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:	Aisling House Nursing Home
Name of provider:	Hussein & Jeanette Ali Limited
Address of centre:	Sea Bank, Arklow, Wicklow
Type of inspection:	Unannounced
Date of inspection:	06 December 2022
Centre ID:	OSV-0000003
Fieldwork ID:	MON-0035426

About the designated centre

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

Aisling House Nursing home is a single-storey centre, which provides residential care for 50 people. It provides care for both male and female adults with general care needs within the low, medium, high and maximum dependency categories. A pre-admission assessment is completed in order to determine whether or not the service can meet the potential resident's needs. Twenty-four-hour nursing care is provided.

There were 34 single bedrooms, 23 of which had en-suite facilities and eight twin bedrooms, five of which had en-suite facilities. Each bedroom was appropriately decorated and contained personal items such as family photographs, posters and pictures. Communal space included a day room, and two smaller sitting rooms. The laundry and sluice room were situated in an adjacent building.

The environment was bright, clean and well maintained throughout. There was a well maintained internal courtyard. Adequate parking was available at the front of the building.

According to their statement of purpose, the centre strives to deliver resident focused care packages tailored to meet the individual needs. The centre aims to promote the quality of life and independence of residents through professional and friendly services.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	36

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 6 December 2022	09:00hrs to 17:10hrs	Bairbre Moynihan	Lead
Wednesday 7 December 2022	09:15hrs to 15:55hrs	Bairbre Moynihan	Lead

What residents told us and what inspectors observed

Overall, on the day of inspection, the inspector observed staff being kind, caring and attentive to residents' needs. Residents informed the inspector that they were happy in the centre and residents were complimentary about the staff and the food. The registered provider representative was onsite for both days of the inspection and it was evident that residents were familiar with her and the person in charge.

The inspector arrived to the centre in the morning for an unannounced inspection following an application by the registered provider to renew the registration of the centre. The inspector was greeted at the entrance by a staff member where a temperature check was taken. Following an introductory meeting with the person in charge the inspector was guided on a tour of the premises.

Aisling House Nursing home is registered to accommodate 50 residents with 36 residents on the day of inspection. The premises is a single storey building containing two units; Mountainview and Seaview. Seaview is an extension to the centre and it is a modern and purpose built containing 19 single ensuite rooms. One wing of this (10 bedrooms) was unoccupied on the day of inspection. A dining room and sunroom with a panoramic view of the sea was within the new extension. Mountainview was the original section of the nursing home. This contained a mixture of single and twin rooms with some en-suite facilities. There was an open plan dining room and sitting room and an additional two sitting rooms available. Residents had personalised their rooms with pictures and photographs. Residents in some of the twin rooms were required to share wardrobes and chest of drawers which will be discussed later in this report. The centre had an internal courtyard for residents' use which had a view of the sea. The registered provider had plans to landscape land at the back of the centre for residents.

The registered provider had no staff member dedicated to activities, it was included in the role of the healthcare assistant. The inspector was informed that they had an activities co-ordinator for a short time but the position was now vacant. Residents were observed to be taking part in an exercise class on both days of inspection via a DVD and guided by a healthcare assistant. A healthcare assistant was reading out the news to residents on the first day of inspection and hand massage was provided to a small number of residents. The inspector was informed that a staff member was trained in sensory activites and this normally took place on Mondays. The residents' Christmas party was scheduled for December 15th. Residents had access to a television and radio in their rooms and in communal areas. WIFI was available in the centre for residents and two daily newspapers were provided and a weekly local newspaper. Residents were observed to reading the newspapers during the two day inspection.

The lunchtime experience was observed. The majority of residents attended one of the dining rooms or a sitting room to eat their lunch. Some residents chose to remain in their room and this choice was respected. Residents were provided with a

choice at mealtimes. Modified diets were provided to residents who required them. Staff were available to assist residents who required assistance and this was provided in a relaxed, discreet and unhurried manner. Outside of mealtimes residents were provided with drinks and snacks.

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

Capacity and capability

This unannounced inspection was carried out over two days following an application by the registered provider to renew the registration of the centre. Additionally, the inspector assessed the overall governance of the centre to establish if the actions outlined in the centre's compliance plan following the inspection in October 2021 had been implemented and sustained. Overall, the inspector found that some of the actions from the previous compliance plan had been implemented for example an additional healthcare assistant was rostered on nights to aide with fire evacuation if required. In addition the registered provider had made a number of improvements around fire precautions but additional work identified in a fire safety risk assessment was still ongoing. Non-compliances were observed in Regulations 21: Records and 28: Fire precautions.

The registered provider was Hussein and Jeanette Ali Limited. The company had three directors one of whom was the registered provider representative. The registered provider was not involved in the running of any other designated centres. The inspector was informed that the registered provider representative was onsite everyday for approximately four hours and attended the feedback meeting at the end of the two day inspection. The person in charge had overall responsibility for clinical and operational support, reported to the registered provider representative and was supported in the role by a senior staff nurse, staff nurses, healthcare assistants, cleaning, catering and maintenance staff. The statement of purpose outlined that the centre should have two senior staff nurses. Due to a vacancy of a senior staff nurse the person in charge was not supernumery at the time of inspection. This arrangement limited the time available to dedicate to the person in charge role and could leave the centre in a vulnerable position, should the person in charge be required to be absent for any extended period. The centre was registered for 50 beds with 36 residents on the day of inspection. The inspector was informed that they were challenged with recruiting staff which resulted in 14 beds being vacant. In addition, the centre had an operations manager who oversaw some administrative aspects in the centre.

The registered provider had engaged with a new provider for providing online education. Staff had access to a wide range of training including mandatory training such as safeguarding and infection prevention and control. In addition staff had

access to dementia training and training in end of life care. The training matrix was overseen by the operations manager.

Systems of communication were in place between the registered provider representative and the person in charge three monthly. Items discussed included resident falls, complaints, outbreaks and audits. Staff meetings also took place on a three monthly basis with fire drills, incident reports and future prevention measures discussed. No time bound action plan accompanied any of the minutes viewed. The registered provider had a system of audit in place. Audits included environmental audits, medication management and hand hygiene audits. Audits were identifying issues and a timebound action plan with sign-off from the person in charge when the action was completed accompanied the audits. The provider had a risk register in place which was reviewed yearly by the registered provider representative and the person in charge. An annual review of the quality and safety of care aligned to the national standards was completed for 2021.

Records reviewed contained the majority of information required under Regulation 21, however the inspector identified that three staff did not have Garda (police) vetting in place. The inspector was informed that additional two staff also required it. This will be discussed under Regulation 21: Records. The directory of residents generally contained all the information outlined in the regulation however, four entries reviewed were incomplete.

The majority of the contracts of care reviewed contained the weekly fee and the additional fees that residents may have to pay. Not all records reviewed outlined the number of residents that would reside in the room.

Incidents requiring reporting to the Office of the Chief Inspector were reported within the required timelines. The majority of incidents reviewed were falls related. Further review of the falls had not taken place to identify trends. Complaints were managed in line with the centre's own policy and in line with the regulation. In addition, all policies required by schedule 5 were in place and up to date.

Registration Regulation 4: Application for registration or renewal of registration

A completed application had been submitted within the required time frame for the renewal of the registration of the centre.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge had been the person in charge of the centre for a number of years, is a registered nurse with the required managerial and nursing experience in

keeping with statutory requirements. The person in charge was actively engaged in the governance, operational management and administration of the service.

Judgment: Compliant

Regulation 15: Staffing

In response to staff recruitment issues the occupancy of the centre was 36 beds on the day of inspection. The centre is registered for 50 beds. A number of gaps in staffing were identified including:

- One senior staff nurse post and two staff nurse posts were vacant. The inspector was informed that a senior staff nurse was due to start in December and a staff nurse in January. Staff nurses had been recruited for two posts but were awaiting visas.
- Three healthcare assistant vacancies existed. One was recruited and was due to start on the week following inspection.
- In addition, two catering assistant posts were vacant with one due to be filled in January.
- Management stated that they were in the process of recruiting an activities co-ordinator.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The provider had engaged with a new online provider for delivering training. Improvements were identified since the last inspection. All staff had completed online training in behaviours that challenge, dementia and safeguarding training. Outstanding training was minimal and included: two staff were awaiting manual handling and fire training. One of these had just commenced working in the centre.

Judgment: Compliant

Regulation 19: Directory of residents

Improvements were required in the directory of residents. The dates of admission for four residents was not completed. In addition, the name and address of a general practitioner was not completed for one resident.

Judgment: Substantially compliant

Regulation 21: Records

A sample of records was reviewed. Gaps identified included:

- Of the four records reviewed, three did not contain a Garda (police) vetting disclosure. Management stated that they were new staff and they had been advised that it was not required. The inspector was informed that a request for the vetting disclosures was sent to the relevant staff during the inspection. In addition, the inspector was informed that a further two staff did not have garda vetting in place.
- Two records contained gaps in the employment history with no satisfaction history for those gaps.
- Three records did not contain an up to date address for staff.

Judgment: Not compliant

Regulation 22: Insurance

The registered provider had a contract of insurance in place against injury to residents which was provided to the inspector for review. The inspector saw that this was renewed yearly and was up-to-date.

Judgment: Compliant

Regulation 23: Governance and management

While the centre had a number of assurance systems in place to be assured of the quality and safety of the service, areas for improvement were identified:

- The registered provider was aware of the risks identified in the fire safety risk assessment around fire and were endeavouring to mitigate them, however, these risks were not documented on the risk register. In addition, risks identified on the inspection in October 2021 such as the lack of availability of dedicated hand hygiene sinks in the centre had not been risk assessed and or placed on the risk register.
- Incidents were reported in the centre, however, tracking and trending of these incidents was not taking place. This did not provide management or staff with an insight into the cause of the incidents and if there were any emerging trends and therefore no learning was derived.

- Meetings minutes reviewed did not contain time bound action plans.

Judgment: Substantially compliant

Regulation 24: Contract for the provision of services

Four contracts of care were reviewed. Two records did not indicate if the resident was occupying a single or twin room. One contract did not outline the resident's weekly fee.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

Discrepancies were observed in the statement of purpose (SOP) and function and floor plans. For example:

- The size of the old sluice room and old laundry differed in the statement of purpose (SOP) and floor plans.
- The dimensions of the hot presses in the centre were not aligned in the SOP and floor plans and one hot press was not included in the statement of purpose.

In addition, the statement of purpose did not include the arrangements made for consultation with, and participation of residents in the operation of the designated centre.

These were discussed with management at the feedback meeting.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

All incidents were notified to the Office of the Chief Inspector in line with regulatory requirements.

Judgment: Compliant

Regulation 34: Complaints procedure

The complaints procedure was on display at the entrance to the centre which identified the person in charge as the nominated person to investigate complaints. The procedure also identified the appeals process and the person responsible for investigating the appeal. The centre had received two complaints in 2022 to date. A review of the complaints log showed that complaints were recorded, investigated and the satisfaction or otherwise of the complainant was recorded. In addition, the provider had an up to date complaints policy in place.

Judgment: Compliant

Regulation 4: Written policies and procedures

All policies required under schedule 5 in the regulations were available for review on the day and were all up-to-date.

Judgment: Compliant

Quality and safety

Overall, residents had a good quality of life in Aisling House nursing home and were encouraged to live their lives to their own capabilities. Residents had good access to their general practitioner if required, a high level of nursing care and health and social care providers if required. Residents care plans and validated risk assessment tools were updated at four monthly intervals or more frequently if required. Improvements were required in Regulations 12: Personal Possessions, 17: Premises, 26: Risk management, 27: Infection control, 28: Fire Precautions and 9: Residents' rights.

The centre had unrestricted visiting. Booking was required at weekends to manage footfall, however, residents and visitors spoken did not find this a constraint. Visitors were complimentary about the centre and about the care their relative/friend received.

Residents in single rooms had their own wardrobe, chest of drawers and bedside locker. However, residents in some shared rooms were required to share storage space and or to enter another residents bed space to access their personal storage. This will be further discussed under Regulation 12: Personal Possessions.

Overall the centre was generally clean on the day of inspection. The registered

provider had two housekeeping staff who covered seven days a week. The provider had built a new wing to the centre which opened within the last year. This was built to modern specifications. The laundry room in the new wing was not operational at the time of inspection as the registered provider was awaiting an upgrade on their electricity grid in order to install industrial washing machines. In the meantime residents laundry, bed linen and towels were laundered off-site. The "old laundry" room was still in use at the time of inspection for laundering residents' clothes protectors. This rooms was small and it was difficult to maintain a dirty to clean flow of the laundry. Actions required in Premises and Infection control will be discussed under the specific regulation.

The provider had an information booklet for residents which contained all the requirements of the regulation. While the centre had an up-to-date risk management policy in place it did not contain all the requirements of the regulation which will be discussed in further detail below.

Since the last inspection the registered provider had engaged with the office of the chief inspector and had made improvements to fire precautions. For example:

- The provider had engaged a competent person and a fire safety risk assessment was completed. This identified areas that required improvement. These improvements were ongoing at the time of inspection. Following the inspection, the Office of the Chief Inspector was informed that the provider had engaged with a fire specialist company to complete the required upgrades and an updated time bound action plan was provided.
- A fire alarm system that covered the whole centre was installed in October 2022. This was an L1 system which is in line with current guidance for designated centres.
- The local fire service had been onsite to do a walkaround of the centre.
- The emergency lighting in the centre and the directions of the signage was reviewed .
- All fire exits were accessed via a key only. A key was in place at every exit and all staff carried a key with them at all times.
- No doors were observed to be wedged open during the two days of inspection.
- Oxygen cylinders had been removed from the centre and two oxygen concentrators were available which were stored in a store room.
- Daily, weekly and monthly checks of for example escape routes and fire alarm checks were carried out.
- The registered provider had engaged with a new fire servicing provider to carry out quarterly and yearly checks of the fire alarm system, emergency lighting and fire extinguishers. These had been completed quarterly with the new provider and a yearly inspection of the fire extinguishers took place in September 2022.

Notwithstanding the number of improvements made since the last inspection, additional improvements were required as identified in the fire safety risk assessment and on inspection. These will be further discussed in the report.

Staff had access to safeguarding training with all staff having completed it. The centre was not a pension agent for any residents and residents' petty cash was managed appropriately by staff.

Residents could undertake activities in private, shared bedrooms had privacy curtains and there were communal rooms if residents wished to spend time alone. Activities were taking place approximately 2 hours per day. Residents' records reviewed indicated that activities were passive for example on the day prior to inspection it was documented that a resident observed mass and listened to the daily newspaper being discussed. On the two days of inspection an exercise class was taking place and approximately 12 residents took part each day. Notwithstanding this residents were observed to be idle for periods of time during the inspection. Residents were consulted about the running of the centre through resident meetings. The last meeting was in May 2022 and management stated that the next meeting was cancelled due to an outbreak of COVID-19. The previous meeting was in January 2021. A residents survey was completed in 2021 with 20 respondents out of 27 residents consulted.

Regulation 11: Visits

Visitors were observed in the centre during the two day inspection. Open visiting was taking place with a temperature check only at the entrance to the centre. Visitors were required to book at the weekend to manage footfall. Visitors confirmed there was no restrictions on them visiting family and friends.

Judgment: Compliant

Regulation 12: Personal possessions

Improvements were required in relation to residents' personal storage and access to the storage. For example:

- Residents in a number of twin rooms in Mountain view were required to share wardrobes and chest of drawers. This was a finding on the inspection in October 2021.
- Personal storage was not always located within the floor space of the resident's room. For example: wardrobes were located within the floor space of another resident.
- Some wardrobes which had to be accessed by both residents were at the end of a residents bed and due to space constraints the doors of the wardrobes could not be fully opened.

Judgment: Substantially compliant

Regulation 17: Premises

While Seaview was purpose built and was operational within the last year, areas of Mountainview in contrast did not conform to the matters set out in schedule 6. For example:

- General wear and tear was noted throughout Mountainview including chipped doors and skirting.
- Storage in the centre required review. For example:
    - Residents wheelchairs and hoists were stored in bathrooms and on corridors.
    - A staff members work bench containing tools was stored in a store room in Seaview which also contained incontinence wear.
    - The medication fridge was stored in a store room with incontinence wear, a hoist, gloves and phlebotomy equipment.

Judgment: Substantially compliant

Regulation 20: Information for residents

The centre had a residents' guide available for residents. The guide contained all the requirements set out in the regulation.

Judgment: Compliant

Regulation 26: Risk management

The risk management policy while in date did not contain all the requirements outlined in the regulations. Specifically:

- One of the identified risks was not contained in the policy or the actions and measures in place to control the risk.
- The arrangements for the identification, recording investigating and learning from serious incidents and or adverse events involving residents.

Judgment: Substantially compliant

Regulation 27: Infection control

While the inspector observed that the centre was generally clean on the day of inspection, improvements were required in order to ensure that procedures are consistent with the national standards for infection prevention control in community services. For example:

- Staff only had access to two hand hygiene sinks in the centre. Neither of these were compliant with the required specifications.
- A small number of hand gel dispensers were empty.
- Housekeeping staff had not received training in the principles and practices of cleaning.
- There was no wall mounted soap in the sluice room in Seaview. This was brought to management's attention on the first day of inspection and soap was subsequently placed in the sluice room.
- The sluice room did not contain a clinical waste bin.
- Management stated that the old sluice room was no longer in use. It was outside the main building but it remained within the footprint of the centre and on the most recent floor plans it remained as the "old sluice room". This room contained contained a water purifier. This room required review and the provider needed to be assured there was no risk of cross contamination.
- The temporary closure on sharps boxes was not engaged on two sharps boxes observed.
- Some personal protective equipment was observed to be out of date for example: surgical masks were out of date since May and June 2022.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Notwithstanding the number of improvements made since the last inspection, additional improvements were required as identified in the fire safety risk assessment and on inspection.

Additional improvements required included:

- The fire evacuation floor plans required improvement as they did not provide clarity on the compartments or escape routes. In the interim the provider had the compartments displayed in writing beside the fire alarm panel.
- Personal Evacuation Emergency plans (PEEPs) were kept in a locked office on one side of the building. While all staff had a key to the office, in the event of a fire time would be lost sourcing these. Staff spoken to were unsure of how individual residents would be evacuated without access to the PEEPs.
- Fire drills were being conducted at regular intervals, however, it was unclear from records reviewed if fire drills were conducted of the largest

compartment with night time staffing levels. Fire drill records did not indicate the number of residents in the compartment being evacuated. Furthermore, four staff were involved in the drills, however, only three staff were on a night shift.
- Certificates of completion of quarterly and yearly checks had not been issued by the fire servicing provider. However, engineers reports were available.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

The inspector observed a sample of care plans. Overall the standard of care planning was good and described individualised and evidence based interventions to meet the assessed needs of the residents. Care plans were updated at four monthly intervals in line with regulations. Validated risk assessment tools were used for example; Waterlow score for assessing the risk of acquiring pressure ulcers and updated at regular intervals.

Judgment: Compliant

Regulation 6: Health care

Residents generally retained their own general practitioner (GP) on admission to the centre. Residents were reviewed routinely every three months and more frequently if required. Outside of working hours an on call GP service was contacted.

The inspector was informed that health and social care providers were accessed through a private company or the HSE except for physiotherapy. This was provided at a fee to the resident. Old age psychiatry reviewed residents onsite following referral. Residents attended the optician and dentist in the local town.

Judgment: Compliant

Regulation 8: Protection

The registered provider had a number of assurances in place to safeguard residents and protect them from abuse.

- Staff had access to safeguarding training with all staff having completed it.
- Staff spoken with were knowledgeable of what constitutes abuse, the different types of abuse and how to report any allegation of abuse.

- Residents' money was kept in a safe with two staff members and the resident or a resident representative required to sign if money was added or removed from the safe. Receipts were available for anything purchased for the resident for example; clothes.
- A sample of records reviewed indicated that three staff did not have the required garda vetting in place. This was discussed under Regulation 21: Records above.

Judgment: Compliant

Regulation 9: Residents' rights

Action was required by the registered provider to ensure that residents' rights were respected and their social care needs were met. Areas to be addressed included:

- Similar to findings from the inspection in October 2021 activity provision required review to ensure that all residents had opportunities to participate in activities in accordance with their interests and capacities.
- No time bound action plan accompanied the residents survey from 2021 to address the issues identified.

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	
Registration Regulation 4: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Substantially compliant
Regulation 21: Records	Not compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Contract for the provision of services	Substantially compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Substantially compliant
Regulation 17: Premises	Substantially compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management	Substantially compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Aisling House Nursing Home OSV-0000003

Inspection ID: MON-0035426

Date of inspection: 07/12/2022

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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: A Recruitment drive began on notification of the registration of 19 additional rooms when our application to vary was complete. A specific and bespoke Admission and Staffing Plan was created and adhered to. The challenges of recruitment in the Nursing Home sector is ubiquitous across all of the other centres that we speak to and interact with; and that sentiment is echoed by the healthcare sector as a whole. Visa processing delays, vacancies and a multitude of other roadblocks and unforeseen issues occur yet we will still follow our Admission and Staffing Plan along with tools to assess dependency and staffing complement, to ensure sufficient staff for the Residents of Aisling House Nursing Home at all times. It is stated in our Admission and Staffing Plan that as the complement of qualified staff increases, so will the occupancy of the registered centre; the milestones that we have instituted are clear and we believe achievable. It is envisaged that by June 2023, Aisling House would have a Staffing complement that would be able to sufficiently cater for 50 Residents.	
Regulation 19: Directory of residents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 19: Directory of residents: The information that required improvements in the physical Directory of Residents were	

made shortly after the day of Inspection. Our digital Directory of Residents was fully up to date along with basic reminder printouts on the office walls. Cross referencing now occurs on a more frequent basis and part of the Management Team Meetings agenda.

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
The five members of Staff without Garda Vetting were all vetted in their native country, prior to being furnished with Employment Visa from the Department of Enterprise, Trade and Employment along with attending subsequent GNIB appointments with the Garda.

The Inspector informed the Director of Nursing that it is a requirement that all staff be formally Garda Vetted and the application for Garda Vetting commenced during day one of the Inspection. All five members of staff received their Vetting Disclosure shortly after, with the final disclosure being made on 23 December 2022.

The two gaps in employment identified were immediately remedied with the staff members in question and all records contain up to date information for Staff, such as addresses. The staff in question had recently moved to Ireland and in the process of acquiring long term accommodation.

Records and Record Keeping has been added to the monthly Management Team Meeting as an agenda item to ensure correct governance.

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Fire Safety Risks that were identified in the Fire Safety Risk Assessment 06 November 2022 were documented in the Risk Register shortly after the inspection. Additional Risks including risks identified in the October 2021 inspection are now risk assessed and placed on the Risk Register as appropriate. A review of this is to conclude on 10 February 2023.

Incidents will now be collated and analysed every three months to assess any themes or trends evident from the Incident Recording Forms and outcomes.

Management Team Meetings template has been amended to include provision for time bound action plans.

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 contracts were reviewed shortly after the Inspection to ensure that the records indicate the correct information as required in Regulation 24.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
The dimensions of the Old Sluice Room and Old Laundry Room were corrected on the Statement of Purpose to reflect the true dimensions illustrated on the Floor Plans.

A number of Hot Presses omitted in the Statement of Purpose were included following a short review.

The Statement of Purpose also clarifies the arrangements made for consultation with, and participation of Residents in the operation of the designated centre.

Regulation 12: Personal possessions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
Individual Wardrobes for the identified twin rooms in Mountain View were sourced and ordered shortly after the inspection. On delivery, these will be placed in the identified rooms.

The layout of the rooms in Mountain View were reviewed and findings documented in the Maintainance Book.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
A robust Maintenance Programme was introduced since the previous inspection in October 2021 where items such as general wear and tear should have been identified in specific areas of the building at the dates that correspond to this. Maintenance has been made aware of this and a general walkaround with documentation of issues was made carried out on 20 January 2023 and the items highlighted for maintenance are now included in the Maintenance Program for remedial works.

Storage in the centre was reviewed on 20 January 2023 and work will begin to correct any storage that required review.

Regulation 26: Risk management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management:
The identified risk and the actions and measures in place to conrol the risk was added to the corresponding policy immediately after the Inspection.

The arrangements for the identification, recording investigating and learning from serious incidents and or adverse events involving Residents shall be analysed every three months to assess any themes or trends evident from the Incident Recording Forms and outcomes.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
The current Hand Hygiene Sinks are being discussed with our Plumber and guidance is also being sought from Nursing Home Ireland as to the required specification.

Hand Gel Dispenser checks were added to the cleaning schedule shortly after the inspection.

Housekeeping Staff received training from the Director of Nursing, utilising years of experience in Infection Prevention & Control, webinars hosted by the AMRIC Team, workshop with the providers of our new single mop system along with current guidance from Public Health, HSE and HPSC. Formal Training is currently being evaluated and will be added to the training matrix as soon as appropriately sourced.

The Sluice Room now has the appropriate soap and a Clinical Waste Bin. This was completed shortly after the inspection.

The Old Sluice Room is still being reviewed and will undergo a name change on completion. No sluicing occurs in this room and once all remedial works are completed within the new extension, this room will be addressed along with the appropriate changes made to the floor plans.

The temporary closure on sharps boxes was engaged and a reminder to all qualified staff was made in regard to our policy on the handling and disposal of sharps.

The PPE store was audited on 10 January 2023 where all out of date PPE was discarded in line with guidance from the HSE CHO6 PPE Team.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: Existing Fire Evacuation Floor Plans are being replaced by bespoke Fire Evacuation Floor Plans, developed by the Fire Safety Consultant and we are awaiting delivery of same. A request has been made to expedite this process.

Consultation with the Fire Safety Consultant on the location for PEEPs commenced and action will be taken pending the outcome of this consultation.

Instructor led Fire Drills including scenario based Fire Drills and Compartment Evacuation Fire Drills with Night Time Staffing Levels took place on 16 June 2022 and 27 September 2022. The reports state the number of Residents in the compartment along with dependency levels of the Residents in the compartment. One such Compartment Evacuation Fire Drill on 27 September 2022 utilised mannequins to simulate immobile Residents, where five of the six Residents in the Compartment where immobile in the exercise. The report concluded that the assessor was satifised the Compartment Evacuation Drill demonstrated the ability of staff to evacuate Residents within a timely manner, within the parameters of the exercise.

The learnings from these Compartment Evacuation Fire Drills inform dependency levels within Compartments and is reviewed every six months or when there is a change in dependency levels of a Resident.

On 02 March 2023 we will be facilitating a Training Day with our Fire Safety Consultants where the Training is concluded with a Compartment Evacuation Fire Drill. This Instructor led Compartment Evacuation Fire Drill will focus on our largest compartment (which has a maximum occupancy of eight Residents but is currently occupied by five Residents).

Certificates of completion of quarterly and yearly checks have been requested from our Fire Servicing Provider. It is envisaged that these will be on-site by our next quarterly inspection which is due by 14 February 2023.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
A new position for a Full Time Activities Coordinator was developed to ensure that all Residents have opportunities to participate in activities in accordance with their interest and capacities. We are now actively hiring for this role with a date for commencement of the role envisioned for 22 February 2023.

The Residents survey document has been modified to include a time bound action plan to address any issues that may be identified.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 12(c)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that he or she has adequate space to store and maintain his or her clothes and other personal possessions.	Substantially Compliant	Yellow	14/02/2023
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Substantially Compliant	Yellow	01/06/2023

Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	10/02/2023
Regulation 19(3)	The directory shall include the information specified in paragraph (3) of Schedule 3.	Substantially Compliant	Yellow	07/12/2022
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	23/12/2022
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.	Substantially Compliant	Yellow	10/02/2023
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,	Substantially Compliant	Yellow	07/12/2022

	including terms relating to the bedroom to be 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 24(2)(b)	The agreement referred to in paragraph (1) shall relate to the care and welfare of the resident in the designated centre concerned and include details of the fees, if any, to be charged for such services.	Substantially Compliant	Yellow	07/12/2022
Regulation 26(1)(c)(i)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control abuse.	Substantially Compliant	Yellow	07/12/2022
Regulation 26(1)(d)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.	Substantially Compliant	Yellow	06/03/2023

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.	Substantially Compliant	Yellow	14/02/2023
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Substantially Compliant	Yellow	06/02/2023
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Substantially Compliant		06/02/2023
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	06/02/2023
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at	Substantially Compliant	Yellow	02/03/2023

	suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.			
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	14/02/2023
Regulation 28(3)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place in the designated centre.	Substantially Compliant	Yellow	06/02/2023
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose relating to the designated centre concerned and containing the information set out in Schedule 1.	Substantially Compliant	Yellow	10/01/2023
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	22/02/2023

Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned.	Substantially Compliant	Yellow	14/01/2023