



**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:	Carna Nursing and Retirement Home
Name of provider:	Teach Altranais Charna Cuideachta Neamhtheorata
Address of centre:	TEACH ALTRANAIS CARNA, Carna, Galway
Type of inspection:	Unannounced
Date of inspection:	20 January 2022
Centre ID:	OSV-0000398
Fieldwork ID:	MON-0034430

About the designated centre

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

Carna Nursing & Retirement Home is a single storey, modern, spacious, purpose built facility established in 2003 set in the Connemara village of Carna. It is located beside the sea and has view of the mountain-scape and a fishing harbour. The centre accommodates both male and female residents with nursing care needs, dementia, physical and mental disability, respite care, convalescence and palliative care.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	43
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This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 20 January 2022	10:30hrs to 16:30hrs	Una Fitzgerald	Lead
Friday 21 January 2022	10:30hrs to 17:00hrs	Una Fitzgerald	Lead

What residents told us and what inspectors observed

Feedback from residents was mainly positive. Residents had a high level of praise for the staff who attended their care needs. Residents that spoke with the inspector knew who the management team were. At the time of inspection the centre had one positive COVID-19 case in the resident population and one positive case in the staff population. Resident's told the inspector that they had been through a challenging time and that restrictions introduced into the centre as a direct result of the COVID-19 virus had changed their lives considerably. In the main, resident's felt that changes introduced were made for their protection. Despite this good intention, the inspector found that a review of some of the changes made required immediate review to ensure that restrictions did not infringe upon resident's rights as they were not appropriately risk assessed and in some instances were disproportionate to the risk. This was evidenced by:

- As a result of the pandemic, the daily newspaper was not purchased and brought into the centre. It was available in electronic version only.
- Resident access to the outside was restricted. There was no risk assessment or protocol in place. As a result, a resident spoken with was of the understanding that going outside for a cigarette was not currently allowed. The residents had to walk past the entrance/exit to get to the smoking room and told the inspector that they failed to see logic in this decision.
- Multiple residents told the inspector that the days were very long. The inspector summarised from the conversations had that there was an over reliance on the television as a source of entertainment. The inspector was informed that art therapy had commenced and that the sessions were enjoyed by those that attended, however, sessions had not been held since prior to the Christmas holidays. One resident when talking about the sessions stated that "Tuesdays were a long time coming around" - the resident meant that one session to look forward to on a weekly basis was insufficient.

This was an unannounced inspection. On arrival, the person in charge guided the inspector through the infection prevention and control measures in place to allow entry into the designated centre. These processes included hand hygiene, face covering, and a temperature check. Residents expressed gratitude that they had been kept safe throughout the pandemic. Uptake on the vaccination programme was 100%. On the day of inspection, all residents and staff had received the booster vaccine. On the days of inspection, the inspector was told that visits into the centre except for the designated visitor's room were not permitted. Residents had been instructed to remain in their bedroom despite having received a negative PCR test. This decision made by the management team was not in line with the COVID-19 Health Protection and Surveillance Centre (HPSC) guidance on visits to long term residential care facilities. There was no risk assessment completed outlining the rationale for why this decision had been made.

Through walking around the centre, the inspector observed many residents had

personalised their rooms and had their photographs and personal items displayed. Residents confirmed that their bedrooms were cleaned daily. The centre has three corridors where resident bedrooms are located. The inspector visited multiple resident en suite facilities. The inspector observed that there was no appropriate system in place to identify the ownership of toothbrushes. For example; toothbrushes in use were not labelled. The staff that provided the assistance to residents with their oral hygiene needs could not clarify who owned which toothbrush. The inspector acknowledges that immediate action was taken and that new toothbrushes were provided and clearly labelled.

The inspector spent time observing residents with dementia and their engagement with staff. While none of the residents met with were able to tell the inspector their views on the quality and safety of the service, in the main, the inspector observed that the residents appeared content and relaxed in their environment. However, on day one of the inspection, the inspector observed that residents did not have appropriate access to their call bells. The inspector counted seven residents that were remaining in their bedrooms as instructed and did not have access to their call bells. The inspector confirmed with the person in charge that there was no risk associated with any of the identified residents having their call bells in easy reach. This meant that the residents were reliant of staff walking up and down the corridors or on their own ability to call out for assistance.

The inspector spent time talking to residents and staff. In the main, interactions were observed to be respectful and kind. There was a familiar rapport observed and staff greeted residents by name when walking past. The atmosphere was welcoming. The centre had an on site physiotherapy service. Residents were observed walking down for their individual sessions accompanied by staff. It was evident from the conversation had that the staff knew the individual residents. The inspector observed that residents were not rushed and that the time was used as a social interaction as well as part of their mobility assessment.

The inspector reviewed the complaints log. There was evidence that when a complaint is logged appropriate steps are taken as per the centre's policy. The documentation in place evidenced that the management engaged with the complainant to ensure that all reasonable measures were taken to ensure a satisfactory outcome. Residents had access to an independent advocacy service and at the time of the inspection there were a small number of residents being supported by the external service. However, the complaints procedure that was on display in the main entrance as a guidance for residents was outdated and directed residents to a person who no longer works in the centre.

While overall, the inspector found that residents feedback was positive and the observation of staff and resident engagement was positive, there was a number of non-compliances with the regulations identified that required immediate review. These findings related primarily to the governance and management arrangements that ensure the service is effectively monitored. In addition, there was a need for clarity on the part of the registered provider regarding the allocation of staffing resources to the centre and for improved oversight to ensure that residents' rights

are upheld.

Capacity and capability

The provider needed to improve and strengthen the overall governance and management structure of the centre in order to ensure effective monitoring and oversight of the service received by the residents. At the time of this inspection, the inspector found that the person in charge did not have support to ensure oversight and supervision of staff. In addition, there were insufficient staff employed delivering the direct care and to ensure residents were supported to engage in activities and meaningful occupation.

The last inspection of the centre took place in February 2020 where non-compliance across multiple regulations was found. A meeting was held with the registered provider following the previous inspection as an escalation. On this inspection, the inspector followed up on the last inspection findings and found that insufficient progress had been made to address or sustain compliance with the requirements of the regulations. Regulations 23 Governance and Management, Regulation 15 Staffing, Regulation 16 Training and staff development, Regulation 34 Complaints Regulation 5 Individual assessment and care plan, and Regulation 9 Residents Right all remain either substantially compliant or not complaint. The provider had failed to implement their own compliance plan. Many of the non compliances found are repeated. For example; the rights of residents to have appropriate screening in shared bedrooms. Also, the rights of residents to have access to a call bell at all times.

Teach Altranais Charna Cuideachta Neamhtheoranta Ltd is the registered provider of Carna Nursing and Retirement Home. The governance structure as outlined in the Statement of Purpose of the centre is made up of a General Manager, Director of nursing (DON), and an assistant director of nursing (ADON). The Inspector found that that there is a lack of succession planning in place. At the time of inspection, there was one person covering the DON and ADON position. The DON/ADON was the registered person in charge. Staffing shortages noted on the days of inspection were mainly due to planned leave and the vacant hours had not been replaced. This had left the allocated nursing hours consistently short. The person in charge had no option but to be the nurse on duty delivering direct care. This was directly impacting on their ability to ensure oversight and monitoring of the service delivered. The negative impact of this shortfall was:

- Monitoring of the service – The audit folder was examined. Since the appointment of the person in charge that was in post on the day of inspection (July 2021) there had been no clinical audit completed on the service.
- Care plans were not completed in accordance with Regulation 5 requirements. Residents assessed needs and associated risks did not always have an appropriate care plan in place to support them.

- The system of risk and incident management required review. At the time of inspection there were forty five open accidents/incidents on the system. While incidents were documented, there was no evidence of investigation, analysis of the incident or learning opportunities from incidence that could be shared with staff to provide opportunities for quality improvement. A large proportion of the incidents were falls and incidents of responsive behaviours.
- Resident feedback was not appropriately responded too. The inspector was informed that a resident/relatives survey had been sent to all residents. In total nineteen forms had been returned. The management team had not looked at the returned completed forms. Therefore, no current staff member was aware if any feedback received required attention.
- The inspector found that there was a poor culture and insufficient leadership to ensure that residents' rights were upheld. For example; the longstanding acceptance that one of the communal resident rooms is not in use due to the inability of the provider to have supervision in place. This lack of access to communal rooms in a persons own home is not in keeping with rights of the resident living in the centre.

The governance systems in place to manage risk and to ensure that the service provided was safe, consistent and effectively monitored required review. While there was a risk management scoring matrix, there was no evidence that the management team had identified or had a process in place to manage the risks found during this inspection. Risks identified on this inspection that require assessment and action include:

- The risk associated with one nurse on duty at night for the 43 residents in the centre at the time of inspection.
- The risk associated with the person in charge working having insufficient management support.
- The risk associated with periods of no visits for residents and the impact this was having on their overall health
- The risk associated with the lack of supervision for newly appointed staff.

On the days of inspection, the centre had one positive COVID-19 case in the resident population and one positive case in the staff population. The COVID-19 contingency plan given to the inspector had not been updated since October 2020 and in the event of a large outbreak could not be implemented. For example; the contingency identified that there would be two nurse lead teams in the event of a large outbreak. There was insufficient nurses employed at the time of inspection to implement this strategy. The inspector acknowledged that to date this was the only positive case of COVID-19 that had effected residents and that the virus had been contained and not spread throughout the centre.

A sample of staff files were reviewed. All nurse registration documentation was available. Vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2021 were in place. The management team were committed to providing ongoing training to staff. There was a training schedule in place and training was scheduled on an on-going basis. The training matrix reviewed identified that staff had received mandatory training in

safeguarding vulnerable adults from abuse, fire safety, people moving and handling, infection prevention and control, hand hygiene and the management of responsive behaviours.

The February 2020 inspection highlighted that the reporting structure and processes required improvement to ensure the quality and safety of the service is being monitored and reviewed accordingly. Monthly management meetings are held. The inspector reviewed the minutes of the meetings and was not assured that the management team were aware of the gaps in the monitoring of the service. For example; resident falls were a rolling agenda item from the minutes reviewed. Despite this awareness, there had been no falls analyses completed since June 2021. This meant there was no active strategy in place on how the number of falls can be reduced. At the time of inspection the person in charge confirmed that there had been no clinical audit completed on the care delivered. Therefore, the provider has failed to make any changes or improvements with the level of monitoring and oversight on the service delivered.

The inspector acknowledges how challenging a time it had been for residents and for staff who had worked additional hours in responding to residents' increased clinical needs. The inspector also acknowledges that staff working in the centre have been through a challenging time. However, significant improvement and focus is now required under management systems to ensure that the quality and safety of care delivered to residents achieves regulatory compliance.

Regulation 15: Staffing

The inspector found that the number of staff available cross referenced with the staffing requirement as detailed in the Statement of Purpose submitted to the Chief Inspector evidenced shortfalls. The Statement of Purpose outlines the whole time equivalent staffing numbers required for a Capacity of 51 residents. While the inspector accept that there were eight residents vacancies, the staffing numbers were not adequate. As a result of the ongoing staffing shortages, the negative impact was:

- the person in charge was the nurse responsible for the direct delivery of care and rotas clearly evidenced this was normal practice. This meant that the person in charge was unable to supervise and monitor the service.
- the second communal sitting room was temporarily not in use as there was no staff available to supervise residents.
- On the days of inspection, there was no staff available to support activities. There was no group or one to one sessions occurring to meet the needs of the 43 residents in the centre.
- There was one nurse on duty at night for the 43 residents in the centre at the time of inspection.

- Allocated nursing hours are consistently short.
- Planned staff leave had not been replaced. In some instances planned leave was for extended periods such as maternity leave which is a minimum of 26 weeks.

Judgment: Not compliant

Regulation 16: Training and staff development

Appropriate arrangements for supervision of staff were not in place as a result of inadequate numbers of management personnel in place. The direct negative has been outlined under the observation section of the report.

The system of staff induction and supervision was not sufficiently robust. For example, a newly recruited staff members file evidenced a check list to cover induction. This was primarily ticked off around the time of commencement of employment. Although there was evidence of training provided, there was no evidence of ongoing supervision of staff.

Judgment: Substantially compliant

Regulation 21: Records

Records were stored securely and readily accessible. A review of a sample of personnel records indicated that the requirements of Schedule 2 of the regulations were met.

Judgment: Compliant

Regulation 23: Governance and management

The inspector found that the development of management systems in place to monitor the overall quality and safety of the service required strengthening. For example:

- There was insufficient monitoring of staff practices. For example; residents who have capacity to use a call bell should have access at all times.
- The system to identify and respond to risks was not adequate. There was poor evidence available that the management team had awareness of the risks identified during this inspection or that any appropriate actions had been

taken to reduce or address these risks.

- The system of incident and accident management was not adequate.
- There were inadequate mechanisms to monitor or drive quality improvement.
- There was no auditing of care.
- There is poor succession planning as evidenced by the system in place to ensure that appropriate staffing levels are maintained and that planned leave is replaced.
- There was no annual review of the service. In addition, consultation processes with residents on the operating of the centre were not adequate.

Judgment: Not compliant

Regulation 31: Notification of incidents

Notifications to the Chief Inspector were submitted in accordance with time frames specified in the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

The inspector reviewed the complaints log and found that appropriate action was taken on receipt of a complaint. Notwithstanding this, the following gaps need to be addressed to be compliant with the regulations.

- The complaints procedure displayed at the main entrance was not easily accessible for residents. It was placed at too high a level for any resident who was not able to stand.
- The complaint procedure was outdated and guided the complainant to personnel that no longer worked in the centre.

Judgment: Substantially compliant

Quality and safety

The inspector found that the provision of good quality care was significantly impacted upon due to nurse management resources in the centre. This lack of supernumerary clinical hours was impacting on the supervision and oversight of care delivered and this was evidenced in the nursing documentation and through the

voice of the residents. While there was an electronic care planning system in place, the oversight was not sufficient. The inspector found that care plans did not always contain the information required to guide the care. In addition, the provision of activities required resources to allow for one to one activities and the recommencement of group activities as per the residents requests.

All residents had a comprehensive nursing assessment completed on admission and a care plan developed. However, the inspector found that the nursing risk assessments completed were not being utilised to inform reviews and updates to the residents care plans. The inspector reviewed a sample of resident records and observed where assessments identified clinical risks associated with malnutrition and falls, this risk was not consistently updated in the residents care plan. Evidence of consultation with the resident or their relative following care plan reviews was not documented and some residents confirmed to the inspector that they were not routinely consulted about changes to their care plan.

Residents had access to a general practitioner (GP) and health and social care professionals. Where residents require further allied health and specialist expertise, this was facilitated through a system of referral. For example, some residents were under the care of the dietetic services for ongoing monitoring of their weight and nutrition. However, the inspector found that referrals made to dietetic services were not always made at the time the risk was identified which resulted in a delay in appropriate action been taken to support the resident.

Residents' lives had been significantly impacted by the COVID-19 pandemic and consequent restrictions. The inspector observed that staff adhered to guidance in relation to hand hygiene, maintaining social distance and in wearing PPE in line with the national guidelines. Staff reported that the training they had received had been of a good standard and they were able to implement it in practice. The management team were committed to ensuring all reasonable measures were in place to prevent the spread of the COVID-19 virus in the centre. This included

- a temperature and COVID-19 symptom check on arrival to the centre
- daily antigen testing of all staff prior to commencing the day at work
- automated alcohol hand sanitizers were available throughout the centre.
- appropriate signage was in place to prompt all staff and residents to perform frequent hand hygiene
- Individual resident slings for manual handling purposes

Regulation 11: Visits

On the days of inspection, visits were confined to the visiting room. This decision was not risk assessed and was not in line with the current COVID-19 Health Protection and Surveillance Centre (HPSC) guidance on visits to long term residential care facilities. The management team on the day of inspection told the inspector that this decision had been made in consultation with public health and had been

communicated to all residents. There was evidence of this communication available for review.

At the time of inspection all residents and staff were fully vaccinated. The person in charge committed to keep this instruction under review so as to ensure that the decision was proportionate to the risk.

Judgment: Compliant

Regulation 26: Risk management

There was a risk management policy in place that addressed the requirements of the regulation. A risk register was maintained as part of the centres risk management strategy. The risk register was not updated as risks were identified and controls in place to mitigate risk. Further development of the system was required as some risk found on the day of inspection had not been updated into the register. This is actioned under Regulation 23 Governance and Management.

Judgment: Compliant

Regulation 27: Infection control

A number of issues which had the potential to impact on effective infection prevention and control measures were identified during the course of the inspection. This was evidenced by:

- Individual resident chair coverings were ripped and torn and in need of repair.
- Specialised seating and shower chairs in some instances were heavily rusted and required replacement.
- The supervision of the cleaning of resident individual equipment required attention. The inspector observed multiple examples where resident equipment was not cleaned appropriately.
- The inspector found that the system for the cleaning of floors utilised the same mop head for the cleaning of two bedrooms. This risk had been identified and the centre was awaiting the delivery of mop heads to ensure there was a sufficient supply of mop cleaning heads so that a one mop per bedroom system could be implemented.
- Resident bathroom flooring was lifting and in many cases was in a poor state with tape applied in an attempt to stop the floor covering from lifting. This gap between the concrete and the floor covering was a reservoir for bacteria and also a trip hazard for residents. The inspector acknowledges that this had been identified by the management and a contractor had been engaged with

on the costing to fix the issue. The date for completion will be addressed in the compliance plan response.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Care plans reviewed were not consistently updated and did not guide care. For example,

- a resident with responsive behaviours observed by the inspector on the day of inspection did not have a care plan to guide staff on the management of incidents of agitation and aggression.
- there was no evidence that care plans were prepared and revised in consultation with the resident or where appropriate the family. Residents spoke with did not recall having any discussions with the team on the content of their care plan documentation.
- Nursing risk assessments were not always accurately completed. This meant there was no care plan in place identifying that the resident had lost significant weight and required intervention management.

Judgment: Not compliant

Regulation 6: Health care

Residents were provided with unrestricted access to a general practitioner. Residents had access to allied healthcare professionals such as physiotherapy, occupation therapy, dietician services and tissue viability expertise.

Judgment: Compliant

Regulation 9: Residents' rights

The registered provider had failed to ensure that resident's rights had been upheld. This was evidenced by;

- Residents did not have access to the daily newspaper.
- Unnecessary restrictions and freedom for residents to go outside for a cigarette
- Resident screening in multi-occupancy bedrooms required review. When

sitting on one bed it was possible to see under the screens when pulled and so the privacy of the resident was compromised.

- At the time of inspection, activities were not occurring in the centre. The provider had failed to ensure that residents were facilitated to participate in activities in accordance with their interests and capacities.
- Residents did not consistently have access to their call bells.
- While resident surveys had been sent out and a number had been returned. The returned forms had not been reviewed.
- The laundry labelling system required further development. There were multiple undergarments for return to residents that staff did not know who they belonged to.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Carna Nursing and Retirement Home OSV-0000398

Inspection ID: MON-0034430

Date of inspection: 21/01/2022

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	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 15: Staffing:</p> <p>S: The Director of Nursing will maintain a supernumerary role and is responsible for overall care delivery and supervision. Robust active recruitment of new carers and Activities staff is currently taking place and these carers will commence employment by the beginning of April 2022. Also, an Activities Co-ordinator is being employed two days a week, with active recruitment for a second full time activities coordinator. The second sitting room will be open fully and be supervised appropriately, daily activities to take place in both dayrooms. Our resident Physiotherapist will continue to do one-to-one and group sessions with residents. Alternative treatment sessions i.e. Reflexology has recommenced post COVID-19 restrictions and this will take place twice a week. One staff nurse has returned from Maternity Leave and the remaining staff nurse will return at the beginning of May. Active recruitment for staff nurses has commenced and same is in progress in order to accommodate excellent care delivery, teamwork, and staff leave. PIC and Provider aim to continue to provide effective and efficient staff nurse cover by day and night to provide and supervise the highest quality care.</p> <p>M: The DON role is supernumerary and is responsible for overseeing, monitoring and auditing care provision on a daily, weekly and monthly basis to ensure the highest standard of care is provided to all residents. Allocations will include both dayrooms being open and activities occurring in each dayroom. An information screen at reception guides residents to where and what day/time an activity is occurring. The Nursing Matrix is under monthly and as needed review to ensure it encapsulates sufficient nursing hours and how they are being utilized effectively within the organization.</p> <p>A: Through active employment and recruitment strategies. By review of the staff matrixes, to identify upcoming gaps, by the PIC, Management and the Registered Provider.</p>	

R: Under review by PIC, Management and Registered Provider on a daily, weekly and monthly basis.

T: 08/04/2022

Regulation 16: Training and staff development

Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:

S: Increase in the number of management personnel will now be in place. The system of staff induction and supervision will be sufficiently robust.

M: The Director of Nursing has returned to duty which has increased the number of management personnel in place. The DON is supernumerary and this allows for audit and review of staff practices.

An Induction booklet, checklist and ongoing appraisal system is being developed.

Every new staff member will be allocated a named mentor/ "buddy" who they will be allocated to work with during the first month of duty.

The Care of the Elderly course will be held again on the grounds of the nursing home so that practical work experience can be undertaken whilst also carrying out theoretical modules.

A: To be completed and managed by the DON and management team Ongoing training such as Safeguarding, Patient Moving and Handling, Infection Prevention and Control, Cardio-pulmonary resuscitation, Dementia, Hand Hygiene, End of Life, Donning and Doffing of PPE, Fire training and Extinguisher training develop and maintain employee's core skills. This is continually updated on the training matrix and all staff training is currently up to date.. Training to be completed by qualified external trainers on site.

R: Director of Nursing has returned to duty.

New Induction processes being developed and rolled out.

"Buddy" system also being rolled out.

Ongoing training continuing and completed as per training matrix.

Actively seeking participants for the Care of the Elderly course.

T: 28/02/2022

Regulation 23: Governance and

Not Compliant

management	
<p>Outline how you are going to come into compliance with Regulation 23: Governance and management:</p> <p>S: The development of management systems to monitor the overall quality and safety of the service will be strengthened by increased monitoring and auditing of staff practices. The system of incident and accident management will be more comprehensive and incidents will be reviewed, acted upon and resolved in a timely manner. Care plans will be overhauled and discussed with residents and, where appropriate, families. Service quality improvement will be guided by residents through ongoing discussions, regular satisfaction surveys and through actions coming from same. Auditing, action plans and future planning will be used to enhance the quality of service for all residents.</p> <p>M: Through regular auditing and review by PIC and Management team.</p> <p>A: Auditing of staff practices will be carried out regularly through observation and audit tools. Action plans will guide the next steps for quality improvement following an audit. Open communication between residents and the management team and follow-up actions will help identify if the service provided is fulfilling their needs for holistic care in this setting.</p> <p>R: Audit tools are available to guide auditing processes. Next steps following an audit are critical to ensure change occurs and promptly.</p> <p>T: 31/03/2022</p>	
Regulation 34: Complaints procedure	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 34: Complaints procedure:</p> <p>S: The complaints procedure at the main entrance will be accessible to all residents and relatives. An up to date complaints officer will also be displayed so that complaints can be dealt with effectively and with a timely and appropriate outcome for the complainant.</p> <p>M: There will be two copies of the complaint's procedure at the main entrance-one at standing and one at sitting height. The complaints procedure has been reviewed and updated to include an appropriate complaints officer.</p> <p>A: By the inhouse maintenance team and DON.</p> <p>R: This has been completed and is insitu.</p>	

T: 17/02/2022

Regulation 27: Infection control

Substantially Compliant

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

S: Residents chairs will be re-covered and replaced as necessary. All shower chairs will be replaced. Cleaning schedules for resident's individual equipment will be more robust. Mop heads will be used in a one mop per bedroom system. The date for completion of bathroom flooring will be 23/02/2022.

M: New chair coverings and new chairs as necessary. New shower chairs have been purchased and are insitu. Cleaning of resident's individual equipment system updated. A one mop per bedroom system in place. Bathroom flooring completed.

A: By suitably qualified tradespeople and in-house management.

R: Company contacted regarding chair coverings and replacements.

New shower chairs delivered and insitu.

Cleaning schedules audited and reviewed.

New mop heads in use.

Bathroom flooring to be completed 23/02/2022.

T: 31/03/2022

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:

S: Careplans will be overhauled and developed so that they guide the care of each resident. Residents, and their families, will have an opportunity to review and discuss their careplans and sign same if satisfied.

M: New careplans in place for each resident, reviewed every 3 months and as necessary and updated in conjunction with the resident and their nominated representative.

A: By the nursing and management team.

R: A new template has been developed and is being implemented.

T: 31/03/2022

Regulation 9: Residents' rights

Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:

S: The daily newspaper will be reinstated for any resident that wishes to receive it. All residents who wish to have access to the front door will have their fingerprint uploaded onto the system. An activities coordinator will commence employment two days a week to begin with. Our resident Physiotherapist will continue to provide one-to-one and group sessions for our residents. Our artist will continue to visit once a week. Our Reflexology therapist will continue their twice weekly sessions. Spot check audits will be carried out to ensure that each resident has access to their call bell and that call bell response times are within recommended timeframe. New resident and family surveys will be sent out six monthly and information correlated and acted upon. The laundry system has been streamlined and all items of clothing are correctly labelled.

M: Daily newspaper is being delivered every day for the residents who wish to receive it. All residents who would like front door access have been given same. An activities coordinator has taken up the post two days a week at present. Our activities taking place at present are continuing. Audits are being carried out on call bells fortnightly. Resident and family surveys are being completed and information correlated. The laundry system has been made more robust and all items of clothing have been correctly labelled.

A: by the in-house management team.

R: Newspapers are delivered from a local shop. Residents fingerprints are uploaded onto the system inhouse. An activities coordinator has taken up the post. Audits are carried out regularly by the DON regarding call bell access for residents and call bell response times. Resident and family surveys in the process of being returned and information correlated. All items of clothing correctly labelled.

T: 15/03/2022

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.	Not Compliant	Orange	08/04/2022
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	21/01/2022
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	15/03/2022
Regulation 23(d)	The registered	Substantially	Yellow	28/01/2022

	<p>provider shall ensure that there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.</p>	Compliant		
Regulation 23(e)	<p>The registered provider shall ensure that the review referred to in subparagraph (d) is prepared in consultation with residents and their families.</p>	Substantially Compliant	Yellow	31/03/2022
Regulation 27	<p>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.</p>	Substantially Compliant	Yellow	28/02/2022
Regulation 34(1)(b)	<p>The registered provider shall provide an accessible and effective complaints</p>	Substantially Compliant	Yellow	17/02/2022

	procedure which includes an appeals procedure, and shall display a copy of the complaints procedure in a prominent position in the designated centre.			
Regulation 34(1)(c)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall nominate a person who is not involved in the matter the subject of the complaint to deal with complaints.	Substantially Compliant	Yellow	17/02/2022
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Not Compliant	Orange	14/02/2022
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in	Not Compliant	Orange	15/03/2022

	activities in accordance with their interests and capacities.			
Regulation 9(3)(c)(ii)	A registered provider shall, in so far as is reasonably practical, ensure that a resident radio, television, newspapers and other media.	Not Compliant	Orange	24/01/2022