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:	Rathkeevan Nursing Home
Name of provider:	Drescator Limited
Address of centre:	Rathkeevin, Clonmel, Tipperary
Type of inspection:	Unannounced
Date of inspection:	06 November 2023
Centre ID:	OSV-0000271
Fieldwork ID:	MON-0032659

About the designated centre

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

The centre was purpose built in 2001 and the premises is laid out in four parallel and interconnected blocks on a spacious site. The registered provider for the centre is called Drescator Limited and this centre has been managed by the provider since it opened 21 years ago. The centre is located in a rural setting approximately eight kilometers from Clonmel town. The centre provides care and support for both female and male residents aged over 18 years. The centre provides care for residents with the following care needs: frailty of old age, physical disability, convalescent care, palliative care, and dementia care. The centre can care for residents with percutaneous endoscopic gastrostomy (PEG) tubes, urinary catheters and also for residents with tracheotomy tubes. However, residents presenting with extreme behaviours that challenge will not be admitted to the centre. The centre caters for residents of all dependencies; low, medium, high and maximum dependencies. There is a qualified physiotherapist based on site who works as part of the management team. The centre currently employs approximately 54 staff and provides 24-hour care.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	50

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 6 November 2023	18:50hrs to 22:00hrs	Catherine Furey	Lead
Tuesday 7 November 2023	08:00hrs to 18:00hrs	Catherine Furey	Lead

What residents told us and what inspectors observed

The overall feedback from residents and relatives was that this was a nice place to live where residents were supported by kind and caring staff. The inspector chatted with a number of the residents and spoke with seven in more detail to gain an insight into their lived experiences in the centre. The inspector also met with three visitors during the inspection. The feedback was positive in relation to life and care in the centre. Residents told the inspector that the staff were "brilliant" and "couldn't be better".

The inspector arrived to the centre in the evening and was met by the clinical nurse manager, and the senior staff nurse, who were both working as registered staff nurses on duty. After a brief discussion, the inspector conducted a tour of the premises. later in the evening the person in charge arrived to the centre to meet with the inspector. During the walkaround of the centre in the evening, and again on the morning of the second day, 15 residents were observed by the inspector to have to have bedrails in place on both sides of their bed. This did not tally with the nine bedrails logged in the restraint register. The inspector was told by staff that there was no current process to review, release or check bedrails and that they did not document checks of any type on bedrails. The person in charge undertook to review overall restraint use during the inspection and by the end of the second day, had begun to implement a new system to ensure bedrail checks were implemented. Further work was required in regard to the oversight of bedrail use, and this is detailed further in the report.

On arrival to the centre, the inspector saw that a number of residents were up and about in the communal areas such as the main and smaller sitting rooms, and the smoking area. Others were sitting out in their rooms watching TV or listening to the radio, and some were already in bed. Staff were busy assisting residents to bed. On resident said at times that you had to wait a while for assistance to go to bed, but that she was happy to do so. Staff told the inspector that they were buy, but were able to facilitate the resident's preferred bedtimes. From 8pm there was two nurses and two healthcare assistants on duty until 8am. The inspector arrived on the second day at 8am and found that the residents were for the most part, all in bed, aside from those who requested to get up earlier.

Overall the centre was seen to be homely and generally well decorated, with some minor areas including woodwork in some residents bedrooms that required repainting or replacing. The sluice room was the only room that required attention due the storage of inappropriate i discussed under the Quality and Safety section of the report. There were a number of bright and nicely decorated sitting rooms which were located at key areas along corridors, ensuring residents had a communal area close to their bedroom. These sitting rooms opened up to lovely outdoor courtyards which could be accessed freely by residents. On the second day of inspection it was cold and residents told the inspector that they wouldn't use the courtyard but enjoyed looking out at it. The walls in the corridors were decorated in some parts

with residents artwork and crafts, and collages and photographs of activities and outings. Residents were encouraged to maintain links with local communities. One resident told the inspector about the recent initiative supported by Tipperary County Council as part of Culture Night. An afternoon poetry reading was held in the centre. The residents said they enjoyed reciting well-known poems and they then contributed their own words and ideas to create a collaborative poem, which was then framed and the inspector saw it hanging in the main reception area.

Residents' bedroom accommodation was provided in 47 single bedrooms and seven twin rooms. All bedrooms had an en suite toilet, wash-hand basin and assisted shower. Residents told the inspector that they loved having their own bedroom and bathrooms as their privacy was very important to them. Bedrooms were seen to be very personalised to each resident, with plenty of space for clothing and belongings. Directional signage was pictorial as well as written, and this assisted residents with cognitive difficulties to find areas of the centre. A number of residents also had relevant pictures outside their bedroom doors to assist them to locate their bedroom. Residents were facilitated to exercise their civil, political and religious rights. The inspector observed that residents' choice was respected and control over their daily life was facilitated in terms whether they wished to stay in their room or spend time with others in the sitting rooms. Some residents said they preferred to stay in their rooms, and they were happy that staff stopped by frequently to check in and have a chat.

On the first day of inspection, the inspector was informed that the activities coordinator had not been on duty earlier that day. The inspector noted that as a result, the activities board in reception was not updated, and the signs throughout the corridors detailed information for activities that had been held three days ago. On the second day of inspection, these were updated by the activities coordinator, and reflected a variety of activities and therapies. The inspector observed the visiting pet therapy group interacting with residents in the main sitting room and residents enjoyed this therapy, and chatting with the facilitator, who was well-known as she visited every week.

Residents were very complimentary about the food and the inspector saw that residents were offered choices at mealtimes. Pictorial menus were displayed at the entrance to the main dining room, and were also available to show residents who remained in their rooms for meals. This pictures assisted residents with cognitive impairment to ensure they understood the choice they were making. The menu was seen to be varied and the residents said if they didn't like what was on the menu they were given other choices. Modified diets were seen to be well presented and appetising. The inspector observed the dining experience at lunch time and found that it was quite chaotic and not in keeping with a home-style service. The dining room opened directly into the kitchen. While this ensured that food served to residents was hot when it reached the table, the amount of staff gathering at the door to the kitchen was excessive, and created a busy and noisy environment. Combined with the noise from the kitchen, and a radio playing, the mealtime was not a relaxing environment. The inspector noted that the main dining room commenced serving food at 12.30pm, and the dining room had completely emptied

by 1.04pm. This presented a rushed service. This was brought to the attention of management on the day.

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

The management systems in the centre required some improvements to ensure the provision of a consistently high-quality service. While there was a clearly defined management structure in place, further strengthening of the current management systems was required, to ensure that risks associated with resident clinical assessment, care planning, daily documentation and the use of restraints were promptly identified and addressed. This is discussed further throughout the report under the specific regulations.

This was an unannounced inspection which took place over two days. The purpose of the inspection was to assess ongoing compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), following an application by the registered provider to renew the registration of the centre. The information supplied with the application was verified during the course of the inspection. The centre has a history of good regulatory compliance. The compliance plan following the previous inspection in March 2023 was reviewed by the inspector. While some of the actions had been completed, new areas for improvement were identified which signified an overall drop in compliance levels.

The centre is operated by Drescator Ltd. who are the registered provider of Rathkeevan Nursing Home. There are two company directors, who are engaged in the executive management of a number of the centre. There is a clearly defined overarching management structure in place. The coordination of clinical care is managed on a daily basis by an appropriately qualified person in charge responsible for the overall delivery of daily care. The person in charge took up her full-time role in September 2022. The senior management team also includes the general manager, who holds responsibilities for recruitment of staff, rostering, staff training, fire management, maintenance and health and safety. A team of staff nurses, healthcare assistants, administration staff, activities coordinators, catering and domestic staff complete the complement of staff supporting residents in the centre. Staff members spoken with told the inspector that the person in charge and general manager were supportive and had a visible presence within the centre daily. The inspector found that the management team were responsive to the issues identified during the course of the inspection and were committed to improving compliance levels.

Prior to the inspection, the person in charge was the only supernumerary member of clinical staff. The lack of additional supernumerary hours for the person in charge meant that some areas of the governance and management of the centre were overlooked which could potentially leave the centre open to risks. Rosters showed that due to increased staff nurse levels, a new clinical nurse manager and a senior staff nurse, were able to be rostered in a supernumerary capacity at least one day a week. The management team outlined that once this arrangement had been embedded, it would allow for heightened oversight of all aspects of care.

Since the previous inspection, the Chief Inspector had received four individual pieces of unsolicited information of concern regarding the centre. The information largely related to a perceived lack of staff in the centre, and delays in residents' receiving appropriate care. The office of the Chief Inspector had engaged with the registered provider with regard to these concerns prior to the inspection, and sufficient assurances were received at that time, that the staffing levels were adequate to support the residents safely. The inspector did not find specific evidence during this inspection to substantiate the concerns. The centre is registered to provide accommodation for 61 residents, and there was 50 residents living in the centre on the day of inspection. The person in charge outlined that staffing levels were reviewed in line with the centre's changing occupancy levels. The inspector found that there was an appropriate level of clinical staff to meet the needs of the residents present during the inspection. There was a minimum of two nurses on duty over 24 hours. Cleaning staffing levels had increased since the previous inspection, and there were a minimum of three cleaners on until 2pm each day.

A sample of staff personnel files reviewed by the inspector indicated that they were generally maintained in compliance with regulatory requirements. Some areas for improvement are identified under Regulation 21: Records.There was a new, comprehensive induction programme in place for each staff grade across all departments. Records viewed by the inspector confirmed that mandatory training in fire safety and safeguarding of vulnerable adults was up-to-date for all staff. Training formats were a mixture of online and in-person training. Additional important training such as moving and handling, infection control, dementia-specific therapy and medication management were provided according to the staff member's role. Despite training in restrictive practice being completed recently, poor practice was seen on the day. This is discussed further in the Quality and Safety section of the report.

There was a suite of centre-specific policies and procedures to guide practice in the centre, however, the vast majority of these were not updated since April 2020, which is outside the regulatory timeframe of three years. Additionally, a number of these were not updated with current guidance and emerging best practice. There was a complaints policy in place which generally detailed the process and procedure to assist residents and relatives to make a complaint, however this required updating to come into compliance with regulatory requirements, as discussed under Regulation 34: Complaints, below.

Registration Regulation 4: Application for registration or renewal of registration

The registered provider had submitted a complete application for the renewal of registration within the required time frame.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge fulfilled the regulatory requirements relating to the experience and qualifications required for the role, was aware of their responsibilities under the regulations and was known to staff and residents.

Judgment: Compliant

Regulation 15: Staffing

Based on a review of staffing rosters and from observations of the inspector, current staffing levels and skill-mix were adequate to meet the assessed needs of the residents. Staffing levels and whole time equivalents aligned with those described in the centre's statement of purpose.

Judgment: Compliant

Regulation 16: Training and staff development

Appropriate training had been provided to staff for their roles, and training was up to date with a plan in place to ensure that staff remained up to date with training to support them in their roles.

Judgment: Compliant

Regulation 21: Records

Documents in respect of four staff members were reviewed. In one record, there was no reference from the staff member's most recent employer. In a second

record, a reference did not tally with the staff member's record of employment. This record also contained a large, unexplained gap in the employment history. A third record had two unexplained gaps in the employment history.

Records of restraint use, including the name of the resident, the reason for use, and the nature and duration of restraint were not in place.

Judgment: Substantially compliant

Regulation 22: Insurance

The registered provider had an up-to-date contract of insurance against injury to residents in place, as required by the regulations.

Judgment: Compliant

Regulation 23: Governance and management

Management systems required strengthening, to ensure that the service provided is safe, appropriate, consistent and effectively monitored. Findings are detailed under the relevant regulations throughout the report.

- policies and procedures were required to be updated and implemented, to ensure that staff were familiar with current best practice and national guidance
- the oversight of restraint use in the centre required improvement. The risk assessment process for the use of restrictive practices was not in line with national policy. There was no comprehensive auditing of restrictive practices in the centre, therefore there was no targeted quality improvement plan
- the system of clinical risk assessment and care planning for residents was not person-centre in nature. A lack of oversight of the assessment and care planning process led to errors in the calculation of some residents' assessments, which could pose risks in the delivery of appropriate care and support
- there was no structured system of communication between management and the kitchen. As a result, kitchen staff were not updated with important nutritional and dietetic advice following resident assessment
- oversight of important documentation such as recording of residents' weights, check charts and repositioning charts required review to ensure that these were carried out when required, to minimise risks to residents.

Judgment: Not compliant

Regulation 3: Statement of purpose

The registered provider had prepared a statement of purpose relating to the designated centre and this contained all of the information as required under Schedule 1 of the regulations.

The statement of purpose was updated following the inspection to reflect the new complaints procedure.

Judgment: Compliant

Regulation 31: Notification of incidents

The person in charge was clear on the procedures for the submission of notifications to the office of the Chief Inspector. All mandatory notifications were submitted within the required time frames

Judgment: Compliant

Regulation 34: Complaints procedure

The complaints procedure had not been updated in alignment with S.I. No. 628 of 2022 - Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) (Amendment) Regulations 2023, which came into effect on 1 March 2023. Updates required to the complaints procedure included the following;

- the nomination of specific complaints and review officers
- the time lines for investigation, conclusion and review of complaints
- the provision of a written response to a complainant
- arrangements for practical assistance to a complainant to understand the complaints process.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

The required policies and procedures, as set out in Schedule 5 of the regulations, were in place. Nonetheless, the majority of these policies had not been updated

within the required three-year time frame, or in accordance with best practice guidance. Inspection findings identified that policies and procedures, for example, those in relation to managing behaviour that is challenging, the use of restraint, monitoring of nutritional intake, and infection control, were not adopted and implemented in practice.

Judgment: Not compliant

Quality and safety

The inspector reviewed aspects of a number of residents' records throughout the inspection which identified areas of poor practice related to residents' care plans. The current system of paper-based assessment and care planning was not effective. This had been identified on previous inspections in June 2020 and November 2021, and the provider had committed to improving the care planning system. Some improvements were seen during the following two inspections in July 2022 and March 2023. However, during this inspection, it was evident that the improvements had not been sustained. Findings showed that a further new system of care planning which had recently been introduced did not contain specific information to direct the residents' care needs. Care plans were formatted from a template more suited to acute services, which did not support individualised care planning. This is discussed in more detail under Regulation 5: Individual assessment and care plan.

The paper-based recording system extended to all records of daily care including intake and output, repositioning and personal care interventions. The system relied heavily on the input of healthcare assistants to document the care provided, however lengthy gaps were found in the documentation records. Staff reported that they did not complete the documentation until lunchtime. While this may be appropriate for some types of records, it was not appropriate for others, for example the documentation of 15 and 30-minute checks of high-risk residents.

Residents' medical needs were supported by access to General Practitioners (GP's) in the centre. There was evidence of good medical reviews and involvement of additional medical expertise through referrals to consultant psychiatry and gerontology services. Residents were supported to access appropriate national screening services such as diabetic retinopathy and cancer screening. Despite this evidence of good medical care, a number of issues in relation to the clinical risk assessment of residents was identified by the inspector during a review of residents' documentation. As identified below under Regulation 6: Healthcare, there was a lack of oversight of aspects of nursing care, for example, incorrect calculation of important risk assessments such as risk of malnutrition and dependency level scores. There was poor oversight of residents' weights and this, combined with incorrect risk assessment scores did not provide assurance as to the appropriate care of the residents. There was a low incidence of pressure ulceration occurring in the centre, and the inspector observed pressure-reliving devices such as cushions

and mattresses in use. Nonetheless, the assessment of wound care required strengthening to ensure best practice was adhered to at all times.

The management of restraint use in the centre was not in line with the centre's own policy, or with national guidance. The bedrail risk assessments viewed by the inspector use did not include details on the trialling of less-restrictive alternatives such as low-profiling beds and alarm mats. These alternatives were available, and were seen in use on the day, however the inconsistencies in the number of bed rails identified on the restraint register, and the number seen in use, coupled with an ineffective assessment tool, did not provide assurance that the centre was committed to promoting a restraint-free environment.

Overall, the main areas of centre were found to be clean. A number of cleaning staff had been newly-recruited and were undergoing a period of induction. The centre's deficits in relation to infection prevention and control were generally centred around the oversight of the cleanliness of equipment for resident use, as discussed under Regulation 27: Infection control. There were good practices observed in relation to hand hygiene and the wearing of personal protective equipment (PPE). Training modules in relation to infection prevention and control were up-to-date for all staff.

The centre's risk management policy contained actions and measures to control a range of specified risks and which met the criteria set out in regulation 26. The centre’s risk register contained information about ongoing, active risks and detailed the control measures in place to mitigate these risks. Fire safety in the centre was well-managed and there was regular reviews of fire safety equipment and means of escape. Regular fire drills were conducted and these included resident input where possible. Personal emergency evacuation plans were in place for all residents which detailed the level of assistance and method of evacuation required to ensure safe and quick evacuation in the event of an emergency.

The inspector found that residents, including those who required a modified diet had a choice of menu at each meal time. 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. There was adequate numbers of staff available to assist residents with their nutrition and hydration intake at all times. Support was available from a dietitian for residents who required specialist assessment with regard to their dietary needs, however, the specific nutrition plans prescribed following these assessments were not communicated to the kitchen staff.

Monthly residents' meetings were held which provided a forum for residents to actively participate in decision-making and provide feedback in a variety of areas of service provision. Standing items on the agenda for each meeting included, activities, food, laundry and concerns. Residents were afforded opportunities at each meeting to discuss any other concerns, suggestion or comments they had. Minutes of these meetings were documented, and issues followed up on. The activities programme in the centre covered a range of diverse activities. The main activities programme was scheduled five days a week, and at the weekends, staff working in the centre ensured that there was a choice of small group and individual activities

for example, gathering to watch popular sports or other TV shows, sing songs and reading. The activities programme could potentially be improved by ensuring that a social assessment of each resident was completed to ascertain each individuals preferences, however, the minutes of the residents meetings evidenced that residents were very happy with the current activities programme in the centre. There was adequate space and facilities for residents to undertake activities in groups, and in private. The inspector found that the rights and choices of the residents in the centre were promoted and every effort was made to safeguard residents from potential abuse.

Regulation 11: Visits

The inspector observed visiting being facilitated in the centre throughout the inspection. Residents who spoke with the inspector confirmed that they were visited by their families and friends.

Judgment: Compliant

Regulation 12: Personal possessions

Each resident has adequate space to store and maintain their clothes and personal possessions. Residents clothes were laundered on site and residents told the inspectors they were satisfied with the laundry services in the centre.

Judgment: Compliant

Regulation 18: Food and nutrition

The inspector identified that not all food provided to residents met the residents' dietary needs, as prescribed by dietetic staff, based on a nutritional assessment in accordance with the individual care plan of the resident. For example, a resident was prescribed a high-protein, high-calorie diet, with specific instructions for fortification of food and drinks. This was not communicated to the kitchen staff.

Judgment: Substantially compliant

Regulation 20: Information for residents

The registered provider had prepared a guide in respect of the designated centre and this was made available to the residents. This guide did not accurately describe the procedure respecting complaints, including external processes and information regarding independent advocacy services.

Judgment: Substantially compliant

Regulation 26: Risk management

A centre-specific risk management policy was in place, in line with the requirements of Regulation 26.

Judgment: Compliant

Regulation 27: Infection control

Some improvements were required in order to ensure the centre was compliant with procedures consistent with the *National Standards for Infection prevention and control in community services (2018)*. For example;

- there is one sluice room in the centre, the location of which presents a long travel distance from some areas of the centre. Best practice guidance outlines that the location of the sluice room should minimise travel distances for staff to reduce the risk of spillages and cross contamination
- on the day of inspection the bedpan washer was not working, and the inspector was informed that it had broken more than two weeks ago. Staff told the inspector that they decanted the contents of urinals and bedpans into ensuites or communal toilets and then rinsed them out. Best practice indicates that sanitary equipment is emptied and decontaminated after every use. Inadequate disinfection of this equipment increases the risk of cross-infection
- improvements were also required in the standard of equipment hygiene and oversight of same. Equipment was not managed in a way that minimised the risk of transmitting a healthcare-associated infection. Some items of resident equipment such as hoists and assistive walking aids were visibly unclean, despite a checklist stating that they had been cleaned.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Records reviewed by the inspector indicated that fire-fighting equipment in the centre was serviced annually and the fire alarm and emergency lighting system were serviced on a quarterly basis. Fire safety training took place regularly and included evacuation procedures and use of fire equipment. Regular fire drills took place which simulated various evacuation with different staffing levels. Staff spoken with confirmed that they had been involved in simulated fire evacuation drills and were knowledgeable regarding the evacuation needs of residents.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

A sample of seven residents' individual assessment and care planning documentation was reviewed. This review identified multiple issues with the current system of care planning, which required addressing, to ensure that residents' care plans are comprehensive, individualised and regularly reviewed.

Some residents had no care plans based on their assessed needs. Examples reviewed by the inspector included;

- a resident assessed as requiring nutritional support had no associated care plan
- a resident assessed as high falls risk had no associated care plan
- a resident assessed as having impaired mobility and requiring assistance of staff had no associated care plan
- a resident with a chronic wound and high risk of pressure-related skin damage had no associated care plan.

A number of residents had no care plans in place to detail the basic activities of daily living including personal care and hygiene, nutrition and hydration, and mobility. The care plans that were in place were not personalised or individualised and did not direct the daily care needs of the residents.

The majority of records viewed did not contain any assessment relation to the residents social care needs and therefore the specific supports necessary for the residents to maximise their quality of life, were not identified and outlined in a personalised care plan.

Care plans were not routinely updated within the required four month time frame outlined in the regulation. Care plans were not routinely updated with changes to a resident's condition.

Errors in some clinical risk assessments, as described further under Regulation 6: Healthcare, meant that associated care plans, when present, did not accurately reflect the needs of the resident.

Judgment: Not compliant

Regulation 6: Health care

The registered provider did not ensure that a high standard of evidence-based medical and nursing care was provided for all residents. This is evidenced by the following;

- there was no clinical oversight or rigorous monitoring of residents weights. Large gaps of up to five months were seen in the monitoring of residents weights. This led to delays in referrals for dietetic or medical input. Additionally, the validated risk assessment tool to measure risk of malnutrition was incorrectly calculated on numerous occasions. This presented a significant risk to residents
- the validated risk assessment tool to measure the residents' dependency level, was being used incorrectly. As a result, only one resident was assessed as maximum dependency. Accurate dependency levels are required to ensure that adequate care is provided, in the centre both individually and collectively.

Recommended medical treatment and professional advice from social and healthcare professionals was inconsistently followed. This could potentially lead to poor outcomes for residents. For example:

- a direction from an acute hospital discharge summary for a resident to have regular two-hourly repositioning was not consistently followed, with large gaps evident in the repositioning chart
- directions from a speech and language therapist in relation to the modification of residents fluids were not followed by all staff. The inspector observed staff providing fluids of incorrect consistency to two residents
- directions from a dietitian to provide a specific diet were not implemented fully

Wound care charts were inconsistently completed. There were no clinical measurements or assessment of the wound documented to show improvement or deterioration of the wound. This is required to demonstrate evidenced based practices. A new template for assessment of wounds had been introduced very recently, and while this was more comprehensive, and directed staff to obtain clinical measurements of the wounds, this was not completed.

Judgment: Not compliant

Regulation 7: Managing behaviour that is challenging

The centre had a local restraint policy in place which stated that a comprehensive assessment would be undertaken and recorded prior to the use of any restraint. However, a number of residents had bedrails in place, with no assessment or rationale for their use documented.

As outlined under Regulation 21: Records, the required records relating to restraint use were not in place. The record of the number of restraints used in the centre was incorrect. The systems in place and oversight of restraint use did not reflect a commitment to restraint reduction and an aim towards a restraint free environment. The numbers were not in line with what was reported to HIQA in the quarterly notifications.

A review of documentation including care plans and behaviour charts for residents identified as displaying behaviours that challenge, found that alternative interventions and de-escalation techniques were not fully outlined to direct the care of the resident.

Restrictive practices and the management of behaviours that challenge were not audited. This is a missed opportunity to identify areas for improvement and potentially improve outcomes for residents.

Staff had been provided with recent training in restrictive practices and the management of behaviours that challenge. However, the findings under this regulation identify a lack of knowledge amongst staff in this area, and present a risk to residents. For example, the routine use of bedrails without a formal assessment does not promote positive outcomes for people, does not demonstrate the least restrictive response and reflects an institutional approach.

Judgment: Not compliant

Regulation 8: Protection

The registered provider had taken all reasonable measures to safeguard residents and protect them from abuse:

- staff spoken with were knowledgeable of what constitutes abuse and how to report any allegation of abuse
- records reviewed by inspectors provided assurances that any allegation of abuse was immediately addressed and investigated
- all staff had the required Garda (police) vetting disclosures in place prior to commencing employment in the centre
- the centre was not acting as a pension agent for any resident. The inspector verified that there was secure systems in place for the management of residents' personal finances

- the registered provider facilitated staff to attend training in safeguarding of vulnerable persons.

Judgment: Compliant

Regulation 9: Residents' rights

A review of residents' meeting minutes and satisfaction surveys confirmed that residents were consulted with and participated in the organisation of the centre. Residents had access to individual copies of local newspapers, radios, telephones and television. Notice boards in the centre prominently displayed details of available advocacy services and some residents were engaged with these services. Residents of all ages were supported to access services appropriate to their needs and capacities.

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	
Registration Regulation 4: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 20: Information for residents	Substantially compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Rathkeevan Nursing Home OSV-0000271

Inspection ID: MON-0032659

Date of inspection: 07/11/2023

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 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: Management will ensure that all staff files have fully completed CVs, without employment gaps. Those recently recruited who have gaps in employment will be requested to fill in the detail pertaining to these gaps. All new staff shall be requested to supply a reference from their most recent employer. Staff will not begin induction until the necessary references have been received. The Person in Charge will review staff files prior to induction. Records shown to the inspector on the day of inspection regarding restraint use are now in use within the centre. Risk assessments, care plans, details of use of trials and their duration, consent forms, appropriate check and release documents are now in place for residents using restrictive practice.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Policies and procedures are under review at present. All schedule 5 policies will be reviewed and updated accordingly by 14th December. All policies will be reviewed within the specified 3 year timeframe, or as necessary. A quarterly report of updated policies and procedures will be provided by the PIC to the Registered Provider for review. Use of restraint has been reviewed following the inspection. Restrictive practice will only be implemented as a last resort following a comprehensive assessment in accordance with the centre's policy. The comprehensive assessment will include risk assessment, leaflets and information being provided to residents, consultation with the MDT, care	

planning, evidence of trials and durations of the same prior to implementing the practice and appropriate check and release recording documents. Management will endeavor to promote a restraint free environment.

We are currently transferring from a paper-based documentation system to a digital one, EpicCare. Given the large volumes of recording of resident's care needs, assessments and progressive documentation the paper-based system is no longer suitable for recording the delivery of care to the residents. The EpicCare system is one which is streamlined and tailored for nursing home recording. This system will allow for individualized care plans and assessments to be completed, reviewed and evaluated more efficiently. Management will be more readily able to access data, KPIs and complete audits using the new system.

Communication between management and kitchen staff has always been strong. Following the inspection, the PIC has spoken to the kitchen staff and devised a folder of Nutritional Information which very clearly outlines resident's nutritional needs. This folder will be updated by staff nurses weekly or as a resident needs change. This folder is available in the kitchen at all times. This folder has now replaced the previous documentation records.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The Complaints procedure was updated in November and is now fully in line with S.I. No. 628 of 2022- Health Act 2007. The Complaints policy was updated which specifically outlines who the nominated complaints and review officers are. A timeline for the completion of any investigation, including conclusion and review is clearly defined. Information regarding practical assistance to a complainant is clearly outlined. The provision of a written response and regular updates to the complainant throughout the investigation is detailed within the policy. Information leaflets have been placed at the front reception regarding the services of SAGE and Patient Advocacy Service (PAS). A detailed summary of the Complaints procedure is available for viewing at the front reception along with the updated Resident's Guide.

Regulation 4: Written policies and procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
All written policies and procedures are currently undergoing review. All schedule 5 policies and procedures will have been reviewed and necessary updates completed by 14th December. All policies will be read by all staff and each staff member will be required to sign that they have read and understand the policies.

EpicCare will allow for all policies and procedures to be uploaded, with specific review dates recorded. The system will alert the management when policies require review. Outside of this review time, the PIC will ensure that policies are amended to reflect changes to legislation, best practice guidelines and any change specific to the centre's procedures. A written report will be reviewed by the Providers on a quarterly basis to ensure all policies are updated within the required timeframe.

The PIC will ensure that all policies and procedures are adopted and implemented in practice.

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
A new folder has now replaced the previous system for kitchen staff regarding dietary information for all residents. The new folder very clearly identifies the resident, room number, consistency of food/fluids, needs for specific diets such as high fibre, high protein, high calorie, low calorie, diabetic and fortified diets. The nutritional information of all residents will be updated by nursing staff on a weekly basis or as the needs of a resident change. This folder is available in the kitchen at all times. A copy of this folder is also maintained in the main dining room as an information resource for healthcare assistants. Kitchen staff and healthcare assistants have been instructed to comply with the nutritional information contained in the folder.

Regulation 20: Information for residents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 20: Information for residents:
The Resident's Guide has been updated (November 2023) to reflect the policy update regarding Complaints management. A detailed summary of the Complaints procedure is available for viewing at the front reception along with the updated Resident's Guide.

Information leaflets have been placed at the front reception regarding the services of SAGE and Patient Advocacy Service (PAS). A resident's meeting was held in November and residents were informed of the information available to them and its location. Resident's meetings will continue to be held on a monthly basis. Complaints will remain an item on the agenda.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
A new bedpan washer has been installed with a maximum 48-hour repair agreement in place. This will ensure there is no extended period of unavailability in the future.

The location of the sluice room is as central as feasible. We have now provided that all commodes, bedpans and urinals are covered with lids to prevent spillages and reduce the risk of cross contamination when in transit to the sluice room.

A revised cleaning protocol has been implemented which will ensure that all equipment is properly and regularly cleaned. A weekly inspection of equipment will be carried out by the General Manager.

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
All care plans are currently under review and are being updated as required. All relevant, person-centred care planning information will be forwarded to the new recording system. Care planning will be detailed, individualized, comprehensive and will be reviewed 4 monthly or as a resident's care needs change. The named nurse concept will remain in place within the centre. A nurses meeting will be held monthly for the next 6 months to ensure nursing staff review and update care plans and assessments satisfactorily and are making optimum use of the EpicCare system.

It will be ensured that care plans accurately reflect the needs of the residents paying particular regard to personal care and hygiene, mobility, nutrition and hydration, social care and specific supports in order to maximize the resident's quality of life. Support and guidance will be provided by the CNM and PIC to all staff nurses to assist them in the compilation and completion of comprehensive care plans.

A care planning audit will be completed by the PIC every 3 months. Findings of this audit will be reviewed by the Registered Provider during a specific quarterly review meeting.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
The Registered Provider will ensure that a high standard of evidence-based medical and nursing care is provided to all residents. Residents' weights will be taken and recorded monthly, or more often as required. Regular audits will be carried out to ensure that all validated risk assessment tools, including malnutrition and dependency, are correctly used.

All recommended medical treatment and professional advice from healthcare professionals will be consistently followed. Relevant care plans and documentation will be updated and communicated with staff for example, recommendations made by the dietician will be updated in the resident care plan, the kitchen folder and communicated verbally during handover times. The GP will also be informed of any recommendations made.

Auditing of wound care, nutrition and hydration and dependency levels will be completed monthly.

Regulation 7: Managing behaviour that is challenging	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
Managing behaviour that is challenging will be in accordance with our policy. The policy will be implemented in full and overseen by the PIC. The PIC will complete a restrictive practice audit on a monthly basis. The findings of the audits will be reviewed by the Registered Provider during the quarterly review meeting. Restrictive practice will only be implemented as a last resort following a comprehensive assessment in accordance with the centre's policy. The Registered Provider and PIC will ensure that the centre continues to work towards having a restraint free environment.

Comprehensive person-centred care plans will be completed for residents who display behaviors that challenge. These care plans will include details of interventions and de-escalation techniques specific to each resident who requires such a plan. An audit of

management of behaviors that challenge will be completed 3 monthly. Again, these audits and findings will be reviewed by the Registered Provider during the review meeting.

Training will be reviewed and updated for all staff in the areas of restrictive practice and management of behaviours that challenge every 2 years.

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 18(1)(c)(iii)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional assessment in accordance with the individual care plan of the resident concerned.	Substantially Compliant	Yellow	06/12/2023
Regulation 20(2)(e)	A guide prepared under paragraph (a) shall include information regarding independent advocacy services.	Substantially Compliant	Yellow	30/11/2023
Regulation 20(2)(c)	A guide prepared under paragraph (a) shall include the procedure	Substantially Compliant	Yellow	30/11/2023

	respecting complaints, including external complaints processes such as the Ombudsman.			
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Substantially Compliant	Yellow	14/12/2023
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	07/12/2023
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	07/12/2023
Regulation 34(2)(b)	The registered provider shall ensure that the complaints procedure provides	Substantially Compliant	Yellow	30/11/2023

	that complaints are investigated and concluded, as soon as possible and in any case no later than 30 working days after the receipt of the complaint.			
Regulation 34(2)(c)	The registered provider shall ensure that the complaints procedure provides for the provision of a written response informing the complainant whether or not their complaint has been upheld, the reasons for that decision, any improvements recommended and details of the review process.	Substantially Compliant	Yellow	30/11/2023
Regulation 34(2)(e)	The registered provider shall ensure that the complaints procedure provides that a review is conducted and concluded, as soon as possible and no later than 20 working days after the receipt of the request for review.	Substantially Compliant	Yellow	30/11/2023
Regulation 34(5)(a)(i)	The registered provider shall offer or otherwise arrange for such practical assistance to a complainant, as is necessary, for the complainant to understand the	Substantially Compliant	Yellow	30/11/2023

	complaints process.			
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.	Not Compliant	Orange	14/12/2023
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Not Compliant	Yellow	14/12/2023
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.	Not Compliant	Orange	06/12/2023
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4	Not Compliant	Orange	20/12/2023

	months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.			
Regulation 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 professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.	Not Compliant	Orange	07/12/2023
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.	Not Compliant	Orange	07/12/2023
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only	Not Compliant	Orange	07/12/2023

	used in accordance with national policy as published on the website of the Department of Health from time to time.			