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:	AbbeyBreaffy Nursing Home
Name of provider:	Knegare Nursing Home Holdings Ltd
Address of centre:	Dublin Road (N5), Castlebar, Mayo
Type of inspection:	Unannounced
Date of inspection:	08 September 2023
Centre ID:	OSV-0000308
Fieldwork ID:	MON-0038833

About the designated centre

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

AbbeyBreaffy Nursing Home is a purpose-built facility that provides care for 55 male and female residents who require long-term care or who require short periods of care due to respite, convalescence, dementia or palliative care needs. Care is provided for people with a range of needs: low, medium, high and maximum dependency.

The centre is located in a countryside setting a short drive from the town of Castlebar just off the N5. The atmosphere created is comfortable and there is plenty of natural light in communal areas and in bedrooms. Bedroom accommodation consists of four double rooms and 47 single rooms of which 50 have ensuite facilities. There are toilets including wheelchair accessible toilets located at intervals around the centre and close to communal rooms. There are several sitting areas where residents can spend time during the day. There were dementia friendly features in place to support residents' orientation and memory and this included signage and items of memorabilia that included displays of china and old style equipment. An accessible and safe courtyard garden is centrally located and has been well cultivated to provide interest for residents.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	46

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
Friday 8 September 2023	09:00hrs to 18:50hrs	Michael Dunne	Lead
Friday 8 September 2023	09:00hrs to 18:50hrs	Ann Wallace	Support

What residents told us and what inspectors observed

Overall, the inspector found that the person in charge and staff team were working to improve the quality of life for residents and to promote their rights and choices in all aspects of their daily lives. Residents spoken with gave positive feedback and were complimentary about the person in charge, staff and the care provided in the centre. Some residents however, reported high levels of noise in the centre created by doors banging and by noise levels in the designated centres' corridors. This was witnessed by inspectors on the day of the inspection, with noise levels elevated due to the transportation of cleaning, laundry and medication trollies throughout the centre. Residents said that this noise affected their peaceful enjoyment of their environment.

During an introductory meeting, with the person in charge and the assistant director of nursing, the inspectors discussed the purpose of the inspection, which included a review of the provider's compliance plan arising from the last inspection held in January 2022 and a discussion regarding the recent changes to Regulation 34 of the Health Act 2007. Following this, the inspectors commenced a walk around the designated centre.

AbbeyBreaffy Nursing Home provides long-term care and respite care for both male and female adults with a range of dependencies and is located close to the town of Castlebar in County Mayo. Accommodation is provided mainly in single room accommodation with a number of these rooms serviced by an ensuite facility which includes a wash hand basin, toilet, and shower area. There are also a number of twin rooms available in this centre, All twin room accommodation observed on the day of the inspection were suitable in size and layout apart from one twin room which is discussed in greater detail under Regulation 17. There were 49 residents living in the centre on the day of the inspection

During the tour of the designated centre the inspectors met and spoke with several residents and visitors. The majority of feedback was positive about the care and support provided to them by the staff team. On the whole inspectors observed positive interactions between staff and residents. Staff were observed to be courteous and polite and were aware of residents communication needs.

All staff and resident interactions observed on the day were person centred in nature apart from one observation where staff were more focused on the task to be completed rather than providing the required levels of encouragement and support to a resident who was being transferred from a wheelchair. In addition inspectors observed that staff were busy attending to the care needs of the residents and had little time to sit and chat with residents.

Residents were observed throughout the day being supported to access all areas of the designated centre. There were a range of activities provided during the day which included quiz games and discussions on current affairs and exercise sessions.

Some residents preferred to follow their own routines and were observed knitting and watching the television.

Residents were encouraged to maintain links with the wider community and their families. Several residents told the inspectors that their families take them out mostly at the weekend. Visits to the designated centre were encouraged, residents were observed meeting their relatives in the centre's visitor room and in their own rooms. The inspectors spoke with family members during the inspection and the feedback received was positive. Family members told the inspectors that the standard of care provided was good and that there was effective communication between them and the designated centre.

There was sufficient communal space available for residents to use and enjoy. Resident communal spaces was tastefully decorated and these facilities were well maintained. However other areas of the premises required decoration and refurbishment and although the provider was aware of the upgrades that were needed to bring the centre into compliance with the regulations these upgrades had not been completed at the time of this inspection. The communal garden area was well-maintained and was well-appointed with flowers and shrubs. There was adequate seating to cater for the number of residents using this facility.

The inspectors observed that mobile residents were able to access all areas of the nursing home without restriction. Several residents who required specialist chairs for their care needs were observed to spent most of their time in the summer room. Staff were available in the room to complete regular checks and to ensure the residents were comfortable and safe.

The views of residents' using the service were obtained in resident committee meetings which were held every second month and through satisfaction surveys. Key topics discussed at that meeting included visiting, vaccinations,infection prevention and control measures, activities,complaints, laundry, catering and outings. Residents has access to advocacy services and to regular religious services.

Residents spoken with said they were happy with the quantity and quality of the food provided. Discussions with catering staff confirmed that they were aware of residents nutritional needs and that they also attended residents committee to access resident feedback on the meal service. On the inspection day the main meal options consisted of a choice of fish or turkey dish. A meal service was observed during the inspection and residents were offered a choice of food according to their preference. However inspectors also found that one resident was served their main meal and dessert at the same time.

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

Inspectors found that overall, this was a well-managed service which benefited the residents living in the designated centre. There were arrangements in place to monitor and review the quality of the services provided to the residents.

This was an unannounced risk inspection to monitor the registered provider's compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and to follow up on actions the provider had agreed to implement as a result of the findings of an inspection carried out in January 2023.

While the inspectors found that the registered provider had made a number of improvements across many areas of the service which are discussed under the quality and safety section of this report, there were also a number of recurring non-compliance's where actions had not been carried out to bring the centre into compliance with the regulations. The failure to allocate resources and a time bound plan to upgrade the premises, infection prevention and control facilities, and fire safety issues meant that known risks had not been effectively mitigated against. In addition inspectors found recurring non-compliance's regarding cover for staff who were absent on the roster.

Knegare Nursing Home Holdings limited is the registered provider for AbbeyBreaffy Nursing Home. There was a clearly defined management structure in place that identified the lines of authority and accountability. The management team consists of the person in charge, an assistant director of nursing and a general manager who had joined the management team since the last inspection in January 2023.

There were a range of monitoring systems in place to monitor the quality of the service which included a system of audits. There was regular oversight of information collected from the auditing process which were reviewed by the management team. This included a review of information collated from weekly clinical reports and analysis provided at monthly provider meetings. Some systems required review, for example, systems that monitored the cleaning of shared resident equipment had not identified some of the findings on this inspection which meant that staff were not consistent in cleaning equipment when they returned it to the equipment storage areas and this meant there was a risk of cross contamination between residents.

There were arrangements in place for the safe storage of residents records however these arrangements were not being fully implemented and the inspectors found that the door to the record store was left unlocked. In addition the arrangements in place for the destruction of records which were held in the centre for over seven years were not satisfactory and did not ensure that these archived records were stored securely before they were destroyed.These findings are discussed under Regulation 21.

Inspectors were not assured that there were sufficient numbers of staff available in the centre taking into account the assessed needs of the current residents. As described in other areas of this report, staff were busy and did not have sufficient

time to sit and chat with residents. A member of the nursing team was distracted from their medication round to attend to visitors calling to the designated centre and to answer the telephone. These distractions increased the risk of medication errors and had the potential to delay the completion of the medication round and for residents to receive their medicines late. In addition inspectors found that cover for household staff absences was a recurring problem and meant that staff had to be redirected from laundry duties to assist with cleaning duties.

A review of complaints records found that complaints were investigated in accordance with procedures set out in the designated centre's complaints policy. Records were well-maintained and there was oversight and evaluation of complaints in the centre in order to drive service improvement. The required changes to the complaints policy resulting from legislative amendments on the 1 March 2023 had yet to be implemented, this meant that there was a risk that complainants may not be fully communicated with about how complaints and requests for reviews were dealt with.

Regulation 15: Staffing

The number and skill mix of staff was not adequate to meet the needs of the current residents taking into account the size and layout of the designated centre. This was evidenced as follows:

- Inspectors found that the roster was not covered on the morning of the inspection for a staff member who was absent. The provider arranged cover later in the day by transferring another staff member to this role.
- All staff were very busy and observations confirmed that they did not have sufficient time to spend time with residents other than providing direct care.This impacted on the staff's availability to provide person centred care and to spend quality time with residents.

Judgment: Substantially compliant

Regulation 16: Training and staff development

A review of staff training documentation confirmed that all staff working in the designated centre were up-to-date with their mandatory training. This included training in fire safety which was provided on an annual basis, while training in manual handling and safeguarding was provided in accordance with the designated centre's policies and was found to be provided every two years.

There was a range of supplementary training available for staff to attend such as falls prevention, wound management, medication management, dementia, infection prevention and control, and cardio-pulmonary resuscitation (CPR). Inspectors found

that training was provided either on the providers online training platform (Social care TV), through HSEland online training, or through face to face training in the designated centre.

Judgment: Compliant

Regulation 21: Records

The designated centre experienced an outage to their broadband connection which impacted on the provider's ability to provide all records requested by the inspector's on the day of the inspection, however the provider submitted all the required documentation post inspection. Inspector's found that some records were not safely secured, for example:

- A number of archived resident records were located in a maintenance shed prior to their disposal.
- The door to a room where residents records were being stored was unlocked.

Judgment: Not compliant

Regulation 23: Governance and management

The registered provider did not ensure that the service had sufficient resources for the effective delivery of care in accordance with the statement of purpose. Vacancies for health care assistants, a receptionist, a clinical nurse manager and part-time kitchen staff remained unfilled at the time of the inspection.

Inspectors were not assured that there were sufficient numbers of staff available to meet all the needs of the residents as on the day of the inspection staff were being designated to cover staff absences in other departments. For example:

- A member of housekeeping staff was transferred from household duties to cover a short notice absences in the laundry on the day of the inspection.
- Nursing staff were observed answering telephone calls and answering the front door to visitors in the absence of reception staff.
- There were six care staff assigned to provide care and support for 46 residents on the day of the inspection. Of these residents,12 were maximum dependency, nine were high dependency and 15 were medium dependency. As a result care staff were busy with care tasks and had little time for meaningful social interaction with the residents.

Premises upgrades remained outstanding including the reconfiguration of bedroom 55 to meet the requirements of the regulations.

- The provider failed to implement actions identified in previous inspections held in June 2022 and January 2023, to reconfigure bedroom 55 to ensure that the layout of this twin bedroom would meet the needs of two residents sharing the bedroom and would be compliant with Regulations 17 and 9.
- The provider failed to fully implement actions to address areas of the premises that required redecoration to include replacement flooring and the painting of walls. This is a recurring finding identified in previous inspections.
- The provider had yet to install suitable hand hygiene sinks despite a commitment to do so by the end of April 2023 in their previous compliance plan response to the January 2023 inspection.
- A number of the actions identified in the provider's own fire safety risk assessment carried out in July 2023 were outstanding with no clear time bound action plan for when these works would be completed.

The inspectors were not assured that some systems of audit were sufficiently robust to ensure the service provided is safe, appropriate and effectively monitored, for example:

- The cleaning of resident transfer equipment such as hoists and slings was not effectively managed and posed a risk of cross infection to the residents.
- Inspector found that the storage of clinical and non clinical items in the same location posed a risk of cross contamination. This is a repeated finding from the last inspection.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose was submitted for inspectors to review post inspection. A review of this document found that while it gave a clear account of the facilities and services offered by the provider, the amended process for managing complaints had not been updated in line with recent legislative changes, this is discussed in more details under Regulation 34 Complaints.

Judgment: Compliant

Regulation 31: Notification of incidents

Inspectors found that all incidents that required a notification to be submitted to the Chief inspector were submitted in line with the Regulations, this included notifications that required submission within three days of their occurrence and notifications which were required on a quarterly basis.

Judgment: Compliant

Regulation 34: Complaints procedure

There was an accessible policy and procedure for dealing with complaints and it was evident that the provider was eager to learn from complaints received to improve the service provided where required. A complaints policy submitted post inspection which was dated the 23 May 2023 had not been updated to reflect the legislative changes that came into effect as of 1 March 2023, for example

- This policy did not contain reference to when an appeal is made by the complainant to review the complaint outcome, that a written response is provided to the complainant by the review officer no later than 20 days from which the complainant made their appeal.
- The policy did not make reference to training support for complaints and review officers in managing the complaints process.

Judgment: Substantially compliant

Quality and safety

Overall residents received a high standard of nursing care to meet their needs. The ethos of care was person centred and residents were supported to maintain their independence, their self care abilities and to lead a full life. Although this is a purpose built designated centre with all private and communal facilities laid out on one level this inspection found that significant refurbishment and redecoration works were still needed to improve the lived environment for the residents. This is a repeat finding from previous inspections.

There were delays in implementing actions to address known fire safety concerns, while at the same time the actions the provider had agreed to implement in their previous compliance plan, to address poor compliance in relation to infection prevention and control had not been fully implemented.

Inspectors found that there were significant improvements found in the maintenance of residents' care records and in the development of person centred care plans. Care interventions were specific to the individual concerned and were updated as and when residents needs changed or on a four monthly basis in line with the regulations. There was evidence of family involvement when residents were unable to participate fully in the care planning process. The narrative in residents progress notes was comprehensive and related directly to the agreed care plan interventions.

Residents had access to a general practitioner (GP) and arrangements for out of hours medical support were in place. There was evidence of appropriate referral to and review by health and social care professionals where required, however while there were oversight arrangements in place, records for one resident indicated that they had not had a medical review in 2023 despite the resident having significant health needs. Residents also had access to specialist services such as psychiatry of old age and nurses had access to expertise in tissue viability when required. There was ongoing oversight of residents clinical needs which included a weekly audit and an end of month review which incorporated analysis of key performance indicators such as falls, wound care, and restrictive practice.

Some residents exhibited responsive behaviours (how residents who are living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). Responsive behaviours care plans gave clear information regarding the triggers that may cause a resident to exhibit responsive behaviours and on the interventions required to de-escalate these situations. Staff were upto date with training for responsive behaviours and were observed to manage potential behaviours in a calm and assured manner. There were a small number of sensors in use which were recorded on the designated centre's restraint register. There were no bed rails in use in this centre and it was clear the provider was working towards promoting a restraint free environment.

There were arrangements in place for residents to access independent advocacy services and the details regarding this service were located in key locations in the centre. There was a good programme of individualised and group activities available in the centre. A number of residents were supported to access community services which enhanced their social well-being and maintained their links with the local community.

Residents' meetings were held on a regular basis, and residents were able to discuss openly their views on the quality of the service provided. Agenda items which featured in resident meetings included the quality of the food, activities, laundry services and staffing. Discussions held with catering staff confirmed their attendance at resident meetings and there was good knowledge known among the catering team about residents dietary requirements.

There were well-established arrangements in place for residents and family members who wished to deposit small amounts of monies for day to day expenditure. These arrangements ensured that these monies were secure, were monitored on a regular basis and were available for residents throughout the week. The provider did not act as a pension agent for any residents living in the designated centre.

The provider had carried out some actions to improve the environment for the residents, such as the provision of additional shower facilities and the replacement of flooring in a number of resident bedrooms. The centre was found to be well-lit,warm and comfortably furnished. Communal rooms were tastefully decorated and were of a sufficient size for residents to be able to enjoy these facilities.

Despite these improvements, some areas of the premises still required decoration and refurbishment to meet the requirements of the regulations, these areas are discussed in more detail under Regulation 17. In particular amendments to the layout of room 55 remained outstanding and meant that it was unsuitable to use as a twin bedded room. Inspectors observed there was only one resident living in this room at the time of the inspection.

Infection prevention and control measures were in place and monitored by the management team. There was evidence of effective interventions in many aspects of infection prevention and control practices such as the provision of alcohol hand rub, to promote hand hygiene, regular infection prevention and control training and the recording of cleaning practices. Inspectors observed however that the cleaning of equipment used in the care of residents was not robust and meant that there was a risk of residents using this equipment of acquiring a cross infection. Infection prevention and controls measures were further diminished by the lack of suitable hand hygiene sinks available in key areas of the centre such as the laundry and sluicing facilities.

A number of records relating to fire safety were found to be well-maintained, these records included, maintenance of the fire alarm system, certificates of servicing, records also confirmed quarterly checks on emergency lighting and on fire extinguishers, although actions to improve the emergency lighting systems had not been implemented at the time of this inspection. The provider maintained and updated residents personal emergency evacuation plans (peeps) which were updated at least every four months or as and when residents mobility needs changed. Despite this good practice there were several areas of fire prevention in the centre that required repair and upgrade which were identified in a fire safety risk assessment commissioned by the provider in May 2023. At the time of the inspection the provider was engaged in obtaining quotes for these works to be completed, however the provider was unable to confirm a date for when these works would be completed.

There was a risk management policy in place to guide staff in developing risk assessments to eliminate or the reduce the impact of risk in the centre. The oversight and management of risks is discussed further under Regulation 23 governance and management.

Regulation 12: Personal possessions

Residents had access to and control over their personal possessions, finances and clothes. Residents had enough storage in their bedrooms to keep their personal items and clothing tidy and safe.

There is a daily laundry service and resident's clothes are laundered and returned to them promptly. There was a discreet labelling system in place to reduce the risks of items becoming lost.

Judgment: Compliant

Regulation 17: Premises

There were a number of issues concerning the premises which did not meet the requirements of this Regulation and incorporated poor ongoing adherence to Schedule 6 and concerns in relation to the layout of a twin bedroom, For example:

Bedroom 55 did not meet the requirements of the regulations;

- All of the wardrobes storage in the bedroom were located in the bed space of the resident occupying bed 1.
- There was no room for a bedside locker beside the beds. This meant that the bedside lockers were located away from the bed and could not be accessed by the resident when they were resting in bed.
- There was no room for a comfortable chair beside the second bed in the room as this would hinder access to the shared en-suite facility.
- The over bed light for the resident in the first bed was located at the foot of the bed and was not accessible for the resident if they wished to use the light when they were in bed.
- The location of the bedside lockers and cupboard surfaces in the bedroom meant that residents could not see their photographs.

In addition, the inspector's found

- The hand washbasin in the laundry room was a small stainless steel basin and did not support effective hand hygiene practices.
- Equipment used to maintain hygiene in the centre was not repaired. The doors on one of the housekeeper trolleys were broken and would not close.
- Poor standard of maintenance in a number of areas with walls, door frames and skirting boards were damaged and needed repair and redecoration.
- Flooring in a number of bedrooms required repair.
- The self closing door mechanisms in a number of rooms were not functioning.

Judgment: Substantially compliant

Regulation 26: Risk management

The registered provider maintained a risk management policy which met the requirements of this Regulation. While the registered provider had arrangements in place to review and manage risks, the inspectors found that some risks identified on inspection did not have mitigation arrangements in place, while strategies to reduce or eliminate known risks had not been fully implemented by the provider. This is

discussed in more detail under Regulation: 23 Governance and Management.

Judgment: Compliant

Regulation 27: Infection control

The provider had not ensured that procedures consistent with the standards for the prevention and control of health care associated infections- published by the Authority were implemented by staff. This was evidenced by:

Compliance plan form last inspection not resourced. As a result

- No hand washbasin in sluice room.
- The hand hygiene sink in the clinical room did not meet the required standards.

The cleaning of equipment did not ensure that all equipment was cleaned thoroughly before re-use. For example;

- Two hoists stored in the hoist charging area were tagged as cleaned and ready for re-use . Inspectors observed visible dust and debris on the footplates of both hoist.
- The patient handling belts located in the wheelchair storage area were not tagged to ensure that they had been laundered and were ready for re-use.
- Supplementary hoist slings were being stored in the main store room. There was no marking to inform staff that these items had been laundered after the last use and were cleaned and ready for storage.

Judgment: Not compliant

Regulation 28: Fire precautions

The registered provider had not taken adequate precautions to protect residents in the event of a fire emergency. For Example

- Two final fire exit doors were being held open by planters wedged against the doors.

A fire safety risk assessment (FSRA) completed by the provider in May 2023 identified a number of fire safety risks in the centre. There was no time bound action plan for these works to be completed. The risks included

- The location of oxygen storage in the centre.
- Fire doors needing to be replaced

- Review of compartmentation in the centre including the laundry area.
- Improvements ot emergency lighting in the centre.
- Review of fire hatches
- Review of fire stopping to include all ducts and vents.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

A review of systems and procedures to manage the administration of medicines found:

- Although out of date and disused medications were being stored securely prior to return to the pharmacy they were not adequately segregated for the stock medications.
- A resident's GP had not signed for medications that were to be crushed on administration.

Inspector's observed that nursing staff were interrupted four times during a medication administration round, twice to answer the centre's main phone line and twice by visitors attending the centre. Inspectors observed that there were no other staff available at this time to take the calls and to speak with visitors. This increased the risk of a medication error occurring and is not in line with An Bord Altranais agus Cnaimhseachais guidance.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

A review of care records confirmed that each resident had a pre assessment of their needs prior to their admission to the centre to ensure that the centre could meet the resident's needs. Following admission nursing staff completed a comprehensive assessment of the residents current status and needs. The assessment covered physical, psychological and social needs and identified resident's self-care abilities and preferences for care and support.

Each resident had an up to date care plan that reflected their current needs. Care plans were person centred and built on the admission assessment information. Residents and families were involved in regular family meetings to review care plans and ensure that residents were satisfied with their care and support.

Judgment: Compliant

Regulation 6: Health care

Inspectors were not assured that all residents had access to their general practitioner (GP) for health reviews. For example:

One resident with significant health care needs had not been seen by the GP in 2023.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

Most staff had received recent training in the management of responsive behaviours and the staff team took a positive approach to supporting residents who became agitated or distressed, demonstrating appropriate knowledge and skills when incidents occurred.

It was evident that the centre was working towards a restraint free environment. Restraints had reduced since the previous inspection and there were no bed rails in use on the day of this inspection. Sensor mats and lap belts were in use and inspectors were assured that these were being monitored and were being used in line with national policy.

Judgment: Compliant

Regulation 8: Protection

There were adequate precautions in place to protect residents from abuse. For example;

- All staff had received training in relation to the detection and prevention of abuse and how to report any concerns or incidents to senior staff. Staff who spoke with the inspectors were clear about their responsibility to keep residents safe.
- Records showed that any incidents that occurred wee investigated by the person in charge and followed up appropriately.
- There was an open culture and residents and staff said that they felt able to talk to senior staff if they had any concerns.
- There were clear processes in place for the safe storage and management of residents' personal monies.

Judgment: Compliant

Regulation 9: Residents' rights

There were no privacy curtains around the two beds in room 55. As a result inspectors were not assured that if two residents were occupying this room that the residents could carry out personal activities in private.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for AbbeyBreaffy Nursing Home OSV-0000308

Inspection ID: MON-0038833

Date of inspection: 08/09/2023

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 15: Staffing	Substantially Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:

• The Group HR Manager has a robust recruitment strategy in place, in addition to contingency measures for cover for unplanned leave which includes a)agreements with a 33 recruitment agencies and b) there is an increase number of casual relieve staff are available in the areas of HCA's (3); Chefs(2); Kitchen Assistant(2), Nurses(1) and Household(2) to ensure that the center can swiftly fill any gaps which may arise due to unforeseen absence of staff - completed and ongoing.

• Since September 2023 there has been 10 new hires commenced (ADON x 1, HCA x 5, KA x 2, Nurses x 2, Reception x 1) and there are currently 2 new staff in the process of Garda Vetting which provide effective staffing in the center.

• The center continues to recruit various roles with a view to creating a panel of staff for 2024 to reduce any delays which may occur in promptly replacing any leavers and ensure continuity in the operations of the center - commenced and ongoing.

• The PiC and HR Manager continue to implement measures to reduce absenteeism with a specific focus on utilising the Bradford Factor tool. This initiative aims to manage and monitor employee absences effectively, contributing to overall workforce stability - commenced and ongoing.

• The direct care hours in the center are reviewed by the PIC minimum fortnightly using a validated Dependency Tool or more frequently if there are significant changes in the residents occupancy and or care needs. The staffing ratio will be included for review at the monthly Governance and Management Meeting - completed and ongoing

• The ADON will complete weekly QUiS engagement assessment tool to observe the level of engagement resident who require it to ensure that residents needs are met through staffing levels. Any gaps identified will be addressed immediately - completed and ongoing.

• The residents committee agenda now has the item of staffing added to it as a means of providing the residents opportunity to feedback to the DON on this area and for necessary actions to be taken - completed on ongoing.

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
• Archived records were relocated from the shed and placed in the locked storage within the home on the day of inspection - completed.

• A log of disposal of records has been commenced and will be maintained and updated as required.

• As part of the daily safety walk completed by the PiC appropriate closure of doors is checked and staff feedback provided where required.

• Communication has been circulated to all staff on the appropriate record management and has been added to the agenda of the next staff meeting.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• The PIC commits to completing a minimum fortnightly staffing review based on a validated Dependency Tool to present at the monthly G&M meeting. This tool will take into consideration the dependency needs of residents with regard to direct care. In addition the PiC will consider the outcomes of monitoring of clinical KPI's, the details discussed at the weekly G&M DON meeting. Alterations to the rostered hours will be acted upon appropriately - completed and ongoing.

• A review of the premises has been completed by an experienced Group Facilities Project Manager in Jan 2024 and a robust action plan developed to address premises and fire management requirements - completed and ongoing

• The twin room referred to by the inspector currently has one resident occupying this room and the resident and their spouse are planning to cohabit in this room in the future and the room is currently laid out to provide each resident with the necessary furniture. If this couple do not occupy the room in the future, the provider assures the regulator

that a reconfiguration plan will be implemented by July 2024 and or prior to the room being used as a twin room, to include privacy curtain rails, bespoke furniture, access to individual wardrobe and overbed lighting - commenced.

• Refurbishment of the center has commenced with painting communal corridors as part of an improvement program addressing flooring, painting, wall and door repairs. Work is ongoing and will be carried out throughout the year as part of a phased works plan - commenced and ongoing.

• A Self-closing door mechanism and fire doors are part of a door repair program that is going to be carried out with immediate action depending on parts and contractor availability. This work is to be completed before the end of July 2024.

• In addition to the assessments and reports commissioned in 2023, the RPR has engaged an independent fire consultant to carry out an extensive fire risk assessment to incorporate the fire doors, fire compartments, signage and emergency lights, review of penetrations and cavity barriers is also included. Based on the scope of work resulting following the comprehensive Fire Risk Assessment, a Project Manager has been appointed to ensure immediate action on the findings. A Report is due to be received before the end of February with work planned to follow based on availability and materials - commenced and ongoing.

• A review of the process and schedule for cleaning of residents equipment has been completed and oversight of this forms part of the Monthly IPC audit and daily spot checks are completed by the PiC - completed and ongoing.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
• The Complaints policy has been reviewed in November 2023 to reflect legislative changes in Reg 34.

• The PiC and ADON have completed HSELand training on Complaints Management.

• A revised induction introduction for all staff now also includes essential information on Complaint management, the relevant processes and the responsibilities of staff.

• Information for residents throughout the center has been updated to reflect the above.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• The twin room referred to by the inspector currently has one resident occupying this room and the resident and their spouse are planning to cohabit in this room in the future. Should this not occur the provider assures the regulator that a reconfiguration plan will be implemented by July 2024 prior to the admission of a second resident to this room to ensure that a resident does not have to enter another resident's private space to access the ensuite.

• The Group Facilities project manager has completed a review of the premises and handwash sinks in December 2023. A program of upgrading the non-clinical hand wash basins will commence and will include upgrades to the facilities with additional clinical hand wash basins and upgrades to the sluice room facilities for new sluice hoppers. This work will be completed by end of Q1 2024.

• The Equipment used by the housekeepers have been repaired - completed

• There is a timebound action plan in place to implement the significant body of redecoration works required to improve the standard of maintenance with walls, door frames and skirting boards under repair and redecoration.

• The RPR had completed upgrade of flooring to several bedrooms, storerooms, laundry, sluice room and kitchen corridor/kitchen housekeeping rooms in recent times and commits to addressing the need for replacement flooring works throughout the home in 2024 on a phased basis. This will commence in Q1 2024.

• There is a tangible schedule in place to repair the self-closing door mechanisms in the center to ensure they are functioning appropriately. These will be checked with onsite maintenance as part of weekly audits with oversight by the PiC.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
• The installation and replacement of clinical handwash basin in the sluice room/laundry and Clinical room has been reviewed and this will be completed as part of the premises and Fire Safety works commencing in Q1 2024.

• The PiC has communicated to all staff the importance of adhering to the cleaning equipment procedure in place and this is being monitored daily. Audit of the equipment also from part of the monthly IPC audit.

• The resident handling belts which are in use are now tagged with appropriate cleaning date.

• The supplementary clean hoist slings stored in the storeroom now also form part of the resident equipment cleaning process.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• As part of the maintenance and PiC daily walk of the center all exits are checked to ensure they are appropriately open or closed. The PIC has provided information to all staff on the importance of adhering to the Fire safety management systems.

• The storage of oxygen has been reviewed, large oxygen cylinders have been removed and replaced by smaller cylinders. The RPR has approved a quote to get the smaller cylinder storage area relocated with works to be completed by Q1 2024. Oxygen concentrators are used in house with one smaller emergency cylinder internally in case of emergency, this is secured appropriately.

• In addition to the assessments and reports commissioned in 2023, the RPR has engaged an independent fire consultant to carry out an extensive fire risk assessment to incorporate the fire doors, fire compartments, signage and emergency lights, review of penetrations and cavity barriers is also included. Based on the scope of work resulting from the comprehensive Fire Risk Assessment, a Project Manager has been appointed to ensure immediate action on the findings. A Report is due to be received before the end of February 2024 with work planned to follow based on availability and materials - commenced and ongoing with a view to completed July 2024

• A Self-closing door mechanism and fire doors are part of a door repair program that is going to be carried out with immediate action depending on parts and contractor availability. This work is to be completed before the end of July 2024.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
• The process around medication management has been reviewed and there is a clear protocol in place for segregating disused medications from any other medications in

place.

• All nurses have completed training on medication management.

• All residents who are prescribed crushed medications have confirmation on file from their GP that the medications is for crushing.

• The center has commenced a bi-weekly audit of medication management practices to include documentation and all errors are recorded, learning disseminated, and findings rectified promptly.

• Since inspection there is a receptionist on duty 5/7 days and this person attends to and triages all phone calls to the center. All staff have been made aware that protective time is allocated to the nurses during their administration of medicines. The nurse continues to wear "Do Not Disturb" red apron.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
• The resident identified has now been reviewed by their GP.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• The twin room referred to by the inspector currently has one resident occupying this room and the resident and their spouse are planning to cohabit in this room in the future. Should this not occur the provider assures the regulator that a reconfiguration plan will be implemented by July 2024 prior to the admission of a different resident to this twin room to ensure that a resident does not have to enter another residents private space to access the ensuite.

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.	Substantially Compliant	Yellow	01/02/2024
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.	Substantially Compliant	Yellow	01/07/2024
Regulation 17(2)	The registered provider shall, having regard to	Substantially Compliant	Yellow	01/07/2024

	the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.			
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Not Compliant	Orange	01/02/2024
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	01/02/2024
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	01/04/2024
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections	Not Compliant	Orange	30/03/2024

	published by the Authority are implemented by staff.			
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	Orange	01/07/2024
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	01/04/2024
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Substantially Compliant	Yellow	15/05/2024
Regulation 29(5)	The person in charge shall ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the	Substantially Compliant	Yellow	15/02/2024

	appropriate use of the product.			
Regulation 29(6)	The person in charge shall ensure that a medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident shall be stored in a secure manner, segregated from other medicinal products and disposed of in accordance with national legislation or guidance in a manner that will not cause danger to public health or risk to the environment and will ensure that the product concerned can no longer be used as a medicinal product.	Substantially Compliant	Yellow	28/11/2023
Regulation 34(2)(d)	The registered provider shall ensure that the complaints procedure provides for the nomination of a review officer to review, at the request of a complainant, the decision referred to at paragraph (c).	Substantially Compliant	Yellow	28/11/2023
Regulation 34(2)(e)	The registered provider shall ensure that the complaints procedure provides	Substantially Compliant	Yellow	28/11/2023

	that a review is conducted and concluded, as soon as possible and no later than 20 working days after the receipt of the request for review.			
Regulation 34(2)(f)	The registered provider shall ensure that the complaints procedure provides for the provision of a written response informing the complainant of the outcome of the review.	Substantially Compliant	Yellow	28/11/2023
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.	Substantially Compliant	Yellow	28/11/2023
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Substantially Compliant	Yellow	28/11/2023