measures to help keep residents and staff safe. There was twice daily symptom monitoring for residents and staff and ongoing arrangements for isolation and testing of suspect cases. The

centre appeared clean to a high standard throughout and there was evidence of daily cleaning and regular disinfection of high touch areas. Cleaning schedules were in place to ensure the centre maintained a good standard of cleanliness and housekeeping staff were knowledgeable of correct cleaning and infection control procedures. Staff were wearing correct PPE and there were ongoing observational audits of hand hygiene to ensure and promote best practice. Some improvements were required in order to reduce infection prevention and control risks in the laundry, the availability of hand hygiene sinks and the condition of parts of the premises that were difficult to clean.

The condition of the premises is intrinsically linked to infection control as when surfaces are damaged or scuffed they are difficult to clean. This is particularly challenging with an older period building in the context of a COVID-19 outbreak, however the provider had an ongoing schedule of preventative maintenance to ensure that the centre was clean and decorated to a good standard. On-site work had commenced to repair and replace the roof on the original building and several bedrooms were in the process of being refurbished. Some additional improvements were required as outlined under regulation 17.

The standard of nursing documentation was good. The inspector found that the assessments and care plans provided a clear picture of the residents' assessed needs and the care they required. Care plans reflected a person-centred approach to care and incorporated the resident's preferences for care and support in addition to their assessed needs. Care plans were routinely reviewed and updated in line with the regulations and in consultation with the resident or their representative.

The quality of service and care delivered to residents was of a high standard, residents had access to GP's who routinely attended the centre. A physiotherapist normally attended the centre weekly to provide individual assessment however there was a temporary disruption due to a recent resignation and the service were in the process of recruiting. A range of allied health professionals were accessible as required and in accordance with residents' assessed needs, for example, chiropody, speech and language therapy, dietician, tissue viability and palliative care. Residents also had access to a specialist frailty team which attended the centre to treat and support residents and prevent admissions to the acute hospital.

The use of bed rails was high and less restrictive alternatives were not always available or trialled in line with the national guidance. Safety checks were in place and carried out correctly and in line with the national guidance.

Some residents had responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). These residents were supported by a person-centred and consistent approach to managing responsive behaviours. Behavioural assessments were completed and informed an holistic approach to managing residents' responsive behaviours. This approach resulted in a reduction in the number of episodes of responsive behaviours and a reduction in the intensity of these episodes. Inspectors observed person-centred and discreet staff interventions

during the inspection.

A risk management policy and risk register was in place and maintained. A process for hazard identification and assessment of risks was in place and subject to regular review. Where risks were identified a plan to mitigate or eliminate these risks was in place. Records of four un-witnessed falls were reviewed and only one had documented evidence of neurological observations recorded. Centre management assured inspectors that it was part of their routine falls care to check the resident's neurological status as it was an important indicator of head injury. Management were undertaking to ensure a better way to record these observations in the resident's electronic files.

While visiting was restricted in one part of the centre due to a recent COVID-19 outbreak, residents in the other part of the centre were receiving indoor visits in line with national guidance and a local risk assessment. Public Health were advising the centre on when to open up fully to visitors in all areas.

There was a rights based approach to care and resident views and opinions were informing service provision. A full time activities staff co-ordinated activities across the centre and residents were looking forward to returning to small group activities again. There were lovely examples of positive risk taking and self- determination where some residents were supported to continue to maintain their connection to the local community.

Regulation 11: Visits

At the time of inspection visiting was restricted in one part of the centre due to the outbreak of COVID-19. Visits on compassionate grounds were facilitated at all times and the entire centre was due to open to open to visitors in line with Public Health advice in the coming days.

Judgment: Compliant

Regulation 17: Premises

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

- Flooring in some bedrooms was damaged.
- A residents' bathroom at the reception did not have a privacy lock.
- Some en-suite bathrooms were accessed by small ramps which were not clearly marked to alert the occupants of the room to the incline.

- In one shower room the floor sloped inward toward the drain and the floor was not marked to alert the occupant, this may be a trip hazard.
- An external fire exit platform at the back of Sea Patrick was corroded.

Judgment: Not compliant

Regulation 26: Risk management

Arrangements were in place to guide staff on the identification and management of risks. The centre had a risk management policy which contained appropriate guidance on identification and management of risks, including those specified in regulation 26.

Judgment: Compliant

Regulation 27: Infection control

Infection prevention and control practices in the centre were not fully in line with the national standards and other national guidance. For example:

- The layout of the laundry did not support the flow of dirty to clean laundry. Clean linen was stored in an area of the laundry where dirty linen was managed, this posed a risk of cross contamination to clean laundry.
- Facilities for and access to staff hand wash sinks were less than optimal throughout the centre. There was a limited number of dedicated clinical hand wash sinks in the centre, all were not compliant with Health Building Note 00-10: Part C standards. Resident's sinks should not be dual purpose.
- Areas of the centre were difficult to clean due to wear and tear and posed a risk of cross contamination as staff could not effectively clean some surfaces, for example, shower drains.

Judgment: Not compliant

Regulation 28: Fire precautions

The registered provider was not taking adequate precautions against the risk of fire. For example;

- Arrangements for the containment of fire required urgent review, for example, several compartment and sub compartment doors were not closing

properly, some door closures were broken and some doors had gaps. In the event of a fire in the centre smoke and fumes would easily spread and hinder the safe evacuation of residents and staff.
- Weekly checks of fire doors were ineffective and were not carried out weekly in accordance with the centre's own fire procedures.
- Assurance were not available as to the performance of fire doors in the centre.
- A lift opened onto a bedroom corridor on two floors in Sea Patrick wing, this was not in line with current guidance for nursing homes and presented challenges to the containment of fire.
- Signage was not available where oxygen was stored.
- Fire procedures to guide staff on how to manage a fire at night were not available. Day time procedures were available but only four staff were on duty in the centre at night and the current procedures did not reflect this or guide staff to safely manage a fire.
- Quarterly servicing of the fire detection and alarm system and of emergency lighting had not been completed in accordance with the guidance.
- Fire drill records did not accurately reflect staffing levels at night and had not factored in procedures for contacting the emergency services, emergency contacts and supervising residents following an evacuation.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

The standard of care planning was good and described person-centered care interventions to meet the assessed needs of residents. Validated risk assessments were regularly and routinely completed to assess various clinical risks including risks of malnutrition, pressure sores and falls.

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

Judgment: Compliant

Regulation 6: Health care

There were good standards of evidence based health care provided in this centre. GP's and consultant psychiatry of older age attended the centre to support the residents' needs. Allied health professionals also supported the residents on site where possible and remotely when appropriate. There was evidence of ongoing referral and review by allied health professionals as appropriate.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

The use of bed rails was high and less restrictive alternatives were not always available or trialled in line with the national guidance. Safety checks were in place and carried out correctly and in line with the national guidance

Judgment: Substantially compliant

Regulation 9: Residents' rights

Residents' rights and choice were promoted and respected within the confines of the centre. Activities were provided in accordance with the needs' and preference of residents and normally there were daily opportunities for residents to participate in group or individual activities. The regular activities schedule was changed during the current COVID outbreak due to the requirement for some resident to isolate in their rooms.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Greystones Nursing Home OSV-0000045

Inspection ID: MON-0034867

Date of inspection: 24/01/2022

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: Staffing levels are always under review and we do use the modified Barthel index to assist us with assessing Resident dependency v staffing levels. Using this index, our dependency levels within the home are 927hours with our rostered hours of 1011. This shows that we have ample staff hours rosters to care for our Residents. As noted during the inspection the "inspectors found that there was sufficient staff on duty to meet the assessed needs of the Residents". Currently our PIC does participate in the clinical care of our Residents as this does afford her valuable time with the Residents and staff to see on a first term basis if there are any shortfalls in the care. This enables the PIC to assess/audit on an ongoing basis the policies and procedures of the nursing home and comfort and wellbeing of the Residents. There is always a second qualified nurse on duty in the home and both the PIC and DPIC have supernumerary hours separate to clinical hours.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Over the past 2 years, our priority was to ensure that all of our staff completed the many different modules of infection control/covid 19 education that suddenly became available and a necessity in order to protect our Residents. At the beginning of the pandemic, our emphasis was on developing our staff to become competent with all of the new and improved measures that we needed to equip ourselves with the new infection. Since the beginning of 2020, our staff have completed over 25 modules in the following	

training and development programmes:
Medication management, pronouncement of death, safeguarding of the vulnerable adult, fire safety and evacuation training, haacp, manual handling, cpr & bls training and dementia training, this is in addition to the infection control modules on hseland about covid 19. We have continued to practice and complete our fire evacuation drills. All of the above are in addition to our own policies which are distributed on a monthly basis for staff to familarise themselves with.
Our staff have also attended various webinars to support their caring for our Residents
We have our own safety statement and our comprehensive Covid pack and policies that has been developed and all staff have undergone training with.
Through our regular safety pause meetings we are able to practice & train our staff on our "tabletop covid exercise".
Now that society is opening up again, we can now plan comprehensively for furthering our staff development in the various different areas that will benefit both our staff and Residents alike. 30/06/2022.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
As mentioned previously – staffing levels are always under review.
The PIC does participate in the clinical care of the Residents however this does enable the PIC to see/assess the policies and procedures in place in the home. At all times, there is another qualified nurse on duty to lead clinical duties.
The time that the PIC is on "clinical duty" is recorded, there is always however separate times allocated to non-clinical duties also. This is reflected in the rosters. It was noted, during the inspection and in the feedback report, that the "Person in Charge is supported by an assistant director of nursing and a team of nurses, healthcare assistants, activity staff, housekeeping, catering and administration staff." This is in addition to the Registered Provider Representative who is available to the management team in the centre and the senior manager who works onsite to further support the PIC.

The oversight of the quality and safety of care is ultimately managed by the PIC, however we have strengthened our own quality improvement plans following any audit to identify ongoing risks or non-compliances. These plans are being implemented over the course of the next few months as we work through our audit schedule. All senior members or staff in each department will be further trained on how to competently complete an audit and report the findings and how to build an action plan from same. We anticipate that with a greater involvement of staff, compliance will follow through. With this in mind we do anticipate a full review of our auditing procedures to be completed by the end of May 2022.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Greystones Nursing Home is made up of two buildings which are conjoined. The older building is a Victorian house which has been adapted over the years and the newer building was purpose built at the time.
As noted by the inspectors, there is a programme of ongoing works currently underway in the home. Due to the recent outbreak, all works have been confined to the outside of the home but will be moving inside now.
We have commenced with painting and redecorating of some of the bedrooms, complete with new furniture in all. We are re-roofing and re-insulating the roof, we are replacing windows. We have retarmaced and repainted the entire exterior of the home. We have renovated our kitchen. We have been able to commence extensive garden works which will benefit our Residents once the weather improves again.
The flooring of the home has been reviewed and some areas have obviously identified as requiring to be either repaired or replaced. We have engaged with a flooring contractor for same.

Areas that were identified by the inspectors on the day are as follows:
1.Flooring in some bedrooms was damaged – this will be addressed once our flooring contractor commences work.
2.A privacy lock has been installed on the Residents bathroom at the reception.
3.Ensuite/Shower rooms that have a sloped floor to enable drainage of water have the floor marked to alert the occupant to the sloped floor. We have a complete risk assessment for same.
4.The external fire exit platform will be fully cleaned down and restorative works will be completed to ensure that it is a safe exit point should we actually need to evacuate the building entirely.

We are awaiting final date from flooring contractors however the rest of the works listed above will be completed by end of March 2022.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
All of our staff have completed the modules on hseland on infection control and the many covid policies also and are knowledgeable about same.
We have implemented a new flat mop system with closed household trolley throughout the two buildings.

The layout of the laundry will be addressed in the coming months to support the safe flow of dirty to clean laundry.

The Guidelines for hand hygiene in Irish healthcare settings, Update of 2005 guidelines January 2015, states that clinical hand wash sinks "should" be independent of patient or ensuite sinks and "should" be located where they are convenient for use.
It also recognises that the requirement for the number of clinical hand wash sinks is with the exception of mental health facilities and learning disability settings. A number of older persons do have mental health issues and cognitive impairments which could place both the person themselves and the other Residents of the centre at risk with having open sinks along the corridor.
With this in mind to further follow this advice "where the location, number or type of clinical hand wash sinks does not conform to the guidelines, a risk assessment must be carried out and a remedial programme agreed locally", we have assessed and addressed the risk involved with both having and not having clinical hand wash sinks solely for staff use located throughout the home and have mitigated their absence with a strengthened hand hygiene programme and the placement of hand sanitising stations throughout the home.

Infection Control Guiding Principles for Buildings Acute Hospitals and Community Settings,2020 states that in long - term care facilities there is generally no requirements for a clinical hand wash sink in every residents room.
In general, one-room-in-ten with a clinical hand wash sink may be appropriate. Hand hygiene can generally be supported by having a clinical hand wash sink within easy walking distance of each room together with appropriate access to alcohol-based hand rub.
This advice is specifically directed to the construction of new purpose built facilities.
Our Home is not a new build nor a recent purpose built home, we would alter the flow of the home and create a hazard along the corridors with the placement of a sink. Staff throughout both sides of the home, do have access to hand washing facilities both in clinical/staff only areas and in communal areas also. We have an ample number of hand sanitising stations throughout the home also to enable staff to perform hand sanitising between addressing the needs of individual Residents, this was noted on our previous inspection in 2020. All staff have completed infection control training in hand hygiene etc.

We do acknowledge that some of the areas within the home are more difficult to clean due to the wear and tear of the home, however in all cases we have assessed and have systems in place to assist with mitigating the risks to our Residents. With the example of shower drains, we have a weekly checklist of drains to be cleaned and disinfected.
31/05/2022

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: As discussed during our urgent compliance meeting on the 28th January 2022, following the inspection, there was work carried out by our own maintenance dept on the fire doors and closers and this work was completed on the 27/01/22. External contactors have been onsite on the 28/01/22 and have carried out further repairs as necessary to our fire doors. This work was to ensure that all doors closed correctly on the sounding of the alarm and that there were no gaps in the smoke seals. The fire doors are checked weekly by our own maintenance staff and there is a checklist to follow when doing this. We amended our own fire door check list to ensure full compliance and have sent a copy of this fire check list to HIQA on the 28/01/22. We have ensured that all places where we store oxygen are clearly marked and staff are cognisant of these sites. As requested during our feedback meeting, we have adjusted our fire evacuation plans to reflect both the day and night time procedures on how to safely manage a fire. We submitted the amended fire evacuation plans to HIQA on the 28/01/22. The firepanel/alarm system and emergency lighting is serviced regularly throughout the year and was last serviced on the 28/01/22. We do and will continue to conduct regular fire evacuation drills throughout the year. We will use night time staffing levels for all fire evacuation drills so that all staff are familiar with our procedures. As requested during the feedback meeting, we conducted a fire drill using night time staffing levels and have submitted this to HIQA on the 28/01/22.	
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: At the time of the inspection, 16 of our 43 Residents were using, with consent, bedrails. This is a reduced number since our last inspection. This number also indicates that 27 of our 43 Residents do not use bedrails (63%). Many of our Residents have used bedrails for years and this does promote a feeling of security and comfort to them. With all Residents we have assessed and discussed with the Resident or their Next of kin the usage of bed rails. We do acknowledge that over a third of our Residents prefer to use bedrails and that this is a higher proportion. We endevour to offer new Residents alternatives to bedrails and will try and limit the number of Residents using same going forward.	

We would like to recognise the wishes of our Residents in their choice of using bedrails. Bedrails are not used to manage any behaviour that is challenging nor are they used by staff to inhibit movement or restrict Residents at any time. Indeed if a Resident is distressed or agitated bedrails are not used at all, as we recognize that this would be an unsafe practice.
This is in line with our own policy and also the national standards on promoting a restraint free environment.

In addition to the above, we have ongoing assessment of any "clinical restraint" and work closely with the Residents GP, Psychology support team and the Resident to assess and reduce the reliance on medication.

Through history and familiarity of staff with Residents we are able to care for those Residents who may present from time to time with "responsive behaviours". We monitor these episodes by using the ABC assessing tool. This is recorded and the information from these episodes is used to create a person centred care plan for the Resident which enables staff to recognize when/if a Resident is becoming distressed and what de-escalations methods are best suited to an individual Resident.

We have a robust policy on "managing behaviour that is challenging" and all of our staff are familiar with same. We will ensure that staff receive training in this area by the end of June 2022.

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	28/01/2022
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	30/06/2022
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.	Not Compliant	Yellow	31/05/2022
Regulation 23(a)	The registered	Substantially	Yellow	31/05/2022

	provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Compliant		
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	31/05/2022
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	30/06/2022
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and	Not Compliant	Orange	28/01/2022

	suitable bedding and furnishings.			
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	31/03/2022
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	28/01/2022
Regulation 28(1)(c)(iii)	The registered provider shall make adequate arrangements for testing fire equipment.	Not Compliant	Orange	28/01/2022
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Orange	28/01/2022
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	28/01/2022
Regulation 28(3)	The person in	Substantially	Yellow	28/01/2022

	charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place in the designated centre.	Compliant		
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.	Substantially Compliant	Yellow	28/01/2022