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:	Glendonagh Residential Home
Name of provider:	Glendonagh Residential Home Limited
Address of centre:	Dungourney, Midleton, Cork
Type of inspection:	Unannounced
Date of inspection:	11 August 2021
Centre ID:	OSV-0000229
Fieldwork ID:	MON-0032527

About the designated centre

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

Glendonagh Residential Home is located near the village of Dungourney in East Cork. It is set on well maintained, extensive grounds. The centre is registered to cater for the needs of 42 older make and female adults. There is 24-hour nursing care available. Glendonagh Residential Home is primarily for the accommodation of dependent older persons, aged 60 years and over. No person under the age of 18 years may be accommodated at Glendonagh residential home at any time regardless of medical condition. Residents are accommodated with the following care needs: General care, Respite care, Dementia specific care, other, etc. Admissions to Glendonagh Residential Home are arranged by appointment following a pre-admission assessment of your needs. This is to ensure that we have all the necessary equipment, knowledge and competency to meet your care needs. There is good access to general practitioner and pharmacy as well as additional health-care expertise. The centre was registered to provide accommodation for 42 residents over two floors. The centre is laid out over three wings, namely the Orchard wing, which accommodates nine residents in seven single rooms and one double room. Residents who required additional support specifically dementia care are accommodated here: the Courtyard wing which accommodates 14 residents in two double and 10 single rooms and and the Manor wing accommodates 19 residents over two floors. The ground floor of the Manor wing has three single rooms, one double and one triple room. The majority of rooms have en suite facilities.This was accessible by two stairs and a lift. Residents used a lift to access the three double rooms and five single rooms on the first floor. A chapel, visitors' room, dining room and large sitting room make up the communal areas. Contacts are available to all residents and activities are organised regularly.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	43

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
Wednesday 11 August 2021	09:00hrs to 18:30hrs	Mary O'Mahony	Lead
Wednesday 11 August 2021	09:00hrs to 18:30hrs	Siobhan Bourke	Support

What residents told us and what inspectors observed

There was a warm and welcoming atmosphere in the centre and in general staff were observed to be kind, respectful and helpful when interacting with residents. Residents told inspectors it was a nice place to live. However, ongoing issues with staff shortages, inadequate fire safety procedures, the condition of some areas of the premises and inadequate infection prevention and control procedures resulted in ongoing risks to the rights, safety and well being of residents and staff. In particular, fire safety risks required urgent action by the provider. Inspectors met most of the residents and spoke in more depth with five of the residents to gain an insight into their lived experience in this centre. In general, residents and visitors who spoke with inspectors were happy with the care and kindness provided by the staff. One relative said that the relative had received "exceptional care" for the four years the resident had been in the centre.

On arrival at the centre, inspectors were guided through the centre's infection prevention and control procedures by a member of staff. The centre was registered to provide accommodation for 42 residents over two floors. During the course of the inspection, inspectors identified that there were 43 residents in the centre on the day of inspection. This will be discussed further in the capacity and capability dimension of this report. The centre was laid out over three wings, namely the Orchard wing, which accommodated nine residents in seven single rooms and one double room. This wing was set up for residents who required additional support specifically dementia care; the Courtyard wing which accommodated 14 residents in two double and 10 single rooms and and the Manor wing accommodated 19 residents over two floors. The ground floor of the Manor wing had three single rooms, one double and one triple room. This was accessible by two stairs and a lift. Residents used a lift to access the three double rooms and five single rooms on the first floor.

During the walk-around of the centre, inspectors saw a number of examples of where the organisation of the centre, premises issues and inadequate cleaning standards had the potential to impact on the safety of residents.

In the Orchard Unit, inspectors observed that renovations and painting of the corridors of the unit were underway. Preparation for this painting resulted in the fire safety point signage, indicating the enclosed cupboard where fire extinguishers were located, being removed which was a risk should the extinguishers be required in an emergency. All the wall mounted alcohol hand sanitiser dispensers in the centre were empty due to a shortage of a supply of refill containers. In response, the provider had distributed bottles of alcohol hand rub through out the centre as a temporary measure. In the Orchard unit inspectors saw that a bottle of hand gel and a spray container with disinfectant was located beside a bottle of soft drink in the kitchenette. This posed a high risk of a resident with dementia inadvertently consuming a toxic substance. This risk had not been identified. Furthermore, cleaning in the dining room of the Orchard unit required review as dried food was

observed by inspectors on the floor and on a table. Hoist slings were shared between residents in the centre and there was no scheduled regime or documentation of the frequency of cleaning of this equipment. This presented a risk of cross infection particularly at this time of higher risk of infection with COVID-19. Additionally, inspectors observed that a number of staff were wearing surgical masks incorrectly during the course of the inspection. This was addressed by the person in charge.

Inappropriate and inadequate storage arrangements throughout the centre posed a risk to the safety of residents and did not indicate respect the privacy and dignity of residents. For example, a pair of latex gloves, plastic aprons and a fire safety ski sheet were seen lying on the floor of one of the open cupboards in the hall of the Orchard Unit. Both cupboards were unlocked and also contained boxes of personal toiletries for residents in the dementia unit, which had been put there for residents' safety. This untidy approach prevented effective cleaning of such areas as well as leaving the toiletry items within reach.

While it was evident that some refurbishment was underway at the centre, a number of areas of the centre required maintenance and refurbishment. Woodwork was observed to be chipped and worn in a number of bedrooms and communal areas. Shower trays in some residents' rooms were stained and grouting required replacing. Inspectors noted a strong malodour in one shared bedroom that was coming from the en-suite toilet. On checking this area inspectors observed that the flooring around the toilet was dark brown, heavily stained with urine and could not be effectively cleaned.

During the inspection, inspectors observed gaps in six double fire safety doors that posed a risk the safety of residents should a fire occur as the gaps rendered the doors ineffective in containing any potential fire and smoke. Furthermore, a large number of fire doors in bedrooms and similar doors to communal rooms throughout the centre were held open with chairs or door holders which meant that these doors could not close automatically to contain smoke and fire if the fire detection system was activated.

Inspectors recognised and acknowledged that the COVID-19 pandemic was a difficult and challenging time for residents, relatives and staff. There had been no outbreak of COVID-19 infection in the centre to date and there was a high uptake of vaccinations by residents and staff which is good practice. It was evident that staff were dedicated to their work in this area and attended appropriate training in this regard.

The centre had plentiful communal space and private smaller rooms were available should residents wish to spend time alone. The corridor which linked the Courtyard wing had comfortable window seating available where residents could sit and look at the beautiful enclosed courtyard garden. This garden could be easily accessed by residents and brightly painted seating with raised beds and flowering plants made it a very restful space. The centre was located on extensive grounds with ample outdoor seating areas and residents saw five residents going out for a walk with staff in the sunshine and fresh air on the afternoon of the inspection. One resident

informed inspectors that she had spent time outside reading the previous day and had really enjoyed this.

Inspectors observed that lunch and the evening meal in the centre's dining room was a sociable event for residents. To facilitate social distancing lunch and the evening meal were facilitated over two sittings at each mealtime. One resident told inspectors that "the food was very good" and that the portions were too big. The majority of residents were highly complimentary about the food choice and quantity available. Inspectors observed mealtimes to be relaxed and unhurried with staff providing assistance in a discreet manner to residents who required it.

While there was no activities scheduled in the morning of the inspection in any unit inspectors observed 18 residents sitting around the perimeter of the main communal room, and four residents in the adjoining chapel room, for a scheduled bingo session in the afternoon. Two care staff from the care staff compliment were encouraging residents to participate and providing assistance where needed in a respectful and energetic way. However, there was no scheduled activity on the day of inspection in the Orchard unit where residents with dementia resided.

Capacity and capability

On this inspection the governance and management arrangements were not well defined or clearly set out. Most significantly the provider was found to be non compliant with the Health Act 2007 by operating outside the conditions of their registration. An urgent action plan was issued to the provider on fire safety and on the requirement to come into compliance with the conditions of registration. A cautionary meeting was scheduled with the provider, at the office of the Chief Inspector to discuss inspection findings. In relation to the management team, the clinical nurse manager (CNM) who normally deputised for the person in charge and undertook audits and other management duties recently left the centre for a proposed period of six months leave. This position had yet to be filled and the person in charge stated it had proved very challenging to replace the CNM.

Even though on previous inspections the provider had been generally complaint with the regulations, on this inspection improved management oversight was required to ensure compliance with regulations and sustainability of good practice. In particular, robust action was required to ensure the centre complied with the regulations relating to governance and management of a designated centre, fire safety, premises upkeep, staffing, records and infection control. Nevertheless, inspectors saw that the audit and management systems set up in the centre by the management team members ensured that good quality nursing and medical care was delivered to residents. Inspectors were not assured however, of the sustainability of this system in the absence of the staff member who undertook the audits and followed up on the issues identified.

The centre was established in 1985 and provider of the centre was Glendonagh

Residential Home Ltd. The company consisted of two directors and the director who represented the provider attended the centre when required, to liaise with the person in charge and staff. The centre also employed a finance and governance manager, who was working remotely at the time of inspection, and two administration staff. The person in charge was experienced in the role of person in charge in this centre. The care and support team in the centre was comprised of a team of nurses and health-care staff, as well as administrative, catering, household and maintenance staff. There was evidence of regular meetings between staff and the person in charge. Complaints management and key performance indicators were reviewed and discussed at these meetings as evidenced in minutes of the meetings. Staff handover meetings ensured that information on residents' changing needs was communicated effectively according to staff spoken with. The detailed information in the daily communications sheets in residents' care plans provided evidence that pertinent information was exchanged between staff.

While the service was generally appropriately resourced there were recent staff shortages reported, as seen on the day of inspection. The clinical nurse manager's post was vacant as well as the post of activity coordinator. The governance manager had been absent from the centre, while working remotely, in recent months. A shortage of staff nurses meant that the person in charge was also required to work a 12 hour day as a nurse. This had a significant impact on her availability to manage the centre, particularly when there was only one other nurse on duty with her. There was only one staff nurse on duty to care for 42 residents at night. This was significant, as although the nurse was supported by three health care assistants (HCAs) at night there was a dementia unit and an upstairs area to be supervised, within the diverse layout of the centre. Inspectors were not assured that the night time staffing levels were sufficient to provide adequate supervision and safe care.

Inspectors found that the regulatory annual review of the quality and safety of care had been undertaken last year. A quality management system which included reviews and audits had been set up by the previous CNM to ensure that the service provided was safe and effective. As this CNM had only recently left the post, inspectors saw that this management and audit system was still in place to monitoring the quality and safety of care. Key clinical data had been collected including on the management of pressure ulcers, falls, bed rail use, complaints and health and safety issues. The sustainability of this system was not assured, as previously discussed, due to the aforementioned staffing shortage. This was confirmed by the person in charge. In addition, findings on inspection did not provide assurance that audits of areas such as infection control and fire safety had identified all the deficits or that appropriate action had been taken to address the issues identified.

The training matrix indicated that a number of staff had received training appropriate to their various roles and staff reported that the training kept their knowledge and skills updated in order to provide evidence-based care to residents. Staff supervision was implemented through performance improvement plans, staff probation meetings and appraisals. However, not all staff had undertaken mandatory training or refresher training as required. In addition, one staff member had undertaken an on-line course on manual handling techniques but had yet to do

the key practical element of this course which related to the safe moving and handling of residents. In the sample of staff files reviewed the inspector found that most of the required regulatory documents were in place. Job descriptions, Garda (Irish police) vetting (GV) clearance arrangements and probation reviews were carried out for new staff in conjunction with policy requirements.

Copies of the appropriate standards and regulations were readily available and accessible to staff. Maintenance records were in place for equipment such as hoists and fire-fighting equipment. Records and documentation as required by Schedule 2, 3 and 4 of the regulations were generally well maintained, however, they were not all completed and were not all appropriately stored on the day of inspection. Residents' records such as care plans, assessments, medical notes and nursing records were accessible to inspectors. Other records such as a complaints log and incident reports were seen to be comprehensively maintained.

Regulation 14: Persons in charge

The person in charge was experienced, qualified and knowledgeable of the regulations and standards. She met the requirements of the regulations.

Judgment: Compliant

Regulation 15: Staffing

Inspectors were not satisfied that night time nursing staffing levels were appropriate to meet the needs of the 43 residents in the centre at the time of inspection. Evidence reviewed showed that there was one registered nurse on night duty to meet the needs of residents located over two floors of the diverse layout in the nursing home.

- On the day of inspection one resident was approaching end of life and required increased nursing care both day and night.
- A recently admitted resident was also observed to require increased supervision and care on the day of inspection.
- In addition, inspectors saw a report of an incident on night duty where appropriate care had been omitted for three residents on one occasion.
- The statement of purpose indicated that eight full time (Whole time equivalent, WTE) nurses were available on the roster, this was not the case as not all nurses on the roster worked full time, the CNM and the activity coordinator had not been replaced.

Rosters reviewed showed that the person in charge was also required to provide clinical care as a full time nurse, and was one of the two nurses on duty on certain days each week, due to nursing staff shortages. This meant that the duties and

responsibilities of the person in charge could not be efficiently or effectively carried out particularly in the absence of the CNM. These duties included audit, staff supervision and staffing levels, records and staff training. The person in charge confirmed that she was under-resourced in this regard.

Judgment: Not compliant

Regulation 16: Training and staff development

From a review of the centre's training matrix and speaking with staff, a number of staff had either not completed or were not up to date with mandatory training such as fire safety, managing responsive behaviour and detection, prevention and response to abuse.

- Four staff were not up to date with fire safety training, nine staff had either not completed or were not up to date with managing responsive behaviour while 18 staff were not up to date with training on detection, prevention and response to abuse.

This was particularly significant in view of the urgent action required on fire safety management and the risks involved in not organising regular fire safety drills in a two-storey building with vulnerable older residents in residence.

Judgment: Not compliant

Regulation 21: Records

A sample of four staff files found gaps in employment records in one file and employment history and references in another. These were required to be on file on the day of inspection. These gaps were addressed by the management team on the day of inspection to ensure the files met the requirements of Schedule 2.

Inspectors found that improvements were required in the storage of residents' records to ensure they were stored in a safe and accessible manner as required by legislation.

- Personal activity care plans for residents were observed in an unlocked press under the sink in the kitchenette in the Orchard unit. Inspectors also observed that unsecured boxes of residents' personal files were stored in the open hairdressing salon, due to ongoing renovations.

Judgment: Substantially compliant

Regulation 23: Governance and management

A number of issues were identified with the governance and management of the centre that did not provide assurance that the registered provider had adequate oversight of the service. The governance arrangements currently in place did not ensure the effective delivery of a safe, appropriate and consistent service in the centre.

The registered provider was operating the centre outside of the conditions of registration and resulted in the provider being required to attend a cautionary meeting with the office of the Chief Inspector.

Condition 1

Subject to any prohibitions or restrictions contained in any other condition(s), the designated centre shall be operated at all times in accordance with the Statement of Purpose. The registered provider shall only provide for the specific care and support needs, and services, within the facilities as set out the Statement of Purpose, as agreed with the Chief Inspector at the time of registration. Any changes to the specific care and support needs and services provided must be agreed in advance with the Chief Inspector.

- Staffing levels were not in line with the whole time equivalent staff set out in the centres statement of purpose

Condition 3

The maximum number of persons that may be accommodated at the designated centre is: 42.

- The centre had 43 residents on the day of inspection

The governance and management in the centre required strengthening to provide effective oversight and ensure the quality of care and safety of the service was effectively monitored:

- The lack of senior nursing staff to support the person in charge to discharge the duties attached to the role
- Staffing shortages resulted in inadequate supervision of staff to ensure a safe and effective service.
- Lack of personnel to support activity provision for residents.
- There was evidence of a lack of effective systems in place to monitor infection control procedures including cleaning, staff training, storage and maintenance of records, premises upkeep, fire safety and care planning for residents with dementia.
- There was a lack of evidence that the audits were used to inform service improvements, as issues such as fire safety deficits and infection control

issues had not been identified or addressed.

These were all outlined and discussed further under the specific regulations.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

All contracts are required to state the room number of each resident and the occupancy of the room in which they would be residing to ensure the resident had a sense of ownership of their room and respect is shown to the right to choose a single or shared room.

- In one contract seen the room number for the resident was incorrect as he had been transferred to a double room. There was no indication on the contract that this had been agreed with the resident.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The statement of purpose provided to inspectors did not reflect the facilities and services provided at the centre on the day of inspection as required in Schedule 1.

There were 43 residents accommodated in the centre contrary to the information set out in the statement of purpose and the Certificate of Registration.

The nursing compliment as described in the statement of purpose of eight whole time equivalent nurses was not reflected in the staff roster seen by inspectors.

Changes in the organisational staff structure was not reflected in the statement of purpose.

Judgment: Not compliant

Regulation 31: Notification of incidents

- A review of a sample of the incident records indicated that one of the required three day notifications had not been sent to the Chief Inspector within the regulatory three day time-frame. This was required to be

submitted retrospectively.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

While complaints seen had been appropriately managed and closed to the satisfaction of the complainant, a copy of the complaints procedure was not displayed in a prominent position in the centre, as required by the regulations.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

Policies and procedures as required under Schedule 5 were available in the centre

Judgment: Compliant

Quality and safety

The majority of residents were found to be happy with the care and services provided in the centre and gave positive feedback about the staff and person in charge. However, the high levels of non-compliance found on inspection posed a risk to the safety and well being of residents and staff, especially in relation to fire safety and infection prevention and control. There were significant and serious concerns about the fire safety procedures for residents in the centre which resulted in the issuing of an urgent action plan on fire safety. This was further addressed under Regulation 28 in this report.

The centre continued to remain free from COVID-19 infection. Despite having a number of measures in place to minimise the risk of infection being introduced to the centre, inspectors identified a number of issues which had the potential to severely impact on infection prevention and control. These collective risks are discussed in detail under Regulation 27: Infection Control. The provider had failed to ensure that the procedures consistent with the standards of infection prevention and control were implemented by staff. For example, the standard of cleaning observed on inspection was not adequate and areas observed as unclean in the centre were signed off as having been cleaned.

An urgent action plan was issued to the provider in relation to significant deficits in

fire safety in the centre. These issues were described under Regulation 28: Fire safety. This urgent action was responded to satisfactorily within the required time frame. Up-to-date service records were seen to be in place for the maintenance of the fire alarm system and emergency lighting. Residents had Personal Emergency Evacuation Plans (PEEPs) in place and these were updated regularly. These identified the different evacuation methods applicable to individual residents for day and night evacuations. Fire training was completed in 2020 and a number of staff had completed training for 2021. Not all staff on night duty had undertaken fire training however and in addition, fire drills had not been undertaken regularly. This was significant as there were reduced staffing levels on night duty thereby presenting a higher risk to residents. Some staff were not familiar with fire drill protocol when spoken with. The person in charge confirmed they had not simulated an evacuation drill of a full compartment with minimal staffing levels such as on a night duty shift. Inspectors requested a fire drill to address this aspect of fire safety following the inspection. This was conducted following the inspection and further drills were planned. The centre had a risk management policy in place and the risk register identified clinical and environmental hazards and risks. However, aspects of risk management required review to ensure that all risks in the centre were identified and responded to as found on this inspection, in particular the use of unsecured bottles of hand sanitiser in the dementia unit.

The external appearance and grounds of the centre were beautifully maintained. Bedrooms in general were spacious with fine picture windows giving a view out over the countryside. Communal rooms were spacious and bright. The dining room was nicely decorated, It was apparent to inspectors that renovations were ongoing at the time of inspection. Nonetheless, inspectors found that the premises required further upgrading in order to comply with Schedule 6 of the regulations.

Residents' health care needs were met in accordance with care plans and clinical assessments. Residents had access to their general practitioner (GP) and health and social care professionals. Entries in residents' care plan files indicated regular GP and consultant access. There was evidence of good access to expertise in tissue viability (skin care) for residents who developed pressure ulcers. However, improvements were required to ensure compliance with Regulation 7, as there was no behavioural support care plan for the management of one resident who demonstrated responsive behaviour due to the effects of dementia. Mandatory staff training was also required in this area for a number of staff.

Some practices in the centre lacked a person centred approach in that they did not demonstrate sufficient respect for the right to privacy and dignity for residents. For example, inspectors found a number of residents' wardrobes were incorrectly labelled on the inside with another resident's name and personal products, such as body creams belonging to residents, were found in other residents' rooms. Residents' personal files were inappropriately stored and were not secure.

Activity provision required enhancement to provide more frequent opportunities for residents to participate in activities in accordance with their interests and capacities. Nonetheless, residents were seen to have access to radios, television, telephones and newspapers. Mass was said in the centre on a weekly basis and music sessions

were facilitated.,

Visiting had recommenced indoors and a designated room was assigned for residents to receive visitors in private. However, on the day of inspection visiting was not facilitated in line with national guidance. Nevertheless, the person in charge outlined that there was flexibility around the arrangements and visits outside of scheduled hours were facilitated where possible. Inspectors saw that two visits were accommodated outside of these hours on the day of inspection. Compassionate visits were facilitated. Inspectors saw evidence of good communication with residents and relatives in minutes of meetings, survey results and letters of information to relatives.

Regulation 11: Visits

Arrangements for visiting in the centre were not in line with the current national guidance (Health Protection and Surveillance Centre (HPSC) Guidance on Visits to Long Term Residential Care Facilities) which state that there is no requirement to limit the duration or number of visits for residents.

Visits to the centre were scheduled in advance on an appointment basis and were generally limited to three visiting slots a day, seven days a week for the 43 residents. This was a total of 21 visits weekly. One visiting slot was seen to be limited to 45 minutes.

Judgment: Substantially compliant

Regulation 13: End of life

It was evident to inspectors that appropriate care and comfort was provided to residents approaching end of life. Compassionate visits were facilitated and care was seen to be provided with dignity and respect to residents' at end of life.

Judgment: Compliant

Regulation 17: Premises

While the premises were generally complaint with the regulations there were a number of issues to be addressed on this inspection:

- Painting and furniture required upgrading.
- The door at the top of the stairs was very stiff and it had no closing

mechanism.

- A number of items were seen unsuitable stored in the 'dirty' sluice rooms including a slide sheet to assist in the movement of residents from bed to trolley and a catheter bag holder.
- Improved signage was required around the halls at a suitable height for residents to indicate for example, reminders of the direction to the dining room and sitting room.
- Flooring in one en suite toilet area was very stained and required replacing as there was as very strong odour from it.

Judgment: Substantially compliant

Regulation 26: Risk management

The centre's risk management policy set out the risks identified in Schedule 5. The risk register had been updated to include the risks associated with COVID-19. There were arrangements in place for recording and investigation and learning from serious events involving residents. The provider had a plan in place for the management of a COVID-19 outbreak should one occur but this required updating to reflect personnel contact details who had since left the service. This is discussed under Regulation 27.

Judgment: Compliant

Regulation 27: Infection control

Improvements were required to ensure that infection prevention and control (IPC) procedures were consistent with the national standards. For example:

- Two staff members wore their face mask inappropriately below their nose.
- Sluice room sinks were rusty and stained and both sluice rooms were very dirty.
- There was no hand washing sink in one sluice room.
- A dirty wet floor mop was seen on the floor of one sluice room despite a flat mop system in use for cleaning.
- A second floor mop was seen in a bucket of dirty water in an unlocked room which was undergoing renovation.
- Not all cleaning records were correctly maintained. Records were not seen for the disinfection of the hoists (used to move residents requiring support) between each resident.
- Damaged surfaces on furniture impeded effective cleaning.
- The COVID-19 preparedness plan and COVID-19 prevention policy required review to reflect the correct responsible personnel in the centre and the most

recent guidelines from the HPSC.

- There was no janitorial sink or suitable room for housekeeping staff which meant that house keeping staff had to use the 'dirty' sluice rooms when filling and emptying their buckets.
- Clean flat mop refills were inappropriately stored on the side of the sluice room sink.
- There was no isolation room available in the event of a suspected case of COVID-19 particularly for those residents who shared double rooms or if the guidelines on admissions reverted to requiring isolation.

Judgment: Not compliant

Regulation 28: Fire precautions

An urgent action plan was issued to the provider under this regulation as follows:

- Fire drills were not undertaken on a regular basis.
- The required fire safety checks were not consistently recorded.
- Location maps for the event of a fire, to indicate present location and direction to nearest fire escape route, were not legible or clearly laid out.
- Compartments were not easily identifiable.
- Six double doors for the containment of fire had unsuitable gaps.
- Ten fire safety doors were kept open with wedges on the floor which negated the efficiency of these doors which were meant to close automatically in the event of a fire or fire alarm activation.
- A number of staff on night duty were yet to attend the annual fire safety training and drill. This was significant as it was two storey building with reduced staffing at night.
- The fire safe door at the top of the stairs was very stiff and could not be closed properly.

A satisfactory response was received to the urgent compliance plan. Ongoing review of staff training, attendance at fire drills and oversight by the provider of fire safety within the centre was required

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The sample of medicine records seen were correctly maintained.

Medicines were signed when administered and the general practitioner (GP)

reviewed medicines on a three monthly basis.

Medicines no longer in use were returned to pharmacy and the controlled drug count checked was correct against the records maintained in the centre.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

There was a good standard of care planning in the centre and care plans were seen to be person centred and updated in line with regulations. Validated risk assessments were regularly completed to assess clinical risks including risk of malnutrition, pressure ulcers and falls. Based on a sample of five care plans viewed appropriate interventions were in place for residents' assessed needs.

Judgment: Compliant

Regulation 6: Health care

There was a good standard of evidence-based health care provided to residents in this centre. Residents were regularly reviewed by their GP. There was evidence of access to health and social care professionals such as physiotherapist, dietitian and occupational therapist.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Not all staff had received the mandatory training related to this behaviour. The impact of this was that a staff member spoken with appeared to lack the required up-to-date knowledge and skills to manage and understand such behaviour. Inspectors found that an appropriate plan of care was not in place for one resident who experienced the behaviour and psychological symptoms of dementia (BPSD). Such a plan would support staff in understanding the behaviour and offer strategies to ensure best evidence-based practice was available to the resident.

Judgment: Substantially compliant

Regulation 8: Protection

Residents stated that they felt safe in the centre. Relatives spoken with confirmed that they never worried about their relatives' care.

A number of staff had yet to receive the required mandatory training or updated training in this aspect of care.

This was addressed under Regulation 16: Staff training and development.

Judgment: Compliant

Regulation 9: Residents' rights

Residents were not provided with adequate opportunities to engage in activities in line with their interests:

- Residents in the dementia specific unit were not seen to be afforded meaningful activity on the day of inspection.
- Staffing had not been made available for a range of meaningful activities over seven days.
- In general, there were no morning activities routinely held in the centre.
- Inspectors observed five residents in the sitting room in the Orchard unit watching TV, without staff input at that time.
- Inspectors were informed that the activity coordinator had recently left the service and care staff were striving to provide these activities along with their caring duties. Therefore there was no staff member assigned to ensuring the coordination of activities throughout the centre
- The lack of this staff member was apparent during the inspection as residents requested more frequent and interesting activities such as quiz or a book club for example. One resident said that it was "boring" at times due to the fact that there was not a good selection of activities. This was evidenced from conversations with residents as well as residents' survey results and minutes of residents' meetings.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Substantially compliant
Regulation 3: Statement of purpose	Not compliant
Regulation 31: Notification of incidents	Substantially compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 11: Visits	Substantially compliant
Regulation 13: End of life	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Glendonagh Residential Home OSV-0000229

Inspection ID: MON-0032527

Date of inspection: 11/08/2021

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: We will ensure there are sufficient staff with the appropriate skill mix on duty both day and night. There are ongoing challenges around recruiting nursing staff at present. Recruitment is ongoing to ensure that eight WTE nurses are on the roster. We continue to advertise in house, online, radio and on print mediums. In addition, our senior job specifications are registered with three dedicated recruiters. In tandem we also continue to recruit from abroad thus ensuring a future pipeline of required nursing skillsets. We have currently committed to two nurses from abroad and expect them to be in place before the end of November. A new dedicated Activity Co-ordinator has been appointed and will be in place by the end of Sept. At present we are recruiting for a CNM (Maternity cover), 2 SRNs and a future DON. Whilst recruiting is ongoing, we continue to be aware of staffing levels and flexibility and will ensure supplementary resources from our HCA Team should additional care and over night be required i.e., resident with increased supervision requirements, EOLC or any other care commitments. This will be assessed by the DON on a rolling basis.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Throughout COVID we relied heavily on hseland.ie during periods of lockdown, now that the facility is open, we will always prioritize onsite training for all mandatory courses as well as ensuring a relevant mix of qualifications. A review of the training matrix will be carried out as part of the monthly management meetings to ensure it is accurate, all staff training will be up to date by Nov and in line with the recruitment and commitment	

to skill mix. At present staff are actively working on hseland.ie. Fire training, training in Dementia and training in responsive behaviour have been organinsed in house.

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
Our policy in relation to records is up to date. Residents' records are audited three monthly to ensure they are up to date to include all required information. Records under schedule 3 that were stored in the hair salon due to present renovations are now stored in a locked press in the Courtyard. Record of those residents that are now deceased are boxed, dated and kept in a locked portacabin for a period of 7 years. Residents' records/activity plans used by HCAs on a daily basis are stored in a locked press in the Orchard unit.
All staff files will be kept up to date with required information in a locked cabinet in the Admin office.
Rosters are filed fortnightly and kept for a period of 7 years.
Any files/inspections relating to health and safety, fire, food will be stored appropriately.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
We were in breach of our registration having 43 residents on the premises to accommodate an individual with respite x 2/52. Going forward this will only be managed if a bed becomes available and in keeping with our registration. The bed used for this purpose has now been removed.
We continue to advertise and recruit for nurses and senior management i.e., Don, CNM and 2 staff nurses' positions. Discussions taking place at present with an experienced nurse with good potential for the position of CNM to replace CNM on Mat leave who will take up position of ADON on her return from maternity leave.
The position of activity coordinator has been accepted by an experienced and talented HCA and discussions are presently being had as how to manage the weekly time table to ensure the activities are meaningful, appropriate and varied.
Even though we have regular meetings with housekeeping staff these have now been stepped up to weekly meetings and a full round of the building to be carried out by the Senior HK and DON/Proprietor on a weekly basis to identify and address any failings.
DON continues her 2 monthly official meetings with HCAs and nurses. Weekly meetings with nutritional team and regular updates with senior HCA group.

Appraisals continue for all staff to help support them and to manage their performance and professional development. Gives staff and management a safe environment for open discussion.
The annual review was updated in May and all residents have access to this document in their rooms.
Regular review by outside agencies to cover auditing of medical and fire equipment.
Essential training in fire drills (weekly) and fire evacuation (monthly) to continue covering day and night staff.
Yearly Risk assessment to be continued highlighting areas to be improved and any failings that require addressing.

Regulation 24: Contract for the provision of services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 24: Contract for the provision of services:
All residents on admission will have a contract of care signed off by Resident/NOK and management. This will outline the care and conditions of the resident while in the care of the Home. Contract will be renewed if there should be a change of conditions or a change of room.

Regulation 3: Statement of purpose	Not Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
Unfortunately, on the day of inspection the Inspector was given an out-of-date Statement of Purpose. The statement of purpose outlines the facilities and services that are provided by the home.

An up-to-date statement of Purpose is now available. The WTEs is reflecting our present staffing levels. 42 residents are the number of residents we have been regulated for and going forward only 42 residents will be accommodated at any given time and this will include respite.
The statement of Purpose is updated yearly.

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
All required notifications are notified in a timely order. In not sending complaint dated 26/01/21 was an oversight on the side of the DON.
A record of all incidents is recorded in the home.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
On admission Residents and their families are made aware of our complaint's procedure. At all residents' meetings this is again reiterated and residents made aware of advocacy services available to them.
Complaint forms now in place in the main reception area and around to building so resident and families have access and they are visible to all.

Regulation 11: Visits	Substantially Compliant

Outline how you are going to come into compliance with Regulation 11: Visits:
Up to date HPSC guidelines are on view for residents, visitors and families to read. All visits are accommodated in two visiting rooms or outside visits/trips as requested.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Painting is being carried out on a rotational basis throughout the Centre. The dementia unit is having a total revamp to make it more dementia specific and provide more dining space. One ensuite in the lower Manor (rm 27) and the ensuite (rm 28) are to have their floor covering replaced.
Curtains in room 27 (3 bedded room) will be replaced with blinds.
Sluice rooms in the Courtyard and Manor have been revamped and are now to be

included in the weekly deep clean schedule. Hand washing sinks are available in both sluices.
Weekly meetings to be held with Head HK. Weekly inspection of the building to be done by head HK and DON to identify failings and work to be carried out.
Maintenance to carry out an audit of all bathrooms to ensure they are of a high standard and in line with infection control.
More signage has been displayed in main public areas to enable visitors and residents find their way more easily.
We acknowledge there are areas in the home that require attention and these are all being addressed with the Proprietor, DON, maintenance and housekeeping staff. The Maintenance staff are working a five-day week at present to bring the home up to acceptable standards.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
Our infection control policy is up to date and available to all staff to make themselves familiar with, 3 monthly audits are carried out to identify failings in the systems and the building.
We endeavor to educate staff on best practice, hand washing, PPE, and infection control, carrying out audits on a regular basis.
A meeting was held with head of Housekeeping to address issues highlighted by HIQA. These are being addressed at present i.e., cleaning of sluice rooms, deep cleaning etc.
Cleaning records for cleaning of equipment are in place and same reiterated to all staff the importance of same.
The sluice rooms have been revamped and deep cleaned and are awaiting painting
Replacing of furnishings and refurbishment is continuing.
Presently being reviewed is our COVID 19 preparedness plan and COVID 19 prevention policy.
Wall mounted hand sanitizing foam dispensers should be in operation in the next week. Awaiting supply of foam to be delivered.
Bins for the bathrooms are being sourced at present. Laundry trolley is supplied in the Orchard unit.
Sanitizing of equipment i.e., wheelchairs, hoists have a cleaning schedule in place between use.
To accommodate a situation where the home may require a single room for isolation/EOLC a room is presently being organized in The Courtyard area.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Fire audits are carried out routinely around the building by our Fire Warden. The location maps around the building will be updated on September 10th to outline the compartments.
Fire training was carried out on July 10th and those four staff who were unable to attend the training in July for various reasons will now have training organized with other staff who are now training on Sept 10th. All staff employed in the home will then have completed fire training.
Fire drills are being carried out weekly to make sure all staff and residents where possible are aware of the procedures to be followed. All those attending will be documented. Fire evacuation will continue monthly so staff are more familiar with the routines for evacuation if a fire should take place.
Procedures that are required in the event of a fire will be displayed in the home.
All fire doors have been attended to by a carpenter and will continue to be checked as part of the weekly routine of fire drills.
Fire door that was stiff at the top of the stairs in the upper Manor has been addressed and now working satisfactorily.
Door wedges are no longer used in the centre to keep doors open.

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
We strive to ensure all staff in particular Healthcare staff are aware of appropriate intervention to effectively care for residents with behaviours that challenge. Following discussions with a training company, inhouse training has been organized for training in dementia and responsive behaviour. As part of new staff induction, responsive behaviour is always discussed and staff who are asked to read the policy and sign off if they have understood. Residents with behaviours that challenge are constantly monitored and behaviours logged over a 24hr period x 7/7 ruling out any infections, pain etc. Nurses will be supported to ensure they are familiar with appropriate assessment and care planning approaches for residents. Input from residents/nok/GP/MH Team and nursing staff will be sought.
Any residents that use restraints i.e., bed rails, medication will be monitored closely and all restraints are reviewed 3/12 by NOK/Resident/GP and nursing staff.

Regulation 9: Residents' rights	Substantially Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: Regular resident meetings are held where residents are encouraged to voice their opinions, make decisions that improve their lives and those who live in the home and we will continue to address issues raised i.e., dining experience, environment, visiting, activities that are appropriate and varied, preferences. Regular resident questionnaires are carried out to give management of the home feedback as to the care provided, Family questionnaire and family meetings will also be held. Residents are encouraged to exercise their civil, political and religious rights. They are informed of advocacy services available, external services i.e., GP services, physio, SALT, TVN etc. A fortnightly programme of activities and events are posted for residents to view and experience and will be led by the newly appointed Activity coordinator. Residents are always given a choice as regard their preference's. Newspapers, TV, and access to phone and Facetime are available on a daily basis. New staff when inducted are always spoken to re the importance of the privacy and dignity of the resident. This is addressed at all staff meetings and discussed at residents meeting.	

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 11(1)	The registered provider shall make arrangements for a resident to receive visitors.	Substantially Compliant	Yellow	01/09/2021
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	30/11/2021
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	04/11/2021
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular	Substantially Compliant	Yellow	01/11/2021

	designated centre, provide premises which conform to the matters set out in Schedule 6.			
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Substantially Compliant	Yellow	01/09/2021
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	13/08/2021
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	13/08/2021
Regulation 24(1)	The registered provider shall agree in writing with each resident, on the admission of that resident to the designated centre concerned, the terms, including terms relating to the bedroom to be	Substantially Compliant	Yellow	01/09/2021

	provided to the resident and the number of other occupants (if any) of that bedroom, on which that resident shall reside in that centre.			
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Not Compliant	Orange	22/10/2021
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Red	12/08/2021
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Red	12/08/2021
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre	Not Compliant	Red	12/08/2021

	to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.			
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Red	12/08/2021
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Red	12/08/2021
Regulation 03(1)	The registered provider shall prepare in writing	Not Compliant	Orange	01/09/2021

	a statement of purpose relating to the designated centre concerned and containing the information set out in Schedule 1.			
Regulation 03(2)	The registered provider shall review and revise the statement of purpose at intervals of not less than one year.	Substantially Compliant	Yellow	01/09/2021
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.	Substantially Compliant	Yellow	01/09/2021
Regulation 34(1)(b)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall display a copy of the complaints procedure in a prominent position in the designated centre.	Substantially Compliant	Yellow	01/09/2021
Regulation 7(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to	Substantially Compliant	Yellow	04/11/2021

	respond to and manage behaviour that is challenging.			
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Substantially Compliant	Yellow	20/09/2021
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Substantially Compliant	Yellow	20/09/2021