Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	Greystones Nursing Home
Name of provider:	Greystones Nursing Home Limited
Address of centre:	Church Road, Greystones, Wicklow
Type of inspection:	Unannounced
Date of inspection:	08 May 2023
Centre ID:	OSV-0000045
Fieldwork ID:	MON-0039640

About the designated centre

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

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

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	51

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 8 May 2023	09:35hrs to 18:35hrs	Mary Veale	Lead
Monday 8 May 2023	09:35hrs to 18:35hrs	Kathryn Hanly	Support

What residents told us and what inspectors observed

Residents enjoyed a good quality of life and were general positive about their experience of living in Greystones Nursing Home. There was a welcoming atmosphere in the centre. Residents' rights and dignity was supported and promoted by kind and competent staff. Care was led by the needs and preferences of the residents who were happy and appeared well cared for in the centre. Inspectors spoke with 3 visitors and 9 residents living in the centre. All were very complimentary in their feedback and expressed satisfaction about the standard of care provided. The inspectors spent time observing residents daily lives and care practices in order to gain insight into the experience of those living in Greystones Nursing Home.

On arrival the inspectors were met by a member of the administration team and signed the centres visitors' book. After an opening meeting with the person in charge, the inspectors were accompanied on a tour of the premises. The inspectors spoke with and observed residents' in communal areas and their bedrooms.

The design and layout of the premises met the individual and communal needs of the residents'. The centre consisted of two distinct buildings, the main house and the Sea Patrick wing. The original house dated from the Victorian period which was a former hotel and the Sea Patrick wing was a three storey extension. The original house retained many of its Victorian features, for example; high ceilings, stair case, coving, ornate fireplaces and sash windows with shutters. The entrance hall contained a piano and photographs of the local area. Communal rooms in the main house consisted of a living room, dining rooms and an activity room which all looked out on to the centres driveway and garden. The ground floor of the main house also had a smoking room. There was living room space, dining rooms, a quiet room and a hairdressing room in the Sea Patrick wing. On the day of inspection it was observed that residents in the Sea Patrick wing used the space at the entrance to Sea Patrick wing and the dinning space. The living room space and quiet room on the first floor in the Sea Patrick wing were observed not used by residents thought out the day of inspection.

The centre was registered to accommodate 64 residents. There were 15 twin rooms and 34 single rooms most had en-suite wash hand sink, toilet and shower facilities. Residents' bedrooms were clean, tidy and were personal to the resident's containing family photographs, art pieces and personal belongings. Residents had access to five assisted showers and a bath.

While the centre generally provided a homely environment for residents, improvements were required in respect of premises and infection prevention and control, which are interdependent. For example inspectors observed that the décor in the centre was showing signs of wear and tear. Several of the surfaces and finishes including wall paintwork, wood finishes and flooring in some resident rooms and ancillary facilities including a housekeeping room were worn and poorly

maintained and as such did not facilitate effective cleaning. Water damaged was observed on the ceilings in one area of the main house.

The provider was endeavouring to improve existing facilities and physical infrastructure at the centre through ongoing painting, maintenance and planned renovations of resident bedrooms. A large number of bedrooms had been redecorated with new flooring, furniture, curtains and fresh paint. A ground floor bathroom in the main building had been refurbished. Work was also ongoing to reconfigure the on site laundry to ensure it supported the functional separation of the clean and dirty phases of the laundering process.

Despite the infrastructural issues identified, overall the general environment and residents' bedrooms, communal areas and toilets inspected appeared appeared visibly clean with some exceptions. For example the sluice rooms and housekeeping rooms were unclean. Findings in this regard are further discussed under Regulation 27.

Alcohol-based hand-rub was available in wall mounted dispensers along corridors. However additional dispensers or individual bottles of alcohol hand gel were required to ensure alcohol hand gel was readily available at point of care. There were a limited number of clinical hand wash sinks available. The available clinical hand wash sinks in treatment rooms and sluice rooms did not comply with the recommended specifications for clinical hand wash basins.

The universal requirement for staff and visitors to wear surgical masks in designated centres had been removed on the 19 April. Residents, visitors and staff expressed their delight at improved communication with staff since the masks had been removed. Staff felt the removal of the mask mandate signaled a return to normalcy which would in turn lead to improved socialisation for residents. A small number of staff said that they had opted to continue wearing surgical masks to protect themselves and residents.

The inspectors observed that compartment doors were installed in the Sea Patrick wing on the ground and first floor to form a compartment boundary around the lift. The inspectors observed that some storage spaces in the centre had new doors installed. The inspectors were informed that the lift in Sea Patrick would be replaced in the coming months.

Personal care was being delivered in many of the residents' bedrooms and observation showed that this was provided in a kind and respectful manner. Residents very complementary of the staff and services they received. Residents' said they felt safe and trusted staff. Residents' told the inspectors that staff were always available to assist with their personal care. However, two resident told the inspectors that the "banging loudly of doors" when staff were entering and exiting residents bedrooms during the day was disturbing.

There were no visiting restrictions in place and public health guidelines on visiting were being followed. Visits and outings were encouraged and practical precautions were in place to manage any associated risks. Visitors were seen coming and going

over the course of the inspection.

There was a relaxed atmosphere within the centre as evidenced by residents moving freely and unrestricted throughout the centre. Residents had a choice to socialise and participate in activities. The daily activities programme was displayed in the main house and Sea Patrick wing. The inspectors observed residents partaking in a group exercise class in the afternoon. The inspectors observed staff and residents having good humoured banter throughout the day and observed staff chatting with residents about their personal interests and family members. The inspector observed many residents walking around the corridor areas of the centre. The inspector observed residents reading newspapers, watching television, listening to the radio, and engaging in conversation. Books, newspapers and games were available to residents.

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

Capacity and capability

This was an unannounced inspection carried out to monitor ongoing compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) 2013, and to follow up on the actions from the previous inspection. At the time of the inspection there were 13 vacant beds in the centre. The provider had progressed some areas of the compliance plan following the previous inspection in October 2022. Improvements were found in relation to Regulation 14: person in charge and areas of Regulation 16: training and staff development, Regulation 17: premises, Regulation 27: infection prevention and control, and Regulation 28: fire precautions. On this inspection, actions were required by the registered provider to address Regulation 17: Regulation 23: governance and management, Regulation 27: infection prevention and control, and Regulation 28: fire precautions. Areas of improvement were required in relation to Regulation 5: individual assessment and care planning, Regulation 8: protection, Regulation 16: staff training and development, Regulation 21: records and Regulation 29: medicines and pharmaceutical services. The centre had repeated findings of non-compliance in Regulation 17: premises, Regulation 23: governance and management, Regulation 27: infection prevention and control, and Regulation 28: fire precautions since 2019.

The centre had a restrictive condition attached to its registration following a risk inspection on the 09 June 2020. This restrictive condition related to works to be completed to comply with Regulation 28: fire precautions by the 30 November 2020. The programme of works to come into compliance with regulation 28: fire precautions was followed up on inspection in January 2022 and October 2022. Regulation 28: fire precaution was found not compliant on both inspections in 2022 and significant works were required to come into compliance with Regulation 28.

The provider had progressed works in the centre following the inspections in 2022. On this inspection, it was noted that the provider had undertaken works in fire safety but was found not compliant in Regulation 28: fire precautions as works were not fully completed to ensure a safe means of escape was provided, that there was safe arrangements to detect and contain fire. This is discussed further in the report under Regulation 28: fire precautions.

The inspectors also followed up one piece of unsolicited information that had been submitted to the Chief Inspector of Social Services in relation to residents rights, safeguarding, protection, the quality of care including care planning, personal care, health care and skin integrity, information governance, communication and governance and management. All these regulations were reviewed and further assurances were required in care planning, protection, and governance and management.

Greystones Nursing Home Limited was the registered provider for Greystones Nursing Home. The company had two directors who were responsible for the provision of care and services. The nursing home was part of the Evergreen care group which had nine designated centres for older persons. The registered provider representative was a company director and was available daily to the management team in the centre. The operations manager supported the person in charge of the centre. Shared group resources were available, for example, human resources. Since the previous inspection the centre had recruited a deputy person in charge who was employed as a clinical nurse manager and deputised for the person in charge. The management structure was clear and the person in charge was supported by a clinical nurse manager, a team of nurses, healthcare assistants, activity staff, housekeeping, catering, administration staff and maintenance staff.

Improvements were found in the oversight of mandatory training needs. There was an ongoing schedule of training in the centre. An extensive suite of mandatory training was available to all staff in the centre and the majority of staff were up to date with training. Staff were supported and facilitated to attend training and there was a high level of staff attendance at training in areas such as fire safety, safe guarding, dementia awareness, and infection prevention and control. All nursing staff had completed medication management training. Staff with whom the inspectors spoke with, were knowledgeable regarding fire evacuation procedures and medication management. The inspectors were informed that dementia awareness training was scheduled to take place in the weeks following the inspection. Efforts to integrate infection prevention and control guidelines into practice were underpinned by mandatory infection prevention and control education and training. A review of training records indicated that the six staff were due to complete mandatory infection prevention and control training.

Management systems in place to monitor the centre's quality and safety required review. Notes of staff meetings were brief, some were handwritten and did not show evidence of actions required from audits being discussed. Staff meetings outlined agenda items but did not record if items were actioned or a time line for completion of items. Monthly governance meeting agenda items included staffing, key performance indicators (KPI's), complaints, infection prevention and control,

staff training, and refurbishment works. Records of governance management meetings did not show evident of actions required from audits completed which was a missed opportunity to provide a structure to drive improvement. Audits were undertaken monthly and quarterly. The centre had a schedule of audits which included wound care, restrictive practice, nursing documentation and infection prevention and control. High levels of compliance were consistently achieved in recent audits in 2023. However audit tools lacked detail and audits were not scored, tracked and trended to monitor progress. Inspectors found that findings of recent audits did not align with the findings on this inspection. Details of issues identified are set out under regulations 5 and 27. There was a comprehensive annual review of the quality and safety of care delivered to residents completed for 2022 with an associated quality improvement plan for 2023.

Inspectors found that the provider did not comply with Regulation 27 and the National Standards for infection prevention and control in community services (2018). Weaknesses were identified in infection prevention and control and antimicrobial stewardship governance, environmental and equipment management. Overall responsibility for infection prevention and control and antimicrobial stewardship within the centre rested with the Director of Nursing. The provider had also nominated a staff member with protected hours allocated, to the role of infection prevention and control link practitioner to support staff to implement effective infection prevention and control and antimicrobial stewardship practices within the centre.

Incidents and reports as set out in schedule 4 of the regulations were notified to the Chief Inspector of Social Services within the required time frames. The inspectors followed up on incidents that were notified and found these were not managed in accordance with the centre's policies. The monitoring and oversight of safety procedures following a residents fall required improvement, this is detailed under regulation 23.

Regulation 14: Persons in charge

The person in charge worked full time in the centre and displayed good knowledge of the residents' needs and a good oversight of the service. The person in charge was well known to residents and their families and there was evidence of her commitment to continuous professional development.

Judgment: Compliant

Regulation 15: Staffing

Staffing was found to be sufficient to meet the needs of the residents on the day of

the inspection. The registered provider ensured that the number and skill-mix of staff was appropriate, to meet the needs of the residents. There were two registered nurses in the centre day and night.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had access to training appropriate to their role. Staff had completed training in safe guarding, fire training, dementia awareness and infection prevention and control and specific training regarding the correct use of PPE and hand hygiene. There was an ongoing schedule of training in place to ensure all staff had relevant and up to date training to enable them to perform their respective roles. Staff were appropriately supervised and supported to perform their respective roles. However; a review of training records indicated that the six staff were due to complete mandatory infection prevention and control training.

Judgment: Substantially compliant

Regulation 21: Records

Actions were required to ensure that staff records contained all information as outlined in schedule 2 of the care and welfare of residents in designated centres for older people Regulations 2013.

- In a sample of four staff files viewed, two of the staff files did not have a full employment history. Actions were required to ensure a full employment history of any gaps was completed for all staff files to ensure that staff records were in line with schedule 2 requirements.
- References were missing from one staff file.

Judgment: Substantially compliant

Regulation 23: Governance and management

Management systems to ensure that the service provided was safe, appropriate, consistent and effectively monitored, as required under Regulation 23(c), were not sufficiently robust. This was evidenced by:

- Systems of communication were not sufficiently robust as minutes of local staff meetings did not record if items discussed were implemented or a time

line for completion of items. There was no record of discussions of audits reviews or action plans in management meetings and staff meetings to ensure cascading of the governance structure to drive quality improvement. Surveillance of healthcare associated infection (HCAI) and multi drug resistant organism (MDRO) colonisation was recorded. However the information recorded was inaccurate.

- The system for assessment of residents post a fall required review as a number of fall incidents involving residents were not managed in accordance with the centre's policies.
- Further oversight was required of issues pertinent to fire safety as outlined further under regulation 28 and Condition 04 required the registered provider shall take all necessary action to comply with Regulation 28 Fire Precautions to the satisfaction of the office of the Chief Inspector no later than 30 November 2020.

Judgment: Not compliant

Regulation 31: Notification of incidents

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

Judgment: Compliant

Quality and safety

Overall, inspectors were assured that residents living in the centre enjoyed a good quality of life. The findings of this inspection evidenced that the management and staff had made improvements to the quality of life for the residents living in Greystones Nursing Home. Residents health, social care and spiritual needs were well catered for. Improvements were required in relation to Regulation 5: individual assessment and care planning, Regulation 8: protection, Regulation 17: premises, Regulation 27: infection prevention and control, Regulation 28: fire precautions and Regulation 29: medicines and pharmaceutical services.

The provider continued to manage the ongoing risk of infection from COVID-19 and other infections while protecting and respecting the rights of residents to maintain meaningful relationships with people who are important to them. Visitors were reminded not to come to the centre if they were showing signs and symptoms of infection. There was no restriction to visits in the centre and visiting had returned to pre-pandemic visiting arrangements in the centre. Residents could receive visitors in their bedrooms where appropriate, the centres communal areas or outside areas.

Visitors could visit at any time and there was no booking system for visiting.

Residents were supported to access appropriate health care services in accordance with their assessed need and preference. General Practitioners (GP's) attended the centre and residents had regular medical reviews. Residents had access to a consultant geriatrician, a psychiatric team, nurse specialists and palliative home care services who all attended the centre and residents attended follow up appointments in hospital. A range of allied health professionals were accessible to residents as required an in accordance with their assessed needs, for example, physiotherapist, speech and language therapist, dietician and chiropodist. The centre had access to a mobile x-ray service in the home and a community paramedic service. Residents had access to local dental and optician services. Residents who were eligible for national screening programmes were also supported and encouraged to access these.

Improvements were found in the condition of parts of the premises since the previous inspection, for example, additional bedrooms in the main house had been redecorated, the centres hot water system and light fixtures were reviewed and were found to be in working order. The provider had reviewed and adjusted the closing devices of the centres doors. Improvements had been made to the centres garden, a patio area had been provided for residents at the front of the centre. Construction work to laundry room was almost completed and a stairwell in the main house remained corded off since the previous inspection. The inspectors were informed that the walls in the stairwell awaiting re-plastering. The inspectors were informed that areas of the premises would be redecorated as part of the 2023 improvement plan and the passenger lift in Sea Patrick would be replaced. However, areas of the centre were showing signs of wear and tear, for example; areas of the centre corridors had scuffed and damaged walls, door frames and radiators. Walls in some of the bedrooms were damaged and required painting. The condition of the premises is intrinsically linked to infection prevention and control as damaged and scuffed surfaces cannot be cleaned and pose a risk to the spread of infection. Improvements were required in relation to the centres premises this will be discussed further under Regulation 17.

Inspectors identified some examples of good practice in the prevention and control of infection. Infection prevention and control information and reminders were displayed on a designated notice board within each unit. Staff spoken with were knowledgeable of the signs and symptoms of COVID-19 and knew how and when to report any concerns regarding a resident. The recent removal of mandatory mask wearing gave the provider flexibility to ensure ongoing COVID-19 measures in the centre were proportionate to the risks of infection within the centre. A small number of staff choose to continue wearing masks. Ample supplies of personal protective equipment (PPE) were available. Waste and used laundry was observed to be segregated in line with best practice guidelines. A range of safety engineered needles were available. However, a number of issues of non compliance required review to ensure it was aligned to best practice guidelines. This is discussed further under Regulation 27.

Improvements were found in fire safety. The furniture within the smoking room had been replaced with metal chairs. Smoking risk assessments for residents who

smoked had been completed so as control measures for the safety and supervision of these residents could be identified , implemented and assured. Large electrical panels were located on a bedroom corridor had been enclosed in fire resisting doors. All bedrooms and compartments had automated door closures. All fire doors were checked over the day of inspection and a small number were found to not close properly to form a seal to contain smoke and fire. Fire training was completed by staff since the previous inspection. Each resident had a personal emergency evacuation plan (PEEP) in place which were updated regularly. The PEEP's identified the different evacuation methods applicable to individual residents. There were additional fire evacuation maps displayed throughout the centre on all corridor areas. Staff spoken with were familiar with the centres evacuation procedure. There was evidence that fire drills took place regularly in 2022 and 2023. Fire drills records contained details of the number of residents evacuated, number of staff involved, how long the evacuation took and a stimulation of a night time evacuation. All fire safety equipment service records since the previous inspection were up to date. There was a system for daily and weekly checking, of means of escape, fire alarm system, fire safety equipment, and fire doors. There was evidence that fire safety was an agenda item at staff meetings in the centre. Fire doors had been installed to the lift enclose on the ground and first floor in Sea Patrick. All escape routes were assessable, free from obstructions and the assembly point was accessible. The inspectors were informed that all doors in the centre would be replaced this year with new automated closing devices. When this work is completed the fire alarm system will be upgraded to work with the new automated closing devices and smoke detection sensors will be fitted to all rooms that currently don't have a smoke detector. However; improvements in fire safety were required , this is discussed further in the report under Regulation 28.

The centre had a risk management policy that contained actions and measures to control specified risks and which met the criteria set out in regulation 26. The centre's risk register contained information about active risks and control measures to mitigate these risks. The risk registered contained site specific risks such as risks associated with falls, obsconding, and individual resident risks.

The centre had arrangements in place to protect residents from abuse. There was a site-specific policy on the protection of the resident from abuse. Safeguarding training had been provided to all staff in the centre and staff were familiar with the types and signs of abuse and with the procedures for reporting concerns. However, improvements were required in procedures to ensure staff were Garda vetted prior to employment.

The inspectors saw that the resident's pre- admission assessments, nursing assessments and care plans were maintained on an electronic system. Residents' needs were assessed prior to admission. Resident's assessments were undertaken using a variety of validated tools, however it was evident that falls risk assessments were not always reassessed on admission or following a fall or care plans were developed. Care plans viewed by the inspectors were generally personalised, and sufficiently detailed to direct care with some exceptions. A review of care plans found that further work was required to ensure that all resident nursing assessments and care plans contained resident's current MDRO colonisation status. Further

improvements were also required to residents care plans follow incidents of falling and a number of residents care plans were not consistently consulted with the resident or where appropriate a residents family. This is discussed further under Regulation 5: individual assessment and care planning.

There was a rights based approach to care in this centre. Residents' rights, and choices were respected. Residents were actively involved in the organisation of the service. Regular resident meetings and informal feedback from residents informed the organisation of the service. The centre promoted the residents independence and their rights. The residents had access to SAGE advocacy services. The advocacy service details was displayed at reception and activities planner were outside the activities room and in Sea Patrick. Residents has access to daily national newspapers, WI-FI, books, televisions, and radio's. Mass took place in the centre regularly. Musicians attended the centre. Group activities of a exercise class and a relaxation session took place on the day of inspection. Satisfaction surveys showed high rates of satisfaction with all aspects of the service.

Regulation 11: Visits

Visiting had resumed in line with the most up to date guidance for residential centres.

Judgment: Compliant

Regulation 12: Personal possessions

Residents had adequate space in their bedrooms to store their clothes and display their possessions. Clothes were marked to ensure they were safely returned from the laundry.

Judgment: Compliant

Regulation 17: Premises

Action were required to ensure compliance with regulation 17 and the matters set out in schedule 6, for example:

- Parts of the centre required painting and repair to ensure it could be effectively cleaned, such as radiators, walls, and skirting boards.
- The ceiling in room 8 and on the corridor adjacent required repair as a water leak had damaged the ceiling.

- Call bells were required in the en-suite toilets of rooms 6, 7, 8 and 20.

Judgment: Not compliant

Regulation 26: Risk management

There was good oversight of risk in the centre. Arrangements were in place to guide staff on the identification and management of risks. The centre's had a risk management policy which contained appropriate guidance on identification and management of risks.

Judgment: Compliant

Regulation 27: Infection control

The registered provider had not ensured effective governance arrangements were in place to ensure the sustainable delivery of safe and effective infection prevention and control and antimicrobial stewardship. For example;

- While antibiotic usage was monitored, there was no evidence of multidisciplinary targeted antimicrobial stewardship quality improvement initiatives.
- Surveillance of MDRO colonisation did not identify all residents colonised with MDRO's. As a result appropriate care plans were not available for some residents. This meant that appropriate precautions may not have been in place when caring for these residents.
- Disparities between the finding of local infection prevention and control audits and the observations on the day of the inspection indicated that there were insufficient assurance mechanisms in place to ensure compliance with the National Standards for infection prevention and control in community services.

Equipment and the environment was not managed in a way that minimised the risk of transmitting a healthcare-associated infection. This was evidenced by;

- Barriers to effective hand hygiene practice were observed during the course of this inspection. Additional dispensers or individual bottles of alcohol hand gel were required to ensure alcohol hand gel was readily available at point of care. There were a limited number of clinical hand wash sinks available for staff use.
- Two cleaning trolleys viewed were visibly unclean. Effective cleaning and decontamination is compromised if cleaning equipment is unclean.
- A dedicated specimen fridge was not available for the storage of laboratory

samples awaiting collection. A urine sample was observed within the a medication fridge. This posed a risk of cross-contamination.

- The design and layout of the housekeeping room in the main building was was not fit for purpose. For example insufficient space for trolleys and other cleaning equipment, there was no janitorial sink, surfaces were damaged and chemicals were stored on the floor.
- Both sluice rooms were visibly unclean. Ineffective cleaning increased the risk of cross infection.
- Staff informed inspectors that urinals were emptied and rinsed in en-suite bathrooms and reprocessed in the bedpan washer periodically. This increased the risk of environmental contamination and cross infection. Two commode basins and three urinals in the sluice rooms were stained. Ineffective decontamination and damaged equipment increased the risk of cross infection.
- Inspectors were informed that an infection prevention and control specialist with the relevant qualifications and experience was not consulted prior to and during ongoing refurbishments works in the centre.
- The provider had undertaken an aspergillosis risk assessment and implemented infection prevention and control aspergillosis risk reduction measures to protect at-risk residents during the ongoing renovations within the centre. However this required review to ensure it was aligned to best practice guidelines.

Judgment: Not compliant

Regulation 28: Fire precautions

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

The means of escape were not adequate, for example:

- The escape corridor from two bedrooms was not adequately protected from fire. There was a PVC screen, behind which was a staff room and store, neither of which were fitted with fire doors

The arrangements for containing fire were not adequate, for example:

- The fire door to a number of rooms were not fitted with an automatic closing device to ensure the door would be closed in the event of a fire. For example, the office for the person in charge and a number of store rooms.
- Bedroom doors with automatic closing devices in rooms 4, 6, 20, 23,40, 41 and 43, were not closing to form a seal to contain smoke or fire.

The arrangements for detecting fire were not adequate, for example:

- Some rooms were not fitted with smoke detection, for example, a store opening from the sluice room and the store adjacent to the staff room

- The category of fire detection and alarm system was not detailed on the service records. The service records available indicated that upgrading will be required to provide the necessary standard for a nursing home.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

There was a comprehensive centre specific policy in place to guide nurses on the safe management of medications. Medicines were administered in accordance with the prescriber's instructions in a timely manner. Medicines were stored securely in the centre. Controlled drugs balances were checked at each shift change as required by the Misuse of Drugs Regulations 1988 and in line with the centres policy on medication management. A pharmacist was available to residents to advise them on medications they were receiving.

The person in charge did not ensure that medicinal products were stored securely or disposed in the centre. For example;

- Three containers of laxative medications were not stored securely, all three bottles were in a residents en-suite bathroom which could be accessed by other residents and posed a risk of cross contamination.
- Eye drop medication prescribed for a resident had being opened on the 31.3.2023 was still in use which was not in line with the manufactures instructions to dispose of after 30 days of opening.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Action was required in individual assessment and care plans to ensure the needs of each resident are assessed and an appropriate care plan is prepared to meet these needs. For example:

- One resident did not have an updated falls risk assessment since admission.
- A number of residents care plans viewed did not include an update on their care following a fall and review of bed rails.
- One residents did not have a care plans to guide staff to care for a fracture following a fall.
- A review of care plans found that further work was required to ensure that all resident nursing assessments and care plans contained resident's current MDRO colonisation.
- Some care plan reviews were not comprehensively completed on a four

monthly basis to ensure care was appropriate to the resident's changing needs.
- It was not always documented if the resident or their care representative were involved in the reviews in line with the regulations.

Judgment: Substantially compliant

Regulation 6: Health care

There were good standards of evidence based healthcare provided in this centre. GP's routinely attended the centre and were available to residents. Allied health professionals also supported the residents on site where possible and remotely when appropriate. There was evidence of ongoing referral and review by allied health professional as appropriate.

Judgment: Compliant

Regulation 8: Protection

The centre had arrangements in place to protect residents from abuse. There was a site-specific policy on the protection of the resident from abuse. In addition the centre were using the national safeguarding policy to guide staff on the management of allegations of abuse. Safeguarding training had been provided to staff in the centre and staff were familiar with the types and signs of abuse and with the procedures for reporting concerns. All staff spoken with would have no hesitation in reporting any concern regarding residents' safety or welfare to the centre's management team.

The centre's procedures for Garda Vetting of staff prior to employment required review in order to ensure the continued safeguarding of vulnerable residents.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Residents' rights and choice were promoted and respected within the confines of the centre. Activities were provided in accordance with the needs' and preference of residents and there were daily opportunities for residents to participate in group or individual activities. Facilities promoted privacy and service provision was directed by the needs of the residents.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Greystones Nursing Home OSV-0000045

Inspection ID: MON-0039640

Date of inspection: 08/05/2023

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Since the inspection, we have completed 1 further session of dementia and challenging behavior training, with a further session booked for the 8th August. As part of our onboarding of new staff and induction – all new staff will complete the infection prevention & control training. This is a rolling subject for continual professional development so will continue throughout the year. We will continue to roll out training to our staff throughout the year to ensure that they have the necessary skills and insights to be able to care for our Residents.	
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: Following the inspection, we reviewed the particular files that were found incomplete and all gaps have been rectified. This is part of a larger project that involves all staff files to be reviewed, checked against the checklist that is attached to each file and any gaps are to be notified to the PIC and followed up and closed off with the staff member.	
Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management: We have now a set template for all meetings that are held within the home, this includes review of prev minutes, new agenda, and matters arising from the meeting & action plan with completion date. We have reviewed and updated our records for any MDRO within the home. The procedure and policy that must be followed for each Resident after a fall or incident has been discussed at handovers with all staff. We do have a quarterly audit tool in use, which is under review to ensure that all information is captured, assessed and a plan introduced as necessary. The PIC & DPIC will review every fall to ensure that the follow up is being completed as per our policy. Items with regard to Reg 28: Fire Precautions will be further discussed under Regulation 28.	
Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: We do have ongoing painting and repairs being conducted within the home. For the larger areas to be repainted we are engaging with an external contractor and the smaller areas, our own staff will be able to address these on an regular basis. The ceiling in rm 8 and the adjacent corridor have been identified and we will have these repaired within the next few weeks. All rooms and ensuites have call bells fitted.	
Regulation 27: Infection control	Not Compliant
Outline how you are going to come into compliance with Regulation 27: Infection control: Safe & effective infection prevention and control and antimicrobial stewardship: We are using the recommendations on good practice for commonly used antibiotics in community setting, in conjunction and as prescribed by each Residents gp. We have updated our antimicrobial register and updated/reviewed the relevant Resident careplans accordingly. We have reviewed an updated our ipc/environmental audit tool and both PIC and DPIC have completed the hseland audit training. The home has the support from our two ipc leads and the dpic has completed the hseland amric training. Equipment and Environment:	

We have additional alcohol gel dispensers and bottles available at point of care.
The cleaning trolleys are included on the weekly checklist for domestic staff and spot checks are completed by pic/dpic and domestic supervisor to ensure effecting cleaning and decontamination.
We have installed a dedicated specimen fridge.
Our housekeeping store in MH along with the store room opposite and the adjoining service corridor will be reconfigured to enable safe and separate storage of chemicals, the housekeeping trolley. As we use the "flat mop system" we do not need a janitorial sink as there is no waste water to dispose of.
The sluice rooms within the home are being cleaned daily and there is a cleaning schedule displayed in each sluice room.
We have reviewed and disposed of any stained urinals or commode basins. Staff have been instructed/reminded how to wash and clean these items correctly. We have a commode cleaning schedule in place.
The aspergillosis risk assessment has been reviewed in accordance with "IPC recommendations for the prevention of nosocomial invasive Aspergillosis during renovation Jan 2018".

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
We have daily means of escape/fire exit checks in place – these are checked at each change of shift. Any faults are reported immediately.
The 2 bedrooms noted by the inspectors, both are fitted with fire doors and automatic door closers. We will have a fire door constructed at the opposite end of this corridor.

Arrangements for containing fire:
We have begun the process of replacing all fire doors within the home and do anticipate this continuing for a number of months. All doors will be reviewed during this process to ensure safety and fire containment.
The bedroom doors noted during the inspection have been repaired to ensure that they close to form a seal to contain smoke/fire. All fire doors will be replaced as previously mentioned.

Arrangements for detecting fire:
The fire detection and alarm system is part of our overall fire protection plan for this year and will be replaced.

Regulation 29: Medicines and	Substantially Compliant

pharmaceutical services	

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
The containers of laxative medication were removed from the Residents room on the day of inspection. Reassurance was given to the Resident that administration of same would continue as prescribed.
A system for removing used medication/eye drops etc at each pharmacy restock of the medication trolley has been re-enforced. These and all similar medications will be dated on day of opening. A pharmacy medication audit has been performed and we will use "date opened by & use by date" labels affixed to medication containers going forward.

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
Careplans and assessments will be reviewed on a 4 mthly basis if not before depending on the changing needs of our Residents.
As mentioned before – we have a set system for follow up/action plans and reviewing of accidents/incidents/falls etc.
All Residents with MDRO colonisations have had their careplans and assessments updated.
We will document our involvement with Residents and their nominated care representative in the Residents care plan, in line with regulations.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
On the day of inspection there was one member of staff whose garda vetting confirmation postdated their start date on the roster. This staff member did supply references which were validated and was supervised at all times by an experienced member of staff during this time and their induction process. We will ensure that the garda vetting procedure is complete prior to staff commencing any rostered duty.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(2)(a)	The person in charge shall ensure that copies of the Act and any regulations made under it are available to staff.	Substantially Compliant	Yellow	30/06/2023
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	31/07/2023
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	31/07/2023
Regulation 23(c)	The registered provider shall ensure that	Substantially Compliant	Yellow	31/08/2023

	management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.			
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Not Compliant	Orange	31/07/2023
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Orange	30/11/2023
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	30/11/2023
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all	Not Compliant	Orange	30/11/2023

	fire equipment, means of escape, building fabric and building services.			
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	30/11/2023
Regulation 28(1)(c)(iii)	The registered provider shall make adequate arrangements for testing fire equipment.	Not Compliant	Orange	30/06/2023
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.	Not Compliant	Orange	30/06/2023
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at	Not Compliant	Orange	30/06/2023

	suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.			
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	30/11/2023
Regulation 28(2)(ii)	The registered provider shall make adequate arrangements for giving warning of fires.	Not Compliant	Orange	30/06/2023
Regulation 28(2)(iii)	The registered provider shall make adequate arrangements for calling the fire service.	Not Compliant	Orange	30/06/2023
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.	Not Compliant	Orange	30/06/2023
Regulation 28(3)	The person in charge shall ensure that the procedures to be followed in the event of fire are	Not Compliant	Orange	30/06/2023

	displayed in a prominent place in the designated centre.			
Regulation 29(4)	The person in charge shall ensure that all medicinal products dispensed or supplied to a resident are stored securely at the centre.	Substantially Compliant	Yellow	30/06/2023
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Substantially Compliant	Yellow	30/06/2023
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.	Substantially Compliant	Yellow	30/06/2023
Regulation 5(5)	A care plan, or a revised care plan, prepared under this Regulation shall be available to the resident	Substantially Compliant	Yellow	30/06/2023

	concerned and may, with the consent of that resident or where the person-in-charge considers it appropriate, be made available to his or her family.			
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Substantially Compliant	Yellow	30/06/2023
Regulation 8(2)	The measures referred to in paragraph (1) shall include staff training in relation to the detection and prevention of and responses to abuse.	Substantially Compliant	Yellow	30/06/2023