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:	Claremount Nursing Home
Name of provider:	Claremount Nursing Home Limited
Address of centre:	Claremount, Claremorris, Mayo
Type of inspection:	Unannounced
Date of inspection:	26 January 2023
Centre ID:	OSV-0000329
Fieldwork ID:	MON-0037522

About the designated centre

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

Claremont Nursing home is a purpose-built, two-storey centre which provides 24-hour nursing care for up to 60 residents requiring continuing care, convalescence, respite, dementia and palliative care. The centre is well laid out. Residents are accommodated on the ground floor. Bedroom accommodation comprises 40 spacious single and 10 twin bedrooms. All bedrooms have accessible en-suite toilet and showering facilities. There is a choice of different communal areas for residents to relax and a separate visitors' room, physiotherapy room and oratory are available. The centre is located approximately 1km outside the town of Claremorris in County Mayo. It has a large accessible internal garden for residents and is set in landscaped grounds.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	48

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
Thursday 26 January 2023	09:00hrs to 17:00hrs	Leanne Crowe	Lead
Thursday 26 January 2023	09:00hrs to 17:00hrs	Ann Wallace	Support

What residents told us and what inspectors observed

Overall, residents spoke positively about their experience of living in Claremount Nursing Home, particularly in relation to the food served and the care provided by staff. Residents were observed to be content and relaxed in the company of staff.

Upon inspectors' unannounced arrival to the centre, they were greeted by a staff member who guided them through the required COVID-19 infection prevention and control measures, including completion of hand hygiene and a temperature check. The inspectors were advised that an outbreak of COVID-19 was ongoing at the time of the inspection and the management team outlined the infection control measures in place.

Following an introductory meeting with the general manager and the assistant director of nursing, the inspectors spent time walking through the centre. The centre was warm, bright and was decorated in a manner that was comfortable and homely. There were a number of communal sitting and dining areas throughout the building and residents were seen relaxing or passing time in these areas during the day. These residents were observed to be well groomed and appropriately dressed. A small number of residents spent time in their bedrooms or quieter areas, such as a small sitting room on one side of the building. Staff who spoke with inspectors were familiar with the residents' preferred daily routines, care needs and their interests.

Residents were accommodated in spacious and comfortable bedrooms. Residents' rooms were warm and bright and were personalised with photos, ornaments, memorabilia and other possessions. A resident who spoke with the inspectors said that they were happy with the layout and decor of their bedroom, as well as the space available for storing their belongings.

The food and drinks served was praised by residents as being "excellent". The inspectors observed two sittings of dinner during the inspection. The mealtimes appeared to be a social occasion for many residents, who were chatting with each other and staff as they enjoyed their meals. While a number of staff were available to service meals and to provide assistance to residents, inspectors identified that some improvement was required to ensure that this assistance supported residents' dignity. Additionally, a small number of staff demonstrated a task-orientated approach which did not optimise the mealtime experience for the residents. This had been a finding on two previous inspections and while significant improvement was noted on this inspection, further action was required to ensure that residents were provided with appropriate care at all times. This is discussed under Regulation 16, Training and staff development.

There was a programme of activities available to residents, both in the large sitting room and small quiet room. The activities on the day of the inspection included storytelling, ball games, online mass service and an exercise class. Residents who

participated in these activities were observed to enjoy them.

Inspectors spoke with a number of residents who expressed their satisfaction with the quality of care they received. The inspectors noted staff to be responsive when attending to residents' requests and needs.

Visitors were observed coming and going throughout the day of the inspection. It was clear the visiting arrangements were flexible and residents were observed meeting with their loved ones in communal areas, as well as their own bedrooms.

The next two sections of the report will present the findings in relation to governance and management in the centre and how this impacts on the quality and safety of the service being delivered. The areas identified as requiring improvement are discussed under the relevant regulations.

Capacity and capability

While inspectors noted that the provider had made significant progress in addressing non-compliances identified at the two previous inspections in February and July 2022, poor governance arrangements were continuing to impact on the quality of the service provided to residents.

This was an unannounced risk inspection to monitor the provider's compliance with the Health Act 2007 (Care and Welfare of Residents in designated Centres for Older People) Regulations 2013 as amended. During the designated centre's previous inspection, a number of non-compliances had been identified. The compliance plan submitted by the provider to address these findings was assessed at this inspection to determine whether all actions had been effectively carried out. The inspectors' findings indicated that some actions were completed in relation to fire precautions, infection control and residents' rights but some remained outstanding, for example, in relation to staff training, premises and governance and management.

The designated centre is owned and operated by the registered provider, Claremount Nursing Home Limited. A company director represents the registered provider. The centre's person in charge had departed the role in August 2022. The provider endeavoured to recruit a person in charge, with someone being appointed to the role in December 2022. However, this person departed the role and at the time of this inspection there was no person in charge that met the criteria set out by the regulations. The nursing management team consisted of an assistant director of nursing (ADON) and a general manager who oversaw the work of a team of senior nurses, staff nurses, health care assistants, a physiotherapist, activity co-ordinators and housekeeping, catering and administrative staff.

The provider had endeavoured to strengthen the governance systems since the previous inspection. They had appointed a general manager who oversaw the work of non-clinical staff. Two senior staff nurses worked to support the assistant director

of nursing. The provider had increased the frequency of management team meetings, which were attended by the person representing the provider, the assistant director of nursing and the general manager. There was a range of audits being completed, including mealtime experience audits. Audits were reviewed at management team meetings, to inform quality improvement. However, inspectors found that some audits needed to be more targeted in terms of the areas that were assessed. Additionally, action plans arising from any audits needed to be recorded and closed out, to ensure that actions were appropriately addressed.

There was a training programme in place for staff. There was evidence that training in fire safety, moving and handling, person-centred care and basic life support had been scheduled for the first quarter of 2023. Training records provided at the inspection indicated that staff had completed up-to-date training in moving and handling practices and fire safety. However, approximately 33% of staff required either initial training or refresher training in the safeguarding of residents. Similar gaps were identified in relation to infection control training while approximately 75% of staff required initial training or refresher training in the management of responsive behaviours (how residents who are living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). While some planned training had been postponed in response to the ongoing outbreak of COVID-19, there was no evidence that sufficient training had been arranged to address these gaps in a timely manner. Additionally, non-compliances in relation to staff training had been identified on the two previous inspections in 2022.

Regulation 14: Persons in charge

At the time of the inspection, there was no person in the role of the person in charge.

Judgment: Not compliant

Regulation 15: Staffing

There were sufficient staff on duty to meet the assessed needs of residents on the day of the inspection.

Judgment: Compliant

Regulation 16: Training and staff development

Significant gaps were identified in relation to some training for staff:

- Approximately 33% of staff required either initial training or refresher training in the safeguarding of residents. This was the third consecutive inspection in which this non-compliance had been identified
- Approximately 33% of staff required either initial training or refresher training in infection control
- Approximately 75% of staff required initial training or refresher training in the management of responsive behaviours (how residents who are living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

While some planned training had been postponed in response to the ongoing outbreak of COVID-19, there was no evidence that sufficient training had been arranged to address these gaps in a timely manner.

Improvement was required in relation to the supervision of staff. For the most part, staff were observed attending to residents appropriately throughout the course of the inspection. However, at residents' mealtimes, the inspectors observed a number of occurrences whereby staff did not provide sufficient assistance or did not support the dignity and choice of residents. For example, a staff member was observed attempting to support two residents to eat their meal at once, while other staff were seen clearing off and cleaning tables while residents were still sitting at these tables. This did not assure inspectors that there was sufficient supervision of staff.

Judgment: Not compliant

Regulation 23: Governance and management

Inspectors noted that some management systems had been strengthened since the previous inspection, but further work was needed to ensure that these were sufficiently robust and that the service was being effectively monitored. For example,

- There was no person in charge of the designated centre, resulting in a reduced level of care delivery oversight and supervision of staff
- Some actions from the previous inspection had not been completed, despite the provider committing to have completed the last of the actions by 30 November 2022, two months prior to this inspection
- There was poor oversight of staff training needs. Gaps in relation to safeguarding training were identified for the third time at the inspection. Training had not been arranged to address those requiring initial or refresher training.

Judgment: Not compliant

Regulation 31: Notification of incidents

Notifications were not submitted in line with the requirements of Schedule 4 of the regulations. The centre maintained a restrictive practice register, which clearly detailed the restraints that were in place. While the use of bed rails for five residents had been reported in the most recent notification to the Chief Inspector, there were a further fifteen residents who had requested the implementation of bed rails that had not been included in the notification.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

There was a policy and procedure in place for the management of complaints, which identified the complaints officer and described the appeals process available to complainants. Inspectors had been informed that no complaints had been raised since November 2021. However, inspectors identified that a verbal complaint had been raised in December 2022. While this had been appropriately investigated and addressed by management, it had not been documented in line with the centre's policy.

Judgment: Substantially compliant

Quality and safety

The inspectors found that managers and staff were working towards a person-centred approach to care. It was evident on this inspection that these improvements created better outcomes for residents, with more focus placed on individual resident's social care needs and access to meaningful activities. However, further actions were now required to ensure that those residents with higher levels of dependencies and cognitive impairment had access to social interactions and meaningful occupation in line with their capacities and preferences.

There was an outbreak of COVID-19 in the designated centre a the time of the inspection. The atmosphere was calm and those residents who had a confirmed diagnosis of COVID-19 or who had signs and symptoms of the virus were being cared for in their bedrooms with enhanced transmission-based precautions in place. Staff were observed donning and doffing personal protective equipment (PPE) correctly and performing good standards of hand hygiene in order to reduce the risk of onward transmission. Staff were knowledgeable about potential signs and

symptoms and all residents were routinely monitored throughout the day.

Records showed that the health and well being of the residents was promoted and residents were provided with appropriate support to meet any identified care needs. This included a COVID-19 care plan for those residents who contracted the virus. Residents had access to a range of health and social care specialists to meet their needs and where specific interventions were prescribed, these were implemented by nursing and care staff. In line with the regulations, each resident had an assessment of needs completed within 48 hours of their admission to the designated centre. These assessments included a range of validated assessment tools, however, the assessment did not include a comprehensive record of the resident's past social history. Therefore, it was not clear how staff identified residents' social care needs or support them to develop and maintain personal relationships and links with the community, in line with their wishes.

Care plans were in place to address identified needs. However, a sample of care plans reviewed by the inspectors did not provide sufficient detail to ensure that they appropriately guided staff to provide safe and appropriate care to residents. Furthermore, it was not clear that care plan reviews were being carried out with residents, or where appropriate, with the resident's family. This is addressed under Regulation 5.

Inspectors reviewed a sample of residents' health care records and spoke with staff and residents. The health needs of each resident were regularly reviewed by nursing and care staff and any changes in base line observations or in a resident's general well-being were identified and reported to their general practitioner (GP).

Records showed that residents had good access to their GP, specialist health care and allied health care services. Referrals to these services such as palliative care and tissue viability nurses were made in a timely manner. Where specialist practitioners prescribed treatments, these were implemented by staff.

Throughout the day, inspectors spent time talking with residents. For those residents who had cognitive impairments or who did not communicate verbally, the inspectors spent time observing staff interactions with these residents. It was evident that the residents felt safe and comfortable with the staff who were caring for them. Residents smiled warmly when staff spoke to them and did not show any signs of distress or concern at these approaches. Staff knew the residents well and were familiar with their care needs and preferences.

A number of staff had completed training in person-centred care since the previous inspection. Overall, staff were seen to address residents in an empathetic and respectful manner and seek their permission before commencing care. However, a small number of staff continued to demonstrate task orientated care which did not support the rights and dignity of the residents for whom they were providing care to. For example, some staff were observed talking to each other over residents and a staff member moved a resident in their wheelchair without explaining what they were going to do which startled the resident and caused them to cry out. As detailed earlier, a member of staff was observed helping to feed two residents at the same

time in the dining room. This is addressed under Regulation 16, Training and staff development.

There was an activity programme in place for residents that was facilitated by an activity co-ordinator and other members of staff. There were appropriate facilities for activities; with a number of communal rooms situated throughout the centre, as well as an outdoor area. The majority of residents were observed spending their day in a large day room beside the reception area. Residents were supported to participate in a number of activities in this day room and one-to-one activities also took place with residents in their bedrooms, if they so wished. The inspectors spoke with the activity staff member on duty on the day of the inspection. They demonstrated that records were kept of residents' engagement in activities, as well as the room visits that were carried out to date. The staff member stated that they were considering planning an outing for residents in May or June of this year, it was not clear why an outing could not be facilitated sooner than this.

Residents with higher levels of physical and cognitive needs spent most of their day in a sitting room known as the 'blue room'. This was a smaller more intimate setting and provided a pleasant and calm environment for those residents. There was a member of staff allocated to supervise and provide care and support for these residents throughout the day. Most of the residents spent all of their day in this room, with the exception of attending the dining room for meals. Residents were offered one-to-one activities such as painting and reading with a member of staff. There was a television in the room which played reminiscence documentaries and music from a range of genres from which the residents were encouraged to choose. However, the majority of residents in the room did not appear to have capacity engage with any of the activities that were offered and spent most of their day sleeping in their chair, only waking when staff sat with them to offer drinks and snacks or a chat. There was a sensory lamp in the room which provided a soothing and changing view for the residents, but this was located out of sight of most of the residents and did not seem to be used to support a stimulating environment in the room**.**

For the most part the centre was bright, warm and decorated in a homely manner. Communal rooms were laid out with comfortable seating and were well used by residents on the day of the inspection. There was additional seating space in the entrance hall and in the oratory. There was also a pleasant visitor's room where residents could spend quiet time with their family and friends. Following the last inspection, the provider had committed to restoring a sitting room on the South Wing. While the majority of items being stored in this room had been removed, it still wasn't available for use by residents.

The premises was visibly clean and inspectors found significant improvements in the housekeeping and organisation of the centre. There was a cleaning schedule in place which included the cleaning of equipment such as wheelchairs and hoists. This demonstrated that an action in relation to cleaning of equipment had been addressed since the previous inspection. Overall, equipment was found to be cleaned. However, a number of armchairs and some specialist comfort chairs were worn and torn which made them difficult to clean. There was no clear refurbishment

plan in place to ensure seating was repaired or replaced in a timely manner.

All bedrooms were en-suite and there were additional communal bathrooms and toilets available. Bedrooms were nicely laid out and had sufficient wardrobe and shelving for residents to store their personal possessions. Bedrooms were of a good size and residents were able to arrange their bedroom to suit their preferences. There were a number of twin bedrooms and inspectors observed that the layout of some privacy curtains did not ensure that the resident was fully screened when carrying out personal activities. The curtains divided the room into two separate bed areas but did not go around the foot of the bed. As such, the resident could be seen by staff or the other resident when they were accessing the en-suite or entering or leaving via the bedroom door.

Storage areas were large, however, they were cluttered with too may items that were closely packed together and there was no clear inventory of what items were no longer in use. For example, the main store room was cluttered with wheelchairs and comfort chairs, some of which staff were not sure were still in use. The communal bathroom on the North Wing was being used as a storage room with a mix of clean and dirty items. For example, the inspectors saw two dirty linen trolleys and two black bag waste bins. In addition, the room also contained a portable hoist and a clean care trolley with clean towels and bed linen on open shelves. There was also a hoist sling hanging on a wall hook. There was no tag or indicator that the sling had been laundered and was ready for use.These issues posed an infection control risk.

Residents were consulted with on the day-to-day running of the centre. Residents' meetings took place regularly, with the most recent meeting occurring on 1 December 2022. Records of these meetings were available for review and demonstrated that topics such as the quality of activities, food and staff were discussed. Resident surveys had also been carried out in 2022 and the assistant director of nursing had commenced surveying residents upon their discharge from the centre.

Visiting arrangements in place on the day of the inspection ensured that residents could meet with their friends and loved ones, in line with public health guidance. Visitors were facilitated to meet with residents in their bedrooms or in dedicated visiting rooms near the entrance to the centre.

Regulation 11: Visits

Residents were able to receive visits from family and friends without restrictions. There was a visitors' room available if residents wished to meet with their visitors outside of their bedroom.

Judgment: Compliant

Regulation 17: Premises

Overall, the premises was appropriate to the needs of the residents and met the requirements of Schedule 6 of the regulations. However, inspectors found that improvement was required in the following areas:

- Equipment and furniture that was worn or stained was not identified and taken out of use
- A day room in the South Wing was not available for use by residents as it continued to be used to store equipment.

Judgment: Substantially compliant

Regulation 27: Infection control

Further actions were required to ensure that infection prevention and control practices achieved the best outcomes for the residents. This was evidenced by:

- Storage rooms were cluttered with wheelchairs and large items of equipment such as comfort chairs. This made it difficult to clean all areas of the room including the floor area
- Clean and dirty items were not segregated creating a risk of transmission of infections
- In the communal bathroom on the North Wing, clean towels and linen were left on open shelves on a trolley next to a black refuse bin, in a room with a toilet which was being used by residents
- Equipment such as arm chairs and comfort chairs were visibly stained or damaged and could not be adequately cleaned
- A hoist sling was being stored on a hook in a bathroom and there was no indicator that the sling had been laundered and was ready for use
- A small number of staff were observed wearing masks incorrectly
- The COVID-19 policies and contingency plans did not include the up to date guidance form the Health Surveillance and Protection Committee (HSPC).

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

The assessments of residents' social care needs did not include sufficient information about the resident's personal life history and preferences for social interactions or meaningful occupation to inform the development of a person

centred-care plan.

Some care plans reviewed by the inspectors did not provide sufficient detail to guide staff. For example;

- Wound care plans were not detailed and made reference to a wound management plan that was kept separately to the care plan. This posed a risk that staff may not have the information they required to provide safe and appropriate wound care
- The progress of the resident's wound was monitored using photographic evidence. However, these records were not available in the resident's care records. As a result, the care plan record did not provide up-to-date information for staff on the progress of the wound so that the wound management plan could be evaluated
- There was an ongoing outbreak at the time of the inspection. However, COVID-19 care plans had not been updated to reflect the current guidance in relation to visiting during the outbreak.

There was no clear evidence that residents, and where appropriate their families, were involved in care plan reviews. In addition, some care plans had not been clearly recorded as discontinued, which posed the risk of staff not being aware that the interventions had ceased.

Judgment: Substantially compliant

Regulation 6: Health care

Residents received a good standard of evidence-based nursing care. However, further actions were required to ensure that nursing and care records were managed in line with best practice guidance. For example, some of the records of daily care given reviewed on inspection were not recorded contemporaneously. This was evidenced by:

- Repositioning charts for seven residents had been completed in advance of this care being given to the residents. As a result, inspectors were not assured that residents were being repositioned in line with their assessed care needs
- Fluid balance and nutritional charts had not been completed for a number of residents to monitor their fluid and nutritional intake during the earlier part of the day including their lunch time meal. Therefore, it could not be ensured that residents were taking adequate fluids and nutrition in line with their assessed care needs.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

There was a low level of responsive behaviours on the day of the inspection. Inspectors observed that where one resident became agitated, the member of staff used appropriate distraction techniques to keep the resident calm and to support them.

The centre was working towards reducing restraints and records showed that where restraints were in use they were implemented following a risk assessment and consultation with the resident or their representative. Restraints such as lap belts and bed rails were monitored so that the restraint was in place for the least time required.

Judgment: Compliant

Regulation 8: Protection

While there were some systems in place to support the safeguarding of residents, action was required to ensure that staff were appropriately trained and any allegations or suspicions of abuse were reported to the Chief Inspector. These non-compliances are actioned under Regulation 16, Training and development and Regulation 31, Notifications of incidents.

Judgment: Compliant

Regulation 9: Residents' rights

The centre had dedicated staff responsible for the provision of activities. However, inspectors' observations and feedback from residents on the day of the inspection did not assure inspectors that residents were provided with sufficient opportunities to participate in activities that were in line with their interests and capacities.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Not compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Substantially compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 27: Infection control	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Claremount Nursing Home OSV-0000329

Inspection ID: MON-0037522

Date of inspection: 26/01/2023

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 14: Persons in charge	Not Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: Recruitment is ongoing for Director of Nursing. In the interim I have promoted two Senior Staff Nurses to Clinical Nurse Managers in order to fully support the Acting Person in Charge. CNM 1 is the former Director of Nursing with 12 years experience as a nurse. CNM 2 has 44 years experience as a nurse. Both CNMs have been working in Claremount for more than 10 years and are extremely competent. The ADON has been Acting Person in Charge since August 2022 and will have the required 3 years' experience on 14th June 2023.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: We will ensure all mandatory training is up to date and a plan is in place for future training. Safeguarding Training is ongoing. 3 sessions 24.2.23, 3.3.23 & 24.3.23 and more to be scheduled until all training is complete. Staff also required to complete HSEland training. IPC training scheduled 12.04.23	

Challenging Behaviour 16.03.23 & HSEland courses completed by staff.
Training schedule to be completed by 30th June 2023.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
We will ensure the quality and safety of care delivered to our residents is monitored on an ongoing basis with regular quality meetings, raising cars to drive improvement & consultation with residents.

Training has been arranged and has commenced.

There is a hierarchy in place to ensure that all staff are supervised appropriately in their work.

We will ensure that at all times there are sufficient numbers of staff with the necessary experience and competencies to meet the needs of our residents and which reflect the size, layout and purpose of our home. The process of ensuring that sufficient staff are available is based on the dependency levels and the staff, with necessary competence, required to meet the level of dependency.

The Roster will be reviewed on a daily basis to ensure that this requirement is compliant and that residents are delivered safe and consistent care.

Staff nurses are now supervising mealtimes. We conduct regular QUIS audits to ensure quality of mealtime experience.

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
All incidents that occur in the centre are recorded in a register as per the policy.
The register is maintained & reviewed by the Registered Provider, Acting Person in Charge & Manager on a weekly basis. Where required, notification to regulator will be submitted as per the policy. The relevant details of each incident are recorded with actions taken and are analysed for learning purposes.

All complaints including verbal, are documented in line with our policy. The complaints register will be monitored & reviewed by the Registered Provider, Acting Person in Charge & Manager on a weekly basis.
The NF02 was submitted following inspection.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
We will ensure complaints are logged and ensure the outcome of the complaint is recorded, if complaints regarding the services are made through the residents meeting we will ensure these are addressed at our weekly Meeting.

We will ensure all complaints are monitored by the Registered Provider, Manager & APIC at our weekly meetings.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The design and layout of the Home is suitable for its stated purpose. We will ensure all areas in the Home meet the privacy, dignity and wellbeing of each resident.

The Curtains have been ordered for the day room in the south wing and painting has been scheduled.
All chairs have been professionally steam cleaned & any worn chairs have been withdrawn from use.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
We will ensure that procedures, consistent with the standards for the prevention and control of healthcare-associated infections published by the Authority are implemented

by staff.
Unused wheelchairs and comfort chairs removed.

We have new enclosed linen trolleys the current dirty linen trolleys have lids and are clearly labelled.
Open shelved trolleys will be removed from use.

All chairs have been professionally steam cleaned and any worn chairs have been removed from use

All Hooks have been removed from bathrooms.

Monitoring and supervision by nursing staff to ensure that all staff are wearing masks correctly.

Policies and contingency plans have been updated to include the up to date guidance form the Health Surveillance and Protection Committee (HSPC).

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:
We will ensure each resident has a care plan, based on an on-going comprehensive assessment of their needs which is implemented, evaluated and reviewed, reflects their changing needs and outlines the support required to maximise their quality of life in accordance with their wishes.

Wound Care plans will be reviewed by Senior Staff nurses on a weekly basis.
Wound photos will be printed and kept in resident's file.
Wound management plans will be kept in the residents file along with all records so to ensure that the residents file has all the up to date information for staff.

All COVID-19 care plans have been updated to reflect the current guidance in relation to visiting during an outbreak.
All Care plans to be signed by resident's families. Discontinued care plans to be recorded as such.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care: We will ensure the health and wellbeing of each resident is promoted and they are given appropriate support to meet any identified healthcare needs. A staff member has been given the responsibilty of ensuring that charts are properly completed by staff on duty daily.	
Regulation 9: Residents' rights	Substantially Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: Each resident is offered a choice of appropriate recreational and stimulating activities to meet their needs and preferences. Photo albums reflecting life story. Imagination gym and group sessions have been scheduled. Hand massages and activities reflecting residents interests have also been scheduled. An Outing to Knock has been planned for Easter.	

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 14(1)	There shall be a person in charge of a designated centre.	Not Compliant	Orange	14/06/2023
Regulation 14(3)	Where the registered provider is not the person in charge, the person in charge shall be a registered nurse with not less than 3 years' experience of nursing older persons within the previous 6 years.	Not Compliant	Orange	14/06/2023
Regulation 14(4)	The person in charge may be a person in charge of more than one designated centre if the Chief Inspector is satisfied that he or she is engaged in the effective governance, operational management and administration of the designated centres concerned.	Not Compliant	Orange	14/06/2023

Regulation 14(5)	Where the registered provider is not the person in charge, he or she shall ensure that the documents specified in Schedule 2 are provided by the person concerned.	Not Compliant	Orange	14/06/2023
Regulation 14(6)(a)	A person who is employed to be a person in charge on or after the day which is 3 years after the day on which these Regulations come into operation shall have not less than 3 years experience in a management capacity in the health and social care area.	Not Compliant	Orange	14/06/2023
Regulation 14(6)(b)	A person who is employed to be a person in charge on or after the day which is 3 years after the day on which these Regulations come into operation shall have a post registration management qualification in health or a related field.	Not Compliant	Orange	14/06/2023
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	30/06/2023
Regulation 16(1)(b)	The person in charge shall	Substantially Compliant	Yellow	30/06/2023

	ensure that staff are appropriately supervised.			
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.	Substantially Compliant	Yellow	30/06/2023
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	30/06/2023
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Substantially Compliant	Yellow	27/03/2023
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure	Not Compliant	Orange	27/03/2023

	that the service provided is safe, appropriate, consistent and effectively monitored.			
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	30/06/2023
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.	Substantially Compliant	Yellow	27/03/2023
Regulation 31(3)	The person in charge shall provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of an incident set out in paragraphs 7(2) (k) to (n) of Schedule 4.	Substantially Compliant	Yellow	27/03/2023
Regulation 34(1)(f)	The registered provider shall provide an accessible and	Substantially Compliant	Yellow	27/03/2023

	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.			
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	27/03/2023
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who	Substantially Compliant	Yellow	30/06/2023

	intends to be a resident immediately before or on the person's admission to a designated centre.			
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	30/06/2023
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	27/03/2023
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to	Substantially Compliant	Yellow	31/05/2023

	participate in activities in accordance with their interests and capacities.			