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:	An Teaghlach Uilinn Nursing Home
Name of provider:	Knegare Nursing Home Holdings Ltd
Address of centre:	Kilrainey, Moycullen, Galway
Type of inspection:	Unannounced
Date of inspection:	14 June 2022
Centre ID:	OSV-0000309
Fieldwork ID:	MON-0037047

About the designated centre

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

An Teaghlach Uilinn Nursing Home is a purpose-built designated centre for older people. Residents are accommodated in single and twin bedrooms. A variety of communal rooms are provided for residents' use, including sitting, dining and recreational facilities. The centre is located close to Moycullen village, Galway. Residents have access to a secure enclosed courtyard. The centre provides accommodation for a maximum of 75 male and female residents, over 18 years of age. The service provides care to residents with conditions that affect their physical and psychological function. Each resident's dependency needs are regularly assessed to ensure their care needs are met.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	60

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 14 June 2022	09:45hrs to 19:30hrs	Oliver O'Halloran	Lead
Tuesday 14 June 2022	09:45hrs to 19:30hrs	Una Fitzgerald	Support

What residents told us and what inspectors observed

Residents and staff welcomed the inspectors into the centre. Residents spoke openly about life in the centre. In the main, two areas of dissatisfaction were reported. Firstly, residents were dissatisfied with the provision of activities in place. This is a repeated finding from the last inspection. Secondly, residents were concerned about the availability of familiar staff to attend to their needs. For example, when asked about staff, one resident replied 'lots of changes in staff but have to get used to that'.

This unannounced risk inspection was carried out over one day. There were 60 residents accommodated in the centre on the day of the inspection and 15 vacancies. On arrival, staff guided the inspectors through the infection prevention and control measures necessary on entering the designated centre. At the time of inspection, there was one confirmed case of COVID-19 in the centre.

Inspectors spoke with residents and also spent time in communal areas observing resident and staff interaction. The main entrance had multiple seating options where residents liked to spend the day watching the comings and goings of staff. Inspectors observed that staff greeted residents when passing by. Inspectors observed that multiple residents mobilised around the centre without restriction. Inspectors observed that some residents had made close connections within the centre and provided support and companionship to each other.

Inspectors were told that there were a small number of residents in the centre who were assessed as high risk of absconsion. On the day of inspection, a resident who was on increased monitoring was observed on multiple occasions entering a closed communal room in an attempt to exit the building. Inspectors observed that allocation charts in use to minimise risk of residents leaving the centre unaccompanied, evidenced the same resident, at the same time in multiple locations. Therefore, the system was not appropriately monitored.

Residents told inspectors that they were dissatisfied with the provision of activities in the centre. When asked if they had time to chat with the inspectors a resident replied “I have all day”. When the inspectors’ explored this comment further the resident explained that there was no activity held on the first floor and that as a result they found the days very long. Throughout the day of inspection, inspectors observed that no activity had occurred on the first floor.

The provider facilitated visiting in line with local policy guidelines. Residents and visitors who spoke with inspectors, expressed satisfaction with the visiting arrangements in place in the centre.

The centre was laid out over two floors with lift access between floors. The centre was warm and there was appropriate lighting in private and communal areas. Although there were multiple day rooms and internal gardens, not all areas were

open and available for the residents to use. For example; the second communal room on the ground floor was closed. While one of the gardens had unrestricted access, the second required staff assistance to disable door locking mechanisms. The hair salon in the centre was located in a communal bathroom on the first floor. Staff confirmed that the facility is used frequently.

In the main, inspectors found that the premises were clean. Inspectors observed there were some areas of dust build up on floors in resident bedrooms, bathroom drains were not clean. Inspectors observed that some items of residents personal seating was ripped and in a poor state. This meant that some items were not amenable to cleaning. Inspectors also observed, resident care equipment such as hoists and wheelchairs stored inappropriately in communal day rooms. There were call bell access facilities for all bedrooms. Residents' personal laundry was managed on site. Inspectors met with laundry staff who demonstrated good knowledge of the system in place. There was a system in place for the segregation of clean and dirty laundry.

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

Capacity and capability

Overall, inspector's found that the provider needed to strengthen the governance and management structure in the centre. The staffing numbers available for the direct provision of care was inadequate. There was a high level of agency staff in use to cover staffing vacancies. Inspectors found that the systems in place to orientate and induct agency staff were inadequate. This meant that the staff did not know the care needs of the residents which had a direct negative impact on the care delivered. The findings of this inspection were that the provider had not ensured that management systems were in place to ensure the service provided was safe, appropriate, consistent or effectively monitored. Inspectors found non-compliance in eight of the ten regulations reviewed; three of the non-compliance are repeated from the last inspection in February 2021.

Knegare Nursing Homes Limited is the registered provider of the centre. This provider is involved in the operation of four other designated centres. The provider has a clinical director who provides support to the person in charge across the five centres that the provider operates. Inspectors were told that the clinical director is on site in this centre one day per week. The person in charge works full time in a supervisory capacity and is supported by an assistant director of nursing, who also works in a supervisory capacity.

The clinical director and person in charge met with the Chief Inspector in March 2022 to provide assurances and clarity on the future staffing strategy for the centre.

The centre had multiple vacancies at the time of this meeting. Following this meeting, assurances in relation to staffing levels were sought. The staffing strategy submitted to provide assurance that the centre would have adequate staffing in place if the centre's occupancy would increase, was not reflected in the staffing level found on this inspection.

The provider is involved in the operation of four other designated centres.The provider has a clinical director who provides support to the person in charge across the five centres that the provider operates. The inspectors were told that the clinical director is on site in this centre a day each week. The person in charge works full time in a supervisory capacity and is supported by an assistant director of nursing, who also works in a supervisory capacity.

Inspectors found that the centre was not in regulatory compliance and that there was insufficient resources and inadequate managerial oversight of the service provided. The management systems in place were not sufficiently robust. This was evidenced by:

- Staffing- there were significant gaps in the availability of staff when compared to the staffing levels described in the centre's statement of purpose. The centre was heavily reliant on the use of agency staff.
- Despite the inadequate staffing levels, the centre continued to accept new admissions. Inspectors were informed that from January 2022 to the day of inspection, the centre had admitted 33 new residents.
- Care plans were not completed in accordance with regulation requirements. .
- The centre had no process in place for being a pension agent on behalf of residents. On the day of inspection there were a small number of residents that were identified as requiring this service. This service was not in place and resulted in these residents not having access to their finances.

The risk management system in place consisted of a risk register whereby risk was identified, control measures were outlined and additional controls added to minimise the impact of risk to residents. The centre's risk policy was not up-to-date. The policy listed personnel such as a previous person in charge, previous operations manager and the previous registered provider. The Risk policy that was available for staff guidance in hard copy form, differed from the policy available on the electronic documentation system in use by the person in charge. The risk register reviewed did not identify any of the following risks associated with

- the staffing deficits in the centre
- the centre's dependence on agency staffing
- having no system in place for residents to access their pension.

There was an audit schedule in place in the centre. Audit activity for 2022 included an infection control and environment audit, a falls audit and a call bell audit. There was some evidence that audit findings lead to quality improvement and that findings were shared with staff to ensure understanding and implementation. For example: the falls audit had led to interventions to reduce falls risks. Notwithstanding this positive finding in relation to the monitoring of the service, the totality of the

findings of this inspection evidenced that there was a lack of effective supervision of the service provided, which negatively impacted on residents.

There was a training programme in place and all staff had the opportunity to participate in mandatory training. The training records evidenced that some staff had not received appropriate training in fire safety and manual handling training. The person in charge confirmed that mandatory training provision was scheduled for the coming weeks.

The centre had a complaints procedure in place. The procedure was in line with regulatory requirements. However, inspectors found that the procedure was not always followed. For example; the outcome of complaints was not consistently documented and the satisfaction level of the complainant was not recorded. On the day of inspection, inspectors found that an open complaint was not being managed in line with the centre's complaints procedure. Another complaint remained unresolved, while remaining open, the complaint had a significant impact on the quality of life of the resident.

Regulation 15: Staffing

There was insufficient staff to meet the social care needs of the residents as described under Regulation 9, residents' rights.

The skill mix of staff in the centre was not adequate. Agency staff were not appropriately inducted to the centre or to the care needs of the residents. For example, agency staff spoken with did not know the resident's names or did not have a list of residents names to refer to.

Judgment: Not compliant

Regulation 16: Training and staff development

A review of the staff training records in the centre found that some staff had not received training required for their role. For example:

- Inspectors found gaps in fire safety and manual handling training.
- Inspectors found that the systems in place to ensure that agency staff were appropriately inducted was inadequate. For example; agency staff were unfamiliar with fire safety procedures.

Judgment: Not compliant

Regulation 23: Governance and management

Inspectors found that the centre was not sufficiently resourced in relation to the availability of staff. The centre had a significant number of staff vacancies on the day of inspection.

- there were ten health care assistants vacancies.
- there were five nursing vacancies.

A review of the staffing rosters for the two weeks prior to inspection evidenced that these vacancies resulted in:

- A high usage of agency staff, who were not familiar with resident's needs to provide direct care to residents
- Redeployment of activities staff to cover health care assistant hours, to provide direct resident care resulting in a poor standard of social care being delivered to residents

Management systems in place did not ensure that the service provided was safe and effectively monitored. This was evidenced by:

- over reliance on the use of agency staff and the impact this had on person-centered care.
- while inspectors acknowledge that agency staff were required, the system in place to orientate agency staff to the centre, was not effective. For example: On the day of inspection, agency staff did not have any detail about the residents and had a poor response when asked how to find out the names of residents
- the provider's decision to admit new admissions despite inadequate staffing levels.
- the risk management policy and system was insufficient. The risk management policy was outdated and the persons who were allocated responsibility no longer worked in the centre.

Judgment: Not compliant

Regulation 31: Notification of incidents

Notifications were submitted to the Chief Inspector in line with the requirements of Regulation 31.

Judgment: Compliant

Regulation 34: Complaints procedure

Inspectors reviewed the complaints log and found that complaints management was not in line with regulatory requirements. For example:

- The outcome of complaint was not consistently documented
- Closed complaints did not consistently record the complainants satisfaction
- An open complaint was being managed through a process outside of the centre's own complaints procedure

Judgment: Substantially compliant

Quality and safety

Overall, the inspectors found that the provision of quality care was negatively impacted upon and inconsistent due to the staff shortages and the over reliance on agency staff. There were multiple gaps in the oversight of care delivered. This was evidenced in the nursing documentation and through the voice of the residents. While the registered provider had systems in place to monitor and document the service, such as the electronic care planning system, the oversight was not sufficient. Information requested specific to care needs was not available. For example; records on the frequency of repositioning of residents who are at high risk of pressure wound development and location records for resident at risk of absconsion were poorly completed. Inspectors found that care plans did not always contain the information required to guide the care. In addition, the provision of activities required resources to allow for the recommencement of group activities in the centre, as per the resident's requests.

Residents' records were stored on a computerised documentation system. Inspectors found that while residents' needs were assessed using validated assessment tools, not all residents' needs were assessed, which resulted in no care plan being developed to guide care. The review of resident care documentation also found that care plan detail was not always accurate with the most updated information. For example; no changes had been made to a care plan when a resident's mobility had deteriorated.

Inspectors found that there were referral pathways to allied health professionals and other health care services. However, from a review of the documentation, inspectors were not assured that the recommendations of allied health professionals were incorporated into the residents care plans and adhered to.

Resident meetings were held in February, April and June 2022 . Records evidenced that residents had expressed that they want more activities. Residents told inspectors they were dissatisfied with the provision of activities in the centre. While

there was an activities programme in place, inspectors found that the availability of staff to ensure there was adequate provision of meaningful activity was not consistently in place. Staff rosters reviewed confirmed that activities were not consistently held in the centre. Due to the staffing shortages, the activities staff were redeployed to provide direct physical care, reducing the time available to provide social care.

Regulation 11: Visits

The registered provider had ensured that visiting arrangements were in place and were not restricted. On the day of inspection, inspectors spoke with residents' relatives who reported that they were kept up to date throughout the pandemic on the visiting restrictions in place.

Judgment: Compliant

Regulation 27: Infection control

Action was required to ensure the provider was in compliance with the national standards for infection prevention and control in community services published by the authority,:This was evidenced by;

- Cleaning equipment was stored on open shelving in a room used as a sluice room on the day of inspection, increasing the risk of cross infection.
- waste bags containing used continence product were hung from trolleys which contained clean bed linen. These trolleys also contained a linen bag which carried dirty linen. These practices increase the risk of cross contamination.
- There were gaps seen on cleaning schedules
- Some residents personal care equipment, such as shower chairs, were noted to have rusted legs, therefore, effective cleaning of these items could not take place.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Inspectors found that the care plan system in place did not meet with regulation requirements and was not person-centered. Inspectors found that nursing documentation did not reflect the actual care needs of residents. For example,

- a mobility care plan was not updated to reflect changing care needs of a resident.
- an assessment of a residents ability to use a call bell did not inform the resident's care plan. For example, a resident with advanced dementia, who could not utilise a call bell, did not have guidance in the care plan on how staff were to monitor their safety.

Judgment: Substantially compliant

Regulation 6: Health care

Nursing documentation was not completed in line with professional guidelines. For example;

- poorly recorded safety location charts did not provide assurance that an appropriate care plan was in place. For example, a resident that was on increased monitoring had records that evidenced them in two different parts of the building at the same time.
- there were no records available to evidence that a resident with a significant wound, had been repositioned two hourly, in line with their care plan.

Judgment: Substantially compliant

Regulation 8: Protection

The provider did not have a system in place to protect resident's finances. For example; the provider acted as a pension agent for a small number of residents. However, the arrangements in place did not reflect the guidelines set out by the department of social protection. These residents did not have appropriate access to their finances.

Judgment: Not compliant

Regulation 9: Residents' rights

The provision of activities in the centre was limited. This meant that there were limitations on the number of residents that had the opportunity to participate in activities in accordance with their interests and capacities. On the day of inspection, there was one staff member allocated to provide activities for 60 residents across two floors. Residents told inspectors that they were dissatisfied with the provision of

activities in the centre. The provider had failed to implement the compliance plan from the last inspection and this is a repeated non compliance from the April 2021 inspection.
Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Substantially compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for An Teaghlach Uilinn Nursing Home OSV-0000309

Inspection ID: MON-0037047

Date of inspection: 14/06/2022

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	Not Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
The agency induction and orientation has been reviewed with a comprehensive and detailed induction now in place for both Nursing and Health Care Assistant staff. All agency staff arriving on duty are given a comprehensive handover and induction in relation to the residents that reside in the centre. Where possible we choose to ensure that we have consistent agency staff in the centre and strive to always ensure agency staff working here are regular agency staff who have a knowledge of the Nursing Home and the systems in place in the centre.

All agency Healthcare Assistant staff (HCA) are assigned a 'buddy' to work with on commencement of their shift. This buddy is a senior member of staff who will guide and direct the agency staff throughout the shift. The use of Agency HCA's has decreased significantly across the Nursing Home post inspection with the expectation that we will no longer require these supports by end of September 2022 due to the number of new staff that have commenced.

Post inspection (and as advised during inspection) we have had a number of staff commence employment across all departments.

1 x Registered Nurse
7 x HealthCare Assistants
1 x Housekeeping
1 x Catering Team

A CNM has been appointed to the centre to enhance the governance structure and support both the DoN and ADoN with the supervision of staff and observation and oversight on the floors. The CNM is due to commence employment on September 19th 2022.

A Senior Nurse has also been appointed to work opposite the CNM and to allow for management presence in the Nursing Home across 7 days. Both these staff will enhance

the management structure and support the DoN and ADoN with the day-to-day oversight of staff and clinical care.

In addition to this we have:
1 x RN due to return from leave
2 x RNs due to arrive in October for RCSI aptitude test.
3 x HCAs due to commence the week beginning August 15th.
We have a further 5 x HCAs awaiting Garda Vetting and ready to commence employment.

All new staff receive an induction which is managed and overseen by the center's senior management team. All staff receive an induction which involves them being supernumery for a period to allow them come to terms with and have a good understanding of the systems and routines in place. All new staff work alongside a senior member of staff (assigned buddy) for this period to ensure a consistent approach to the induction process. All inductions are formal and recorded to ensure there is a detailed account of the elements of the role that is required of them. Training is provided pre-commencement of the role and during the first month of employment. Training is blended in its approach with both practical and theory-based training provided both on and off site.

Rosters reflect the needs of the centre and its residents. Rosters and shift patterns have been reviewed to ensure adequate and appropriate staff and skill mix on duty to meet the expressed and assessed needs of residents.

Recruitment remains ongoing within the centre. There is a planned trip abroad in September 2022 to recruit Nursing Staff

Brookhaven Healthcare continues to use the support of a recruitment agency to employ staff across all departments. Extensive recruitment campaigns have been ongoing locally, nationally and internationally to ensure our staffing levels within the centre adhere to those outlined in the Statement of Purpose.

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
Post inspection a review of the training records has taken place. As advised at the time of inspection several training dates had been booked for staff training and these went ahead as planned for:
Fire Safety
Safeguarding
Manual Handling

The agency induction and orientation checklist has been modified and updated and now includes additional information on Fire Safety Procedures. A comprehensive induction and handover now occurs with all agency staff in respect of the safety procedures on site. The checklist requires the agency staffs signature to ensure their understanding and acceptance of the procedures in place.

An external support has been to the centre on several occasions over the past month to audit staffs understanding and competency in areas of training to include both safeguarding and fire precautions. Manual handling techniques and practices have also been audited on site. These competencies which were completed 1:1 on all occasions are available for inspection within the centre. The findings of these audits were shared with staff and indicated deficits and refresher trainings required for individual staff.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The centre has reviewed practices relating to oversight and management. All Nursing staff are to receive additional training in effective leadership and management. The reporting structures and escalation pathways have been discussed with all staff to ensure that all opportunities for learning and improving of services and service delivery are identified and acted upon.

An external clinician has been on site weekly working with the HCAs in respect of their roles and responsibilities. Practices have been reviewed and deficits noted have been acted apon. Staff have received additional support in respect of changes to practices that are not supported or led by best practice.

A CNM and Senior Nurse have been appointed to the centre. Both these positions will strengthen the management structure within the centre and assist the DoN and ADoN with the oversight of both staff and clinical care. The CNM is due to commence on 19-09-2022 and the Senior Nurse on 05-09-2022.

The Management Team on site meet with Board of Management weekly to ensure communication of all concerns, to review staffing levels and the workforce plan for the centre.

The centers risk assessments in relation to staffing and agency usage has been reviewed and updated.

The centers admissions continue to be limited only to beds contracted with Service Level Agreements in place.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The complaints process within the centre has been reviewed. The Complaints Policy is currently being updated.

The complaints logged and reviewed during the inspection have been reviewed. Where appropriate, complaints were revisited with complainants and outcomes noted and satisfaction reassessed.

Complaints management training has been scheduled in the centre for September 2022 to ensure all staff are fully aware of the complaints policy and procedure within the centre.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
Training has taken place with all housekeeping staff on 11-08-2022 and cleaning schedules are monitored and audited by the Management Team.

An audit of all personal medical equipment has taken place and several items have been ordered for the centre to ensure the equipment on site is appropriate for use and can be maintained in accordance with IPC guidance.

Incontinence waste collection has been reviewed with separate trolleys for incontinence in place and in use across the Nursing Home.

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual

assessment and care plan:
Care plans are currently under review by the Management Team in the Nursing Home. All staff nurses are to receive training on care planning in September 2022.

An external Nursing Tutor has been hired on a consultancy basis to work with all Nursing staff to ensure the standard of recording and documentation meets with the regulatory requirements. This programme of training will be ongoing over a number of weeks and will audit competency for all Nursing Staff in respect of maintaining appropriate documentation.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
A review of all documentation being maintained in the centre is underway.
Those residents that are on increased monitoring have been reviewed and a system has been put in place whereby monitoring is assigned to staff for individual periods of time to ensure no cross over with record keeping.

All staff have debriefed on the recording of interventions with residents to ensure records are an accurate reflection of the care given.

Management review documentation daily to ensure it is maintained appropriately.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
Appropriate arrangements are in place within the centre to ensure all monies are safeguarded and protected for all residents, in line with Department of Social Protection guidance.

Those residents that have funds collected by a nominated pension agent within the centre have evidence of all transactions available to them in an account dedicated to Residents funds only. These accounts are managed by the finance team and subject to auditing at least quarterly.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: There is 2 appointed Activity persons working in the centre.

Post inspection these staff have been dedicated to activity provision and have not been deployed to other departments.

Senior Management has met with both staff to prepare a plan for activities moving forward. A meeting with residents has been scheduled for input to the activity plan.

Residents are currently actively involved in decision making regarding ongoing improvements to the Nursing Home and have assisted with choices around paint, patterns and materials for their home.

Several new activities have been trialled in the centre bearing in mind residents' abilities and capacity. Residents are constantly being encouraged to make suggestions in respect of activities in house.

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 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	23/09/2022
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	23/09/2022
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	23/09/2022
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the	Not Compliant	Orange	23/09/2022

	effective delivery of care in accordance with the statement of purpose.			
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	23/09/2022
Regulation 23(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.	Not Compliant	Yellow	31/01/2022
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	Substantially Compliant	Yellow	30/08/2022

	Authority are implemented by staff.			
Regulation 34(1)(f)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.	Substantially Compliant	Yellow	28/09/2022
Regulation 34(2)	The registered provider shall ensure that all complaints and the results of any investigations into the matters complained of and any actions taken on foot of a complaint are fully and properly recorded and that such records shall be in addition to and distinct from a resident's individual care plan.	Substantially Compliant	Yellow	28/08/2022
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment	Substantially Compliant	Yellow	28/09/2022

	referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.			
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Substantially Compliant	Yellow	28/09/2022
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.	Substantially Compliant	Yellow	28/09/2022
Regulation 8(1)	The registered provider shall take all reasonable	Not Compliant	Orange	10/08/2022

	measures to protect residents from abuse.			
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Not Compliant	Orange	15/09/2022