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:	Tara Winthrop Private Clinic
Name of provider:	Tara Winthrop Private Clinic Ltd.
Address of centre:	Nevinstown Lane, Pinnock Hill, Swords, Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	16 November 2022
Centre ID:	OSV-0000183
Fieldwork ID:	MON-0038423

About the designated centre

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

Tara Winthrop private Clinic is situated close to the village of Swords, Co Dublin. The centre provides nursing care for low, medium, high and maximum dependency residents over 18 years old. The centre is organised into five units made up of 140 beds of which 112 are en-suite bedrooms. There are eight sitting room areas and six dining room areas and at least 15 additional toilets all of which are wheelchair accessible.
The centre is set in landscaped grounds with a visitor's car park to the front of the building. It is serviced by nearby restaurants, public houses, library, cinemas, community halls, the Pavilions Shopping Centre, a large variety of local shops, retail park and historical sites of interest and amenity such as Swords Castle, Newbridge House and Demense, Malahide Castle and Demesne.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	128

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
Wednesday 16 November 2022	08:05hrs to 18:30hrs	Jennifer Smyth	Lead
Wednesday 16 November 2022	08:05hrs to 18:30hrs	Siobhan Nunn	Support

What residents told us and what inspectors observed

From what residents told us and from what inspectors observed, it was evident that most residents were happy living in Tara Winthrop.Residents who spoke with inspectors expressed satisfaction with the staff and the service provided to them. There was a calm and relaxed atmosphere in the centre throughout the day of the inspection. Staff were observed to treat residents with kindness, inspectors observed that staff knew the residents well and residents were seen to be content and relaxed in the company of staff.

Following a short opening meeting, inspectors were accompanied on a tour of the premises by two members of management. The designated centre is set out across two floors with a lift and stairs available between floors. Resident accommodation is divided into five units which are located on the ground and first floors, and are referred to as the Lambay unit, the Erris unit, the Shennick unit, the Columba unit and the Iona unit. Most units were set up as separate units with day and dining rooms in each unit, however the Columba and Iona units shared the day and dining room space available.

Residents' bedrooms comprised of 82 single occupancy and 29 twin occupancy rooms. Residents had access to either an en-suite or to a shared bathroom. Overall, the centre was homely and suitably decorated.Inspectors observed that the personal floor space and storage facilities for residents in the shared bedrooms was not adequate. The allotted floor space for many of the multi-occupancy bedrooms, did not include the space occupied by a chair and personal storage space for each resident of that bedroom. However, management informed inspectors that there was a plan of work to reconfigure bedrooms to address these issues. An external company had visited the centre and had advised what works were required to be carried out as part of the reconfiguration.

Inspectors observed the lunch time dining experience in two units. Residents were offered a choice regarding the food they ate and where they wished to eat their meals. A menu was on display, and inspectors saw there were options available at for lunch, dessert and for the tea time meal. Assistance provided by staff for residents who required additional support during meals was observed to be kind and respectful. Good interactions were observed between staff and residents. Most residents spoken with on the day of the inspection confirmed that they enjoyed the food on offer. However inspectors saw that the pictorial menu on the Lambay unit did not reflect what was on offer on the day. On the Columba and Iona units pictorial menus were not on display to guide residents. During the lunch time meal on the Lambay unit, staff were seen to have their own lunch plated up, this meant there was increased activity levels during the resident's mealtime. Staff continued to use resident communal areas to take their breaks for example a dining room and activity room, thus this limited the time these areas were available for residents' use. This was a finding from the last inspection.

On the day of the inspection there were three activity therapists who were providing activities to the five units. However the activity schedule in the Lambay unit was dated back to August 2022, which meant residents did not know what activities were being provided on a given day. On Columba and Iona units, there was an exercise activity in the afternoon, however the music was very loud and intrusive, residents were not seen to be actively engaging in the session.

Residents told the inspector that they were delighted that they can receive visitors and inspectors observed many visitors meeting with residents throughout the day, having complied with all infection control procedures on their arrival. Three visitors reported to inspectors that in the recent past there were insufficient staff on duty, and they expressed their concerns about staff turnover.

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

While there were management systems in this centre, ensuring good quality care was delivered to the residents, improvements were required to ensure regulatory compliance with all regulations. These improvements are highlighted under the regulations relating to governance and management, premises, infection control and notifications.

The centre had a clearly defined management structure which identified lines of authority and accountability. The management structure involved the person in charge being supported in their role by two assistant director of nursing and four clinical nurse managers. Tara Winthrop Private Clinic Limited is the registered provider for Tara Winthrop Private Clinic. There were clear governance and management arrangements in place, with the person in charge regularly meeting members of the registered providers' senior management team, to discuss clinical and non-clinical issues.A recently established falls committee had clinical oversight for falls audits carried out within the designated centre.

On the day of inspection, there was an appropriate number and skill mix to meet the clinical care needs of residents. However in terms of activity provision, there was insufficient staff available to meet the social needs of residents. There was provision for four activity staff on the roster.On the day of inspection, there were three activity staff rostered. The three dedicated activity staff were observed to have a dual role, as well as activities they assisted at mealtimes. Four of the residents who the inspectors spoke with, reported their dissatisfaction with the activities provided.

There was a complaints procedure displayed throughout the centre. There was a nominated person to oversee the management of complaints. Evidence of effective management of complaints was viewed with the satisfaction of the complainant recorded. However not all verbal complaints were recorded, this is further discussed under Regulation 34:Complaints.

The registered provider had developed an infrastructure action plan to address issues identified from the previous inspection in relation to Regulation 17 :Premises. The works that were required to address the layout of the multi-occupancy rooms had been identified by an external company. While the plan had commenced, no responsible persons or time frames had been identified.

Staff were supported to access mandatory training. Records reviewed showed that there was high attendance at mandatory training on safeguarding, manual handling and.Staff were aware of the lines of accountability in the centre and knew who to report issues to. However, inspectors were not assured staff were appropriately supervised. Staff were not seen to wear personal protect6ive equipment (PPE) appropriately, this is further discussed under Regulation 16:Training and Staff Development.

There was an up to date risk register available which included a risk assessment for residents who smoked. A control measure was for staff to hold all lighters and matches, this was not reported in the quarterly notification as a restrictive practice. The hydrotherapy room also had a risk assessment, this room was being used to store PPE and equipment, which was not in line with designated centre's statement of purpose. This risk assessment stated that boxes were not to be stored above shoulder height, and the inspectors observed that there were boxes stacked above the shoulder. There was a make shift rope around some of the perimeter of the pool, this was not a sufficient control measure to eliminate the risk of a person falling into the unused pool.

Regulation 15: Staffing

The number of staff required action in terms of activity provision. There was three staff rostered to cover the five units on the day of inspection out of a possible four. These staff had dual purpose roles which included serving tea during the morning and afternoon and helping out at the lunchtime meal. This in effect limited the time for dedicated meaningful activities with the residents.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Further supervision was required to ensure that staff were wearing personal protective equipment (PPE) correctly. Inspectors observed PPE such as masks, were used inappropriately during the course of the inspection. For example, staff were seen not to be wearing masks or to wear their masks with their nose exposed or with their face masks at their chin. This was observed during lunchtime in the Lambay unit, in the afternoon on the Iona unit, where three staff were observed wearing their masks below their noses and in the morning on the Lambay unit where two staff were in the corridor having delivered personal care in a residents room.

Judgment: Substantially compliant

Regulation 23: Governance and management

While there were regular management meetings, systems required improvement to ensure the service is safe and effective, for example:

- Identified issues for example the layout of multi-occupancy rooms, while having an action plan had no identified timeframe.
- The outside smoking area had no call bell, no fire extinguisher and no shelter. These were a finding from a previous inspection, no timeframe was identified to rectify these issues,
- Staff wearing PPE incorrectly had been identified in the designated centre's audits, this continued to be the practice on the day of inspection.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

Inspectors were not assured a record of all verbal complaints including details of any investigation were being recorded. One resident who spoke with inspectors, stated that they had made numerous verbal complaints, there was no record maintained of these complaints.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The person in charge had not submitted a report of all restrictive practices to the Chief Inspector. The quarterly report did not include the front door being locked. The door was locked for an hour at 12:30 daily. The report did not include the practice of holding residents' lighters or matches.

Judgment: Substantially compliant

Quality and safety

Residents had access to good quality health care however action was required in respect to individual assessment and care plan, residents' rights, infection prevention and control practices and premises.

There were care plans in place for residents, reflecting their health care needs, and the documents were reviewed at least every four months. However, inspectors found that while they were reviewed, they were not consistently updated to reflect the current needs of the resident. This is further discussed under Regulation 5: Individual Assessment and Care plan.

The registered provider ensured that residents had appropriate access to health care through regular visits from a doctor who was employed Monday to Friday. A physiotherapist was employed Monday to Friday, access to a speech and language therapist, dietitian, occupational therapist and chiropodist was through a referral system.

Inspectors spoke with staff who had good knowledge in relation to recognising and reporting safe guarding incidents. Residents had access to an advocate and an advocacy organisation was advertised on public notice boards on all three floors.

The designated centre had a policy on the use of restraint dated and a restraints register in place. However not all restrictive practice was recognised. This is further discussed under Regulation 7: Managing Behaviour that is Challenging.

Residents were facilitated to exercise their civil, political and religious rights. Residents had access to radio, television, newspapers both local and national, together with access to the Internet. An activity schedule was advertised which included weekends. However, inspectors on reviewing records of activities and the activity staff roster, were not assured that all residents had sufficient recreational opportunities. This was also a finding from the previous inspection. Inspectors were not assured the privacy and dignity of each resident was protected, management were in the process of developing an infrastructure plan to re-configure these bedrooms. This is further discussed under Regulation 9: Resident's rights

Overall inspectors found the premises was clean, of sound construction and was in a good state of repair externally. However inspectors found areas that require action for example there was inappropriate storage in a decommissioned hydrotherapy pool room. This is further discussed under Regulation 17:Premises.

While there was evidence of good infection prevention and control practice in the centre there were gaps in practice such as inappropriate storage, hand hygiene and inappropriate wearing of PPE which are further detailed under Regulation 27: Infection Control.

Regulation 17: Premises

Action was required to ensure the premises conformed to the matters as set out in Schedule 6. For example:

- Not all bedrooms had a lockable storage space for the safe keeping of resident's personal money and valuables.
- An oxygen cylinder was not securely chained to the wall in a trolley, there was no signage to alert staff that there was oxygen stored in the clinical room.
- A strong odour was detected in a communal bathroom in Lambay, this was identified on the previous inspection, which may be caused by poor ventilation.
- The identified smoking area had no emergency call bell facility to call for assistance, this was a finding from the previous inspection.
- Inappropriate storage was found in a decommissioned hydrotherapy pool room, with boxes and equipment stored in an unsafe manner.
- Resident's dining space and activity room was seen to be used by staff for their breaks, this impacted on the availability of the rooms for resident's. This was also a finding on the previous inspection.
- Maintenance issues were identified for example:splash backs of sinks were not sealed and vinyl cladding in bathrooms were in disrepair.
- Room signage didn't reflect the purpose of the room for example the hydrotherapy room was used fro storage and a toilet had no signage.

Judgment: Not compliant

Regulation 27: Infection control

There were issues fundamental to good infection prevention and control practices which required improvement:

- Staff were seen to wear excessive PPE. Gowns were worn by staff into a resident's bedroom, this resident did not have an active infection.
- A clinical sharp's bin was filled over the safety line and the safety mechanism was not closed which could lead to a needle stick injury.
- Bottles of chlorine solution were seen to be left in numerous unsecured locations, for example communal bathrooms, and corridors. This could pose a risk to the safety of residents. Bottles were removed by staff by the end of the inspection.
- Inappropriate storage of a mop in a communal bathroom and a dirty mop bucket was stored in a store room. This may lead to cross contamination.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Action was required to ensure resident's care plans were in compliance with the regulation, for example:

- A comprehensive assessment was not carried out on all residents prior to admission, a resident's care plan reviewed by inspectors did not have a pre-assessment available.
- One resident had no careplan for activities, there was no record in the resident's daily notes for activities that the resident may have participated in.
- A careplan of one resident was not updated to reflect the recommendations by a speech and language therapist.
- A resident who was on two hourly repositioning according to their care plan did not have a complete record. On the day of inspection the repositioning record had two entries, which did not provide assurance that the resident was receiving care in line with their care plan. Incomplete records was a finding from the previous inspection.
- A resident who displayed responsive behaviours, (How people with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment) did not have a care plan in place to guide staff on how to respond and effectively manage such behaviours. There were no identified risks or control measures to manage their behaviours.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

Inspectors were not assured that all restraint in use in the designated centre was in accordance the the national policy. For example:

- The restraint register did not include the front door lock, the door was locked for an hour at 12:30 daily nor did it include the practice of holding residents' lighters or matches.
- A resident's care plan for managing responsive behaviours did not include PRN (medicines only taken when the need arises) medication prescribed. There was no guidance in terms of when the resident should receive the medication, for example when all other options had been exhausted.

Judgment: Substantially compliant

Regulation 8: Protection

There was a policy in place for the prevention, detection and response to allegations or suspicions of abuse. Inspectors found that safeguarding incidents had been appropriately investigated.

Judgment: Compliant

Regulation 9: Residents' rights

Inspectors were not assured all residents had the opportunity to participate in activities in accordance with their interests and capabilities, for example:

- Inspectors observed highly dependant residents on the Columba and Iona units not being capable to fully participate in an exercise activity which involved loud music.
- Two residents spoken with in the Lambay unit, reported that they did not enjoy group activities. They both informed the inspectors that they would like the opportunity to participate in one to one activities, these were not available to them.
- The activity schedule advertised on the Lambay unit was not in date, it was dated back to August 2022.
- A resident meeting minutes identified that residents had given feedback that the evenings were 'boring', there was no action plan identified to improve the situation.

Residents were not afforded the opportunity to undertake all personal activities in private due to the layout of multi-occupancy bedrooms.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

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

Compliance Plan for Tara Winthrop Private Clinic OSV-0000183

Inspection ID: MON-0038423

Date of inspection: 17/11/2022

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The compliment of activities staff within the centre is 3.6 WTE. 1 WTE was on long term sick leave on the day of inspection and has subsequently returned from sick leave since then. This was in place December 12th 2022. On the day of inspection there was 3 activities coordinators in the centre, 2 of these had only recently joined the centre and were going through the induction process and getting to know the residents on their allocated units. The Director of Services plans to meet with the activities coordinators and CNMs in January 2023 to review their roles and responsibilities and to promote a 'whole team' approach to meaningful activities to ensure that the care team supports all activities coordinators in their roles. This will be completed by January 31st 2023, with ongoing review and support by the Director of Services	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Increased supervision for all staff in the correct use of PPE commenced immediately after the inspection by the management team. This is ongoing in the centre, with informal education sessions being delivered in all units, and the adherence to standard precautions monitored on an ongoing basis. This was completed by December 2022. Individual feedback was provided in particular to the staff observed not adhering to mask	

wearing by the Director of Services. Their adherence will be monitored through the increased supervision and audits carried out by the management team. This was completed December 2022.

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Information about the plan for addressing multi occupancy rooms was presented to the inspector on the day with details of required changes included. Verbal confirmation was given in the inspection and closing meeting of the expected timelines and who was responsible and involved in the project- the COO, maintenance manager and DOS, who were all present at the closing meeting.The works that need to be done to reconfigure the rooms in line with regulatory requirements include the conversion of additional facilities such as bathrooms to ensure adequate facilities and square footage for all residents, therefore a timeframe of June 2024 is realistically required.

The smoking area will be reviewed and the feasibility of a call bell established. As per the external fire expert's recommendation, an extinguisher should not be placed outdoors due to extremes in temperatures and the risk that this may affect the functionality of an extinguisher in an emergency. Therefore an additional extinguisher is to be placed at the nearest point to the smoking area, this was ordered in December 2022 and is due for installation the week of January 20th 2022. Supporting signage will be put in place in the smoking area upon it's delivery. As an additional control measure additional fire aprons have been purchased for each unit that has residents who smoke.

A plan to erect a shelter in the Lambay smoking area has been confirmed and will be completed by June 30th 2023.

Increased supervision for all staff in the correct use of PPE commenced immediately after the inspection by the management team. This is ongoing in the centre, with informal education sessions being delivered in all units, and the adherence to standard precautions monitored on an ongoing basis. This was completed by December 2022

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:

A review was undertaken of the complaints process within the centre and changes to practice now ensure that in the instance where someone states that they do not want to formalise their complaint, these will now be captured as a concern to support the closure of them in real time and the assurance of recording of same. This is in place since December 2022 and ongoing review and audit will be carried out on this. This will be completed by March 31st 2023.

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
Quarterly notifications to the regulator will include instances of restrictive practice such as the front door being locked and the practice of holding resident's lighters or matches. The Q4 notifications for 2022 and onwards will include this information. This will be completed by January 31st 2023.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
All residents who do not currently have access to their own lockable area will have a lockable area/safe placed in individual bedrooms to ensure they have a space to safe keep their personal money and valuables. This will be completed by February 28th 2023.

The oxygen cylinder on the unit was for the single use of a specific resident and upon review this was no longer required so was removed from the unit, this was completed in December 2023. Anywhere in the facility where oxygen is stored has had signage and chains put in place. This was completed January 2023.

The maintenance team reviewed the timing of the ventilation system in the bathrooms to ensure a longer ventilation cycle. This was completed in December 2022.

A call bell will be installed in the smoking area. This will be completed by March 31st 2023.

As per the external fire expert's recommendation, an extinguisher should not be placed outdoors due to extremes in temperatures and the risk that this may affect the functionality of an extinguisher in an emergency. Therefore an additional extinguisher is to be placed at the nearest point to the smoking area, this was ordered in December 2022 and is for installation January 20th 2023. Supporting signage will be put in place in

the smoking area upon it's delivery. As an additional control measure additional fire aprons have been purchased for each unit that has residents who smoke.

A plan to erect shelter in the smoking area has been completed and this will be installed by June 30th 2023.

The storage area in the hydrotherapy pool has been decommissioned and all stock removed. The door is now permanently locked with access strictly limited. There is now no need for any staff member to enter this space. This was completed the day after inspection.

The use of resident's space by staff for break times has ceased in the centre. This was completed December 23rd 2022.

Maintenance issues identified on the day have been reported and are on a schedule of works for the maintenance team. Furthermore, findings from any environmental audits are shared with the team and help inform a planned schedule of works within the centre. This is in place and ongoing review required. It has also been added as a set agenda item at the Senior Management Team meeting to ensure oversight of same. These will be completed by June 30th 2023.

A full review has been undertaken of all door signage in the centre. This was completed in December 2022 in line with the reregistration process and signage has been ordered to address any inconsistencies of door signage. Their expected delivery is April 2023 due to supplier lead time.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
A full review was undertaken of the IPC training needs of all staff and any identified needs planned and scheduled for 2023. In addition to formal IPC training, informal education sessions (toolbox talks) are completed by the Senior Management Team, who are also supported in IPC training by the CNM IPC lead and CNS Gerontology outreach nurse. They also support the management team in the completion of IPC audits, the findings of which are presented to all staff in a timely manner. This will be completed by March 31st 2023.

The IPC committee is also underway in the centre, with meetings conducted in December 2022. The purpose of this committee is to share findings of audits, promote best practice and education for all staff and ensure a focus on basic IPC principles is advocated throughout the centre. This is supported on an ongoing basis through supervision of staff by the management team and a renewed focus on IPC supervision

since the inspection, this includes sharps management, cleaning and disinfection and equipment storage within this.

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:
The comprehensive assessment in question on the day of inspection had been completed but had been misplaced. To avoid the recurrence of this, a photocopy of all pre assessments are now taken and stored in the ADON office. This was completed from January 1st 2023.

It is acknowledged that there was no activities care plan for a resident. The Director of Services plans to meet with the activities coordinators and CNMs in January 2023 to review their roles and responsibilities and to ensure that all residents have activities care plans in place and there is clear responsibility of same. This will be completed by January 31st 2023, with ongoing review and support by the Director of Services. This will be monitored on an ongoing basis through care planning and assessment audits.

Audits and feedback from same will be communicated to all staff to ensure that oversight of care planning and assessment is in place in the centre. This encompasses informal refresher training and support for all staff, as well as encouraging staff to escalate in a timely manner if they are unable to complete relevant documentation. This will be completed by March 31st 2023.

There is ongoing communication with all staff to ensure that care is documented in a timely and consistent manner. This is supported by ensuring that the individual needs for each resident are clearly communicated to the team at handover. This will be monitored through audit and observation by the Senior Management Team. This will be completed by March 31st 2023.

The care plan in use for the management of behaviours that challenge was updated and a version submitted to HIQA for review following the inspection.

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
The restraint register has been amended to include the locking of the front door over lunchtime and the practice of holding resident's lighters or matches, and these will also be reported in the quarterly notifications to the inspector. In instances of restraint being utilised in the centre, it is risk assessed to ensure it is for the shortest possible duration and reported and reviewed on a regular basis. This was competed January 2023.

Any care plan for resident's who experience managing behaviours have been reviewed to ensure that detail is included on all non- pharmacological interventions that are to be exhausted before PRN medications are required. While the specific name of a PRN drug may not be recorded in this care plan, the option of PRN medication is clearly documented within the plan. Education has been provided to all staff about the correct documenting of this information and ongoing audit by the management team will monitor adherence to this change. This will be completed by May 31st 2023.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
The Director of Services has met with activities coordinators to devise an action plan on activity provision in the centre in line with the interests of the residents. This is being done in line with reassessment of all PAL assessments and 'A Key to Me' assessments for all residents, as well as all care plans, to ensure that activities are being provided in line with their current capabilities and interests. This is underway and will be completed by March 31st 2023.

A review of the type and location of individual and group activities provided in the centre is also underway, with the opportunity to engage external providers also being explored. Activity schedules in each unit will reflect any updates and this will be monitored on a regular basis by the Senior Management Team. Our commitment is that there is a dedicated person on all units to support activity provision to all residents on all units on a daily basis. This allocation will be reviewed on a daily basis and any impact from potential staff shortages or unexpected illness will be minimised on the provision of activities in the centre where possible. This will be completed by March 31st 2023.

Education and communication is being provided by the management team to all staff to support the facilitation of activities in private for any resident, through increased awareness of how to support this. Simple signage to alert staff that private activities are underway have been introduced.

To facilitate residents completing activities in private the initial action will include puling the curtains around to offer privacy or they will be afforded the opportunity to move to another space within the unit if they wish to do so. For example, the sitting rooms, vacant rooms or other spaces in the unit. This will be completed by March 31st 2023.

The minutes of all resident meetings will be reviewed by the management team to ensure any issues raised are addressed, solutions identified and managed to completion.

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	31/01/2023
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/12/2022
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	30/06/2023
Regulation 23(c)	The registered provider shall	Substantially Compliant	Yellow	30/06/2024

	ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.			
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Substantially Compliant	Yellow	31/03/2023
Regulation 31(3)	The person in charge shall provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of an incident set out in paragraphs 7(2) (k) to (n) of Schedule 4.	Substantially Compliant	Yellow	31/01/2023
Regulation 34(1)(f)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall ensure that the nominated person maintains a	Substantially Compliant	Yellow	31/03/2023

	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 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.	Substantially Compliant	Yellow	01/01/2023
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Substantially Compliant	Yellow	31/03/2023
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in	Substantially Compliant	Yellow	31/05/2023

	a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.			
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Not Compliant	Orange	31/03/2023
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	31/03/2023
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned.	Substantially Compliant	Yellow	31/03/2023