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:	22 August 2023
Centre ID:	OSV-0000733
Fieldwork ID:	MON-0040990

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 three 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:	113

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 22 August 2023	08:30hrs to 18:30hrs	Sean Ryan	Lead
Tuesday 22 August 2023	08:30hrs to 18:30hrs	Una Fitzgerald	Support

What residents told us and what inspectors observed

Residents living in Esker Rí Nursing Home told the inspectors that staff were attentive to their requests for assistance and attributed this to a stability in the staffing levels, and availability of staff. Residents told the inspectors that, in general, staff were kind, friendly, respectful, and that staff made them feel safe in the centre. Staff spoken with identified improvements in the duration and quality of time they spent with each resident and attributed this to lower resident occupancy numbers in the centre.

Inspectors arrived unannounced at the centre and were met by the person in charge. Following an introductory meeting with the person in charge and regional operations manager, inspectors walked through the centre and spent time talking to residents and staff, and observing the interactions between residents and staff, and the care environment.

There was a busy atmosphere in the centre throughout the morning of the inspection. Some residents were observed enjoying each other's company in the communal dayrooms and reception area, while other residents were observed sitting in their room waiting for assistance from staff. Staff were observed busily attending to residents requests for assistance, and polite and respectful conversation was observed between residents and staff.

Residents told the inspectors that in recent weeks, there was a notable reduction in the duration of time residents waited to receive assistance from staff. Residents described how some staff were familiar with their care needs and spoke about how this made them feel comfortable. The residents described how staff supported them to select their clothing, maintain their individual style and appearance, and knew their individual likes and preferences such as the time they like to get up from bed. Notwithstanding the positive feedback, some residents described how there were 'a lot of new staff' assisting them with their care needs. While residents told inspectors that staff were kind and attentive, residents reported that some staff did not always socially engage with them, and this made it difficult to 'get to know the staff'.

The premises was warm, bright, spacious, and appropriately decorated for residents. The centre was registered to accommodate 126 residents in both single and multi-occupancy bedrooms. Residents were accommodated in five of the six wings of the centre. Each wing had a communal dayroom that was observed to be in use by residents throughout the inspection. The premises was generally maintained in a satisfactory state of repair, with the exception of some bedroom doors that were observed to be held open with items of furniture as a result of the door closure device not functioning correctly. Inspectors observed that the provider had progressed to replace window restrictions in windows on the ground floor. Staff informed the inspectors that this intervention was necessary to protect residents who may seek to exit the building unaccompanied.

Inspectors observed the residents dining experience and observed that there were adequate staff available to assist residents with their nutritional care needs. Residents were complimentary about the food served in the centre, and confirmed that they were always afforded choice. While nursing staff were present in the dining room during meal times, they were observed to be engaged in medication administration practices.

Residents were engaged in activities throughout the day and could choose what activities they wished to attend. An activities board was displayed that detailed the planned activities for the day.

Residents were observed receiving visitors throughout the inspection in both their bedroom accommodation, and designated visiting areas.

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 provided to residents.

Capacity and capability

This unannounced risk inspection was carried out 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).
- review unsolicited information received by the Chief Inspector, pertaining to the safeguarding and protection of residents living in the centre.
- review the detail of an application to remove two restrictive conditions from the registration of the centre.

Inspectors found that, where the provider had taken action to manage risks to residents safety and welfare, with particular regard to residents at risk of leaving the centre, general oversight of the service provided to residents required further significant action to ensure full compliance with the regulations.

Inspectors found that the quality and safety of care continued to be impacted by poor governance and oversight of the service, and ineffective systems of management. Additionally, inspectors found repeated non-compliance in the implementation of the centre's policies, designed to protect residents and support the provision of a safe and monitored service. This included safeguarding, risk management, and complaints management policies and supporting procedures. Repeated non-compliance was identified under the following regulations;

- Regulation 5; Individual assessment and care plan,
- Regulation 16; Training and staff development,

- Regulation 21; Records,
- Regulation 23; Governance and management,
- Regulation 25; Temporary absence or discharge of a resident.

In addition, the following regulations were found not to be compliance on this inspection;

- Regulation 8; Protection
- Regulation 31; Notification of incidents.

Inspectors reviewed unsolicited information received by the Chief Inspector. The information received pertained to concerns regarding the governance and management of the centre, the systems in place to safeguard and protect residents, the supervision of staff, complaints management, and the communication of resident information that is used to plan and deliver person-centred, safe and effective care. This information was found to be substantiated on this inspection.

Blackden Limited is the registered provider of Esker Rí Nursing Home. It is a company consisting of two directors, one of whom represents the registered provider. The management structure supporting the designated centre had been increased since the last inspection with the appointment of a regional operations manager, who was a person participating in the management of the centre. The regional operations manager was responsible for monitoring clinical and operational aspects of the service, in addition to providing support to the person in charge. However, inspectors found that while the increased presence of the senior management in the centre had improved the management of risks specific to the absconsion of residents from the designated centre, the change was not found to have positively impacted the overall governance and management of the designated centre.

Inspectors found that lines of accountability and authority were not clearly defined within the organisational structure. For example, it was unclear who held responsibility for key aspects of the service such as the oversight and management of risk, safeguarding, and the management of complaints. The impact of this was inadequate and ineffective risk management systems, and systems to monitor and evaluate the quality of the service. Systems in place to escalate risks and concerns to the senior management remained weak. For example, inspectors found incidents of complaints and safeguarding concerns that had not been appropriately escalated to the senior management team.

The management systems in place did not ensure that the service provided was safe, appropriate, consistent or effectively monitored. While the provider had implemented some audits to evaluate aspects of the service, those audits did not include an analysis of the findings, or identify learning to ensure an effective quality improvement action plan could be developed. Consequently, inspectors were not assured that there were effective systems in place to identify, monitor, and improve the quality and safety of key aspects of the service such as clinical documentation, resident's nutritional risks, and medication management practices.

The system in place to manage risk was not effectively implemented. Risks that had

been identified by the provider were not managed in line with the centre's own risk management policy. For example, the provider had identified staff training deficits and poor medication management practices as potential risks to the care and welfare of residents. However, the risks has not been assessed or recorded in the centre's active risk register. Consequently, controls to mitigate and appropriately manage identified risks to resident's safety and welfare were not in place. Additionally, while the risk management policy detailed the personnel responsible for the oversight and management of risk in the centre, the risk management systems were not known to the personnel responsible for the oversight of risk.

The policies and procedures, as required by Schedule 5 of the regulations, were reviewed by inspectors. While some of the policies had been reviewed by the provider at intervals not exceeding three years and were made available to staff, the registered provider had failed to ensure that some policies and procedures were implemented.

The provider had failed to ensure there was adequate documentation of adverse incidents involving residents. A review of a resident's care file found information that was indicative of potential safeguarding concerns. The provider had failed to recognise a potential safeguarding incident and therefore the incident was not documented, investigated in line with regulatory requirements or the centre's own safeguarding policy, or notified to the office of the Chief Inspector of Social Services. Inspectors found that the action taken by the management following notification of a further potential safeguarding incident was not in line with best practice guidelines, or the centres own policy.

Despite being identified on a previous inspection, the management systems in place to recognise and respond to complaints did not ensure that complaints and concerns were acted upon in a timely manner. The record of a complaint regarding the quality of care provided to a resident had not been reviewed by the personnel responsible for the management of complaints, or escalated to senior management, in line with the centre's own complaints management policy.

Inspectors found that the systems of record management, and oversight of clinical records, remained poor. Records were not maintained as required by Schedule 2 and 3 of the regulations. This included records to be held for each member of staff, and records regarding the nursing care provided to a resident.

The organisation and management of the staffing resources had improved. While the staffing resource available did not reflect the resources committed to by the provider in the statement of purpose, there were adequate levels of staff on the day of inspection to meet the needs of the current 113 residents, and for the size and layout of the centre.

Staff had access to education and training appropriate to their role and a training schedule was in place. Staff had attended training specific to the procedure to commence in the event of a fire emergency, and missing persons, and demonstrated an appropriate awareness of this training. There were, however, gaps in staff attendance in training sessions such as safeguarding of vulnerable adults

and some staff demonstrated a poor awareness of the systems in place to safeguard residents. Inspectors found that the arrangements in place to supervise and support staff to implement the centres policies and procedures and to maintain records was not effective.

Regulation 15: Staffing

There was sufficient staff with an appropriate skill mix on duty to meet the needs of the current residents, having regard to current occupancy of the centre, for the size and layout of the centre.

While the staffing resource was adequate for the number of residents currently accommodated in the centre, the current staffing resource was not appropriate to ensure safe staffing levels if the centre was at full occupancy. This is addressed under Regulation 23: Governance and management.

Judgment: Compliant

Regulation 16: Training and staff development

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

- Some staff did not demonstrate an appropriate awareness of their training in relation to the detection, prevention and responses to abuse. Ten staff had not completed training specific to safeguarding of vulnerable people.
- 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 provided with training appropriate to their role, specific to resident's nutrition.

Staff were not appropriately supervised. This was evidenced by failure to;

- maintain accurate nursing care records.
- administer medication, in line with the centre's own policies, and relevant professional guidelines.
- implement policies and procedures designed to protect and support residents.

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 21: Records

The management of records was not in line with the regulatory requirements. For example;

- Staff personnel files did not contain all the necessary information required by Schedule 2 of the regulations. For example, one staff file did not contain two written references, a full employment history, or evidence of the person's identity including their full name, address, date of birth and a recent photograph.
- A record of an incident and investigation of an incident in which a resident may have suffered potential abuse or harm was not documented in line with the centre's own policy, or contain the detail required by Schedule 3 (4)(j) of the regulations.

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 23: Governance and management

The registered provider failed to ensure there was an effective management structure, with clear lines of accountability and responsibility in place. The organisational structure, as described in the centre's statement of purpose was not effective. The specific roles of the senior management team were not clearly defined. For example, accountability and responsibility for the oversight and monitoring of key aspects of the service were not clear. This included the the oversight of risk management systems, and the complaints management system. Additionally, there were inconsistent and poorly defined systems in place to escalate risks to the senior management.

The poorly defined organisational structure impacted on the management systems in place to ensure the service provided was safe and appropriately monitored. This was evidenced by;

- a failure to implement the centre's risk management systems to monitor and manage known risks with the potential to impact safety and welfare of residents living in the centre. Furthermore, the provider failed to implement the centre's safeguarding, and risk management policy to appropriately document and investigate potential safeguarding incidents.
- ineffective systems to monitor, evaluate, and improve the quality and safety of the service. For example, audits of clinical records, medication management, and resident's nutrition risks failed to identify potential contributing factors to poor audit findings as there was no analysis, trending, or learning identified. This meant that effective quality improvement action

plans could not be developed.
- poor oversight of record management systems to ensure compliance with the regulations.
- poor oversight of the centre's complaints management system, and escalation of complaints, to ensure complaints were managed in line with the requirements of the regulations. For example, concerns regarding the safeguarding of a resident, the quality of communication specific to a residents care and support needs, and the quality of care had been brought to the attention of the management team. The complaint had not been acknowledged, documented, or investigated in line with the centre's own policy.
- poor monitoring and oversight of the submission of statutory notifications to the Chief Inspector.

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 31: Notification of incidents

The provider had failed to notify the Chief Inspector of incidents occurring in the designated centre.

- Notification had not been submitted within three working days of an incident of suspected abuse of a resident.

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 policies in relation to;

- The prevention, detection and response to abuse,
- Risk management,
- Management of incidents and accidents,
- Complaints management.

This is a repeated non-compliance.

Judgment: Not compliant

Quality and safety

The inspectors found that the interactions between residents and staff was kind and respectful throughout the inspection. On the day of inspection, the resident's care needs were observed to be attended to appropriately and residents were observed to be content and felt safe in their environment. While the provider had progressed to review the assessments and care plans of residents who may seek to exit the building unaccompanied, further action was required to ensure that residents care plans were informed by a comprehensive assessment of their needs. Inspectors found that the quality and safety of the care provided to residents was impacted by inadequate oversight and implementation of the management systems and policies in place to protect residents. Consequently, significant improvement was required in relation to the protection of residents, and the safe transfer of residents from the centre.

The procedure to safeguard residents was underpinned by a safeguarding policy that provided guidance and support to staff on the appropriate actions and measures to take to protect residents should a safeguarding concern arise. However, inspectors found that appropriate action had not been taken to investigate incidents or allegations of abuse, in line with the centre's own policy.

Inspectors reviewed a sample of assessments and care plans and while there was evidence that the residents' needs were being assessed using validated assessment tools, the care plans reviewed were not informed by these assessments and did not reflect person-centred, evidence-based guidance. This is discussed further under Regulation 5; Individual assessment and care plans.

Inspectors were not assured that the transfer of residents from the centre were carried out in line with the requirements of the regulations. A review of the transfer records of one resident from the designated centre did not ensure that the transfer process ensured information pertinent to the care of the resident was communicated to the receiving health care facility.

Regulation 25: Temporary absence or discharge of residents

The provider did not ensure that all relevant information about a resident was provided to the receiving hospital.

For example, records of transfer letters sent with residents who were transferred to hospital did not outline the rational for the referral, and the current health status of the resident was accurately recorded in the transfer records.

Judgment: Not 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 or accurate assessment. For example, a review of an assessment of a wound found that the wound was healing, however, the residents was observed to have a deteriorating wound that required significant care intervention. The care plan reviewed did not detail this intervention. Consequently, care plans did not provide staff with accurate information to guide the care to be provided to the resident.
- Care plans were not developed in a timely manner, in line with the assessed needs of a resident. For example, a resident with a history of responsive behaviours did not have a care plan in place. This meant that the detail of known triggers were not documented and the intervention management steps were not recorded to guide the staff on the most appropriate step to take during these episodes. Therefore, staff did not have the required information to support the resident's care needs.
- While nutritional assessment had been completed on resident with weight loss, where required, the care plans were not updated to reflect the changes in the weight management plan.

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 8: Protection

The registered provider failed to take reasonable measures to protect residents from abuse and to provide for appropriate and effective safeguards to prevent abuse. This was evidenced by a failure to;

- ensure that staff had training in relation to the detection and prevention of, and response to abuse.
- recognise and respond appropriately in a timely manner to an allegation of abuse.
- instigate an investigation into a suspicious/allegation of abuse in a timely manner.

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	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	Not compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 25: Temporary absence or discharge of residents	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Esker Ri Nursing Home OSV-0000733

Inspection ID: MON-0040990

Date of inspection: 22/08/2023

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: • The 10 identified staff have completed their training. All staff continue to be facilated to attend training, as required. Numerous supervision sessions have been completed over the last 3 months. Additional 1;1 supervision sessions have been provided to ensure staff understanding of key safeguarding awareness. - All nursing staff have completed MUST training Sept '23. 1:1 staff supervision sessions will continue (as required) where staff require additional support re:the nutrition & hydradtion policy to ensure staff understanding, this includes instruction on recording of resident nutrition & hydration into the electronic system, when to raise concerns regarding nutritional intake to the nurse in charge. Monthly audits continue to be completed by the CNM, regarding nutritional risk. These audits continue to evidence significant resident nutritional status improvments as per the monthly MUST data & KPI records. - All identified at risk residents continue to be appropriately referred to GP, dietitian and SALT team. The dietitian continues to review all required residents, last review on Aug 30th & 31st , Sept 1st & 11th & Oct 11th '23. And appropriate changes to their care needs were recorded in their care plan/risk assessment. Identified at risk residents were reviewed by SALT on 11th Sept. Dietary changes recommended by the dietitian were relayed to the GP, as required, changes to the residents' scripts were implemented. All care plans, MUST risk assessments were updated to reflect same. - All Nursing & HCA & catering staff continue to be informed daily of any changes to dietary requirements, including changes to modified diets, as recommended by SALT team. - All residents' nutritional & hydration charts continue to be reviewed & a clear list is shared at every handover with all staff to ensure consistency & accurate monitoring. Individual training / tool-box sessions are held to support new staff on the electronic recording system, where all resident monitoring charts are recorded. - CNM staff provide support to the nursing staff & continue to have direct oversight daily regarding management of nutritional risks, any concerns discussed daily with PIC.	

- All catering staff continue to be communicated with on all changes regarding residents identified at nutritional risk. This resident list (prompt sheet) is displayed in the kitchen & on all serving trolleys for all catering staff to ensure the correct modified consistency diet is prepared for each resident.
- Daily nutritional intake & hydration is recorded in the resident progress notes & any concerns are communicated to the CNM, DPIC, PIC.
- As part of the ongoing monthly audits regarding documentation, care planning, medication management; the CNM, DPIC & PIC review all documentation & provide additional support where required to the nursing team. All new nursing staff read all home policies & continue to complete training on medication management, care plan documentation on commencement.
- All nurses have completed their updated medication management training, also the outcome of external and internal audits regarding medication management is discussed at nurse meeting on 29.8.23; compliance with same is monitored. Further training and meetings to review internal audits are planned for the purposes of communication and learning.

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
- The identified personnel files (missing schedule 2 information) was resolved on the day of the inspection. A full audit checklist has been completed to ensure all personnel files are compliant with schedule 2 of the regulations, to include all new staff going forward.
- Following review of the incident reflected in the report, an NF06 was submitted. Supervision was provided to the nurse regarding accurate reporting & record keeping & safeguarding policy.

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 as stated in the Statement of Purpose. The person in charge continues to ensure the service provided is safe, consistent, appropriate & effectively monitored to provide effective oversight supported by her deputy and CNM team (who all remain supernumery). The Operations Manager continues to be an additional support along with other members of the Support Office team.

All staff have read & signed the policy on Safeguarding and Risk Management, the adherence to this policy will be monitored as part of the daily oversight by CNM/DPIC/PIC and will be included in the auditing process. Additional training on Risk management, complaints management, health and safety, safeguarding was completed in August/Sept 2023.
Any issues regarding risk / resident care continue to be discussed at the daily handover, where appropriate, an incident report is completed/discussed with PIC and senior management team /safeguarding team advised (as required) and notification to HIQA completed.

A new auditing system has been acquired to support a more effective auditing system. This will help identify any deficits & will ensure quality improvement plans are implemented - new audit system commencing 1.11.2023. The current auditing system now has a clear date/action plan to be completed with the responsible person identified to ensure compliance is achieved for each audit.
Monthly audits will continue to identify any areas of improvement in respect of record keeping standards. Any complaints are reviewed daily by the PIC and appropriate action is taken, as per the amended complaints policy and procedure. All concerns / complaints are recorded into the electronic records system and areas of concern are communicated to all staff daily.

CNM's remain supernumerary. The recruitment drive continues for nursing staff and any vacant nursing positions continue to be replaced by Agency Nurses. 3 New nurses have been recruited and are expected start on the 31.10.23

Any identified resident risks/concerns are discussed with staff through daily team meetings and monthly health safety and staff meetings.

Incidents are reviewed daily, to ensure comprehensive account, investigation, assessments reviewed & care plans updated. Identified learnings informed to staff. All incidents are audited & analysed on a monthly basis. All incidents reviewed daily at PIC meeting and where appropriate notification to HIQA completed.

a new electronic Risk Register management system has been purchased- all risks will be uploaded by 20.12.23. The current risk register was reviewed and updated on 25.8.23 to include risks associated with medication management /clinical documentation and staff training.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
All notifications are submitted within 3 working days.

Regulation 4: Written policies and procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
- The policies related to safeguarding; management of incidents & accidents & complaints management are fully implemented within the home. All staff have read & signed the above policies. Training has been completed & additional supervision sessions with individual staff are ongoing, to ensure understanding. This will continue to be monitored as part of the auditing process.
- All potential residents' risks are discussed at the daily team meeting with the PIC, appropriate actions continue to be implemented immediately.

Regulation 25: Temporary absence or discharge of residents	Not Compliant

Outline how you are going to come into compliance with Regulation 25: Temporary absence or discharge of residents:
- all future transfer letters clearly document the rationale for the transfer documents, including an up to date record of the current health status . Findings of the inspection shared with all nursing staff and they will complete the required comprehensive electronic nursing transfer document ,ensuring all relevant transfer information is communicated clearly.
- As further support to staff and to ensure a complete process, the nurse in charge (day/night) will assist with the transfer documentation ,additional support implemented with immediate effect 22.8.23.

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:
- The PIC /DPIC + CNM communicated the inspection findings to all nursing staff . A review of wound/responsive behaviours and weight loss care plans was completed on

18.10.23 ,alongside relevant assessment tools. Any identified careplan/or relevant assessment tools were updated. This will ensure care continues to be sperson centred and meets the needs of each resident . Staff continue to be supported,as required to ensure

- Every, resident's care plan & risk assessments were reviewed in July & August; this included a complete change to a holistic care plan.
- Monthly care plan audits continue & any corrective action is taken as required. All new admissions are audited by the CNM / DPIC within 2 days to ensure full compliance.
- Daily team meetings identify any resident changes for example changes to weight management / wound management / responsive behaviors. Agreed actions are implemented & recorded in the updated care plan.
- All audit outcomes are discussed at the monthly departmental meetings as appropriate.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

- All staff have completed training on safeguarding. All staff have read & signed the safeguarding policy; where appropriate additional training or supervision sessions are completed to support understanding.
- All staff are fully aware of when & who to report any suspected safeguarding issue. The PIC will continue to report as appropriate to HIQA any safeguarding concerns.

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.	Substantially Compliant	Yellow	18/10/2023
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	18/10/2023
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	20/10/2023
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	Not Compliant	Orange	18/10/2023

	details responsibilities for all areas of care provision.			
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	18/10/2023
Regulation 25(1)	When a resident is temporarily absent from a designated centre for treatment at another designated centre, hospital or elsewhere, the person in charge of the designated centre from which the resident is temporarily absent shall ensure that all relevant information about the resident is provided to the receiving designated centre, hospital or place.	Not Compliant	Orange	25/08/2023
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.	Not Compliant	Orange	15/09/2023

Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.	Not Compliant	Orange	20/12/2023
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.	Not Compliant	Orange	18/10/2023
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Not Compliant	Orange	18/10/2023
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	Not Compliant	Orange	24/11/2023

	it, after consultation with the resident concerned and where appropriate that resident's family.			
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Orange	30/08/2023
Regulation 8(2)	The measures referred to in paragraph (1) shall include staff training in relation to the detection and prevention of and responses to abuse.	Not Compliant	Orange	18/10/2023
Regulation 8(3)	The person in charge shall investigate any incident or allegation of abuse.	Not Compliant	Orange	18/10/2023