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:	Our Lady of Lourdes Care Facility
Name of provider:	Melbourne Health Care Limited
Address of centre:	Kilcummin Village, Killarney, Kerry
Type of inspection:	Unannounced
Date of inspection:	13 February 2023
Centre ID:	OSV-0000265
Fieldwork ID:	MON-0038219

About the designated centre

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

Our Lady of Lourdes Care Facility is a designated centre located within the rural setting of the village of Kilcummin and a short distance from the town of Killarney, Co. Kerry. It is registered to accommodate a maximum of 68 residents. It is a two-storey facility set out in three wings: Dun Beag is a dementia-focused unit accommodating 18 residents; Tus Nua on the first floor accommodating 28 residents; and Deenagh on the ground floor accommodating 22 residents. Our Lady of Lourdes Care Facility provides 24-hour nursing care to both male and female residents whose dependency range from low to maximum care needs. Long-term care, dementia care, convalescence, respite and palliative care is provided.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	57

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
Monday 13 February 2023	10:00hrs to 18:00hrs	Breeda Desmond	Lead
Tuesday 14 February 2023	08:30hrs to 16:00hrs	Breeda Desmond	Lead

What residents told us and what inspectors observed

Overall, the inspector found that the person in charge and staff were working to improve the quality of life and promote the rights and choices of residents in the centre. The inspector met with many residents during the inspection and spoke with five residents in more detail. Residents spoken with gave positive feedback and were complimentary about the staff and the care provided in the centre.

There were 57 residents residing in Our Lady of Lourdes Care Facility at the time of inspection. On arrival for this unannounced inspection, the inspector was guided through the centre's infection prevention and control (IPC) procedures by a member of staff, which included a signing in process, hand hygiene, face covering, and temperature check. An opening meeting was held with the person in charge and clinical nurse manager (CNM), which was followed by a walk-about the centre.

The centre was set out in three units: Deenagh (22 beds) on the ground floor, Tus Nua (28 beds) and Dun Beg (18), both upstairs. Dun Beg was specifically designated to care for residents with a diagnosis of dementia.

There was a large welcome sign at reception welcoming visitors to the centre. The main entrance was wheelchair accessible and led to the main reception and main day space downstairs. These were decorated with hearts, garlands and other decorations for Valentine's day. The free-standing pedestal displayed the activity programme for the day. The notice board had a variety of local news and information about the community of Kilcummin and Killarney. The events planner for the month was displayed by the day room. This included birthdays, bank holidays and feast day celebrations such as St Brigid's day and St Valentine's day for February. Another white board showed the activities for the week of exercise classes, sing-along, reading local news papers, games, quiz, aromatherapy and mass. The display unit by reception had documentation such as the statement of purpose, residents' guide, HIQA inspection reports, complaints policy and the annual review displayed for easy access. A suggestion box was clearly accessible at the main entrance. The oratory, hairdressers' room and bedrooms were located to the right of main reception; nursing and administration offices, dining area for Deenagh, and residents bedroom accommodation were located to the left of main reception. Additional toilet and bath facilities were available here. The laundry and storage facilities were accessible via a secure corridor on the ground floor.

There was good directional signage throughout the centre to inform residents of rooms such as the dining room, day room and bedrooms, to allay confusion and disorientation.

Upstairs was accessed via a lift and stairs, and these opened into the expansive day room on Tus Nua. The day room had glass frontage which opened into a large secure patio area with garden furniture with tables, chairs and raised flower boxes and potted plants. The day room itself had ample room for specialist chairs,

expansive table which was seen to be used for activities and some resident had their meals and snacks there. The coffee doc was a lovely quiet room found off the day room, where residents and visitors could meet in private. There was inappropriate items stored here and these were removed immediately to ensure the room was free of clutter and available to residents and visitors. There were water dispensers available on both floors.

Dunbeg was partially secure in that the main entrance to it was keypad access, nonetheless, there was an archway access between the day room in Tus Nua and Dunbeg for residents to move around independently. The shower room on Dunbeg was upgraded since the last inspection and looked well, nonetheless, items such as urinals, shower gel, shampoo and equipment were left on the shelving here. One of the shower rooms on Dun Beg had a large domestic waste bin, the top of which overhung the hand wash basin and partially obstructed it.

Call bells were fitted in bedrooms, bathrooms and communal rooms. On the inside window pane at the entrance to bedrooms, the front door code was displayed to enable residents to independently access the outdoors when they wished. An additional 'night light' was mounted by the door should residents prefer soft lighting at night time. During the walkabout, the inspector observed that staff knocked on residents' bedroom doors before entering, then greeted the resident by name in a respectful manner, and asked residents how they were. Lovely conversation and interaction was heard throughout the day between staff and residents. Staff were seen to escort residents to rooms such as the day room or dining room, and this was done in a respectful and easy manner where staff positively engaged with residents as they were walking.

Most bedrooms were of adequate size and layout and could accommodate a bedside locker and armchair. Low low beds, mattresses, specialised pressure relieving mattress, and specialist wheelchairs were seen. Flat-screen televisions were wall-mounted in bedrooms, some were a good size and others were small and possibly difficult to see, for example, one television was seen to be on top of a very high window sill. Due to the lay out of some twin bedrooms, the television was not visible from one bed space. Another was positioned over the door and was too high to be viewed. Some residents had access to a double wardrobe for their personal clothes and some had access to a single wardrobe. The layout of two twin rooms did not enable unobstructed access by both residents to the en suite facilities. Many bedrooms were decorated in a homely manner and were very personalised, however, some bedrooms were devoid of personalisation and bedside lockers were seen to be located away from the resident's bedside and not accessible. Some bedrooms such as 132, 133, 129, and 128, did not have appropriate shelving to display photographs and mementos; the shelving in these rooms was the windowsill which was near the ceiling. Bed rail holders remained on beds that did not have a bed rail; these metal holders protruded from the side of the beds. While some bedrooms had matching and complementary furniture others seen had three different coloured furniture such as dark wood bed side locker, oak coloured wardrobe, and cream coloured table. The bed rail in one twin bedroom had not been readjusted when the bedroom was reduced from a three-bedded to twin room. Consequently, the bed screen was positioned in the middle of the bed so they could

not be drawn. Some doors to vanity units were quite worn. Some twin bedrooms did not have storage units in en suites for residents to store their toiletries separately. One single room did not have a storage unit for toiletries as these were seen in a basket on the cistern.

Mealtimes were observed. Medications were administered either before or after meals to ensure meals were protected. In general, staff providing assistance to residents in dining rooms and bedrooms actively engaged with people chatting as they were assisting with mealtime; two members of staff were seen to stand over residents while providing assistance with their meal. Breakfast was seen to be served throughout the morning with residents having their breakfast in the dining rooms up until 11:00hrs. The dining room upstairs was a large bright room with dressers on either end. Tables were set with cutlery and condiments prior to residents sitting for their meal. The inspector spoke with residents downstairs while they were waiting for their meal to be served. It was noted that women were served before men regardless of whether they were sitting at the same table or not; one gentleman and lady were sitting together at the dining table, she was served first but he was not served until all the ladies in the dining room were served. This was brought to the attention of the person in charge who addressed the issue immediately and said she would follow it up again after the inspection.

Photographs were displayed of resident enjoying parties, birthdays and celebrations. There were two resident cats, Twinkle and Ginger and some residents had feeding bowls and bedding for the pets in their bedroom. Misty was the name of the donkey in the paddock alongside the centre which residents could access from the side of the building. There was an outdoor garden area where one resident had developed a vegetable garden which had an array of vegetables. Aside from this, the outdoor space downstairs was not developed. While there was an expansive veranda upstairs where several bedrooms had patio-door access, this was not developed to facilitate residents using it. In addition, the balcony wall was not of sufficient height to be assured that it was safe, unlike the secure patio area off the lounge in Tua Nua which had additional clear re-enforced perspex on top of the wall ensuring the area was safe.

Two activities staff provided activation for residents, one on each floor on the day of inspection. Residents were seen to enjoy arts, exercises and a sing-song session. For the singing, residents where they were given sheets with words of songs and sang along with the activities person. As it was Valentine's day, all the songs were love songs from the old movies and residents were seen to enjoy it. The physiotherapist was on site on the first day of the inspection and facilitated group therapy for resistance and strengthening of shoulder, arm, neck, and legs, and breathing and chest exercises. Residents interacted well in the session and were seen to have good fun; they said smilingly afterwards, they were 'exhausted' after being 'put through their paces'.

Another resident spoken with praised the staff and the care they received. The resident loved the cats and had feeding bowls for them and they were seen to come and go as they pleased, but knew the rooms they would get a good welcome and food. This resident reported that the lens from their reading glasses had fallen out.

The person in charge addressed the issue when it was brought to her attention and had it fixed in the opticians for the resident. This resident enquired when the mobile library was recommencing as the service was suspended during COVID-19 precautions. The person in charge said she would contact the service to enquire about it as the resident missed their access to books, and reading was their primary enjoyment.

Visiting had resumed in line with the HSE 'COVID-19 Normalising Visiting in Long-term Residential Care Facilities' of February 2023. Visitors were known to staff who welcomed them and actively engaged with them. There was a separate entrance to the up-stairs which remained in operation, and visitors were seen to collect residents from here to take them out for the afternoon. Infection control checks were seen to be completed in line with their infection control protocol.

Hand-wash hubs were available on both floors; clinical hand wash sinks had metal outlet and overflows. Wall-mounted hand sanitisers were available throughout the centre and staff were observed to comply with best practice hand hygiene. Dani centres were available throughout the centre which stored personal protective equipment (PPE). Laundry was seen to be segregated at source. There was a separate laundry lift shaft to enable laundry to be moved between floors in a safe manner. The hand wash sink in the laundry was visibly unclean. Most of the centre was visibly clean, nonetheless, some low shelving on corridors had a lot of dust visible. Vacant rooms were examined; terminal cleaning checks had not been completed as items such as hoist slings, a commode and kidney dish remained in bedrooms and en suites; inside the drawers of some bedside lockers were visibly unclean and sticky.

There was a sluice room on both floors. While there was a bedpan washer downstairs, there was none in the sluice room upstairs.

Regarding the premises, flooring in some bedrooms was worn and some wooden panels on the floor were missing; surfaces to bed-rails, bed frames, bedside lockers and wardrobes were quite worn. Some handles or knobs were missing from bedside lockers and the retaining screws were exposed and protruded.

Emergency evacuation plans were displayed in the centre with accessible information. Additional evacuation notices were displayed opposite three bedrooms reminding staff of the evacuation route for those particular beds. Appropriate signage was displayed on rooms where oxygen was stored.

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

Capacity and capability

Overall, this service promoted a rights-based approach to care and residents' were supported to have a good quality of life. The governance structure was clear and was know to staff.

Our Lady of Lourdes Care Facility was a residential care setting operated by Melbourne Health Care Limited. It was registered to accommodate 68 residents. The governance structure comprised the board of directors, with one of the board members nominated as the person representing the registered provider. The person in charge reported to the nominated person. The person in charge was supported on site by the clinical nurse manager 2 (CNM2), CNM1s (Deenagh and Dun Beg), administration, clinical, and maintenance staff. The CNM2 deputised for the person in charge when absent from the centre.

In general, there was evidence of good governance with monthly clinical governance meetings, with set agenda items; improvements identified had associated action plans with responsibilities assigned, progress status and completion due dates which enabled good accountability. Nonetheless, issues identified on previous inspections relating to the premises and some residents' access to personal storage space, remained unaddressed.

The audit schedule for 2023 was evidenced with clinical, observational and work practices audited. While observational audits were introduced following the last inspection, these required further action to enable better quality improvement. The provider nominee and maintenance person had completed an audit of the premises which highlighted areas to be upgraded; this report was with the management team for costing and procurement. Nonetheless, this audit of the environment was an annual occurrence, and evidence detailed under regulation 17 demonstrated that more frequent audits of the environment were necessary to facilitate ongoing improvement along with a programme of works to ensure the continuous maintenance and upkeep of the premises.

The incidents register was part of their quality and safety management. This document detailed thorough information on the incident, care planning status, whether an action or intervention was required, and controls put in place to mitigate recurrences of such incidents, such as referrals to the physiotherapist. Clinical observations were completed at the time of the incident in line with a high standard of nursing care, providing assurances that all due care and attention was provided at the time of the accident or incident.

Up-to-date service records and periodic reports were seen for water supply, environmental health and microbiological food surveillance, and these were seen to be complaint. The statement of purpose was updated on inspection to ensure information was easily accessible for residents. Schedule 5 policies and procedures were updated on inspection to ensure regulatory compliance. There was a current certificate of insurance which complied with the regulations.

There was adequate staff to the size and layout of the centre. Duty rosters viewed showed staff allocation per unit and this included care and household staff. The training matrix was examined and showed that mandatory training was up to date

for all staff. Professional registration PINs were in place for all nurses employed in the centre. Schedule 2 records, staff files, were updated on inspection to ensure regulatory compliance.

In conclusion, this was a good service where a rights-based approach to care delivery was promoted.

Registration Regulation 4: Application for registration or renewal of registration

The registered provider applied to re-register Our Lady of Lourdes Care Facility in a timely manner. Prescribed documentation was submitted and fees were paid.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge was a registered nurse, working full time in post and had the necessary experience and qualifications as required in the regulations. She actively engaged in the governance and operational management of the service, and positively engaged with the regulator.

Judgment: Compliant

Regulation 15: Staffing

The staff roster showed that the number and skill mix of care staff was appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the centre. Prior to the inspection it was identified that additional maintenance support was necessary to facilitate the upkeep of the centre. A new part-time maintenance person was due to commence working the week following the inspection. The inspector followed this up and the additional maintenance person was in post.

Judgment: Compliant

Regulation 16: Training and staff development

Mandatory training was up to date for all staff. The training schedule was seen and

this showed ongoing staff training booked to ensure training remained current.

Judgment: Compliant

Regulation 19: Directory of residents

The directory of residents was upgraded following the last inspection to ensure information relating to the temporary transfer of a resident could be recorded in line with regulatory requirements.

Judgment: Compliant

Regulation 21: Records

Staff files were updated on inspection to include the following to ensure they met the requirements of Schedule 2:

- documentary evidence of qualifications attained in accordance with their curriculum vitae
- evidence of verification of references.

Judgment: Compliant

Regulation 22: Insurance

A current insurance certificate was in place and included insurance against other risks, including loss or damage to a resident's property.

Judgment: Compliant

Regulation 23: Governance and management

While there was a clear governance structure with clear lines of accountability and responsibility for the service, action was required to ensure the management systems effectively monitored the service. Evidence of this was further discussed under Regulation 17, Premises, Regulation 12, Personal possessions, and Regulation 18, Food and Nutrition.

Regarding risk, action was necessary to ensure risk was reported when identified, as follows:

- the medication trolley could not be attached to the wall to ensure it's security in line with professional guidelines; this had not been reported to maintenance for repair,
- bed-rail holders remained on beds even though the bed rails were removed; these protruded and comprised a potential risk to residents; while they were removed on inspection they had not been identified as a hazard to residents,
- handles and knobs were missing from bedside locker drawers which resulted in the retaining screws being exposed and protruding creating a potential risk to residents,

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The statement of purpose was updated on inspection to reflect the following to ensure compliance with the requirements as set out under the regulations:

- the current oversight of the complaints process, and
- easy accessible information regarding the terms of occupancy in the centre (contracts of care).

Judgment: Compliant

Regulation 31: Notification of incidents

Notifications submitted to the Chief Inspector correlated with the incident and accident log examined. Clarification was provided on inspection regarding the six-monthly returns for notifications not requiring submission in the previous six months.

Judgment: Compliant

Regulation 34: Complaints procedure

While residents reported that there were no obstacles to them reporting anything to staff or the person on in charge, complaints records were not maintained in line with regulatory compliance as appropriate records of complaints were not maintained in

line with their policy.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

Schedule 5 policies and procedures were available as hard and soft copies for staff. They were updated on inspection as follows:

- the policy relating to the creation of, access to, retention of, maintenance of, and destruction of records referencing in line with current legislation
- the temporary absence policy to include information on updating relevant documentation of the temporary transfer
- medication management to reflect the 'exceptional' practice of transcription of medication
- complaints policy to reflect the current practices relating to the maintenance and management of complaints.

Judgment: Compliant

Quality and safety

The inspector observed that, in general, care and support given to residents was respectful; staff were kind and facilitated care in a friendly manner.

Residents had regular access to on-site GP consultation. Residents medications were reviewed as part of consultation with their GP; documentation showed that there was ongoing monitoring of and responses to medication to ensure best outcomes for residents. Residents had access to specialist services such as psychiatry of old age, palliative care, speech and language, physiotherapy, occupational therapy, dietitian and optician. The 'Kerry Integrated Care Pathway for Older People (Kerry ICPOP) team included speech and language therapy (and associated dysphagia training for staff) and access to consultant geriatrician. This scheme mitigated the need for some residents to attend the accident and emergency services as consultation enabled better outcomes for residents. The physiotherapist was on site every Monday and Thursday providing assessment and healthy living exercise programmes.

Pre-admission assessments were undertaken by the person in charge to ensure that the service could provide appropriate care to the person being admitted. Care plan documentation reviewed showed mixed findings which required improvement, and these were further discussed under Regulation 5, Individual assessment and

careplan.

Copies of transfer records for times when residents were temporarily absent from the centre were maintained on site. Following discharge back to the centre, comprehensive information was available when the resident returned to the centre. Good clinical oversight with monthly records of restraint including chemical restraint was maintained and this information fed into their clinical governance meetings.

In the sample of medication documentation examined, medication administration records were comprehensively maintained. Improvement was noted since the last inspection regarding management of controlled drug records maintained.

Residents' meetings were held every three months. The person in charge facilitated these and there were lots of discussion and information sharing. 'Wellbeing' meetings were facilitated by the person in charge and staff with responsibility for the activities programme, to discuss the activity plan for the month and daily activities. Satisfaction surveys were completed on a daily basis following activities, where residents were asked about the activity, whether they enjoyed it and their suggestions.

Laundry was segregated at source. Sluice rooms were secure access to prevent unauthorised access to hazardous waste and clinical products, however, the sluice room upstairs did not have a bedpan washer.

Appropriate certification relating to fire was in place. Emergency floor plans and evacuation routes comprehensively displayed the escape routes available. In addition, there was additional signage for three bedrooms indicating the escape route for that particular bed. Personal emergency evacuation plans were available and the folder was set out per zone per unit with the evacuation type and assistance needed per individual resident along with their photograph for easy identification. These were updated on a weekly basis to ensure the information available reflected the current status of the resident and the assistance for emergency evacuation should the need arise.

Regulation 11: Visits

Visiting was facilitated in line with February 2023 HPSC guidance. Measures were taken to protect residents and staff regarding visitors to the centre with hand sanitising gels and advisory signage available throughout the centre. Residents spoken with were familiar with the current visiting regimes and understood the rationale for mask-wearing.

Judgment: Compliant

Regulation 12: Personal possessions

Some residents had access to a double wardrobe for hanging and storing their clothes, however, others had access to a single wardrobe which would not be adequate for people in long-stay residential service. Feedback in some of the resident surveys completed showed that residents identified this and said they were unhappy with the personal storage space available to them for their clothes. While the provider nominee gave assurances that this would be addressed, this was a repeat finding and had been identified in previous inspection reports.

Judgment: Not compliant

Regulation 17: Premises

Overall, the premises, having regard to the needs of residents in the centre, did not conform with all the requirements as set out in Schedule 6 of the regulations; this was a repeat finding:

- access to the outdoor space was not maintained to enable residents to access them safely or independently (veranda off bedrooms in Tus Nua or outdoor area down stairs); residents' surveys showed that some residents reported they were were unhappy with the access to the outdoor spaces and would like better access to outside
- the layout of two twin bedrooms did not allow for the unobstructed access by both residents to the en suite facilities
- one single bedroom did not have a bedside locker; other bedside lockers were not kept beside the bed so that the resident could easily access it
- some televisions were small and possibly difficult to see; other were wall-mounted very high over the door frame or on the very high window sill and could not be viewed; due to the lay out of some twin bedrooms, the television was not visible from one bed space
- bedrooms such as 132, 133, 129, 128, did not have appropriate shelving to display photographs and mementos; the shelving in these rooms was the windowsill which was near the ceiling,
- the privacy curtain rail in one twin bedroom had not been readjusted when the bedroom was reduced from a three-bedded to twin room. Consequently, the bed screen was positioned in the middle of the bed so they could not be drawn
- 12 twin-bedded rooms required re-configuration to ensure both residents occupying twin rooms had adequate space for their bedside locker, chair and wardrobe while at the same time maintaining natural light into the rooms.

Judgment: Not compliant

Regulation 18: Food and nutrition

The inspector saw that residents sitting together at tables were not all served together and one resident could be nearly finished their meal before the resident beside them was served. A review of serving at meal-times was required to ensure all residents were served appropriately in line with a normal dining experience where people sitting together at tables are served together.

Judgment: Substantially compliant

Regulation 20: Information for residents

The residents guide was updated on inspection to reflect the oversight and management of complaints.

Judgment: Compliant

Regulation 25: Temporary absence or discharge of residents

The national transfer template was used when residents were transferred out of the centre, and included information regarding the infection history and MDROs ensuring comprehensive history to inform care in the receiving facility. Copies of the transfer letters were maintained on-site. Transfer information was available as part of the care documentation when the resident returned to the centre; this included both nursing and medical transfer letters.

Judgment: Compliant

Regulation 27: Infection control

Management of the environment required action to minimise the risk of transmitting a healthcare-associated infection; many of these were repeat findings. This was evidenced by:

- not all clinical hand wash sinks were compliant as some had metal outlets and overflows which did not comply with the Dept. of Health HPN 00 – 10 document
- terminal cleaning checks were not completed to ensure rooms was deep

cleaned and ready for occupancy following the discharge of a resident
- surfaces to many pieces of equipment such as bed rails, bed frame, bedside lockers, vanity units for example were quite worn and effective cleaning could not be assured
- the sluice room upstairs did not support effective infection prevention and control as there was no bedpan washer for decontamination of human waste receptacles such as urine bottles, bedpans and commode basins. Assurances were not provided that decontamination of such equipment was being managed in line with best practice. Manual cleaning and disinfection of utensils must be avoided due to the high risk of contamination,
- one single room did not have a storage unit for toiletries as these were seen in a basket on the cistern and some twin bedrooms did not have storage units in en suites for residents to store their toiletries separately, to prevent the risk of contamination
- one shower bathroom had a urinal, shampoo and shower gel on a shelf; residents' wash bowls were seen to be left on the window sill of another shower room along with a bag of equipment
- the large domestic waste bin in a shower room was partially obstructing the hand-wash sink making it difficult for people to access it to use
- practices observed regarding one member of staff carrying clean supplies in one hand while going from one waste bin to another, packing down the waste in the bins, rather than emptying them.

Judgment: Not compliant

Regulation 28: Fire precautions

Action was required in relation to fire safety evacuation drills:

- while simulated fire safety evacuation drills were undertaken on a monthly basis, records showed that these took a prolonged period to complete. Cognisant that there was a noteworthy staff turn over in the previous year, more frequent evacuations were necessary to be assured that residents could be safely evacuated in a timely manner.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

While transcribing of medication was an exceptional practice, the medication charts included space for two staff to co-sign transcribed medication in line with best practice. As required medications (PRNs) were recorded separately to routine medications and the rationale for administration of PRNs was detailed, such as pain,

temperature, and nausea for example. Short-term medications such as antibiotics were maintained separately as well, and had the start date, duration and completion date included. The controlled drug registers were maintained in line with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Care plan documentation reviewed showed mixed findings. While assessments detailed information to inform person-centred care planning, some care plans were not individualised. For example, care plans associated with safeguarding and protection had standard narrative and did not guide staff to the individualised risks to safeguard particular residents; another resident had their catheter removed in December, however, the care plan continued to discuss catheter care. One resident's care plan referred to another named resident and the information included medication management but this pertained to the other resident. While a formal review was signed as completed, the above evidence suggests that the care documentation was not reviewed in line with regulatory requirements.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had good access to GP care. Residents notes showed timely referrals and reviews by specialist services such as speech and language and progress and implementation of different regimes to improve residents' quality of life.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Good oversight was demonstrated regarding restrictive practice in the centre. A restrictive practice register was maintained and reviewed and signed off by the person in charge on a weekly basis. This information formed part of the monthly clinical reviews and ensure continuous oversight of restrictive practices in the centre.

Judgment: Compliant

Regulation 8: Protection

Staff training was up to date for safeguarding residents. Observation on inspection showed that staff were respectful in their interactions with residents and treated them with dignity.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 4: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Not compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 20: Information for residents	Compliant
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Our Lady of Lourdes Care Facility OSV-0000265

Inspection ID: MON-0038219

Date of inspection: 14/02/2023

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 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • Taking Regulation 23 into account, Management has reviewed it monitoring system and acknowledges some improvement is required in this area. Since inspection, the Provider Nominee has agreed to complete a full walkabout the facility with the Maintenance Team and Head of Housekeeping every 4 months. This will include looking at Fire Safety, Infection Control, Risk and Health & Safety, room layouts & comfort, maintenance work, furniture, flooring, lighting & heating. • PIC has had meetings with the Heads of each work area and the monitoring of them. o Head of Housekeeping is now completing spot checks on cleaning of units and also signing off on terminal cleaning of rooms and furniture completed by her staff. o All staff to document in maintenance book all maintenance issues on the day they find it. o Extra person now working on the Maintenance Team to share the workload & reduce risk to residents & staff o Maintenance persons to impress upon staff that they will not accept a verbal request to assess a maintenance issue – must be documented. o Furniture which required repair has either been repaired or replace at this time. o Nurse on duty to monitor mealtime experience & rectify any issues seen o PIC & CNM 2 to spot check all areas & document findings. These will be actioned & reviewed. o 6 weekly meetings to be held with CNMs and/or Nurses to review Risk, Health & Safety, Infection Control, Complaints, Restraint & Education – action required and person to be responsible for completion of action. Medication near misses/errors and Complaints book to be brought to these meetings. PIC /CNM 2 will log complaints issues into the register. o Resident satisfaction survey has been completed in March 2023 by residents & actions taken. · PIC has contacted the Mobile library who will review the service in June 2023. • Where a change in practice has occurred, appropriate policies will be/ are being	

updated
• Auditing of all services provided to the residents will continue, with extra auditing & actions taking place where a deficit is noted in practice/system
• An updated compliance plan will sent in mid-May 2023

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
• While complaints had been dealt with successfully, they had not been logged into the Complaints Register. On review of this area, it was noted that only the more serious complaints had been dealt with and daily issues had not been recorded. To rectify this, a Daily Issues Book has been placed in each Unit, whereby, issues, comments passed or concerns are now logged. This book also requires documentation of action taken to resolve the issue, dated and signed.
• Complaints requiring more robust action or investigation will be logged electronically on Epiccare system.
• The Complaints policy has been updated to reflect this information.

Regulation 12: Personal possessions	Not Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
The Provider Nominee has commenced work in this area.
• The twin bedrooms had double wardrobes for each resident within the bedroom space, however, both wardrobes were at one side of the bedroom, meaning the second resident had to enter the private space of the first resident to gain access to their belongings.
• Since previous inspection, the Provider Nominee supplied a single wardrobe into the second residents private space, however, this wardrobe did not have enough space to hold all belongings
• Since this inspection, the Provider Nominee has requested a Specialist consultant to assess the bedrooms and to configure a new layout for the twin bedrooms and providing space in both resident's areas for a double wardrobe.
• He assessed 12 bedrooms and reported that a new configuration could be completed in 10 of the 12 bedrooms. As a result, the Provider Nominee has converted 2 twin rooms into single rooms and work has commenced on the remaining 10 bedrooms. It is expected that work will not be fully completed until mid -May 2023, as 3 bedrooms will require extensive reconfiguration, residents who already live in these rooms will be moved to other rooms for the duration of the works. The work will be completed in

rotation to accommodate safety of residents and provision of appropriate alternative rooms during the works.
• Works such as shelving in bathrooms, bedrooms, & storage in Communal bathrooms in Dun Beag Unit has already commenced.
• The Provider Nominee has agreed to complete a full walkabout of the facility every 4 months with view to observing rooms and their contents, risk issues, health & safety, IPC, fire safety and any other area which may present.
• Resident surveys will be completed quarterly.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
With regards to Regulation 17 & Schedule 6, the Provider Nominee has set out a plan of works to be completed in order to attain full compliance.
• A secure garden area is already on the ground floor and plans are in place to extend this area. The Provider Nominee has met with a contractor to commence this work, however, the contractor has advised that it would be wiser to wait until the end of June to commence work, as the ground is too wet at present.
• The work will consist of :
o increasing the size of the garden area
o Walkways around the garden
o Shrubbery & foliage
o Seating
o Garden furniture with shade for hot weather
o Fencing
o
• A garden area in Tus Nua which will extend from the Grotto area along the length of Tus Nua.
o As this is a shaded area naturally, seating, walkways, seating, fencing & appropriate greenery will be provided
o Work will commence in June 2023, as ground is wetter in this area
o
• Veranda which extends along the length of Tus Nua Unit has an existing barrier in place, which complies with Building regulations, however, in the interest of safety, The Provider Nominee will extend the height of the barrier/wall x 60cm. This work is extensive and the Provider Nominee has consulted with a Quantity Surveyor for professional guidance, costing, risk assessment & professional contractor to complete the work. The Provider Nominee has received a full report from the QS. Due to the workload of the manufacturer, fabrication of the new railings will commence late August / September with a view to installation being carried out late October 2023.
o Residents and their families have been informed of the inpending works, which are likely to commence & continue throughout the Autumn 2023
o The Provider Nominee will complete a Risk Assessment for Our Lady of Lourdes and have all necessary safety controls in place prior to commencement of works.

o The QS will complete a risk assessment of works to be completed.
o
• The layout of 2 bedrooms in Tus Nua which impeded complete access to ensuite facilities have been assessed by a consultant and these rooms will be configured to allow compliance. This work will commence in April 2023
• With regards to bedside lockers, the Provider Nominee has ordered new lockers and where existing lockers coud be repaired, this has been completed.
• Staff have also been instructed in the correct placement of bedroom furniture.
• With regard to TV points, an electrician has commenced & is continuing to work in relocating TV points to areas whereby residents may view their TVs easily.
• Shelving for personal photographs & artefacts in rooms, 128,129, 132 & 133 is now in place
o Maintenance has assessed all other bedrooms and wherever this type of shelving is required, has now or is in the process of being installed
• The bedrail which had remained in place has now been removed which has redefined the area as 1 space and not 2.
•
• Since this inspection, the Provider Nominee has requested a Specialist consultant to assess the bedrooms and to configure a new layout for the twin bedrooms and providing space in both resident's areas for a double wardrobe, locker and chair for both residents.
• He assessed 12 bedrooms and reported that a new configuration could be completed successfully in 10 of the 12 bedrooms. As a result, the Provider Nominee has converted 2 twin rooms (109 & 130) to single bedrooms and work has commenced on the remaining 10 bedrooms. It is expected that work will not be fully completed until mid -May 2023, as 3 bedrooms will require extensive reconfiguration, residents who already live in these rooms will be moved to other rooms for the duration of the works. The work will be completed in rotation to accommodate safety of residents and provision of appropriate alternative rooms during the works.
The Provider Nominee will risk assess all works to be completed prior to commencement, taking into consideration resident & staff safety, ventilation, noise control
Families & residents had already been informed of the work to be completed
Staff to be informed as soon as dates for work commencement are agreed
PIC will update residents, families and staff of progress and any necessary changes to practice which may be temporarily required.

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
• In January 2023, the PIC had organised for a Head Waiter from a reputable Restaurant to assess and educate staff in the correct serving of meals with the view to enhancing the mealtime experience for the residents. Unfortunately, staff interpreted some of the education incorrectly. This has been rectified by the PIC and staff are now serving meals appropriately.

• Also, Nurses are supervising the dining areas during mealtimes and rectifying any issues noted.
• Resident satisfaction surveys have been completed in March 2023, which includes questions on mealtime experience.
• PIC / CNM 2 spot checking the dining areas on a regular basis.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
The Provider Nominee is sourcing new clinical hand wash sinks for any area which requires it to comply with Dept. of Health HPN 00 – 10 document. These will be installed after delivery.

Regarding Terminal cleaning, PIC held meetings with CNMs and Head of Housekeeping. The plan going forward will be that on discharge of a resident:
o The Nurse on duty will inform Head of Housekeeping.
o The Nurse on Duty will instruct her team to remove any belongings the resident may have left behind
o The Head of Housekeeping will document the information in the Housekeeping Diary
o Before commencement of next shift, the Housekeeping Team will read the diary and sign
o Housekeeeping Team will complete a terminal clean of the now unoccupied room
o Housekeeper who completes the terminal clean will sign a revamped Terminal cleaning sheet and present it to the Head of Housekeeping
o Head of Housekeeping will check the room and also sign that she is satisfied te work has been fully completed
o The CNM of the unit will also check that the room is clean and inform her Team to dress the room.
o Head of Housekeeping will retain the terminal cleaning sheets in a file and present them at meetings with PIC.
• CNM2 has revamped the original terminal cleaning sheet to make it user friendly and appropriate to Our Lady of Lourdes needs.
• Cleaning policy has been changed to reflect new system or Terminal cleaning and supervision, showing responsibility and accountability

Regarding equipment surfaces being worn:
o New lockers are on order for bedrooms
o Bedrails and frames have been replaced or repaired
• Post meetings with Housekeeping and CNMs, an instruction has been issued to report all issues regarding furniture, equipment, flooring, heating, lighting, and any other area which may impact the resident /staff negatively, to the maintenance staff via the maintenance book.
• Provider Nominee & Maintenance have planned a full walkabout the facility every 4

months with view to observing rooms and their contents, risk issues, health & safety, IPC, fire safety and any other area which may present.
• PIC will continue to complete resident satisfaction surveys quarterly to ascertain residents opinions and suggestions

With regards to bedpan washer in Tus Nua Unit:
• Provider Nominee has ordered a unit to be installed in Tus Nua Unit sluice room.

Ensuite bathrooms required a vanity unit to store personal items:
• All twin rooms in Deenagh and Tus Nua units have storage cabinets which are labelled with the resident's name.
• One twin bedroom, rm 154, which is not ensuite but does have a sink in the bedroom, did not have separate storage cabinets in the bedroom. This work will be completed by 20 April. Since March 2020, we have kept this bedroom as a single room, for infection control purposes. As this room is now returning to a twin room status, a second resident will not be introduced until the work is completed.
• Shelving in the single room ensuites in Dun Beag Unit has commenced.

Communal Bathrooms Dun Beag:
• The large household bin which partially blocked the sink in one bathroom has been removed from that position and is now in a secure area not interfering with any movement or practice which may be required in that bathroom.
• Storage units are on order for both bathrooms

Poor IPC practice by a staff member:
• This practice was informed to Head of Housekeeping at a meeting
• She has been asked to observe all her team & to instill good IPC & Housekeeping practices
• The CNM 2, who is responsible for IPC in the Facility, has taken all the Housekeeping Staff for a refresher IPC training, outlining the only practices acceptable regarding housekeeping & IPC at Our Lady of Lourdes
• Head of Housekeeping is doing formal spot checks
• DON/CNM2 are doing random spot checks during walkabouts

An overview of IPC at Our Lady of Lourdes shows a deficit in premises and Housekeeping practices.
• The Provider Nominee has agreed to do a 4 monthly walkabout with Maintenance and Housekeeping staff to ensure good practice and compliance with resident comforts.
• DON /CNM2 will continue to do spot checks of the whole Facility, which special notice on these 2 areas.
• CNMs to observe and report any deficits/ practices noted within their own units immediately
• Formal IPC audits will increase to quarterly audits
• CNM 2 will continue to give IPC refresher training throughout the year
• Policies will reflect any changes that may be required
• Resident surveys will be completed quarterly

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• All staff have completed formal fire training in February 2023
• There is a Fire Manager on staff who has completed formal training in educating staff on Fire safety and Awareness. This manager completes Fire drills on the last week of every month & evacuations of every compartment 3 monthly. The last fire evacuation of every compartment had been completed on the last week in January 2023, 2 weeks prior to inspection.
• All drills & Evacuations are timed, recorded, analyzed & actioned.
• All fire drills & evacuations are cognizant of the night duty staffing numbers and drills & evacuations are completed and timed as if the fire was occurring on the night duty shift. Night staff attend the drills & evacuations.
• Due to having new hires, the timings for drills and evacuations were slower than previously and the Fire Manager has increased the frequency of Fire Evacuations to monthly at present.
• To aid the Fire Manager with this increased workload, a second person will complete the same formal training in April 2023, and will be able to coach staff in Fire safety on a more regular basis when required.
• As some staff only work weekends, the Fire Manager attended the facility to capture these staff and completed a full evacuation at end of February 2023.
• Timings of drills & Evacuations have been reviewed by the Apex Fire Officer, who expressed that due to the presence of Fire Doors in both bedrooms and corridors, that an approximate time of evacuating 1 minute /resident, while in their beds, was satisfactory, however, did advise to continue with practice drills/evacuations.

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:
OLOL acknowledges that there were some issues with documentation od some Care Plans, in that they were too generic, as in Safeguarding Care Plans and that while the care had been correct, this was copied & pasted from a care plan template without being personalized for the individual to which the care plan applied.
• Care planning education will be scheduled for the latter half of 2023
• In the meantime, PIC & CNM 2 have given informal education to Nurses who require this support
• All Care plans have been audited since inspection and are now appropriate to each individual resident

- An audit of Care Plans & Clinical Risk Assessments will be undertaken every 4 months.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 12(c)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that he or she has adequate space to store and maintain his or her clothes and other personal possessions.	Not Compliant	Orange	28/05/2023
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.	Not Compliant	Orange	30/11/2023
Regulation 18(1)(c)(i)	The person in charge shall ensure that each	Substantially Compliant	Yellow	20/02/2023

	resident is provided with adequate quantities of food and drink which are properly and safely prepared, cooked and served.			
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Substantially Compliant	Yellow	03/03/2023
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Not Compliant	Orange	30/04/2023
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	16/04/2023
Regulation 34(1)(f)	The registered provider shall provide an accessible and effective complaints procedure which	Substantially Compliant	Yellow	27/02/2023

	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	27/02/2023
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 than 48 hours after that resident's admission to the designated centre concerned.	Substantially Compliant	Yellow	27/03/2023
Regulation 5(4)	The person in charge shall	Substantially Compliant	Yellow	27/02/2023

	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.			