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

Issued by the Chief Inspector

Name of designated centre:	TLC Centre Maynooth
Name of provider:	Veritdale Limited
Address of centre:	Straffan Road, Maynooth, Kildare
Type of inspection:	Unannounced
Date of inspection:	02 February 2023
Centre ID:	OSV-0000684
Fieldwork ID:	MON-0038959

About the designated centre

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

TLC Centre Maynooth is a ground-floor nursing home located on the outskirts of Maynooth, Co. Kildare. The centre is registered to accommodate up to 125 residents within two buildings that are divided into five areas- Kinvara House, The Courtyard, Oak House, Arkle House and Champ House (Corridor 4). Kinvara House is in a separate building that accommodates 57 residents. Bedroom accommodation consists of 41 single bedrooms and eight double/twin bedrooms with full en-suite facilities. A variety of open-plan and communal spaces were available. Meals were transported to the Kinvara House kitchenette/dining room from the kitchen located in the other/main building. Oak House, located in the main building, accommodates 13 residents living with dementia or Alzheimer's disease. Bedrooms comprise eight single and two twin/double. The Courtyard accommodates 31 residents in single en-suite bedrooms. Arkle House and Champ House (Corridor 4) consist of 22 twin/double en-suite bedrooms. These areas share the facilities and communal areas within the main building. The ethos of the centre is to promote residents' independence and value individuality. The aims of the centre are to meet the individualised needs of residents by encouraging them to continue to lead as active and fulfilling a life as is within their desires and capacities.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	117

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 2 February 2023	09:10hrs to 19:00hrs	Helena Budzicz	Lead
Tuesday 14 February 2023	17:55hrs to 21:10hrs	Helena Budzicz	Lead
Wednesday 15 February 2023	08:50hrs to 18:10hrs	Helena Budzicz	Lead
Thursday 2 February 2023	09:10hrs to 19:00hrs	Brid McGoldrick	Support
Tuesday 14 February 2023	17:55hrs to 21:10hrs	Brid McGoldrick	Support
Thursday 2 February 2023	09:10hrs to 19:00hrs	Geraldine Flannery	Support
Wednesday 15 February 2023	08:50hrs to 18:10hrs	Brid McGoldrick	Support
Wednesday 15 February 2023	08:50hrs to 18:10hrs	Manuela Cristea	Support

What residents told us and what inspectors observed

Overall, inspectors observed that while a number of residents in the centre enjoyed a good quality of life and their rights were respected, this was not found for other residents, including residents with high-dependency needs. Inspectors met a number of residents and spoke with residents who were willing and able to converse. The inspectors also met with four family members who were visiting residents during the inspection. The overall feedback from residents and relatives was that TLC Maynooth was generally a nice place to live and that the staff were kind to residents. However, they did identify that there had been a number of issues with the provision of the activities and the unpleasant view from their bedroom windows on Corridor 3 in the Main building.

This risk inspection was conducted over three separate days. The inspectors arrived at the centre unannounced on the first morning of the inspection and were met by a staff member at the reception. Inspectors saw that the reception area was bright and welcoming, and a number of residents were sitting at the reception and watching the morning activity in the centre. There were plenty of communal spaces for residents' use, with large dining rooms, television rooms, large lounge rooms and an oratory. Inspectors acknowledge that the provider had improved the premises and fire precautions in the centre. The floor covering was replaced in the communal areas and the bedrooms in the Main building units. The bedrooms in the Oak unit were reconfigured with new furniture to create adequate privacy for residents in the double-occupancy bedrooms. Inspectors also acknowledge that the provider had installed new hand washing sinks across the centre following the first day of the inspection. However, during the walkabout, inspectors checked equipment and found several deficits in the premises; these will be further expanded under Regulation 17: Premises.

The centre had completed works in the maintenance and storage rooms beside the Oak unit, which had significantly reduced the risk of fire containment in the centre. Some additional work had been completed by the provider following the completion of a risk assessment by their competent person in October 2021. This report identified a number of high-level and medium-level risks. Inspectors acknowledge that some works had been completed; however, significant improvements were still required to comply with Regulation 28: Fire precautions.

The inspectors saw that the majority of bedrooms were personalised in line with residents' preferences, with displays of family photographs and personal possessions. However, inspectors observed that not all bedrooms and bathrooms were cleaned to appropriate standards and were well-ventilated throughout. There was good hand hygiene practice observed throughout the day of inspection; however, inspectors observed many occasions where staff did not wear face masks appropriately. For example, staff were seen touching the front of their face masks or wearing them below their nose or chin repetitively during the inspection. This may result in the onward transmission of infections to residents. This and further issues

identified during the inspection are discussed further under Regulation 27: Infection Control.

The dining room was to the left of Kinvara reception and had full views of the entrance to the centre. The inspector observed the lunch time meals on the first and third days of the inspection and noted that the food served to residents appeared appetising and nutritious. Tables were seen to be set before residents came to the dining room for their meals. Residents were observed to chat and joke with other residents, visitors and staff. Staff were observed to be respectful and discreetly assisted the residents during meal times.

Nonetheless, the food serving experience in the communal room in the Oak dementia-specific unit required improvement as the residents living with dementia were not facilitated to have as pleasant a dining experience as the residents in the other units. Tea and pastry were not served in a dignified manner. Additionally, inspectors saw that the hydration needs of residents with high-dependency needs in the Kinvara unit were not satisfactorily met on all three days of the inspection, and inspectors saw that residents with dysphagia (difficulties with swallowing) were not always adequately supported by staff while assisting with their eating and drinking. This is further discussed under Regulation 18: Food and nutrition.

Residents had access to local and national newspapers, televisions and radios in their bedrooms and in the communal areas. Information regarding advocacy services was displayed in the centre, and inspectors were informed that residents were supported to access this service if required. However, residents' privacy and dignity were negatively impacted by the high level of noise from the call-bells in the Main building at night, the inaccessibility of the call-bells and that residents' personal possessions, such as clothes, were not stored in neat order. Additionally provision of activities in all units required an improvement to ensure continuity and accessibility of activities provided for residents as evidenced under Regulation 9: Residents' rights.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impacted on the quality and safety of the service being delivered.

Capacity and capability

Overall, inspectors found that the governance and management systems in place did not ensure that high-dependent residents living in the centre were provided with a good standard of care. Significant and sustained improvement is required to ensure quality and safe care is delivered to all residents accommodated in the centre.

This was an unannounced risk-based inspection to monitor regulatory compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for

Older People) Regulations 2013 (as amended). In preparing for this inspection, the inspectors reviewed actions from the last inspection, the information provided by the provider and the person in charge and unsolicited information received by the Chief Inspector of Social Services.

The findings of this inspection were that the provider had failed to fully implement their compliance plan following the previous inspection completed in August 2022. Inspectors found ineffective management systems of monitoring and oversight resulted in repeated issues of substantial or non-compliance under; Regulation 16: Training and staff development, Regulation 21: Records, Regulation 23: Governance and management, Regulation 31: Notification of incidents, Regulation 27: Infection control, Regulation 28: Fire precautions, Regulation 29: Medicines and pharmaceutical services, Regulation 5: Individual assessment and care plan, Regulation 6: Health care and Regulation 9: Residents' rights.

Following the first day of the inspection, an urgent compliance plan request was issued to the registered provider in respect of significant immediate risks and associated non-compliance with; Regulation 16: Staff training and development, Regulation 18: Food and nutrition, Regulation 6: Health care, Regulation 8: Protection, Regulation 27: Infection control, Regulation 28: Fire precautions and Regulation 23: Governance and management. The responses to aspects of the urgent action plan submitted by the provider did not provide sufficient assurance; for example, it was evident that some staff members did not adhere to best-evidenced practices although they had received and were up-to-date with the relevant training, as evidenced in this report. Furthermore, the provider stated that there was equipment available for high-dependency residents, such as shower beds or specialised chairs to assist them with showers and personal care. However, this equipment was not available in the centre, and one shower bed seen was not fit for purpose.

Inspectors conducted further evening and day inspections to assess the actions taken in response to the urgent action. Following the third day of the inspection, inspectors requested a copy of the evacuation plans from the Kinvara unit and sought further assurances in respect of the fire precaution in the unit. The provider submitted sufficient assurances confirming that adequate steps were taken to ensure that fire precautions and evacuation procedures were appropriate and safe.

The registered provider of the centre is Veritdale Limited. This centre is part of the Orpea Group, which owns and operates a number of nursing homes throughout the country. The organisational structure of the centre and the lines of authority and accountability had remained unchanged since the previous inspection. The management team within the centre consists of a person in charge, two Assistant Directors of Nursing and a team of clinical nurse managers. The management team within the centre also had support from the group's regional director of operations, human resource department and finance department.

Inspectors reviewed a sample of staff duty rotas and, in conjunction with information received from talking with staff and residents, found that the number and skill-mix of staff were not sufficient to meet the needs of residents, having

regard to the size and layout of the centre, especially in the Oak and Kinvara unit as discussed under Regulation 15: Staffing.

There was a programme of both online and face-to-face training available for staff at the centre that included fire safety, manual handling, safeguarding vulnerable adults and infection control. However, from the observation of the staff practices and speaking with the staff members, inspectors found that not all staff had adequate knowledge of the cleaning, safeguarding and fire procedures, communication with residents with dementia and manual handling practices. Further actions were required to ensure that staff were supervised in accordance with their roles and responsibilities as detailed under Regulation 16: Training and staff development.

Inspectors reviewed incidents submitted to the Office of the Chief Inspector and found that the action taken by the management and staff following some safeguarding incidents was not in line with the centre's own policy. As a result, there was a lack of assurance that the residents concerned were safe or that the safeguarding systems in place ensured the safety of all the residents in the centre. This is further discussed under Regulation 31: Notification of incidents and Regulation 8: Protection.

Management of records required better oversight to ensure that records were maintained in line with specified regulatory requirements.

Regulation 15: Staffing

This inspection found that the staff complement in the Oak and Kinvara unit was not appropriate having regard to the needs of the residents assessed in accordance with regulation 5, evidenced by:

Kinvara unit:

- There was inadequate staff available to continually meet the social needs of all residents, as the residents were seen with little to do.
- There was no staff available for support for residents observed in the bedrooms, where on some occasions, residents spent the whole day.

Oak unit:

- There were two care staff allocated to work in the Oak dementia-specific unit. A staff nurse was also allocated to work between Oak and Corridor 1. Inspectors observed that when the staff assisted high-dependency residents who required the assistance of two staff, there was no staff available to supervise the other residents residing in the unit. This staffing level was not adequate when considering the dependency levels and complexity of the needs of residents living in this unit.
- While the staff were busy supervising residents, inspectors observed that very

little social stimulation was provided for residents.

Judgment: Not compliant

Regulation 16: Training and staff development

Inspectors were not assured that there was adequate supervision in place to ensure that staff adhered to safe and appropriate practices at all times when supporting residents with their needs in a timely manner. This was evidenced by the following;

- Inspectors found that staff demonstrated poor awareness and practice with regard to the appropriate and safe manual handling of a resident during the repositioning of the resident.
- Some residents with higher dependencies and who were at risk of developing pressure ulcers were not repositioned at appropriate intervals.
- Inspectors observed a number of incidents whereby staff acted inappropriately or did not support the dignity and choice of residents living with dementia. There was a lack of knowledge regarding residents' rights as some staff did not provide an appropriate explanation to the resident and gain their consent before commencing a care intervention.
- Inspectors observed a lack of understanding and support for residents with communication difficulties.
- Staff did not recognise and act on signs of dehydration, and as a result, some residents did not receive care in line with their needs. The level of clinical oversight by nursing and supervision of care staff required improvement. Some staff members who spoke with the inspectors were not aware of the safeguarding procedure to follow if there was an allegation of abuse.
- There was ineffective planning for staff allocation resulting in a lack of resident supervision during staff handovers, particularly in the evening time. For example, inspectors observed residents calling for assistance whilst all staff were gathered together at the staff handover.
- The supervision of cleaning in the centre required improvement as areas of the centre were not cleaned to a high standard.
- There were inconsistent staff practices in respect of the fire precautions and evacuation of the centre as evidenced under Regulation 28: Fire precautions.

Judgment: Not compliant

Regulation 21: Records

Record keeping and file management required action to ensure compliance with regulatory requirements. For example;

- Nursing care records did not sufficiently provide staff with a complex overview of the resident's day spent, the current condition of the resident or the plan for care. Some entries were copied and duplicated over several days.
- Inspectors observed conflicting personal emergency evacuation plans (PEEP)- one record dated 2015 was found in a resident's wardrobe, while another one was in the wall-holder beside the door. This could lead to errors.

Records were not stored securely; for example, safeguarding plans and other nursing notes were found in unlocked drawers in the nursing stations in Corridor 4, Oak unit and in Kinvara unit.

Judgment: Not compliant

Regulation 23: Governance and management

Even though there were management systems in place, the quality assurance systems were not sufficiently robust and failed to ensure that the service provided in the centre was safe and effective in a number of areas. For example:

- The registered provider did not ensure that sufficient staffing levels and appropriate resources and equipment were available for residents with high-dependency needs as outlined under Regulation 17: Premises.
- There was inappropriate recognition and management of clinical risks as evidenced under Regulation 6: Health care. Inspectors saw that key areas of the clinical care being provided to residents were not being monitored, which could result in ineffective care being provided to residents. For example, information on residents' food and fluid intake was not being gathered and analysed; inspectors observed two expired items in the emergency kit which had not been identified by provider's checks.
- The management systems in place to address previously identified non-compliances were not effective.
- A number of significant risks were identified during the inspection, which required immediate and urgent action plans to be issued to the provider. There was a lack of assurance in the provider's response to the urgent action plan issued on the first day of the inspection and, as confirmed by the subsequent inspection days.
- The provider's quality system of fire checks in the centre was not adequate.
- There was ineffective supervision and oversight of practices as a number of local policies were found not to be implemented in practice, as further detailed under Regulation 4: Written policies and procedures. Oversight of systems in place to ensure incidents were notified to the Office of the Chief Inspector and were recorded and appropriately investigated required action.
- The inspectors were not assured that a comprehensive analysis, review and all necessary actions were taken to prevent re-occurrences of safeguarding incidents as discussed under Regulation 8: Protection.
- In addition, the oversight of the physical environment was not robust. The

provider's arrangements did not ensure that all areas of the centre's premises were appropriately cleaned and maintained to reduce the risk of cross-contamination and infection. Disparities between the findings of local infection prevention and control audits and the observations during 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.

- Inspectors found that the provider was in breach of condition 1 of its registration certificate as areas in the centre designated for residents' use had changed the purpose and were used as a staff facility.
- There was a lack of assurance in the provider's response to the urgent action plan issued on the first day of the inspection and as confirmed by the subsequent inspection days.

Judgment: Not compliant

Regulation 31: Notification of incidents

During the first day of the inspection, inspectors identified that two notifiable incidents had occurred; however, the Office of the Chief Inspector had not received the appropriate notifications. The person in charge submitted the required NF06 notifications retrospectively.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

While Schedule 5 policies were in place, inspectors found that they were not effectively implemented in practice. For example;

- There were gaps in the implementation of the medication management policy, such as staff not adhering to appropriate processes in respect of the storage and administration of medications.
- Inspectors observed that the staff were not adopting the centre's End-of-life care policy as a 'Limited care' document in respect of the end-of-life wishes of the resident was not in line with the centre's policy on End of life care.
- The provider failed to implement its own policy, for example, recognising and responding to an incident of suspected abuse. A safeguarding coordinator was not appointed to investigate or take the protective measures outlined in their policy.

Judgment: Not compliant

Quality and safety

Overall, residents' clinical health and care needs and preferences for social engagement and meaningful occupation were not adequately met, including assessment and support of residents' rights, protection of residents, medication management and risk of deterioration in residents' health and well-being and associated documentation needed improvement. Inspectors were not assured that residents were adequately consulted and had opportunities to discuss their end-of-life wishes.

While the centre had systems in place for referral to specialist services such as dietetic, speech and language and occupational therapy services, inspectors were not assured that residents had timely access to general practitioner (GP) services and to health and social care professionals, as requested by residents or required for additional professional expertise. Although the centre had 24-hours access to GP services, inspectors found that residents with weight loss or deteriorating skin issues were not timely referred to GP or health care professionals. Furthermore, these issues in respect of the residents' condition and delivery were not accurately identified in the residents' assessments, daily care notes or care plans, and as a result, appropriate and timely care was not consistently provided.

A review of the nursing documentation, observations by the inspectors and attendance at handover found that residents' care needs were not communicated effectively to staff and, therefore, not delivered to the residents.

Inspectors reviewed a sample of residents' files. Care plans were supported by comprehensive assessments using evidence-based tools for assessing issues such as the risk of falling, the risk of developing pressure sores or the risk of malnutrition. However, there were areas that required improvement in order to ensure that the information was comprehensive, accurate and up-to-date, which are outlined under Regulation: 5 Individual assessment and care plan.

The inspectors observed that residents were provided with a choice of nutritious meals at mealtimes. Meals appeared varied and wholesome. However, action is required to improve residents' meal experience in the Oak unit, and access to drinks for residents with high-dependency needs as outlined under regulation 18: Nutrition and hydration.

There was a safeguarding policy and clear procedure to inform staff regarding the steps to take to ensure the safeguarding of vulnerable adults. Records indicated that the majority of staff had received up-to-date training in the safeguarding of vulnerable adults. While speaking with staff members and based on the findings from this inspection, the inspectors were not assured that all staff had the confidence and knowledge necessary to report any suspicion, allegation or concern of abuse. Or to follow the appropriate safeguarding procedure to ensure that all

residents are adequately safeguarded.

Residents had access to religious services and were supported to practice their religious faiths in the centre. However, inspectors found that not all residents in the centre had adequate arrangements in place to support their recreational needs according to their abilities and preferences. Further action and review were required to ensure that residents' right to privacy and dignity was supported at all times, as discussed under Regulation 9: Residents' rights.

Inspectors identified some examples of good practices in the prevention and control of infection. Staff were knowledgeable of the signs and symptoms of respiratory infections, and appropriate controls were in place for any resident showing symptoms of respiratory infection. However, inspectors also observed inconsistent application of standard and infection prevention and control precautions. For example, disposable gloves were observed to be inappropriately and excessively worn by staff in communal areas on several occasions. This practice increased the risk of cross infection. Clinical hand wash sinks were being installed on day two of the inspection.

The antibiotic use was monitored each week. However, the overall antimicrobial stewardship programme needs to be further developed and strengthened. From speaking with staff, inspectors identified that further staff training was required to ensure staff are knowledgeable and competent in the management of residents colonised with MDROs (Multi-Drug Resistant Organisms). Surveillance of colonisation with MDRO was not routinely undertaken and recorded. A small number of residents who had a bloodstream infection did not have an appropriate care plan in place to guide safe care.

A fire risk assessment had been completed in October 2021. This risk assessment identified 36 red and 27 orange-rated risks. Inspectors were informed that the red-rated risks were completed and that a sign-off on the works completed would be provided to the Chief inspector when available. While training on fire safety had been provided, the findings of this inspection were that further training and oversight were required to ensure residents were safe from the risk of fire.

Regulation 11: Visits

There were suitable arrangements in place for residents to receive visitors. The inspectors saw and met visitors coming and going to the centre during the inspection.

Judgment: Compliant

Regulation 12: Personal possessions

Inspectors were not assured that residents were able to retain control over their clothes as some clothes were not labelled properly, and some personal clothes were found in the communal store, communal bathrooms, flower pots or in the nursing stations. Inspectors also observed that residents' clothing in personal wardrobes was not always arranged in a neat and tidy manner.

Judgment: Not compliant

Regulation 17: Premises

The registered provider did not ensure that the premises were used in line with the Statement of purpose and the certificate of registration.

- In the Kinvarra unit, the 'Accessible WC' dedicated for residents' use was locked with a key-pad lock and used as a staff facility. Inspectors observed staff lockers present in this facility, and despite bringing this to management's attention on the first day of inspection, no action was taken to rectify this. The key-pad on the door continued to be engaged on the door by the third day of the inspection.

Some areas of the premises did not conform to the requirements set out in Schedule 6 of the regulations as follows;

- Emergency call-bells were missing in some of the communal bathrooms.
- Grabrails were missing in the communal bathrooms. This was a finding from the last inspection.
- While the management informed inspectors that all ventilation units were serviced and worked properly, there was a very strong odour in some of the resident's bathrooms, clinical rooms, and communal bathrooms. Also, there was no appropriate ventilation in the hairdressing room.
- The maintenance of equipment and aspects of premises required improvement. For example, one hand washing basin was not secured properly on the wall, posing a safety hazard; The radiator cover in the main dining room was not secured to the wall; There was a broken water dispenser in the Oak unit.
- While the double-occupancy bedrooms were of a suitable size, the layout of some of these bedrooms had not been reconfigured to ensure that the emergency call-bells, light switches, and lights were accessible to residents; some were outside of the privacy curtain areas.
- External premises outside of the Corridor 3 and 4 units were not in a good state of repair and were not appropriately maintained.
- There was a concrete floor without a proper and safe floor covering in one of the drug rooms in Corridor 4.
- There was no suitable equipment provided for residents with high-dependency needs, such as specialised shower chairs, shower slings or

Shower gurneys (beds) with specialised shower slings. While the response to the urgent action plan stated that this equipment was available, inspectors saw on the third day of the inspection that there was no such equipment available in the centre. Inspectors saw one shower gurneys bed stored in the hydrotherapy room, which was not fit for purpose. Staff confirmed that this equipment was not in use and did not fit into the residents' bathrooms.

- Other resources and equipment used by the resident required replacement due to wear and tear. Inspectors saw examples where bed sheets and duvet covers were damaged. Some of the pillows had lost their shape and required replacement.

Judgment: Not compliant

Regulation 18: Food and nutrition

Inspectors were not assured that the residents with high dependency needs in the Kinvara unit received adequate quantities of drinks, as observed during the three days of the inspection.

Inspectors were not assured that the dietary needs of residents prescribed by health care or dietetic staff were met as residents who required a high-calorie and high-protein diet were not offered this diet, and the kitchen staff were not aware of such requirements. Furthermore, inspectors observed that where the care plan directed that the resident was prescribed to receive thickened fluids level 3, the resident was served with Level 1 diet by care staff.

There were stark differences in the dining experiences between the units. Inspectors observed that the food and drinks were not properly served, and choices were not offered to all residents in the Oak unit; for example, the tea was served to residents in cups without saucers. The baked pastry was stored in a plastic box. There were open packs of biscuits on top of the pastry. Inspectors observed staff serving this food which did not support a dignified meal experience.

Judgment: Not compliant

Regulation 27: Infection control

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

- There was inconsistent use of PPE (Personal Protective Equipment) observed. Staff were seen inappropriately wearing gloves in the corridors or masks

underneath their chins and nose.
- Several items of resident equipment and furniture observed during the inspection were visibly unclean and were not being fully cleaned as per national and evidence-based guidelines.
- Daily cleaning records were not consistently signed. This meant that the provider could not be assured that all areas were cleaned according to the schedule.
- There was no evidence of targeted antimicrobial stewardship quality improvement initiatives, training or guidelines.
- Additional education was required to ensure staff were knowledgeable and competent in the management of residents colonised with MDROs.
- A number of water coolers had stagnant water in them and were dirty. This poses a risk of cross contamination.
- The provider did not consistently follow their own policy for cleaning equipment; for example, some equipment had the sticker 'I am clean ', and some did not. Therefore it could not be determined if the equipment was being cleaned between use.

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

- The kitchenettes on Kinvara and Oak units had not been cleaned to an acceptable standard. Ineffective cleaning increases the risk of cross infection.
- Medical equipment, air mattresses, and ski sheets were stored uncovered or unclean in the storage room.
- Cleaning trolleys were seen to be unclean, with unlabelled spray bottles or spray bottles labelled with chlorine dated January 2023.
- The bedrooms and bathrooms on the Kinvara unit were visibly unclean and required deep cleaning- an urgent action plan was issued after the first day of the inspection. Inspectors acknowledge that they observed the deep cleaning of the bedrooms on the third day of the inspection.
- Inspectors observed that the hairdressing room had hair all over the floor and chair and had not been cleaned appropriately.
- Clean linen was not transported safely, as items such as razors, laundry bags, or hygienic products for communal use were seen on the trolley. Covers on the trolleys were unclean and stained. This increased the risk of cross contamination.
- Portable fans and some ceiling fans in bathrooms were visibly unclean.
- Some equipment, such as commodes or shower chairs for use by residents, was rusty, preventing effective cleaning and leading to a risk of cross contamination.

Judgment: Not compliant

Regulation 28: Fire precautions

The registered provider was failing to meet the regulatory requirements on fire precautions in the centre and had not ensured that residents were protected from the risk of fire. The provider must take action in order to comply with the regulations.

Day-to-day arrangements in place in the centre did not provide adequate precautions against the risk of fire. Action is required to improve the maintenance of the building fabric and the means of escape. For example:

- Inspectors observed that some fire doors were severely chipped and damaged. Gaps were noted at the bottom and between doors. Furthermore, a number of fire doors did not close fully when released. These deficiencies posed a significant risk to residents in the event of a fire.
- Inspectors observed that staff used wedges and a flower pot to hold the fire doors open. Fire exits and fire doors were blocked by personal care trolleys and kitchen trolleys.
- There was no fire blanket in the kitchenette in the Kinvara unit.
- Inspectors observed batteries for hoist equipment were being charged along protected corridors.
- Some emergency exit signage on corridors and above fire exits was not functioning to indicate the route to access a fire exit. In the event of an emergency, this could cause confusion and could delay an evacuation. Externally, emergency lighting was missing along some fire exit routes and above fire exits to illuminate the route of escape in the event of a fire evacuation at night time, and this required a review by the provider.

Inspectors acknowledge that some fire works had been completed, such as upgrading the fire alarm and detection system to a fully addressable system and replacing ironmongery on some fire doors. It was not clear if the system in both buildings are linked. It was not clear if the system in both buildings was linked, and assurances were requested from the provider.

Several areas in the centre were noted to have utility pipes or cabling that penetrated through the fire-rated walls and ceilings and required appropriate fire-sealing measures. There were a number of ceiling hatches for which confirmation was required that these were fire rated.

The procedures for the evacuation and safe placement of residents in a fire emergency in a timely manner required attention. While fire evacuation drills were taking place, further fire drill practice was required in order to further support staff to protect residents from the risk of fire. For example, from speaking with a number of staff members, the inspectors noted staff gave conflicting accounts of fire safety procedures in the event of an evacuation. Staff were not knowledgeable about the location of compartment boundaries. In addition, assurances were required as to the ability of staff to safely evacuate residents from the largest compartment using night time resources and taking account of resident dependencies. The documentation viewed in respect of drills indicated times which were excessive.

The provider needs to review the front porch and office area in the Main building to

provide assurance that this area is compartmentalised. There is a single means of escape for this office area, and this requires review by a competent person.

The display of procedures in the centre required action as they did not accurately:

- reflect the location of fire extinguishers.
- there was an insufficient number of plans displayed, for example, in the Kinvara unit.

The arrangements for residents who smoke were not sufficient, as inspectors observed residents smoking in the courtyard in the Kinvara unit on the first day of the inspection. On the third day of inspection, inspectors saw that there was no dedicated fire extinguisher or fire apron allocated in one of the smoking rooms. One of the smoking shelters provided was a timber structure, and assurance was required that it was fire rated and suitable for use by residents who smoke.

The external evacuation routes were not suitable, as the car park was obstructing them. Inspectors observed that there was no safe and clear path to the fire assembly point.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Inspectors were not assured that medication practices were in line with the safe administration of medicines professional guidance, for example:

- Inspectors observed that thickened juice was left on the trolley and was used for medication administration for all residents who were required to have their medication administered in a crushed format or for residents with swallowing issues, which was not in line with the direction of the prescriber.
- Inspectors observed that the insulin pen was not stored according to the manufacturer's instructions.
- Ongoing refusal of the medications was not documented in the residents' care plans.
- Medications such as creams and solutions were found unlabeled in communal rooms or in the residents' lockers.
- Inspectors saw a medicinal product which was out-of-date in a resident's locker, and boxes with unused medications were stored in the sluice room. This was medicine no longer required by the residents and which was not disposed of in accordance with national legislation.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Some care plans reviewed were generic in nature and did not provide adequate detail of the individualised care to be delivered to residents in accordance with their assessments. For example:

- The care plan for residents with blood stream-infections diseases did not contain enough information to guide the staff in the safe care delivery should the resident's condition worsen or with respect to precautions required to prevent onward transmission and cross-contamination.
- Care plans were not consistently reviewed or updated following a recommendation by a health care professional.
- Food intake records were not completed on a consistent and detailed basis to inform effective monitoring of residents with unintentional weight loss or at risk of malnutrition. Action was also necessary to ensure the electronic system used to record residents' food and fluid intake facilitated sufficient detail to guide care as outlined in the centre's policy on nutrition. The nutritional care plans did not contain details about the baseline of daily fluid income for residents whose daily food and fluid income were monitored.
- Adequate details were not provided in care plans to identify the care of residents with indwelling urinary catheters and urine output monitoring.
- Inspectors reviewed a sample of end-of-life care plans and found that not all residents had been regularly consulted in respect of their advance healthcare directive in order to give them an opportunity to change it or amend it as per their wish. Inspectors also observed that when the person did not have decision-making capacity, there were gaps in the regular discussion with the person who was appointed on behalf of this resident.

Judgment: Not compliant

Regulation 6: Health care

From a review of care records, the inspectors were not assured that residents received and the documentation in place supported a high standard of evidence-based nursing care and that associated clinical risks were timely identified and responded to. This was evidenced by the following:

- Residents with unintentional weight loss were not referred to health care professionals in a timely manner for their input, and as a result, they did not receive an appropriate treatment plan.
- Residents who required specialised equipment (pumps) for their air mattresses did not have an appropriate setting on their mattresses according to their individual requirements (weight).
- Residents with worsening skin conditions and declining the recommended treatment was not referred promptly to appropriate health care professionals

for a review and alternative treatments

- Risk of aspiration and choking in the management of residents with dysphagia (swallowing difficulties)was not effectively managed as inspectors observed instances where insufficient assistance and care were provided.
- Monitoring and management of dehydration was insufficient.
- There was a lack of assurance that the regular repositioning of residents identified as at risk was taking place and in line with assessed needs as per the care plan.

Judgment: Not compliant

Regulation 8: Protection

The provider did not take all reasonable measures to protect residents, as evidenced by the following findings:

- Inspectors found that not all staff were knowledgeable regarding the actions they should take if an allegation, suspicion or concern of abuse was reported to them or if they observed or suspected abuse to have taken place. The inspectors saw that two allegations of abuse were not recognised and appropriately reported and investigated in the centre.
- Inspectors reviewed actions taken by the person in charge in respect of some allegations which had been notified to the Office of the Chief inspector. The safeguarding measures put in place by the provider did not provide sufficient assurances that all reasonable precautions had been taken to prevent re-occurrence. An immediate action was given to the provider in this respect.

Judgment: Not compliant

Regulation 9: Residents' rights

Action is required in relation to supporting residents' rights to meaningful occupation and engagement and their rights to privacy and dignity, as evidenced by;

- There were no CCTV signs in the areas commonly used by residents, staff and their families informing them about ongoing surveillance monitoring in that area.
- Inspectors observed residents' beds being positioned underneath the window without access to a call-bell which was located outside of the privacy screen curtains. Inspectors also observed non-verbal residents with mobility impairment having difficulties reaching a call-bell when they needed assistance.
- Inspectors observed institutionalised practices where staff members did not

inform residents about the task they were planning to perform and continued to carry on the task without the resident's consent. On other occasions, staff members were observed to be dismissive and did not orientate confused residents looking to go home.

- Some residents reported to inspectors that they chose to close their curtains as the view from bedroom windows in Corridors 3 and 4 was overlooking skip containers.
- Inspectors observed limited activities on the first day of the inspection in the Kinvara unit and on the third day of the inspection in the Oak unit. There was little interaction between staff and residents during this inspection and mainly limited to personal care or supervision. Residents were observed sitting in one of the centre's communal rooms watching TV for long periods of time with little else to do.
- Residents' privacy was negatively impacted by the noise from a sensory box linked with the chair and bed posey alarms in the unit. In addition, the setting of the volume for call-bells ringing at night in the main building was too high. The sound was centralised, causing disturbance to all residents in the unit, not just in the corridor where a resident was looking for assistance. This resulted in prolonged call-bells ringing at night time.

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	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Substantially compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Not compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Not compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for TLC Centre Maynooth OSV-0000684

Inspection ID: MON-0038959

Date of inspection: 15/02/2023

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 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • From 10/04/2023, HCA staffing in Oak increased by six hours per day. (Complete). • A 'Dementia' specialist has commenced work in the centre with staff to enhance activity provision and communication with residents. Training for all staff to be complete by 30/06/2023. • An activity log has been introduced which now evidences provision of dedicated 1:1 activity provision where required. (Complete). • The nature of activity provided is informed by the dementia specialist (complete) and will be further complemented by the enhanced training provided to staff. Training to be complete by 30/06/2023. • Activity staff are now allocated to the Oak unit at dedicated times of the day to better support the provision of activities. (Complete and in place). • A review is currently ongoing in relation to the dependency levels and complexity of needs of residents living in the Oak unit and what changes might be made to the day to day operation of the centre to best meet these needs. This review will be concluded by 31/05/2023.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • A Physiotherapist/Manual Handling Instructor is working with staff in the daily delivery of care to ensure the implementation of best practice manual handling techniques and to reinforce the formal training previously provided. A weekly audit is completed to assure improvement. (Complete and on-going).	

• Revised documentation has been introduced in relation to the repositioning of residents. This is reviewed after each shift and signed off by the registered nurse. Staff have been trained on the revised documentation. (Complete and ongoing).
• The dementia specialist will complete Quality of Interaction Schedule (QUIS) observations to assess the quality of interactions between staff and residents and inform the nature of the training provided to staff within the centre. To be complete by 30/06/2023
• Revised documentation has been introduced in relation to the monitoring of fluid intake for residents that will now ensure that a more contemporaneous record is maintained. This is reviewed after each shift and signed off by the registered nurse. Training on the revised documentation has being provided to staff. (Complete and ongoing).
• The Household/Catering Manager will continue to monitor the standard of cleaning within the centre on a daily basis. This is further supported by a weekly in-house audit and validated by a monthly audit completed by the regional accommodation manager. (Commenced and ongoing).
• A deep clean of the centre (main building & Kinvara) arranged prior to the inspection has been completed. (Complete)
• Immediately following the inspection, daily fire evacuation drills were completed for two weeks to ensure that all staff were competent in fire evacuation. These drills included the simulation of evacuation from the largest compartment within the centre using nighttime staffing levels. (Complete).
• A series of safeguarding workshops is being provided to all staff that includes updates on the escalation and management of safeguarding concerns. To be complete by 30/04/2023.
• The Director of Nursing (DON) has previously completed dedicated training on safeguarding. Further Designated Officer training for the DON and an ADON is scheduled to take place on 26/04/2023.
• The daily allocation now clearly identifies which staff member is responsible for the supervision of residents on each corridor during each handover period. (Complete).

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
• All daily progress notes have been reviewed and a more person-centred model has been adopted. This revised approach has been communicated to all staff nurses and is reinforced at each handover and safety pause meeting. (Complete).
• Routine checks of care records by local and regional management teams ensure that the practice of 'copy and pasting' in care records has ceased. (Complete).
• At the time of inspection, the dated PEEP found in a wardrobe was removed immediately. Staff have been reminded of the need to removed legacy PEEPs when these have been updated. (Complete).
• All care records are now held securely. The storage of care records in now routinely monitored by the local and regional management teams through observational audit of the centre. (Complete)

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• A new Deputy DON post has been introduced to enhance the governance and management of the centre and to support the DON in the provision of enhanced clinical oversight of the team. Recruitment for this post has commenced and it is anticipated that the post will be filled by 30/06/2023.
• New dedicated storage areas have been designated for the storage of trolleys throughout the centre so as to ensure fire exits remain unobstructed at all times. (Complete).
• Dedicated Fire Warden Training has been completed by designated staff to enhance the governance of fire management within the centre. Fire wardens are rostered on each shift and take a lead role in the oversight of fire safety including ensuring doors remain free from obstruction. (Complete)
• The WC located near to Kinvara restaurant is reconfigured back for resident use. (Complete).
• All medications for disposal are now stored in the clinical room and all nurses reminded of safe storage. (Complete).
• The document referred to as 'Limited Care' will be removed and a new DNAR form introduced that more closely reflects our Policy. All residents and next of kin (as appropriate) will be fully involved in this process. To be complete for all residents by 31/07/2023.

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
• All staff have been reminded of the need to immediately escalate incidents to the DON, ADON, CNM or nurse in charge at the time. All nursing staff have been reminded of the need to clearly document incidents on EpicCare and to escalate to the DON/ADON for notification to HIQA where required by legislation. (Complete).

Regulation 4: Written policies and procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
• New policies have been recently introduced and training is being provided to all staff to ensure practice aligns with policy. Implementation of the policy will be assessed through increased supervision by local and regional management teams. Training to be complete by 30/06/2023.
• The document referred to as 'Limited Care' will be removed and a new DNAR form introduced that more closely reflects our Policy. All residents and next of kin (as appropriate) will be fully involved in this process. To be complete for all residents by 31/07/2023.

Regulation 12: Personal possessions	Not Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
• A Standard Operating Procedure has been developed to ensure the appropriate labelling of clothes. All families have been advised of the labelling system in place within the centre and of the need to provide the clothes to staff for labelling. Staff will continue to monitor and observe for unlabeled clothes and action accordingly. (Completed).
• In conjunction with residents (and where applicable next of kin), decluttering of all communal areas and wardrobes is ongoing with additional storage provided as required to improve wardrobe tidiness. To be complete by 30/04/2023.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• All emergency call bell leads have been replaced where applicable. (Complete).
• Grab rails in all wheelchair-accessible toilets have had a drop bar installed. (Complete).
• The centre has undergone a deep clean and robust checks (including audits) are now in place in relation to monitoring the standard of cleanliness going forward. (Complete)
• The hand wash sink has been removed. (Complete)
• The radiator cover has been fully affixed to the wall. (Complete)
• All water coolers have been serviced. (Complete).
• All rooms have been reconfigured to ensure access to call bells and lights. A risk assessment has been completed and care plans updated to reflect the wishes of those

residents who choose to place their beds adjacent to the wall. (Complete).
• The external premises and garden area outside Corridors 3 & 4 have been tidied and decluttered and work is ongoing to enhance the appearance of the wall. This work will be complete by 31/05/2023
• A floor covering has been laid over the concrete floor identified by inspectors. (Complete).
• Duvet covers and sheets have been replaced in Kinvara. Additional linen is on order for the remainder of the centre and should be in place by 30/04/2023.
• Ventilation units have been serviced and are in working order. A ventilation unit is on order for the Hair Salon and should be supplied and fitted by 30/06/2023.
• A review of all equipment in the centre has been undertaken and new equipment has now been ordered including high dependency shower chairs, commodes and standard shower chairs. Delivery of all equipment is expected before 30/04/2023.

Regulation 18: Food and nutrition	Not Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
• The dining service provided has been reviewed and a consistent high standard is now provided in all dining rooms within the centre. (Complete)
• The Practice Development Nurse completes a weekly audit of the dining experience including obtaining feedback from residents to ensure the high consistent standard is maintained. (Complete and ongoing).
• The training provided by the dementia specialist in addition to auditing by the Practice Development Nurse and oversight by the nurse management team ensures that the privacy, dignity and rights of residents is maintained. Training for all staff to be complete by 30/06/2023.
• Training has been provided to all staff in relation to dysphagia management. All nurses have received update training on the MUST tool. (Complete).
• A report on the nutritional status of residents is completed monthly. Any changes in a residents' assessed needs is discussed with staff (including the chef and catering staff), is recorded in the care plan and daily handovers where applicable so as to ensure all are aware. (Complete).

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
• All staff have been updated on the Infection Control Policy and SOP in relation to

MDROs.
• A new system for cleaning equipment was introduced with a new cleaning tracker as per policy. To be fully implemented by the 30/04/2023
• Targeted antimicrobial stewardship has been introduced and is monitored monthly at governance meetings with any learning identified and used to inform future training. Training has been completed by the DON and nurse management team and is being rolled out across the centre. This will be fully complete by 30/05/2023
• Air mattress covers are now in place in the storage area. (Complete).
• Chemical training, including the storage of chemical bottles has been completed for all staff. (Complete).
• An updated schedule has been introduced that includes the deep and ongoing daily cleaning of cleaning trollies, the hair salon, fans and ventilation units. (Complete and ongoing).

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• Instructions in relation to fire have been placed above fire extinguishers and fire drawings are in place as appropriate throughout the centre. (Complete)
• The designated smoking area has a fire extinguisher and call bell. All residents who smoke have an individual smoking apron. (Complete).
• The Safety Statement has been updated to more clearly evidence the evacuation route from Kinvara to the main building and from the main building to Kinvara. (Complete)
• A designated Fire Marshall is allocated on every shift. (Complete)
• A Fire extinguisher is placed directly outside the door to the restaurant and this is clearly evidenced on the fire map. A fire extinguisher is available in the restaurant and kitchenette. (Complete).
• All emergency lighting across the centre has been quality checked and a programme is in place to replace/upgrade equipment as required. This work is to conclude by 30/04/2023.
• Work continues to enhance the levels of fire safety within the centre that includes the upstairs office area and upgrade/refurbishment of fire doors as required. To be complete by 30/06/2023

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:

• All nurses have received update training on the appropriate practice for the storage and administration of medication. Medication audit will be completed every quarter and practice observed by the nurse management team. (Complete).
• All care records now evidence where a medication has been refused by a resident (Complete).
• Nurses have been educated on the safe storage of medicated creams. These have been appropriately labelled and stored in drug trolley or resident's personal locker. (Complete).

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
• All nursing staff have received update training in relation to care planning and the need to ensure that the care prescribed for each resident is fully reflective of the assessed care needs. (Complete).
• A new framework for progress notes using a person-centered model of care has been introduced to better support the assessment, planning, implementation and delivery of nursing care within the centre (Complete).
• All healthcare directives are currently being reviewed as per policy. These will reflect a comprehensive multi-disciplinary approach and will be reviewed 4-monthly or more frequently as required. To be complete by 31/07/2023.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
• High-dependency shower chairs have been ordered. Delivery due by the 30/04/2023.
• Care plans have been reviewed and where necessary revised to ensure that choice and the most appropriate equipment has been identified for each resident. (Complete).
• A daily documented check on air mattresses has been introduced (Complete and ongoing).
• A skin integrity weekly wound audit has been introduced. Complete and on-going).

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection: • A series of safeguarding workshops is being provided to all staff that includes updates on the escalation and management of safeguarding concerns. To be complete by 30/04/2023. • The Director of Nursing (DON) has previously completed dedicated training on safeguarding. Further Designated Officer training for the DON and an ADON is scheduled to take place on 26/04/2023.	

Regulation 9: Residents' rights	Not Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: • Signage is now in place to highlight that CCTV is in operation. (Complete). • A battery replacement programme has been introduced for sensory boxes (Complete and on-going). • The sound of the call bell in the main building has been reduced at the display. We are currently working with the company concerned to adjust and review the impact of the noise in different zones throughout the building. To be complete by 31/05/2023.	

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 12(a)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that a resident uses and retains control over his or her clothes.	Not Compliant	Orange	30/04/2023
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	30/06/2023
Regulation 16(1)(b)	The person in charge shall	Not Compliant	Orange	30/06/2023

	ensure that staff are appropriately supervised.			
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.	Not Compliant	Orange	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	30/06/2023
Regulation 18(1)(c)(i)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are properly and safely prepared, cooked and served.	Not Compliant	Orange	31/03/2023
Regulation 18(1)(c)(ii)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which	Not Compliant	Orange	31/03/2023

	are wholesome and nutritious.			
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.	Not Compliant	Orange	31/03/2023
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Not Compliant	Orange	31/03/2023
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	30/04/2023
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	31/07/2023
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the	Not Compliant	Orange	30/05/2023

	prevention and control of healthcare associated infections published by the Authority are implemented by staff.			
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	30/06/2023
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	30/04/2023
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	30/06/2023
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is	Not Compliant	Orange	31/03/2023

	reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.			
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	31/03/2023
Regulation 28(3)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place in the designated centre.	Not Compliant	Orange	31/03/2023
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.	Not Compliant	Orange	31/03/2023
Regulation 29(5)	The person in charge shall ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with	Not Compliant	Orange	31/03/2023

	any advice provided by that resident's pharmacist regarding the appropriate use of the product.			
Regulation 29(6)	The person in charge shall ensure that a medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident shall be stored in a secure manner, segregated from other medicinal products and disposed of in accordance with national legislation or guidance in a manner that will not cause danger to public health or risk to the environment and will ensure that the product concerned can no longer be used as a medicinal product.	Not Compliant	Orange	31/03/2023
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.	Substantially Compliant	Yellow	31/03/2023
Regulation 04(3)	The registered	Not Compliant		31/07/2023

	provider shall review the policies and procedures referred to in paragraph (1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.		Orange	
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	31/07/2023
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord	Not Compliant	Orange	30/04/2023

	Altranais agus Cnáimhseachais from time to time, for a resident.			
Regulation 6(2)(c)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the care referred to in paragraph (1) or other health care service requires additional professional expertise, access to such treatment.	Not Compliant	Orange	30/04/2023
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Orange	30/04/2023
Regulation 8(3)	The person in charge shall investigate any incident or allegation of abuse.	Not Compliant	Orange	30/04/2023
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Not Compliant	Orange	30/04/2023
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Not Compliant	Orange	31/05/2023