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:	Oakwood Private Nursing Home
Name of provider:	Oakwood Private Nursing Home Limited
Address of centre:	Hawthorn Drive, Athlone Road, Roscommon, Roscommon
Type of inspection:	Unannounced
Date of inspection:	02 November 2021
Centre ID:	OSV-0000372
Fieldwork ID:	MON-0034547

About the designated centre

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

The centre offers long and short term care for 56 adults over the age of 18 including people with a diagnosis of Alzheimer's disease or dementia. The centre is purpose built, single storey and has a safe cultivated garden for residents' use. All bedrooms are single with full ensuite facilities. They have good natural light, a functioning call-bell system and appropriate storage. The kitchen, dining and sitting room areas are centrally located. There are appropriately equipped sluice rooms. The centre is located a short distance from the town of Roscommon and is near restaurants, shops, pharmacies, doctors' surgeries as well as the local general hospital.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	55

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 2 November 2021	10:00hrs to 18:00hrs	Catherine Sweeney	Lead
Tuesday 2 November 2021	10:00hrs to 18:00hrs	Gordon Ellis	Support

What residents told us and what inspectors observed

Inspectors spoke with a number of residents during the day of inspection. Overall, residents reported that they were well looked after in the centre. They stated that the staff knew them well and that they were kind and respectful in their interactions with them. This reflected the observations of inspectors on the day of the inspection.

Resident and staff interactions were observed to be courteous and kind. Staff demonstrated empathy with the residents they cared for and staff demonstrated a good knowledge of each residents likes and dislikes.

Some residents told the inspectors that they felt safe in the centre. They stated that if they had a concern, they would discuss it with the person in charge and that action would be taken to address the issues. However, this did not reflect the findings of this inspection in relation to the systems to record, investigate and review complaints and concerns in the designated centre. This is discussed further under the quality and safety section of this report.

A walk around the centre found that most residents spent their day between two communal day rooms. Residents were seen to be socially engaged and facilitated to engage in activities of their choice. A small number of residents chose to spend the day in their bedrooms. They were observed to have access to television, radio and the internet. Local and national newspapers were also made available.

Some residents were observed mobilising around the centre independently and had unrestricted access to an internal courtyard. Inspector observed that internally, mobilising independently was made difficult by the communal corridors and bathrooms being cluttered with items such as hoists, wheelchairs and walking frames. This posed a risk to those residents who were mobilising independently. Furthermore, the supportive equipment was seen to be in a poor state of repair and did not facilitate effective cleaning, increasing the infection control risks to residents.

All the rooms in the centre were single rooms with en-suite bathrooms. Residents rooms were observed to be personalised with residents photos and belongings. Residents spoken with stated that they liked their room and that they were free to arrange the room to their preference.

The next two sections of this report will summarise the findings of the inspection and discuss the levels of compliance found under each regulation.

Capacity and capability

This was an unannounced risk inspection by inspectors of social services to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). The lead inspector was supported by a fire and estates inspector. Inspectors followed up on the action taken by the provider to address issues of non-compliance found on the last inspection in March 2020.The provider had had a history of good compliance with the regulations prior to this inspection. However, this inspection found that significant focus and resources were now required to ensure that the centre was brought back into compliance with the regulations and that residents were adequately protected from the risk of a fire.

Inspectors reviewed the progress of action required following a fire risk assessment completed by the provider in June 2021. Following this assessment, the provider had given the Chief Inspector assurance that all fire safety work would be completed by 30 September 2021. On this inspection, inspectors found that while some fire safety work had been completed, the provider had failed to complete all of the fire safety actions to the required standard. Furthermore, the provider was unable to provide a clear time bound plan of works to monitor the progress of the works and ensure they were completed in an appropriate time frame. In addition, the inspectors found that the provider had failed to take appropriate actions to mitigate the risks to the residents until the works were completed. Following this inspection, the Chief Inspector issued the provider with an urgent compliance plan to address the on-going fire safety risks and to ensure the safety of the residents until the works were completed. This is discussed further in the quality and safety section of this report under Regulation 28.

The registered provider representative was also the person in charge of the centre. The provider informed the inspectors that there was no other person involved in the management of the centre. In their role as the person in charge, the provider was was supported on a day-to-day basis by an administrator and a senior nurse. The current management structure did not assure the inspectors that there was adequate governance and oversight of the service, and that the organisational structure was sustainable in the longer term.

The provider did not ensure that the designated centre had sufficient resources to ensure that care and services were provided in accordance with the designated centre's statement of purpose. For example, a review of the rosters found that staffing levels, especially at night, when there was three members of staff rostered to provide care for 55 residents, did not ensure that all residents were provided with a high standard of care. In addition, inspectors were not assured that night time staffing levels were adequate to ensure residents' safety in the event of a fire emergency, where an evacuation of a section of the building may be required.

The provider failed to provide appropriate medical equipment to meet the assessed needs of residents in the centre. For example, six residents did not have a record of their weights. The provider explained that weights were not available for these residents because there was no appropriate weighing equipment available in the designated centre.There was a sit- on weighing scales, however these residents were not able to sit on the scales and no alternative equipment had been sourced to

ensure that these residents could be weighed safely. As a result, these residents could not be monitored to see if they were losing or gaining weight and no care plans were in place to manage any nutritional risks identified.

The organisational structure of the centre did not reflect the structure outlined in the centres' statement of purpose. The statement of purpose outlined a management structure that included a person participating in the management of the centre, a person in charge and two clinical nurse managers. The provider confirmed that although there were two senior nurses identified on the roster, there were no clinical nurse managers as outlined in the statement of purpose. Furthermore, rosters showed that the two senior nurses did not have any supernumerary hours in which to carry out clinical supervision of nursing and care staff.

The oversight of clinical care was not robust and did not ensure that residents received appropriate care, in line with their assessed needs. For example, a nutritional audit had been completed in July 2021 with a follow-up nutritional risk audit scheduled for July 2022. The audit identified three residents at high risk of malnutrition and 12 residents as medium risk. There was minimal analysis of the findings of this audit and the only action from the audit recorded was that the results would be discussed by management with the nurses and carers. Inspectors reviewed staff meeting records for these dates and found that there was no reference to this audit in the meeting notes.

Infection control audits had been completed every three months, however, all audits reflected 100% compliance with no quality improvement action required. These audits did not reflect the findings of the inspectors on the day of the inspection. Notes from an external infection control audit had been included within the internal audit documentation. The external audit recommended a de-clutter of the staff areas and the toilets. Inspectors found that no action plan to address this issue was recorded and on this inspection a number of same areas were cluttered which made them difficult to keep clean.

There were no governance meeting notes or quality and safety meeting notes available for review. In addition, there was no documented plan to address outstanding health and safety issues in the centre. A review of staff meeting notes found that only the agenda was documented. Meeting notes reviewed were handwritten and difficult to review. There was no record of the discussion in relation to the agenda items, no action plan and no review of any action taken since the last meeting. Furthermore, an annual review of the quality and safety of the service for 2020 had not been completed.

Inspectors found that policies and procedures had not been appropriately reviewed and updated in accordance with best practice. As a result, inspectors were not assured that staff had access to updated guidance in relation to key areas such as Infection Prevention and Control procedures.

The provider had changed the purpose of an assisted bathroom to a storage room for clean linen. The bath had been removed. This change in room usage removed the residents choice of having a bath rather than a shower and there was no other

facility available in the centre for showering or bathing residents with complex physical needs. The change in purpose of this bathroom was not in line with Condition 1 of the designated centre's current registration.

A review of the complaints log found that no complaints had been documented since November 2020. Inspectors spoke with residents who stated that they often brought their complaints to the person in charge. A review of the residents meeting notes found numerous complaints from residents since November 2020. There was no evidence that these issues had been investigated in line with the centre's own complaints policy or in line with the requirements under Regulation 34.

Regulation 15: Staffing

The staffing level and skill mix of staff was not appropriate to meet the assessed needs af the residents or for the size and layout of the centre. There were 55 residents accommodated in the centre on the day of the inspection. Of these, 22 residents were assessed as having high to maximum levels of dependency, with 33 assessed as having low to medium dependency levels.

A review of the rosters found that the number of nurses available did not reflect the number of nurses committed to in the centre's statement of purpose. Rather than a total of two clinical nurse managers and ten nurses as per the statement of purpose, the roster identified two senior nurses and seven staff nurses available for duty. The provider told the inspectors that active recruitment was on-going for nursing staff.

Night time staffing levels required review. There was one staff nurse and two carers rostered for 55 residents from 9pm to 8am. With 22 residents having high to maximum levels of dependency, inspectors were not assured that the needs of all the residents in the centre could be met, with particular regard to the increased levels of monitoring required during the COVID-19 pandemic.

In addition, the provider had not assessed the on-going risks to residents in relation to having incomplete fire safety systems in the centre. Staffing levels had not reviewed as part of a risk assessment process that may have mitigated some of the outstanding risk.

Judgment: Not compliant

Regulation 16: Training and staff development

A review of the staff training record found that some staff had not received mandatory training in safeguarding vulnerable adults, and in the management of

responsive behaviours.

The inspectors were not assured that the content of the fire safety training that was provided for the staff contained the knowledge and competencies as required under Regulation 28 (1)(d).

There was no documented evidence that staff had completed an appropriate induction program to ensure they had the appropriate skills and knowledge for their roles. In addition, there were no staff appraisals for review. It was therefore difficult for the inspectors to assess the system in place to ensure staff development and performance was supported and reviewed.

There were no clinical nurse managers available in the centre to provide supervision, oversight and support to the nursing and care teams.

Some staff did not have a fluency in English and could not communicate with residents. This was a risk to residents who wished to express their needs or preferences to staff.

Judgment: Not compliant

Regulation 23: Governance and management

Inspectors found that significant improvement was required to strengthen the overall governance and management of the centre. This was evidenced by the failure of the provider to;

- provide sufficient resources to ensure the effective delivery of care
- a clearly defined management structure that identifies lines of authority and accountability.
- ensure that management systems were in place to ensure the service provided was safe, appropriate, consistent and effectively monitored.
- identify risks associated with inadequate staffing levels
- identify risk in relation to on-going fire safety works
- provide adequate assurance of fire safety measures in place to protect residents
- ensure an appropriate, up-to-date and effective system of risk management
- update policies and procedures in accordance with best practice.
- ensure appropriate safeguarding procedures including training and Garda Síochana (police) vetting were completed for every member of staff prior to commencing employment.
- notify the Chief Inspectors of serious incidents to residents, safeguarding issues and suspected COVID-19 infections.
- recognise and respond to residents complaints and concerns
- notify the Chief Inspectors in relation to changes to the function of rooms in

the centre.

The failure to provider good governance and oversight extended to the following clinical areas;

- poor oversight of clinical issues such as weight management
- poor oversight of clinical documentation
- failure to recognise and appropriately respond to potential safeguarding issues
- failure to recognise the care requirements of residents
- failure to oversee effective management of infection prevention and control procedures .

These non-compliance's are discussed under the relevant regulations in the quality and safety section of this report.

Judgment: Not compliant

Regulation 31: Notification of incidents

At the start of the inspection the provider disclosed that one resident had presented with symptoms of COVID-19 and had been referred for testing. This suspected case had not been notified to the Chief Inspector, as required. The provider stated that an approximate further 20 COVID-19 tests had been complete on symptomatic residents over the past few weeks. The provider had failed to notify the Chief Inspector about any suspected COVID-19 infections in the centre. The provider stated that he was not aware of the requirement in relation to the notification of suspected COVID-19 cases to the Chief Inspector.

A review of the accident and incident log found that three falls, that resulted in a resident being transferred to hospital for treatment, were not notified to the Chief Inspector as required under regulation 31, notification of incidents.

Judgment: Not compliant

Regulation 34: Complaints procedure

A review of the complaints log found that complaints and suggestions were not followed up in line with the centre's own Complaints Policy. For example, a complaint relating to a nurse call bell had been reported to staff on several occasions, however, there was no evidence that the fault had been investigated in line with the centre's own complaints policy or in line with the requirements under Regulation 34.

Inspectors found that the call bell referred to in the complaint was not functioning on the day of the inspection.

Judgment: Not compliant

Regulation 4: Written policies and procedures

A review of the policies required under schedule 5 of the regulations found that they were not updated in accordance with best practice. For example, the policy in relation to the protection of residents was not updated to reflect the HSE (2014) National policy and procedure in relation to safeguarding vulnerable persons at risk of abuse. Furthermore, the risk management policy did not contain the information required under regulation 26, risk management. Policies reviewed did not outline or reference to origin of the information included.

Judgment: Not compliant

Quality and safety

Inspectors were not assured that residents were receiving safe and appropriate care and services in line with their assessed needs. Furthermore, inspectors found that urgent action was required to ensure that residents were safe in the event of a fire emergency. Significant improvement was also required in relation to protection of residents, infection prevention and control, health care and residents' rights.

As described in the capacity and capability section of this report, poor clinical governance and oversight was found to impact on the quality of care of residents in the centre. The provider failed to demonstrate how risk was managed in the centre on a day-today basis. In addition, inspectors found that environmental risks were not identified and addressed in a timely manner. For example, the risk register had not been updated to reflect both the risks identified during this inspection and the significant fire risks that had been identified in the fire safety risk assessment for the designated centre that was completed in June 2021.

Gaps noted in the training record of staff in relation to safeguarding, together with a poorly written safeguarding policy and gaps in the staff vetting process did not provide assurance that systems in place to protect residents from abuse were robust. Furthermore, a review of residents' meeting notes found that a number of significant concerns including a number of potential safeguarding issues had been shared by residents during these meetings but these had not been reported to the person in charge or nursing staff. Inspectors were concerned that these issues were not identified as a risk to the protection of residents and therefore not managed in a

way that would ensure that all residents were adequately safeguarded.

The provider had a COVID-19 contingency plan in place. The person in charge had not notified any confirmed or suspected outbreaks of COVID-19 in the centre at the time of the inspection. Inspectors were not assured that the provider had sufficient staff to implement their COVID-19 contingency plan in the event of an outbreak in the designated centre. The clutter in some areas made the premises difficult to clean to the required standards. In addition, the poor state of maintenance of the fixtures and fitting in the centre and of the resident's equipment created significant challenges to ensuring that all areas of the building and all equipment could be cleaned to a good standard.

An electronic nursing documentation was in place to record residents' records. A sample of residents' files were reviewed. While each resident had a number of assessments and care plans in place, care plans did not always reflect the findings of the assessment. Furthermore, resident care plans were inconsistent in quality. Some care plans, such as the residents' social care plans, were well written and contained appropriate detail to guide staff how to care for the resident. In contrast, other care plans lacked person-centred detail and some care plans were out-of-date and did not reflect the resident's current needs. For example, one nutritional care plan detailed the date of referral to a dietitian as March 2018 with no review recorded since that date.

Inspectors noted a lack of clinical oversight in relation to the documentation of a resident's daily progress. A review of a sample of residents' notes found multiple examples of entries that had been duplicated from the previous day. This is not in line with professional guidelines for clinical documentation.

Inspectors found that the provider failed to ensure that residents voices were heard in the centre. While residents meeting were scheduled and well attended, residents concerns were not responded to in an appropriate and timely manner.

During the walkabout of the centre, the inspectors observed that the centre was cluttered with items such as hoists, wheelchairs and walking aides. Many of these were being stored along corridors and in assisted bathrooms which created obstructions and risks for residents using these areas.

The assisted bathrooms were in a poor state of repair. Toilet seats appeared worn, foam padding in place to protect residents when using the toilet was split and could not be cleaned effectively.

The provider had changed the function of an assisted bathroom in to a linen store. This was achieved by removing the only bath available to residents in the centre. This meant that residents could not choose to have a bath rather than a shower.

Regulation 26: Risk management

The risk management policy did not contain the information required under Regulation 26. The risk register given to the inspectors for review had not been reviewed or updated since 2016. The day following the inspection the provider submitted an updated health and safety risk assessment that was last reviewed in January 2020.

Judgment: Not compliant

Regulation 27: Infection control

The provider did not ensure that infection prevention and control procedures were consistent with the standards for the prevention and control of health care associated infections published by the Authority. This was evidenced by

- residents did not have individual hoist slings
- communal use of toiletries
- call bell strings were visibly unclean
- shower chair wheels were rusted and in a poor state of repair
- the flooring in the assisted toilets was visibly unclean
- clean laundry was stored in an assisted bathroom
- some of the assisted toilets were malodorous
- used incontinence wear was disposed of in residents uncovered bedroom bins
- hoists, wheelchairs and walking frames were stored in corridors and communal spaces

Judgment: Not compliant

Regulation 28: Fire precautions

An urgent compliance plan was requested in relation to fire safety precautions following inspection due to the following:

Inspectors were not assured that adequate arrangements were in place for fire containment and adequate means of escape:

- On inspection it was noted that while door closers had been fitted to bedroom doors they were not linked to the fire alarm system. This presented a high risk to residents in the centre in relation to fire containment and providing an adequate means of escape in the event of a fire. There was no evidence that a robust policy was in place to ensure bedroom doors were monitored and kept closed by staff.
- Night time staffing levels did not provide assurance that residents could be safely evacuated in the event of a fire due to the lack of functioning door

closers to bedroom fire doors.

- Inspectors were not assured of the likely fire performance of all door sets (doorleaf, frame, brush seals, intumescent strips, hinges, closers and ironmongery). Some doors were missing either portions or all of the required heat and smoke seals around the head and sides of the fire doors. Some fire doors had inadequate ironmongery, were damaged, corridor compartment doors did not close properly and had gaps. In particular. the kitchen did not have adequate fire doors at two of the three entrances to this area and the door from the kitchen to the protected corridor was left open.
- The provider confirmed that works to compartment lines and fire stopping have now been completed. A previous request by the Chief Inspector for a final sign-off and certification for these works by a suitably qualified person remained outstanding.
- Fire safety work remains outstanding on the upgrading of fire doors and screens identified in the fire safety risk assessment. The provider had given assurance to the Chief Inspector that all work was due to be competed end of September 2021. The provider could not give a date for when this would be completed.

In addition, inspectors also found that

- oxygen cylinders were stored outside, chained to a timber fence, which is combustible.
- personal emergency evacuation plans (PEEPs) were in place displayed behind a residents bedroom door. The PEEPs were not signed or dated so it was not clear if they had been reviewed as part of the resident assessment process.
- the smoking area was not risk assessed and did not have fire safety equipment close by,
- lack of emergency lighting in two corridors, to enable safe evacuation in the event of an emergency
- no evidence of quarterly or annual inspection certificates for emergency lighting
- the procedure to be followed in the event of a fire was not clearly displayed in the centre. There were no floor maps displayed to direct residents, visitors and staff to the nearest fire exit or fire fighting equipment.
- the function of an assisted bathroom was change to a store room for laundry. No fire door had been fitted as required for a linen store.
- a large amount of lint found in dryer in laundry room. There was no evidence of a lint cleaning schedule for this machine. This posed a significant fire risk in the laundry
- lack of emergency lighting and directional signage to the outside of the building for residents and staff to follow in the event of a fire evacuation at night time.
- protected corridors were cluttered with furniture and hoists.
- refuse area directly outside the external means of escape was messy and littered with refuse. This presented a falls risk to residents.
- fire stopping and a review of loose wires was required to the service penetrations in the dining room.
- the gas cooker extractor fan was clean on inspection, but there was no

evidence that an annual certification had been completed
- staff participated in annual fire training once a year however, the content of the training did not include the requirements under regulation 28 (1)(d).

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Inspectors reviewed the residents nursing notes and found assessments were not always up-to-date or used to inform the development of a care plan. For example;

- a resident who had been assessed as having a high risk of malnutrition did not have a nutritional care plan in place.
- a resident assessed as high risk had not been referred to a dietitian for review.
- a manual handling assessment on display in a resident's bedroom was dated September 2016.

Care plans were not consistent and a number of care plans reviewed by the inspectors did not provide sufficient information to guide safe and appropriate care for the residents.

The processes in place to monitor residents were not robust. For example, there were six residents in the centre who did not have a weight recorded. Some of these residents had been assessed as having a high risk of malnutrition

Judgment: Not compliant

Regulation 6: Health care

Residents had access to a doctor of their choice. Residents were seen to be supported by allied health care professionals such as dietitians, speech and language therapists, and tissue viability nurses. A physiotherapist attend the centre twice a week. Referrals could also be made to the community palliative care team and the psychiatry of later life team.

Daily care records did not provide an accurate record of the care provided for each resident. For example, a review of the daily progress notes for a sample of residents found that information had been duplicated from previous entries. This did not reflect person-centred practice and was not in line with the Nursing and Midwifery Board of Ireland (NMBI) Recording Clinical Practice guidance.

Judgment: Substantially compliant

Regulation 8: Protection

Inspectors found that the systems in place to protect residents required review and improvement. This was evidenced by

- failure of the provider to recognise and respond to allegations of abuse
- poorly described and reviewed safeguarding policy
- a review of the roster and staff files found that two new members of staff had commenced employment in the centre prior to having their Garda Síochana (police) vetting status confirmed.
- gaps in the safeguarding training of staff

Judgment: Not compliant

Regulation 9: Residents' rights

The provide did not ensure that residents could exercise choice in line with their preferences and needs for care and support. For example, the bath had been removed from the assisted bathroom which meant that residents who preferred a bath could not have one and those residents who could not sit in a shower chair did not have appropriate access to bathing facilities.

Inspectors were not assured that residents were consulted about and able to participate in the organisation of the designated centre. For example, a review of the residents meeting records found that residents voices were not being listened to.

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	Not compliant
Regulation 34: Complaints procedure	Not compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 26: Risk management	Not compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Substantially compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Oakwood Private Nursing Home OSV-0000372

Inspection ID: MON-0034547

Date of inspection: 02/11/2021

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: 1. Since the inspection, we have increased the number of staff on night duty to 1 RGN and 3 healthcare assistants. 2. We are currently in the process of recruiting additional nurses. It is our intention to have two nurses on night duty as soon as they commence employment with us, hopefully early February and March 2022, in the meantime we are putting a nurse on call every night should the nurse on duty require assistance. . 3. We have submitted a plan to the inspector to address the fire safety concerns raised at the inspection.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: 1. All staff have completed training in safeguarding vulnerable adults and responsive behaviours. Certificates were available in training records but were awaiting signatures for verification. This is now in place. 2. We will update the fire safety training programme to ensure that it includes all aspects outlined in Regulation 28 1(d).	

3. We will develop a training induction programme for new staff commensurate with their roles and maintain a record of induction completed by each staff member in individual staff files.

4. New systems of clinical governance will be implemented which will provide monitoring and oversight of clinical practice. A schedule for auditing residents' assessments and care plans will be developed. Feedback will be given to nursing staff on areas requiring improvement. This will be used to facilitate oversight of clinical care and clinical supervision.

5. A schedule will be developed to ensure staff have performance appraisals completed and documented annually or more often as required by the previous appraisal.

6. An annual training plan is in place based on mandatory training needs, changes to national and / or local policy and findings of quality and safety monitoring.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
1. We have nominated a senior member of our nursing staff to act as the quality and safety coordinator for the centre and have allocated supernumerary hours weekly for same. We have made arrangements for this staff member, the person in charge and senior nurses to be mentored by external consultants in the development of the following systems:

· A governance and management framework for the centre to outline roles, responsibilities, accountabilities and reporting relationships for all staff and managers in the centre.
· A clinical governance framework for the centre to include the collection, collation, trending and analysis of key quality and safety data to direct continuous quality improvement action plans for the centre.
· An annual audit programme that will be directed by and responsive to monitoring of quality and safety data. The programme will include auditing of infection prevention and control practices, medication management, use of restrictive practices, assessment and care planning, end of life care, food and nutrition and any other area requiring improvement as identified through quality and safety monitoring.
· A clinical governance committee, with clear terms of reference, which will review quality and safety data and develop action plans to address quality improvement needs. The committee will also oversee clinical risk management for the centre.
· A risk management framework to include processes for identifying, assessing, managing and monitoring of risks in the centre.
· A live risk register of environmental, occupational and clinical risks.

· A health and safety committee, with clear terms of reference to review environmental and occupational hazards and risks, develop action plans to address risks and monitor the efficacy of same.

2. A schedule for auditing residents' assessments and care plans will be developed. Feedback will be given to nursing staff on areas requiring improvement. This will be used to facilitate oversight of clinical care and clinical supervision. Findings from these audits will also be used to identify any training, coaching or mentoring needs of nursing staff.

3. Policies and procedures will be revised and updated as required to ensure they are evidence based and site specific.

4. A schedule of meetings will be developed to include committee and staff meetings. Minutes will be typed up and retained in a designated folder.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
Notifications will be submitted in accordance with regulatory requirements going forward.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
All verbal complaints will be recorded by the staff member who receives them. This will include actions taken to address the complaint at the point of contact and /or the referral of the complaint to the person in charge. Concerns raised and complaints made during resident' meetings will be recorded as a complaint and followed up by the person in charge in accordance with the complaints policy.

Regulation 4: Written policies and procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
Policies and procedures of the centre will be revised and updated as required.

Regulation 26: Risk management	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management:
1. The risk management policy for the centre will be revised and updated to ensure it contains all of the information required by Regulation 26.

2. As outlined under regulation 23, a senior member of nursing staff will be designated as the quality and safety coordinator for the centre. This staff member will receive mentoring from external consultants on the development of:
· A risk management framework to include processes for identifying, assessing, managing, and monitoring of risks in the centre.
· A clinical risk register.
· A health and safety committee, with clear terms of reference to review environmental and occupational hazards and risks, develop action plans to address risks and monitor the efficacy of same.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
1. Individual hoist slings have been ordered for residents.

2. All residents have their own toiletries and environmental hygiene audits will include monitoring for the presence of toiletries in communal bathrooms.

3. Household staff have been reminded to ensure call bell strings have been cleaned, a record will be created to include instructions for cleaning of items in all areas and the recording of same.

4. New shower chairs have been ordered to replace those showing wear and tear.

5. The flooring in the toilets and the bathroom will be replaced.

6. Covered clean laundry trolleys have been procured for the storage of linens.

7. New bins that can be brought outside residents' rooms have been purchased to ensure appropriate disposal of used incontinence wear.

8. External storage space will be built and made available for storage of equipment. Hoists, wheelchairs and walking frames will be removed from corridors and communal areas.

9. Daily environmental checks are carried out by nursing staff and a schedule of auditing of environmental hygiene has commenced.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
1. A plan for upgrading fire safety systems was submitted to the inspector as attached.

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
1. Training for nursing staff on assessment and care planning has been scheduled for the 6th and 10th January 2022.

5. A schedule for auditing residents' assessments and care plans will be developed. Feedback will be given to nursing staff on areas requiring improvement. This will be used to facilitate oversight of clinical care and clinical supervision. Findings from these audits will also be used to identify any training, coaching or mentoring needs of nursing staff.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
1. Training for nursing staff on assessment and care planning has been scheduled for the 6th and 10th January 2022. This will include recording daily progress notes.

2. A schedule for auditing residents' assessments and care plans will be developed. Feedback will be given to nursing staff on areas requiring improvement. This will be used to facilitate oversight of clinical care and clinical supervision. Findings from these audits will also be used to identify any training, coaching or mentoring needs of nursing staff.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
1. The safeguarding policy for the centre will be revised and updated.

2. Going forward, all new staff will have their Garda Síochana (police) vetting status completed.

3. All staff have received training in safeguarding.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
1. The bath referred to in the report will be returned to the assisted bathroom.
2. The form used to record minutes of residents' meetings will be upgraded to ensure it includes a record of all issues, concerns and complaints raised, actions to address same, responsible person and follow up of same.

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	14/02/2022
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	10/12/2021
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	31/01/2022
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the	Not Compliant	Orange	14/02/2022

	effective delivery of care in accordance with the statement of purpose.			
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Not Compliant	Orange	17/12/2021
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	28/02/2022
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	Not Compliant	Orange	31/01/2022

	under section 10 of the Act.			
Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.	Not Compliant	Orange	17/12/2021
Regulation 26(1)(b)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the risks identified.	Not Compliant	Orange	17/12/2021
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.	Not Compliant	Orange	17/12/2021
Regulation 26(1)(c)(ii)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the unexplained absence of any resident.	Not Compliant	Orange	17/12/2021
Regulation	The registered	Not Compliant	Orange	17/12/2021

26(1)(c)(iii)	provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control accidental injury to residents, visitors or staff.			
Regulation 26(1)(c)(iv)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control aggression and violence.	Not Compliant	Orange	17/12/2021
Regulation 26(2)	The registered provider shall ensure that there is a plan in place for responding to major incidents likely to cause death or injury, serious disruption to essential services or damage to property.	Not Compliant	Orange	10/12/2021
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Not Compliant	Orange	31/01/2022

Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Red	05/11/2021
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Red	05/11/2021
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.	Not Compliant	Orange	13/12/2021
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	13/12/2021
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures,	Not Compliant	Orange	10/12/2021

	building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.			
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Red	05/11/2021
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.	Not Compliant	Orange	10/01/2021
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.	Not Compliant	Orange	08/12/2021
Regulation 34(1)(d)	The registered provider shall provide an accessible and effective complaints procedure which	Not Compliant	Orange	10/01/2022

	includes an appeals procedure, and shall investigate all complaints promptly.			
Regulation 34(1)(g)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall inform the complainant promptly of the outcome of their complaint and details of the appeals process.	Not Compliant	Orange	10/01/2022
Regulation 34(1)(h)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall put in place any measures required for improvement in response to a complaint.	Not Compliant	Orange	10/01/2022
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	Not Compliant	Orange	10/01/2022

	recorded and that such records shall be in addition to and distinct from a resident's individual care plan.			
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Not Compliant	Orange	31/03/2022
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.	Not Compliant	Orange	14/01/2022
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later	Not Compliant	Orange	14/01/2022

	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.	Not Compliant	Orange	14/01/2022
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	14/01/2022
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Orange	10/12/2021

Regulation 8(2)	The measures referred to in paragraph (1) shall include staff training in relation to the detection and prevention of and responses to abuse.	Not Compliant	Orange	10/12/2021
Regulation 8(3)	The person in charge shall investigate any incident or allegation of abuse.	Not Compliant	Orange	10/12/2021
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Not Compliant	Orange	10/01/2022
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.	Not Compliant	Orange	10/01/2022