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:	Adare and District Nursing Home
Name of provider:	Mowlam Healthcare Services Unlimited Company
Address of centre:	Adare Road, Croagh, Limerick
Type of inspection:	Unannounced
Date of inspection:	19 May 2021
Centre ID:	OSV-0000404
Fieldwork ID:	MON-0033045

About the designated centre

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

Adare and District Nursing Home is a designated centre which is located in the village of Croagh, a few miles from Adare, Co. Limerick. It is registered to accommodate a maximum of 84 residents. The entrance to the centre is the foyer and this is an expansive place with seating areas for residents and visitors to gather. Most of the building is single storey with a two-storey edifice to the right of the foyer which houses two single occupancy apartments. The centre comprises two units: The Main House (46 bedded) and The Willows (35 bedded) which is the memory care unit. Bedrooms are single and twin occupancy and all have en suite shower, toilet and wash-hand basin facilities. Additional toilet and bath facilities are located throughout the centre. Each unit has their own main dining room, smaller dining room, day room, quiet room and resting areas. Residents have access a sensory room, and to paved enclosed courtyards with seating, parasols, garden furniture and raised flowerbeds. Adare and District Nursing Home provides 24-hour nursing care to both male and female residents whose dependency range from low to maximum care needs. Long-term care, respite, convalescence and palliative care is provided.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	69

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 19 May 2021	09:00hrs to 17:45hrs	Ella Ferriter	Lead
Wednesday 19 May 2021	09:00hrs to 17:45hrs	Abin Joseph	Support

What residents told us and what inspectors observed

The overall feedback from residents was that Adare and District Nursing Home was a nice place to live, and that the staff were kind and caring. Inspectors arrived at the centre in the morning for an unannounced inspection. At the entrance to the centre there is a large foyer with comfortable couches, coffee tables and a reception desk. Inspectors observed residents relaxing in this foyer throughout the day and on arrival one of the residents was observed in this area relaxing and playing video games on an electronic tablet. Inspectors were guided to complete infection prevention and control protocols such as hand sanitising, application of face masks, temperature checks and a COVID-19 questionnaire.

Inspectors were informed that the person in charge was on annual leave on the day of this inspection and the Assistant Director of Nursing was in charge of the centre. The centre is registered to accommodate 84 residents and there were 69 residents living in the centre on the day of inspection. The centre is divided into "The Main House" and "The Willows" (a dementia specific and memory care unit for 35 residents). The centre also has two single bedroom apartments on the upper level. Bedroom accommodation within the centre comprised of 18 single and 33 double rooms. All bedrooms had en suite facilities. Inspectors observed that some bedrooms were personalised with residents belongings.

The centre had recently experienced a COVID-19 outbreak. Some residents spoke to the inspectors regarding the outbreak, and how difficult a time it was for them. They spoke of the loss of friends within the centre, and they expressed how relieved they were that it was now over. They stated they looked forward to life returning to normal and being able to get out more freely. All residents spoken with were complimentary about the care they received from staff during the outbreak and the information they were provided with.

Inspectors found that staff were keen to promote residents' privacy, dignity and independence throughout the day of inspection. Inspectors observed staff listening and responding efficiently to residents' requests. Residents appeared well cared for, which was further reflected in residents' comments that their daily personal care needs were met. Some residents independently walked through the corridors and the communal areas. At the same time, some residents required support and assistance of staff to move around. Interactions between staff and residents were seen to be caring and respectful at all times.

Overall, the centre was clean, however, there were areas throughout the premises that required painting such some bedroom walls, doors and bathrooms. Some floors also required upgrading as floor covering was torn. Inspectors were informed that work to the premises was delayed due to the COVID-19 pandemic and there was plan to commence work soon. The inspectors also noted that there was limited storage available in the centre for equipment such as hoists. As a result, equipment was stored inappropriately against walls on corridors and in sluice rooms. This

practice restricted movement for residents along corridors, as well as directly affected infection control practices and fire safety in the centre. This is discussed further under Regulation 28 and 34. The centre had a smoking room in the Main House and residents who smoked were seen enjoying this space independently, following risk assessment. However, inspectors noted that this room was adjoined to a dining area and the odour of smoke lingered in this area throughout the day. The smoking room was also cluttered and used to store excess chairs, therefore, access to the fire extinguisher was impeded. The management team were requested to review the location of this room.

The Willows memory care unit was enhanced with a number of wall murals of shops, a bakery, a bus stop, a post office and a pharmacy. Light background music played in the unit creating a relaxing ambiance. The corridors were designed in such a way to facilitate safe wandering of residents with dementia. There were adequate staff to assist and support residents. Residents reported that they had choices in their daily lives, and that they were happy living in the centre.

There were two areas to accommodate visiting in the foyer of the Main House, and there was a system of screening visitors to the centre which was in line with the Health Protection and Surveillance Centre (HPSC) guidelines. Inspectors had the opportunity to meet with a small number of visitors on the day of this inspection. Visitors the inspectors spoke with were complimentary about the care received by their relatives in the centre. They told the inspectors that the staff were very kind, caring and respectful. One visitor expressed the desire that their family member have access to pet therapy and more external activities when the COVID-19 restrictions are over. Visitors told inspectors they were extremely happy to be facilitated to visit their families again, as the last year had been very difficult.

The centre had ample outdoor facilities with lovely seating, decor and flower beds. Despite the good weather on the day of inspection, inspectors did not see many residents using this outdoor space. Two residents' inspectors spoke with in the Willows Unit expressed their wish to go outdoor more often and records of residents meetings also referenced this request. The inspectors noted that the outdoor secure garden in the Main House was locked internally, therefore access was restricted for residents. Staff spoken with assured the inspectors that residents that wished to go outside would be facilitated to do so. Management informed inspectors that this was due to structural work that required completion, and assured the inspectors that this would be more easily accessible when a ramp had been removed.

Activities were being provided in both units that were interesting to residents, and they appeared to be engaged and enjoying themselves. The Main House had a large communal room in which many residents used throughout the day. It was a very homely space with comfortable furniture and decor. The activities coordinator was observed engaging very well with residents. Inspectors observed residents enjoying a EuroVision morning, where a large cinema style screen displayed videos of EuroVision songs from this year and past years. Residents were also observed to be enjoying hand massage. In the Willow Unit inspectors observed the activities coordinator doing individual sessions with residents in the morning and a virtual music session in the afternoon. However, the activities coordinator also had

responsibility for facilitating visiting within the Willows Unit, which interrupted on the time allocated to residents.

Inspectors had the opportunity to observe residents' dining experience on the day of inspection. Residents had a choice to have their meal in dining room, day room or in bedrooms. The food served was wholesome and there was adequate staff to support the residents during meal time. The menu for the day was displayed in the dining area and pictures of food served on the day was available on each table in the Willows Unit. This helped residents to easily choose their preferred meal. Inspectors observed staff assisting residents in a discrete and sensitive manner during meal times. Residents were served with fluid and snacks at regular intervals throughout the day. Residents inspectors spoke with were complimentary about the food served in the centre.

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

This was an unannounced risk inspection by inspectors of social services to monitor compliance with regulations, and to follow up on the actions from the previous inspection of July 2019. Overall, this inspection found that the health care needs of the residents were met to a very high standard in Adare and District Nursing Home, and were in compliance with the regulations. However, improvements were required to ensure clear and effective oversight of the service, to address the training and supervision of staff, staff records, fire precautions and infection prevention and control practices. The inspectors also reviewed the actions required from the previous inspection and found that some areas identified as not compliant, had not been addressed by the registered provider.

The registered provider of this centre is Mowlam Healthcare. The Chief Executive Officer (CEO) is also CEO of a number of other nursing homes operating throughout the country. The organisational structure in the centre had changed since the previous inspection. Although there was a clearly defined management structure in place, with clear lines of authority and accountability, there were gaps in this management structure. This was due to the absence of two Clinical Nurse Managers, due to extended leave of absence. This directly impacted on the supervision and oversight of staff and monitoring of the infection prevention control practices and fire precautions within the centre.

A new person in charge had been appointed in April 2021, who was appropriately qualified, however, this person did not work full time in the centre, and was allocated to another centre within the group one day per week, which is contrary to the requirements of the regulations. The person in charge was supported in the clinical management of the centre by an Assistant Director of Nursing. At an

operational level support was provided by a person participating in management (PPIM) and the provider. There was evidence that regular management meetings had taken place and the PPIM visited the service weekly to provide support.

On the day of inspection, there were sufficient numbers of suitably qualified staff on duty to meet residents' assessed needs. However, there was limited supervision arrangements in place, as the person in charge was absent and there were no Clinical Nurse Managers available to the roster. Therefore there was one manager on site with responsibility for the clinical oversight of 69 residents, with various dependencies and the supervision of 24 staff. Management of the centre at weekends, and night time staffing levels also required review to ensure that there was adequate nursing and supervision resources in place to meet the assessed needs of the residents, and considering the size and layout of the building. This is discussed further under Regulation 15: Staffing. Inspectors also found that recruitment practices within the centre required significant improvement to ensure systems were more robust. A review of personnel files demonstrated records were not maintained in line with Schedule 2 of the regulations, which is discussed further under Regulation 21: Records.

A review of the training matrix found that there were significant gaps in the training completed. Staff did not have up-to-date training provided in safeguarding vulnerable adults, or in management of responsive behaviours. This posed a risk to residents in the centre whose assessed needs included management of complex behaviours. Some gaps were also noted in safe manual handling practice and fire training. All staff had completed additional training in infection control practices in response to the COVID-19 pandemic.

Although this centre had remained COVID-19 free during the first waves of infection throughout 2020, in January 2021 the centre experienced a significant a COVID-19 outbreak, where 47 residents and 24 staff contracted COVID-19. From a review of the evidence provided on inspection, and daily communication with the centre throughout the outbreak, the inspectors were satisfied that the provider maintained staffing levels in the centre by utilising agency and relief staff, and redeployment of staff from sister centres. Sadly, some residents confirmed to have COVID-19 passed away during this time. The outbreak was recently declared over by public health on 14 April 2021. The centre had managed the outbreak of COVID-19 well, and it had implemented its comprehensive COVID-19 contingency plan. The provider had put infection control procedures and protocols in place to mitigate the effects of the outbreak in the centre. These included an isolation area for COVID-19 residents, who were cared for by a separate team of staff. Inspectors acknowledged that COVID-19 restrictions posed a significant challenge to residents and staff. The provider had also engaged with Infection Control experts from the Health Service Executive (HSE) to seek advice in relation to preparation and management of COVID-19 outbreak. Inspectors were informed that the COVID-19 outbreak was in the process of being reviewed as recommended by the HPSC.

A schedule of organisational audits was completed in areas such as infection prevention and control, medication management, falls and restrictive practices. Auditing of some practices as scheduled were delayed due to the recent COVID-19

outbreak in the centre. The centre had a comprehensive complaints policy and procedure which clearly outlined the process of raising a complaint or a concern. Information regarding the process was clearly displayed in the centre. A record of incidents occurring in the centre was maintained. Although all incidents and allegations had been reported in writing to the Chief Inspector as required under the regulations, within the required time period, information submitted in relation to pressure ulcers was found to be inaccurate and not reflective of the clinical profile of residents.

Regulation 14: Persons in charge

There was a new person in charge appointed in April 2021. This person met the requirements of the regulations with regards experience and a management qualification. However, this person did not work in the centre full time and was allocated to another designated centre one day per week. Therefore, they could not take responsibility for the operational management, governance and administration of the designated centre while committed to another centre.

Judgment: Substantially compliant

Regulation 15: Staffing

On the day of inspection there were four nurses and 12 healthcare attendants to provide care to the 69 residents living in Adare and District Nursing Home. At night these numbers reduced to two nurses and five care staff. A review of night-time nursing staff levels was required to ensure that all residents could be monitored and supported in line with their assessed care needs. A review of staff allocated to activities was also required, as there were no staff rostered at weekends, which is discussed under regulation 9.

Judgment: Substantially compliant

Regulation 16: Training and staff development

A training matrix was in place showing all the mandatory and relevant courses completed by staff. The inspector acknowledges that some training was delayed due to the COVID-19 outbreak in the centre. However, in the records reviewed there were significant gaps in mandatory training dating back in some instances to 2018 and 2019, for example:

- Safeguarding training had expired or there was no record available for 36

percent of staff
- Moving and handing training had expired for 10 percent of staff
- Managing behaviours that challenge training was only being delivered every three years and 21% of staffs training had expired, or there was no record of training. Considering the profile of residents in the centre and the dementia specific unit, this was inadequate to ensure that residents who had symptoms of disease, which included responsive behaviors, were cared for by appropriately trained staff.
- Fire training had expired for 10% of staff.
- Two RGNs had no record of completion of Cardiopulmonary resuscitation training.

Supervision arrangements for staff could also not be assured due to the absence of key managerial positions and there was not manager rostered at weekends.

Judgment: Not compliant

Regulation 21: Records

Significant improvements were required in ensuring that when staff were recruited there were robust systems in place regarding obtaining references. The inspectors reviewed five staff files and found that references were not obtained as per Schedule 2 of the regulations. For example

- some files contained character references
- some files did not have references from the most recent employer
- some files did not have two references on file.
- One file had no references and only contained a statement of employment.

Therefore, assurances could not be provided that there were robust recruitment procedures in place to safeguard residents. The management team were requested to review staff files following this inspection and ensure all staff had references. There was evidence that all staff had received Garda Siochana (police) vetting clearance prior to commencing employment in the centre.

Judgment: Not compliant

Regulation 23: Governance and management

There were a number of management processes in place in the centre, including regular audits of care provision and quality assurance initiatives, and there was evidence of identified learning outcomes. However, these management systems required improvement in some areas to ensure that the services provided are

consistently safe and effectively monitored. A number of issues were identified with the governance and management systems that did not provide assurances that there was adequate oversight of the service. Issues with the governance arrangements included:

- There were gaps in the management structure of the centre due to the absence of two Clinical Nurse Managers since late 2019.
- Oversight of infection prevention and control practices within the centre required improvement
- Insufficient monitoring and provision of mandatory training
- Recruitment of staff was not robust and in line with the requirements of Schedule 2
- Oversight of fire precautions within the centre required improvement.
- Failure to address non compliance identified on the previous inspection, namely the issues pertaining to inappropriate storage of equipment on corridors and in sluice rooms.

Judgment: Not compliant

Regulation 31: Notification of incidents

While notifications to the Chief Inspector were submitted in accordance with time frames specified in the regulations, they did not include all occasions when a resident obtained a pressure ulcer. For example the Chief Inspector had been notified that there was one resident with a pressure ulcer in the centre, however, it was found that there was five.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

There was a policy in place to manage complaints. A summary of the complaints procedure was displayed prominently in the centre. Residents had access to an appeal process in accordance with the regulatory requirements. Inspectors reviewed a sample complaints and found that complaints were recorded and each complaint was investigated appropriately. Improvements were implemented when it was identified that improvements were required.

Judgment: Compliant

Quality and safety

Residents in the centre were generally satisfied with the quality of the service they received and stated they felt safe in the centre. Inspectors observed staff engaging with residents and providing care in dignified and respectful manner. However, some improvements were required in relation to fire precautions, infection control, the premises and residents rights.

Inspectors acknowledged that the recent COVID-19 outbreak and restrictions posed a significant challenge to residents and staff. Staff were committed to providing a good quality care to residents. The centre had an electronic resident care record system. Residents were assessed using standard assessment tools, and care plans were developed to meet the identified needs. Inspectors reviewed six care plans during this inspection. These care plans were person centred and periodically reviewed and updated at least every four month as per the regulation.

The registered provider ensured the residents in the centre had good access to general practitioners (GPs) and there was evidence of GP access for residents during the COVID-19 outbreak and restrictions. Dietetic services were provided by a private nutritional company. There was access to weekly physiotherapy and occupational therapy services. Residents also had access to specialist services including speech and language therapy (SALT), podiatry, tissue viability, palliative care and old age psychiatry when required. These multidisciplinary team's inputs were evident in sample care plans reviewed by the inspectors. There were effective medication management system in place.

The centre was cleaned to a high standard, and the housekeeping staff were knowledgeable regarding cleaning systems. However, on observation it was evident that there were insufficient facilities for hand hygiene throughout the building. Personal protective equipment (PPE) was readily available to staff and was used in line with the national guidance. The centre had a COVID-19 contingency plan folder with most relevant guidelines, which had been reviewed recently. However, some improvements were required in relation to the infection control practices which are discussed under Regulation 27, infection control.

The fire register reviewed by inspectors indicated periodic servicing of the fire alarm, emergency lights and fire fighting equipment. Staff were able to explain the fire evacuation procedure in the centre and the steps to be taken in the event of fire alarm. Documents indicated that periodic drills had been conducted during daytime and night time and these were adequately documented to include learning and improvement plans. However, some findings during the inspection compromised the fire safety of the centre which are described under Regulation 28.

There was a low use of restraints in the centre and where in use it was evident they were monitored appropriately. There were only two residents using bedrails and one resident using a lap belt. One of the nurses on duty explained and showed the records of assessing the 'need' and 'effectiveness' of psychotropic medicines. This practice helped nurses to avoid the unnecessary use of PRN (as required) psychotropic medications which is a form chemical restraint. Records indicated that

there was a good system in place to care for residents with behavioural symptoms associated with dementia.

The centre had a safe system in place to receive visitors in accordance with the current guidelines. There was evidence of an open communication system between the centre and residents' families during the COVID-19 pandemic. COVID-19 restrictions significantly impacted the residents' access to external activities. Internal activities were provided five days per week. Residents had opportunities to attend residents' committee meetings and complete surveys. However, some improvements were required in this area which are described under Regulation 9, Residents Rights.

Regulation 11: Visits

The centre had an effective system in place for residents to receive their visitors in line with HPSC guidelines. Visits were facilitated every day including weekends. The residents and visitors inspectors spoke with were complementary about the visiting arrangements in the centre. Separate entrances were assigned for visitors in the two different units of the centre.

Judgment: Compliant

Regulation 17: Premises

The centre was clean, bright and nicely decorated. However, some improvements were required in relation to the following areas identified on inspection:

- painting and flooring in some parts of the building required attention
- there was inadequate storage space for equipment such as linen trolleys, housekeeping trolleys, wheel chairs and hoists. This was also a finding on the previous inspection and the provider had committed to addressing the storage deficit in the compliance plan submitted.

The inadequate storage had negative impacts on centres infection control system and fire safety. This is further described under Regulation 27 and Regulation 28. It also posed a risk to residents as it impeded their space when mobilising on corridors.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Residents in the centre had access to food, fluids and snacks at regular intervals and at reasonable times. Residents had a choice of menu at meal times. Residents were provided with adequate quantities of wholesome and nutritious food and drinks, which were properly and safely prepared, cooked and served in the centre. Residents who required specialist assessment and advise for their dietary needs were supported through dietetic experts. There was adequate number of staff available to assist residents at meal times.

Judgment: Compliant

Regulation 27: Infection control

Improvements were required in following areas to comply with infection prevention and control standards, for example:

- although there were three sluice rooms in the centre, there was only one bedpan washer. As a result staff had to carry the items for decontamination though the corridors and communal areas including reception foyer.
- sluice rooms were inappropriately used for equipment storage. Therefore, the hand washing sink was not accessible to staff.
- there were no dedicated housekeeping facilities for storage and preparation of cleaning trolleys and equipment. This was carried out in one of the sluice rooms.
- there were insufficient local assurance mechanisms in place to ensure that the equipment was effectively cleaned and decontaminated
- some surfaces, finishes and flooring were poorly maintained and as such did not facilitate effective cleaning, especially in one of the sluice rooms
- there were a limited amount of wall mounted hand sanitizers accessible to staff in the centre. The inspectors observed one per corridor.
- some improvements were required in relation to compliance with the centres own policy on the wearing of protective clothing by all members of staff entering the kitchen, as clinical staff were observed entering the kitchen area, which posed a risk of cross contamination.

Judgment: Not compliant

Regulation 28: Fire precautions

improvements were required in relation to the following:

- fire training was out of date for seven staff
- four fire doors were found faulty, for example, a broken magnetic release button and damaged fire seals

- a fire exit was partially blocked with a hoists and a privacy screen
- records were not available to demonstrate that faulty emergency lights identified during recent preventive maintenance in April 2021were repaired. This was subsequently submitted post the inspection.
- fire extinguishers in the smoking room were not easily accessible in the event of a fire, as these were obstructed by chairs as the room was also being used for storage.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The provider ensured that there was an appropriate pharmacy service and adequate systems in place to prescribe, order, store and administer medicines for residents. There were also adequate system in place to segregate unused or out of date medicines and its return to the pharmacy for safe disposal. Medication management practices within the centre were being audited three monthly. Nursing staff inspectors spoke with were knowledgeable about medication management system, and the action to be taken in the event of a medication error.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Care planning documentation was to a high standard. Residents' needs were assessed using standard tools, and a person centre care plan was developed to direct the staff to assist residents to meet those needs. These assessments and care plans were reviewed at least every four months. There was a system in place to alert and allocate staff to review care plans at regular intervals. Staff demonstrated efficiency in navigating through the electronic care record and easily locate the required information related to residents care.

Judgment: Compliant

Regulation 6: Health care

There was evidence of good access to medical care with regular medical reviews. Residents had access to a range of other health professionals which had continued throughout the pandemic. There was evidence of very good access to GPs. The registered provider also employed a physiotherapist and occupational therapist who

visited the centre once per week. Wound care documentation within the centre was reviewed and was found to be in line with evidence based practice.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

The centre was working towards a restraint free environment and was guided by a policy and procedure to inform the care and management of residents who experienced responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment). There was a restraints register in place, which was updated regularly. Records also confirmed that where restrictive practices were in use they were only implemented following a risk assessment process. A review of the frequency of training staff in responsive behaviours, which was talking place every three years was required, to ensure that staff had the skills and competencies to manage behaviors that challenge as discussed under regulation 16; Training and Staff Development.

Judgment: Compliant

Regulation 9: Residents' rights

The registered provider of the centre ensured that resident had access to television, radio, newspapers and other media. There was a choice of menu and residents expressed their satisfaction about the choice of food served in the centre. Residents had opportunities to attend residents' committee meetings and participate in the running of the centre. However, improvements were required in following areas;

- even though the residents' survey indicated residents wished to have more access to outdoor space, residents were not seen to be encouraged or assisted to use the outdoor area on the day of inspection.
- the arrangement of the same staff member managing visiting and residents' activities required review, as it impacted the residents' opportunity to engage in sufficient meaningful activities in the Willow unit
- smoking facilities in the centre required review to ensure residents that did not smoke were not exposed to fumes from the smoking room which was situated beside a dining room
- There were no activities coordinators rostered for weekends in the centre, and activities scheduled were between Monday-Friday.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Substantially compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Adare and District Nursing Home OSV-0000404

Inspection ID: MON-0033045

Date of inspection: 19/05/2021

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 14: Persons in charge	Substantially Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: There is a suitably qualified Person in Charge (PIC) working fulltime in the nursing home who will take responsibility for the operational management, governance, and administration of the centre. The PIC is supported by a regional Healthcare Manager and Director of Care Services, who are PPIMs for the nursing home.	
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • The PIC, supported by an Assistant Director of Nursing (ADON) will produce and monitor the staff roster, always ensuring that a suitable skill-mix of staff are deployed, whose duties are allocated appropriately; that there is always a suitable ratio of clinical staff to residents to enable all care needs to be safely and effectively met; and that effective supervision, support and cohesive teamworking are integral to the culture of the nursing home. • A comprehensive review of rosters, including night-time nursing staff levels, has been undertaken to ensure that staffing levels and skill mix are always sufficient to ensure that all residents are monitored and supported in line with their assessed care needs. The PIC will monitor the rosters closely, ensuring that planned rosters are implemented in practice. • Rosters are produced in fortnightly cycles and are published in advance of the start date to ensure that staff are aware of their rostered shifts. • The PIC and ADON will ensure that staff are appropriately deployed and that they are	

allocated appropriate duties commensurate with their skills, qualifications and abilities.
• The ADON will be present on the floor to provide advice, supervision and direction to nursing and care staff and to ensure that the care delivered is in accordance with the individual assessments and best practice.
• Together, the PIC and the ADON will monitor, develop and continually strive to improve the quality and safety of care provided to residents on an ongoing basis, to provide assurance that the service is safe, appropriate and consistent.
• A review has also taken place of staff allocated to activities. The staff roster has been updated to include rostered activities 7 days a week, ensuring to be compliant with Regulation 9.

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
• Staff Training Needs Analysis: The PIC and Healthcare Manager will undertake a review of all staff training by 08/07/2021. Following this review, a targeted staff training and development plan will be developed which will address any updated training needs with further staff training scheduled as required. This will include dates for provision of refresher courses as required to ensure that every staff member is up to date regarding mandatory training.
• All staff are required to complete a programme of mandatory training, including, but not limited to: Safeguarding and Protection of residents, Fire Safety, Manual & People Handling, Care of the Person with Dementia, Management of Behavioural & Psychological Symptoms of Dementia (BPSD)/Responsive Behaviours, and Medication Competency Assessment among other training courses, depending on the employee's role and scope of practice.
• A training schedule is in place to ensure that all staff, including any new staff and staff who require updates, are provided with a training schedule during their initial induction phase and where possible within the first 4 weeks after commencement of employment.
• All RGNs will complete CPR training.
• Staff training needs are also discussed with individual staff members during probationary, performance appraisal and clinical supervision meetings, and staff are given the opportunity to identify any areas of training they feel they require.
• Targeted education and training are also put in place when there has been observation of staff skills deficits based on individual training needs analysis.

• The Assistant Director of Nursing / Clinical Nurse Manager / Senior Staff Nurse are now rostered at alternative weekends to ensure that there is a presence of key management within the home, providing support and supervision to all staff.

• The management team has recently been enhanced with the return of 2 Clinical Nurse Managers (CNMs), which will result in improved oversight, supervision and mentorship in

each clinical area. They provide support and guidance to all staff, ensuring that staff are appropriately deployed and allocated to undertake duties suitable to their roles and qualifications.

• The ADON and CNMs evaluate the induction and performance of each staff member, so that specific training and education can be targeted to address individual staff development areas. This will form part of the clinical supervision and reflective practice cycle that will contribute to the overall performance appraisal of each staff member.

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
• All staff files have been reviewed and any outstanding references at the time of inspection are now in place. We will ensure that all employees will have the requisite two references on file, including a reference from the most recent employer, and that all staff records comply with Schedule 2 of the Health Act.
• The PIC will ensure that only validated references will be accepted during the recruitment stage, in line with the requirements of Schedule 2 of the regulations, as part of our resident safeguarding measures.
• The PIC will ensure that all personnel files are maintained in full compliance with Schedule 2 and are available for inspection by the Authority.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• The PIC is supported by the Healthcare Manager and the Director of Care Services in the achievement of all required objectives and in ensuring that there are safe, high quality systems of governance and management in place. Key Performance Indicators and operational issues in the home are recorded and reviewed on a weekly basis by this senior management team to ensure sustainability of progress, to identify areas in need of improvement and to take corrective actions if required.
• The gaps in the management structure of the centre have now been rectified. The centre comprises of a Person in Charge, Assistant Director of Nursing and 2 Clinical Nurse Managers: 1 CNM has returned from maternity leave (23/06/21) since the time of the inspection, and another CNM will return from extended leave on 07/07/21.
• There is a designated Infection Prevention & Control (IPC) Lead, who provides oversight of all IPC practices within the nursing home. The IPC Lead is a nurse who

chairs the IPC Committee which meets each month.
• Regular IPC audits are carried out in the home and any non-compliances identified are addressed through a corrective action plan which is reviewed at the monthly management team meeting and the monthly IPC Committee meeting.
• There is a monthly management team meeting in the home which reviews all operational aspects of the home, including key performance indicators, risk management, audits and progress on identified actions and updates on quality improvement initiatives. This meeting is well attended and includes at least one representative from each department.

• The Mandatory Training planner has been updated to ensure that all staff training and education is suitably scheduled in a timely manner. The training matrix will be regularly updated and will be reviewed by the PIC to ensure that no refresher updates are overdue.
• The PIC will ensure that only validated documentation including references will be accepted prior to the offer of employment for all staff, in accordance with Schedule 2 of the regulations.

• All overdue fire safety training updates have been completed and further dates have been scheduled to ensure refresher training is undertaking before the due date for all staff.

• Fire safety drills will be conducted every month, simulating night-time conditions. There will be record of staff attending, an evaluation of the drill, a timed evacuation of the largest compartment and lessons learned/recommendations for improvement.

• The inappropriate storage of equipment on the Corridor and in the sluice rooms was addressed on the day of inspection and there are no items inappropriately stored. Compliance will be monitored daily by the senior nurse on duty to ensure that all equipment continues to be suitably stored.

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
• To ensure that there is full compliance with Regulation 31 and accuracy of detail in Notifications to the Chief Inspector, the PIC will review all documentation pertaining to the appropriate notification and discuss with the Healthcare Manager as required.
• Following a training needs analysis, it has been identified that additional training and education on wound care and maintaining skin integrity is required. This will be provided for all nursing and care staff and several sessions will be scheduled to take place by 31/08/2021.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• Due to the COVID19 restrictions in place, the painting and decorating schedule had been paused. This schedule has now recommenced in line with the revised Public Health guidelines. The painting and flooring will be completed by 31/08/2021
• Inadequate storage space for equipment has been reviewed/risk assessed in line with Regulation 27 and Regulation 28. Housekeeping and linen trolleys will be stored in appropriate designated areas identified in the nursing home. Wheelchairs and hoists are now stored in more suitable and safe areas, and corridors are free from equipment and obstruction. Excess PPE has been removed and stored off site to make more space available for suitable storage of equipment.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
• There is a main sluice room and a satellite sluice room in the nursing home. The bedpan washer is located in the main sluice room. All bedrooms have en-suite bathrooms, and waste will be disposed of in the en-suite before transporting vessels to the sluice room.
• Following the inspection, inappropriate storage of equipment in the Sluice Rooms was addressed. Items were removed and appropriately stored, allowing staff to have unobstructed access to handwashing facilities.
• A dedicated Housekeeping/Cleaners' Room has been identified in the nursing home. A Belfast sink will be installed in the room together with associated detergent dispensers and signage put in place (30/08/2021).
• A daily cleaning and decontamination programme is in place and is reviewed daily by the senior housekeeper and monitored by the Assistant Director of Nursing. Random spot checks are also conducted.
• The painting and decorating programme to include upgrading of identified work surfaces and flooring is in progress. The anticipated completion date for these works is 31/08/2021.
• A review of the location of hand sanitisers has been carried out with extra units installed on corridors.
• All clinical staff are aware not to enter the kitchen area due to the risk of contamination; management will continue to monitor compliance.
• All staff who are authorised to enter the kitchen have been provided with appropriate protective clothing.
• IPC training and refresher updates are in progress for all staff.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• Fire training has now been completed for the seven staff identified as out of date on the day of the inspection, and training for all staff will be completed on or before the anniversary of expiry; the training matrix will be updated to reflect this.
• The fire doors with broken/faulty magnetic release buttons have been repaired. A full fire door survey has been undertaken and all issues arising will be addressed (30.07.2021)
• The equipment that was partially blocking a fire exit on the day of inspection was immediately removed. Management and the Fire Warden will conduct daily checks throughout the nursing home ensuring that all fire exits are kept free from any obstruction. Staff are reminded of the importance of keeping exits free in the event of an emergency requiring evacuation.
• The emergency lighting report/records demonstrating that faulty emergency lights identified during recent preventive maintenance in April 2021 were repaired has been supplied to the Inspector.
• All inappropriate items including furniture stored in the Smoking Room obstructing access to the fire extinguishers in the event of a fire were removed on the day of the inspection, and the room is checked each day to ensure that the fire extinguishers are easily accessible.
• Fire extinguishers are clearly marked and accessible at all times. Staff are reminded of the importance of being able to access fire equipment in the event of a fire.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• Human rights approach: A human rights approach is in place in relation to the care and welfare of residents. For example, residents are facilitated, monitored and supported in the home to live as independently and safely as possible. Their rights are always respected, and the PIC will implement a risk-balancing approach to ensure that individual rights, choices and decisions are upheld.
• We will consult with residents and their families to ensure that we respect their choices and preferences.
• The Activities Programme has been revised in conjunction with residents' input. It now includes more outdoor activities i.e., short walks, gardening, music sessions, afternoon tea and family visits, in line with Public Health guidelines.
• A review of the visiting management plan has been undertaken whereby the care team

are involved in the facilitation of the residents' visits from families and friends. This will ensure that the Activities Coordinator has protected time for activities and that one-to-one resident engagement will not be disrupted.
• Door closers and cold smoke seals to the Smoking Room are to be upgraded to ensure the doors close fully and to prevent any smoke leakage. Management will ensure that Residents who do not smoke are not exposed to fumes from the smoking room (30.07.21)
• The staff roster has been reviewed and updated to include rostered Activities Coordinators are on duty 7 days a week, including weekends.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 14(4)	The person in charge may be a person in charge of more than one designated centre if the Chief Inspector is satisfied that he or she is engaged in the effective governance, operational management and administration of the designated centres concerned.	Substantially Compliant	Yellow	07/06/2021
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	30/06/2021
Regulation 16(1)(a)	The person in charge shall	Not Compliant	Orange	31/07/2021

	ensure that staff have access to appropriate training.			
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	07/07/2021
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	31/08/2021
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Not Compliant	Orange	30/06/2021
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	30/06/2021
Regulation 27	The registered provider shall	Not Compliant	Orange	31/07/2021

	ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.			
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	10/06/2021
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	31/07/2021
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting	Not Compliant	Orange	30/06/2021

	equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.			
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	07/06/2021
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Substantially Compliant	Yellow	31/07/2021
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Substantially Compliant	Yellow	30/06/2021