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:	Esker Ri Nursing Home
Name of provider:	Blackden Limited
Address of centre:	Kilnabin, Clara, Offaly
Type of inspection:	Unannounced
Date of inspection:	18 July 2023
Centre ID:	OSV-0000733
Fieldwork ID:	MON-0040868

About the designated centre

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

Esker Ri Nursing Home is a purpose-built premises. The designated centre is situated on an elevated site off the Tullamore road on the way out of the village of Clara. The designated centre currently provides accommodation for a maximum of 126 male and female residents aged over 18 years of age. Residents' accommodation is provided on two floors. Residents are accommodated in single and twin bedrooms with full en suite facilities. The designated centre provides mainly residential care to older adults and also provides respite, convalescence and care for people with an intellectual disability, physical disability, acquired brain injury, dementia and palliative care needs. The provider employs a staff team consisting of registered nurses, care assistants, activity coordination staff, administration, maintenance, housekeeping and catering staff. The provider states in their statement of purpose for the designated centre that their aim is to provide a residential setting wherein residents are cared for, supported and valued within a care environment that promotes their health and well being.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	118

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
Tuesday 18 July 2023	09:50hrs to 18:00hrs	Sean Ryan	Lead
Tuesday 18 July 2023	09:50hrs to 18:00hrs	Catherine Sweeney	Support

What residents told us and what inspectors observed

Residents living in Esker Rí Nursing Home told the inspectors that they felt safe living in the centre. Residents reported that staff were kind and treated them respectfully. While residents reported improvements in the visiting arrangements in the centre, residents continued to express dissatisfaction with regard to the inconsistent wait times they experienced when they required assistance and support from staff. Residents identified that this issue was mainly confined to the evening time when many residents required assistance with their care needs.

Inspectors were met by the person in charge on arrival at the centre. Following an introductory meeting, the inspectors walked through the premises and met with residents and staff.

On the morning of the inspection, the atmosphere was busy. Staff were observed attending to residents' requests for assistance, while also answering call bells, and assisting residents with their breakfast and tea in their bedrooms. Some residents were observed walking through the corridors independently, while other residents were observed in the communal dayrooms chatting to one another about local news and events.

Inspectors spoke with a number of residents in their bedrooms. Residents were complimentary in their feedback about the staff and described their engagements with staff as kind, respectful and caring. Residents acknowledged how busy the staff were and described how this impacted on the care they received. One resident told the inspectors that there were 'a few new people' assisting them with their care needs, and this sometimes caused delays because 'they wouldn't know how I like things to be done'. Another resident told the inspectors that while staff came to assist them when requested, they were often late getting ready to go to bed as staff were interrupted during evening care to answer the call bells of other residents, or assist residents who were calling out. Residents told the inspector that those issues mainly occurred in the afternoon and night-time.

Residents told the inspectors that the visiting arrangements had improved in the centre. The inspectors spoke with a number of visitors who confirmed that they could visit their relatives and friends at anytime without the need to book appointments, or visit at specified times. Visitors were observed coming and going throughout the inspection.

On the day of inspection, maintenance works were in progress to repair and replace components of the windows and external doors in line with the actions detailed in the provider's urgent compliance plan. Inspectors observed that maintenance works were being carried out in a communal room in the newly established secure wing that was home to 14 residents with increased supervision and complex care needs. A number of vacant bedrooms in this wing were found to be locked, and accessible only through obtaining a key from the nurses station. While staff informed

inspectors that this restriction was intended to protect residents with increased supervision needs from exiting the building, the impact on the timely access to the room in the event of a fire emergency had not been considered.

Inspectors observed that most residents were engaged in meaningful activities throughout the inspection. Residents were observed enjoying a walk around the grounds of the centre, accompanied by staff. Inspectors observed that while most residents attended group activities in the main communal room on the ground floor, there was also a number of residents that did not take part. Staff informed inspectors that a small number of residents could not leave the secure unit to join those activities as a result of their increased supervision needs. Inspectors observed periods during the inspection where there were no activities taking place for residents in the secured unit.

The following sections of this report detail the findings with regard to the capacity and capability of the centre and how this supports the quality and safety of the service being provided to residents.

Capacity and capability

This unannounced risk inspection was carried out over one day by inspectors of social services to;

- monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centre for Older People) Regulation 2013 (as amended).
- follow up on the urgent actions taken by the provider to address significant issues of non-compliance identified on a risk inspection of the centre on 28, 29 June, and 2 July 2023 with regard to the governance and management of the centre, including the systems in place to manage the risk associated with residents assessed as requiring high levels of supervision, leaving the centre unaccompanied. Inspectors also reviewed the actions taken to ensure resident's nutritional care needs were met.
- review the actions taken by the provider following a further monitoring notification submitted to the Chief Inspector, pertaining to the unexplained absence of a resident from the designated centre.

Significant risk and regulatory non-compliance were found on the two previous inspections of the centre. The provider had failed to identify and manage risks in the centre that impacted on the safety and welfare of residents. Furthermore, the provider had failed to organise and manage the staffing resource to ensure safe staffing levels were available to support the needs of residents, particularly those residents assessed as requiring close supervision. As a result of those failings, a significant incident occurred whereby a resident with poor safety awareness left the designated centre unnoticed and unaccompanied, and was subsequently located on a main road.

As a consequence of identified repeated regulatory non-compliance's and the associated risks to resident's safety and wellbeing, additional restrictive conditions were attached to the registration of the designated centre. Condition 4 required the provider to carry out a comprehensive assessment of risk related to resident absconsion from the designated centre, and to put in place suitable and safe governance systems, and staffing to mitigate the risk of absconsion of residents from the designated centre. Condition 5 required the registered provider not to admit any new residents to the designated centre until the Chief Inspector was satisfied that the registered provider has complied with Condition 4. Simultaneously, the number of residents who may be accommodated in the designated centre was reduced from 143 to 126, the occupancy at the time this regulatory enforcement action was taken.

The registered provider submitted an urgent compliance plan following the risk inspection of the centre on 28, 29 June and 2 July 2023. The registered provider was required to confirm the actions they would take to ensure the safety and well-being of residents, by dates specified by the Chief Inspector. The findings of this inspection were that, the provider had not taken all necessary action to establish or implement effective risk management systems to ensure the safety and welfare of residents who may seek to exit the building unaccompanied. Consequently, there continued to be inadequate and ineffective risk management systems in place to ensure the safe, and monitored delivery of care to residents, and significant action was now required by the provider to protect residents following a further incident involving the unexplained absence of a resident from the designated centre.

Furthermore, while the provider had taken some action to identify and monitor the nutritional care needs of residents assessed as being at risk of malnutrition, further action was required to ensure that there were effective management systems in place to monitor residents' nutritional care.

Blackden Limited is the registered provider of Esker Rí Nursing Home. The Chief Inspector had been notified of changes to the identity of the company personnel. The board of directors, which comprise the registered provider, consisted of two directors. One of the directors represented the registered provider.

Following the previous inspection in June and July 2023, the registered provider outlined a revised organisational structure consisting of a board of directors, chief operations officer, and a regional operation manager. The regional operations manager was responsible for monitoring clinical and operational aspects of the service, in addition to providing oversight and governance support to the person in charge through an increased presence in the centre. On the day of the inspection, the organisational structure was not clearly defined, or in line with the commitment given by the provider in the urgent compliance plan. The regional operations manager was on leave, and the arrangements in place to escalate risks to the provider during their leave had not been established.

Lines of accountability and responsibility in the centre were not clear. An example of this was observed in relation to the organisation and management of the staffing resource where it was unclear who was responsible for ensuring appropriate staffing

levels were maintained in the event of unplanned staff leave. This was compounded by a lack of a clear procedure to escalate staffing risks to the provider or a pathway of action to manage unplanned staff leave.

Within the centre, the person in charge had limited support to ensure there was effective oversight of the quality and safety of the service. Inspectors found that while the provider had improved the staffing resources in the centre through the support of external agency staff, there continued to be a requirement for the clinical nurse managers to suspend the management component of their role to support the delivery of direct nursing care to residents as a result of short-notice unplanned staff leave. Consequently, this impacted on the management and supervision of nursing and care staff, and oversight of the service to ensure the safe delivery of care to residents.

The management systems in place did not ensure that the service provided was safe, appropriate, consistent or effectively monitored. While the provider had completed a review of resident's nutritional risks, there was little evidence that the management systems in the centre had been strengthened. A review of completed nutritional audits did not provide assurance that there was an effective system in place to identify, monitor, and manage residents nutritional care needs, and nutritional risks. For example, the audit had failed to identify potential contributing factors to the poor quality of nutritional care provided to residents, such as deficits in the knowledge of staff, and the poor quality of the clinical care records. Additionally, the audit schedule had not been revised to ensure adequate monitoring of known risks in the centre.

Despite being identified on the last inspection, the provider had failed to review risk management systems to effectively identify and manage risks in the centre. Risks that had been assessed by the provider were not managed in line with the centre's own risk management policy. For example, the risk associated with residents assessed as requiring high levels of supervision, leaving the centre unaccompanied had not been reviewed or updated following a further significant incident in the centre. The provider had not progressed to review the effectiveness of existing risk mitigating controls, or consider alternative actions to manage the risk to residents to ensure the safety and welfare of the residents. Inspectors found that the provider had not yet carried out a comprehensive assessment to identify risks related to the absconsion of residents from the designated centre. This impacted on the provider's ability to identify, monitor, and manage risks to resident's safety and welfare.

The provider had failed to ensure there was adequate documentation of adverse incidents involving residents. Inspectors reviewed the record of an incident involving the unexplained absence of a resident from the designated centre and found that the incident was not documented, or investigated in line with regulatory requirements or the centre's own policy. Consequently, this meant that incidents could not be investigated or analysed, and no quality improvement action could be implemented to ensure that risks to residents would be reduced. As a result, the provider could not be assured that the residents concerned were safe or that the risk management systems in place ensured the safety of all the residents in the

centre.

Inspectors reviewed the systems of record management in the centre. While the provider had committed to improving the oversight and management of records, inspectors found that records were not maintained in line with the requirements of the regulations. This included records pertaining to incidents involving residents, and nursing documentation.

While staff were facilitated to attend further training with regard to fire safety, and missing persons, inspectors found that staff did not demonstrate an appropriate awareness of the procedure to be followed in the event of a fire emergency or missing person. There was no system in place to evaluate the quality of the training provided.

Overall, the provider had failed to ensure that robust management systems were in place to monitor the quality and safety of the service provided to residents.

Regulation 16: Training and staff development

Staff were not appropriately trained to deliver effective and safe care to residents. This was evidenced by;

- Staff did not demonstrate an appropriate awareness of their training in relation to the procedure to follow in the event of a missing person, or in relation to fire safety procedures.
- Staff did not demonstrate an appropriate level of knowledge to identify and address the nutritional needs of the residents. For example, staff demonstrated a poor awareness of the pathway of care to take in response to a resident's risk of malnutrition.

Staff were not appropriately supervised to carry out their duties to protect and promote the care and welfare of residents. This was evidenced by;

- lack of oversight of the residents' clinical documentation to ensure the assessment and care planning were accurate and up-to-date.
- poor supervision of staff to ensure residents received care and support in line with their assessed needs.
- failure to implement the policies and procedures in place to support and protect residents.

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 21: Records

The provider did not ensure that the records set out in Schedule 3 of the regulations were maintained in line with regulatory requirements, and were available for review. For example;

- A record of an incident that involved the unexplained absence of a resident who required close supervision was poorly documented and did not contain the detail required under Schedule 3(4)(j) of the regulations.
- Nursing records were not completed in line with the requirements of Schedule 3(4)(c). For example, a review of residents' nursing records found that nursing notes were duplicated from previous entries. This meant that the record did not provide assurance that the daily care needs of the residents had been met.

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 23: Governance and management

The registered provider had failed to organise and manage the staffing resource to ensure there were sufficient resources in place to ensure the staffing levels could be maintained in the event of planned and unplanned leave, in line with the centre's statement of purpose. An inadequate availability of staff nurses meant that clinical nurse managers, responsible for the monitoring and oversight of the service, were reallocated to perform nursing duties. This impacted on the governance and oversight of the service.

A weak and undefined organisation structure contributed to the provider failing to address or take appropriate action following the significant high risk findings of the previous inspection of the centre. This resulted in repeated non-compliance with the regulations assessed. The roles and responsibilities of the clinical management team were poorly defined. For example, accountability, responsibility and oversight of key aspects of the service such as the management of risk, monitoring of residents' nutritional care needs, and the oversight of clinical care records were not clear and resulted in poor outcomes for residents.

The registered provider had failed to ensure there were effective governance and management systems in place to ensure the service provided to residents was safe, appropriate, consistent and effectively monitored. Inspectors found repeated failings in the governance arrangements that included;

- Repeated non-compliance across all regulations reviewed on this inspection.
- Ineffective management systems to ensure that the service provided was

safe, appropriate, consistent and effectively monitored with specific reference to the oversight of risk related to unexplained absence of residents from the designated centre.

- Poor oversight of incidents involving residents. There were 12 open incidents relating to unexplained absence, falls, and responsive behaviours. There was no evidence of those incidents being reviewed or investigated to identify learning.
- Ineffective auditing systems. For example, a nutritional audit that occurred in July 2023 did not include an analysis of the findings, and areas for learning had not been identified. Therefore, there was no quality improvement plan developed to ensure residents' nutritional care needs, and nutritional risks were appropriately identified, monitored, and managed.
- Ineffective systems to ensure key clinical information regarding residents' care needs was effectively communicated to staff. For example, all staff were not informed of incidents involving residents leaving the designated centre unaccompanied, or falls incidents. Consequently, staff did not demonstrate the required knowledge of some residents individual support needs to effectively manage the risks to residents.
- Poor oversight of nursing documentation. A review of the quality of resident's care plan found that care plans were not based on the assessment of residents needs or risks. Care plans, particularly those relating to residents at risk of falls, and unexplained absence from the centre, were not based on assessment and did not reflect the current care needs of the residents. Therefore, care plans lacked the required detail to ensure residents received safe and effective person-centred care.
- Poor oversight of record management systems to ensure compliance with the regulations. For example, there was poor oversight of records pertaining to nursing documentation, and the records of incidents were found to be poorly documented.

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 4: Written policies and procedures

The registered provider had failed to adopt and implement policies and procedures designed to support and protect residents. This included the policies in relation to;

- Risk management,
- Management of incidents and accidents,
- Missing persons policy,

This is a repeated non-compliance

Judgment: Not compliant

Quality and safety

On the day of inspection, the residents' care needs were observed to be attended to appropriately and residents were observed to be content in their environment. Nonetheless, inspectors found that the quality and safety of care provided to residents was compromised as a result of ineffective systems of governance and management described in the Capacity and Capability section of this report. Significant action continued to be required in relation to residents' assessment and care plans to ensure residents received safe and effective person-centred care. Action was also required in relation to the discharge of residents from the centre, and upholding the rights of the residents.

A review of the food and nutrition aspect of the care service was completed due to the high risks identified on the previous inspection. The provider had taken some action to ensure residents who were at risk of malnutrition were identified through appropriate clinical assessment. Arrangements had been made for residents to access the expertise of allied health care professionals such as dietetic services, and speech and language therapists for further expert assessment. However, inspectors were not assured that there were robust processes for monitoring and audit in place to ensure the provision of consistent safe and quality nutritional care. This is actioned under Regulation 23; Governance and management.

A review of a sample of residents' assessments and care plans found that care plans were not informed by an assessment of the resident's care needs. Consequently, the care plans reviewed did not reflect person-centred, evidence-based guidance on the current care needs of the residents. This is discussed further under Regulation 5; Individual assessment and care plans.

Inspectors were not assured that the discharge of residents from the centre were carried out in line with the requirements of the regulations. The record reviewed for one resident found no evidence that the discharge process was carried out in consultation with the resident, or their representative.

Inspectors found that the rights of residents were not upheld by the failure in the governance and management of risk and incident reporting in the centre. This was further evidenced by the failure of the provider to ensure access to independent support and advocacy services for residents.

Regulation 25: Temporary absence or discharge of residents

The provider did not ensure that;

- the discharge of a residents was discussed, planned for and agreed with a resident and, where appropriate, their representative.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

A review of residents' assessments and care plans found that they were not compliant with regulatory requirements. For example:

- Care plans were not informed by a comprehensive assessment of the residents care needs. For example, some residents' care plans did not accurately reflect the needs of the residents and did not identify interventions in place to protect residents when identified as being at a high risk of falls. Consequently, staff did not have accurate information to guide the care to be provided to the residents.
- Care plans were not reviewed or updated when a resident's condition changed. For example, a care plan to support a resident's increased monitoring and supervision needs was not reviewed or updated following an incident of a resident's unexplained absence from the designated centre. Therefore, staff did not have the required information to support the resident's care needs.

This is a repeated non-compliance.

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 16: Training and staff development	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 25: Temporary absence or discharge of residents	Substantially compliant
Regulation 5: Individual assessment and care plan	Not compliant

Compliance Plan for Esker Ri Nursing Home OSV-0000733

Inspection ID: MON-0040868

Date of inspection: 18/07/2023

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	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: - To ensure staff knowledge & understanding of the training received in the event of a missing person / in relation to fire safety procedures – direct 1:1 supervision sessions were held with each staff member to assess their understanding & actions to be taken, this has been completed by the PIC /DPIC/CNM / HCA supervisory. - All staff have completed direct supervision sessions and training on managing Missing Persons in July/Aug 2023. - Specifically: The Missing persons policy was reviewed and updated. The amended policy was shared with all staff, direct 1:1 supervision was also held to assess understanding of this policy. The supervision sessions assessed the actions each staff would take if a resident was missing. Training has begun on risk of absconscion. This training is ongoing and further training sessions have been booked for Sept 2023.Missing persons drills have also been completed weekly with prompt response from staff. - Also training on fire safety: with special emphasis on the care and management of at-risk residents during fire drills. Fire action notices were reviewed and displayed at each repeater fire panel: staff understanding was assessed, as competent by supplying direct supervision for all staff on individual Actions to be taken when: - 1. A fire is discovered and 2. What to do on hearing the Fire Alarm. Nighttime fire drill scenarios have been begun and will continue monthly. Staff response to date has been prompt and PIC/CNM will continue to monitor. - A risk review and nutritional audit was completed on each resident's nutritional needs. Areas of improvement to reduce identified risk have been identified and communicated to staff. - Training has commenced for all nurses /care staff on nutritional risk. Several training sessions have already been completed & further training has been arranged for Sept to Dec 2023 to capture all staff on planned leave.	

- Additional to the monthly nutritional audits, the CNM staff will have direct oversight and governance daily to ensure all the training completed will be assessed on an ongoing basis. Direct feedback is given daily, as required to each nurse regarding care plan records/documentation, risk management.

- HCA supervisory receives direction directly from the PIC / DPIC/ CNM at the daily meeting; to observe practices in each area to ensure staff have the understanding & are following procedures correctly when providing direct care. Any deficits identified are reported directly to the CNM & nursing staff. HCA supervisor remains supernumerary to support the CNM & nurses to ensure good care practices are delivered to all residents. This required direct training & supervision, documentation of care given & recorded onto electronic system. All resident charts have been reviewed & care staff are given clear directions on every shift, regarding specific risks/ resident needs. The completion of all documentation will form part of the audit process.

- Daily team meetings are now held with CNM, DPIC, PIC to discuss every resident & any identified risks or concerns. CNM staff are still supernumerary to directly support & oversee the quality of care provided to each resident. Additional support recommended from visiting allied health professionals is discussed at each team meeting to ensure all actions required are followed. The CNM will ensure direct oversight & follow up. Audit of care plan documentation has been completed & is ongoing, where immediate issues are identified the CNM supports the nurse with required actions & update.

- A daily risk prompt sheet has been implemented which provides a summary over 7 days of each resident. Improvements in resident care have been noted following implementation of same.

- Staff nurse in charge of each unit communicates specific care needs at handover to the care team & monitors the effectiveness of the care given. The staff nurse is also supported with CNM, DPIC & PIC input.

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
- An incident/accident audit was completed for June /July 2023 to review records and ensure oversight and governance regarding incident management. Deficits identified were communicated to all nurses and corrective actions taken. PIC/DPIC/CNM staff now review all incidents daily to ensure accurate, comprehensive details are documented, to comply with Schedule 3 (4) (j). All incidents are communicated daily to appropriate staff to ensure follow up actions are taken. - nursing progress notes are reviewed by the CNM to ensure there is no duplication & the progress notes reflect the care needs of the resident have been met. All documentation is discussed with the nurse & supported by the CNM to ensure understanding & improved knowledge.
- The CNM is continuing to complete monthly care plan audits, outcome of same,

communicated to named nurse.
- Areas identified at the inspection were communicated directly to all staff at each shift handover.
- Following completion of incident management training & direct supervision by CNM, PIC all incident documentation is completed in full to the required standards.
- All incidents are discussed daily & checked by PIC, DPIC / CNM to ensure required standard.
- The next training regarding NMBI record keeping standards is booked for 2/10/23 for the last 6 nurses to complete.

- CNM/PIC have daily direct oversight in respect to nurse documentation: specifically reviewing electronic records, to check progress notes and MDT follow up. This will ensure person-centred records are maintained to reflect the daily care needs of each resident, as per Schedule 3(4)(c). Any deficits identified in respect of documentation are actioned immediately by CNM/PIC.
- Any issues identified are documented in the daily progress notes, risk assessment, care plan or MDT as appropriate. This will ensure the nursing records are person centred & reflect the resident care needs on that day.
- All residents care plans audits have been completed on 31/8/23 & action plan in place; all corrective actions have been completed by the named nurse. Revising the current care plans to holistic care plans; this is expected to be completed by 30/10/23.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
- A clearly defined organizational structure is in place & has been communicated to all staff; to ensure the service provided is safe, consistent, appropriate & effectively monitored to provide oversight. Operations Manager continues to be in the centre 4 days per week.
- CNM's are no longer required to fill nursing shifts; the CNM's are supernumerary. Recruitment drive continues for nursing staff, currently 5 nursing staff have been recruited, any vacant nursing post will be filled by agency staff.
- All records are electronically documented, this is reviewed on a daily basis with PIC / CNM meeting to ensure accurate comprehensive detail is documented to reflect person centred care; where any deficits are identified, the CNM discusses this with the named nurse to provide support & supervision to ensure understanding. -
- A review was completed of all incidences of absconscion from Dec 2022 to June 2023. This included a review + analysis on staffing/skill mix/compliance with procedures/awareness of those at risk/handover communication and training/fire exit doors+ windows /CCTV system/visiting policy/records and documentation following incident or near misses. All identified actions have been completed and shared learning communicated to staff through daily team meetings, health safety and general staff

meetings.
– incidents are reviewed daily, to ensure comprehensive account, investigation, assessments reviewed & care plan updated. Identified learnings informed to staff. All incidents are audited on a monthly basis. Residents' identified at higher risk of absconion are risk assessed & monitored in a specific wing; where the risk identified increases; 1:1 will be put in place.
- All incidents reviewed daily at PIC meeting and where appropriate notification to HIQA completed.
- An audit matrix has been implemented to provide governance & effective management systems. This includes completed audits in July & August on care planning, nutritional risk & weight loss, incident analysis, including falls, medication management & a review of the resident risk register & relevant risk assessments. Regular monthly staff meetings have also been held for all departments including a health & safety meeting. All issues identified in the audits are communicated to all staff as part of the daily handovers & improvements will continue to be monitored by PIC & CNM.
- – A new auditing system has been acquired to comprehensively audit, identify deficits, to effectively monitor & evaluate, Ensuring quality improvement plans are implemented- new audit system set up has been commenced and expected to be fully implemented by Dec 2023. The current auditing system will continue until the new system is up & running.
- A gap analysis was completed regarding the absconion incidents & submitted to HIQA. Any deficits identified have been addressed.
- As per previous all communications regarding any resident risk are clearly communicated daily via team meetings, shift handovers to all staff. This will ensure that all staff are informed of all risks or incidents.
- All CNM's remain supernumerary; this will ensure direct oversight and completion of supervision sessions, as required for all staff. This supernumerary role includes, daily monitoring of resident care and clinical standards and record keeping, through direct observation of practices/completion of clinical audits, example: audits on care plans/nurse documentation/infection control/incidents and management/nutritional risk /responsive behaviours/medication management.

- Daily team meetings are now held with CNM, PIC to discuss every resident & any identified risks or concerns. The CNM will ensure direct oversight & follow up. Audit of care plan documentation has been completed & is ongoing, where immediate issues are identified the CNM supports the nurse with required actions & update.
- A daily risk prompt sheet has been implemented which provides a summary over 7 days of each resident. Improvements in resident care have been noted following implementation of same.
- This identifies all risks for each resident & is followed up on a daily basis with the CNM & nurse to ensure, assessments are reviewed, follow up where necessary with members of the MDT is completed promptly & all documentation completed in a comprehensive, reflective manner.
- Training began for all nurses on care planning, nurse documentation, incident management & records, dementia awareness, responsive behaviour, health & safety, risk management, fire & medication management. Several training sessions have already been completed & further training has been planned.

- Additional to the monthly care plan audits, the CNM staff will have direct oversight and

governance daily to ensure all the training completed will be assessed on an ongoing basis. Direct feedback is given daily, as required to each nurse regarding care plan records/documentation, risk management and incident recording.

Regulation 4: Written policies and procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
- Policies that have been reviewed & updated, have been circulated to staff & confirmation of understanding received; this is followed up with direct supervision sessions to ensure understanding. – Supervision / observation of staff when completing for example missing persons & fire drills, to ensure residents are supported & protected. Monitoring of the electronic system to ensure that information is input at point of care.
- Risk assessments for absconscion/governance and leadership/nutrition/staffing and responsive workforce management have been updated and reviewed to reflect current changes in controls systems. All risks assessments are currently under review across each department - expected completion of same 30.11.2023.
- Training was commenced in July '23 on Risk management, management of incidents & accidents, missing persons policy, nutrition & hydration policy & complaints management, this training will continue over the next 3 months to ensure staff fully understand their role regarding these policies; to ensure residents are supported & protected.
- Specifically, Policies have been reviewed on management of incidents and accidents/missing persons/nutrition and hydration/complaints management. These policies have been updated & discussed with staff, as part of the staff supervision / toolbox support sessions – through direct supervision/observation of completed documentation + handover the PIC/CNM will review understanding of same.

Regulation 25: Temporary absence or discharge of residents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 25: Temporary absence or discharge of residents:
- Discharges will be planned, discussed with the resident, their representative & MDT, to ensure appropriate support is in place prior to discharge.

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:

- Following the care plan audit of all residents', deficits identified have been reviewed & updated by the named nurse. The CNM is supporting the nursing staff with direct supervision to ensure the plan of care for each residents' identified risks / need are accurately reflected in the care plan. This information is available to all staff on the electronic system.
- Where there is a change in a residents' condition; this is discussed at the daily PIC / CNM meeting & assessment / care plan are reviewed to ensure they have been updated. The CNM discusses any change directly with each team to ensure staff have the required information to support the residents needs. The current electronic system highlights when care plan review is due & this is followed up by the CNM with the named nurse. The care plan action plan will clearly state, corrective actions, responsible person & date of expected completion.
- Care plan reviews are in progress with the named nurse, resident & nominated person.
- Care plan audit has been completed -all identified deficits have been addressed.
- All residents care plans have been audited by & action plan in place.
- The named nurse list has been updated where required CNM is supporting the nursing staff with direct supervision regarding comprehensive assessment of resident's needs. All care plans will be reviewed to ensure a comprehensive assessment & holistic care plan is in place. This will also reflect identified risks for each resident.
- Training on care planning & documentation commenced in July '23 with further onsite training planned. Feedback from this training has been very positive.
- All care plans will reflect individual resident's needs, risk identified & the required level of supervision. Any concerns regarding resident care are discussed at the daily team meeting & communicated to all staff.
- Care plan meetings have commenced with residents, their representatives & the PIC.

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(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	30/10/2023
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/10/2023
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.	Not Compliant	Orange	30/10/2023
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	Not Compliant	Orange	03/07/2023

	the statement of purpose.			
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Not Compliant	Orange	03/07/2023
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	19/07/2023
Regulation 25(4)	A discharge shall be discussed, planned for and agreed with a resident and, where appropriate, with their family or carer, and in accordance with the terms and conditions of the contract agreed in accordance with Regulation 24.	Substantially Compliant	Yellow	19/07/2023
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out	Not Compliant	Orange	30/11/2023

	in Schedule 5.			
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.	Not Compliant	Orange	30/10/2023
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.	Not Compliant	Orange	24/11/2023