



Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	Glyntown Care Centre
Name of provider:	Zealandia Limited
Address of centre:	Glyntown, Glanmire, Cork
Type of inspection:	Unannounced
Date of inspection:	08 November 2021
Centre ID:	OSV-0004921
Fieldwork ID:	MON-0034755

About the designated centre

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

Glyntown Care Centre is located on an elevated site over the village of Glanmire. It is a 39 bedded purpose-built care facility. The bedroom accommodation is laid out in two single bedrooms (non en-suite), 1 double bedroom (non en-suite), 17 single bedrooms (en-suite), nine double bedrooms (en-suite). Our mission is to create an environment where residents and staff work in partnership to promote individualised quality care in equitable, safe and harmonious environment. Residents will be comprehensively assessed prior to admission to the care centre using the pre-admission assessment document. We will endeavour to accommodate residents requiring the following: general nursing care, respite care, convalescence care, palliative care, and any other care following the comprehensive assessment. All residents admitted to Glyntown Care Centre will be over 18 years of age and can be either male or female. 24 hour nursing care will be provided which is supported by a team of Healthcare Assistants and other support services. Other services available are: hairdresser, chiropodist, physiotherapy, speech and language therapy, etc. Initial admission assessment and short-term care plans will be completed with 24 hours of admission. The residents detailed care plan will be commenced within 48 hours of admission and completed within 2 weeks. We view mealtimes and above all partaking in one's meals, as a very important social event in the daily life of the resident in Glyntown Care Centre. Mealtimes give residents important opportunities to interact. We operate an open visiting policy with Glyntown Care Centre and warmly welcome all visitors, however to protect our residents we ask that all visitors sign in and out on entering and leaving. A comprehensive activity programme is provided 5 days per week by the Activities Coordinator. Outings are held several times during the year, these are facilitated with the An Garda Siochana community buses. A resident committee is in place in Glyntown Care centre. Residents of all religious denominations will be catered for in Glyntown Care Centre.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	35
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This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Monday 8 November 2021	08:15hrs to 16:30hrs	Ella Ferriter	Lead

What residents told us and what inspectors observed

This unannounced inspection took place over one day, and the Inspector communicated with many of the residents living in the centre, and seven residents in more detail, to identify their experiences of living in Glyntown Care Centre. From what residents told the Inspector, and from what the Inspector observed, this centre was a nice place to live, and residents were offered choice in how they led their lives. A number of areas were identified as requiring improvement on the day of this inspection, and these areas are highlighted under the relevant regulations in the report.

The Inspector commenced this inspection in the morning and was met by the person in charge, who ensured that hand hygiene, temperature and symptom checks for COVID-19 were carried out, prior to entering the centre. After an opening meeting, the Inspector was guided on a tour of the premises. Glyntown Care Centre is a designated centre for older people, registered to provide care for 39 residents. It is situated on an elevated site, on the outskirts of Glanmire village, Cork. There were 35 residents living in the centre on the day of this inspection. The centre is divided into three wings, all depicting names of trees: Beech, Ash and Oak. The centre provides accommodation in both single (19) and twin rooms (10), and all but three bedrooms have en suite facilities. The Inspector saw that some bedrooms were personalised and contained things like residents memorabilia and pictures, while other bedrooms were very minimal and some required painting and flooring to be reviewed as it worn and chipped. The Inspector observed that overall, the majority of the centre was clean throughout, however, some areas pertaining to cleaning processes in place, required to be addressed, which is discussed further under regulation 27.

The previous two inspections of this centre found that there was insufficient storage in the centre for equipment, and this resulted in equipment being stored inappropriately in bathrooms and on corridors. The provider had responded to this finding and was in the process of converting one of the single bedroom into an additional storage room and a sluice room.

There was adequate communal space in the centre, which consisted of a dining room, a sitting room, a relaxation room and a library. The library was a very homely space, which was situated to the front of the building. It was being used for visiting on the day of this inspection, and the Inspector observed visitors meeting their family members there, during the day. Visitors the Inspector met with were very complementary with regards to the care and compassion of staff working in Glyntown Care Centre. They told the Inspector that visiting had recently been reduced to 15 minutes per visit, which they described as very short. They said that this was due to the risk of COVID-19, however, this was contrary to national guidelines, which advised that visitors should be facilitated for one hour. This was brought to the attention of the management team on the day and they agreed to

review the current procedure in place.

Residents told the Inspector that their rights were respected in the centre. Staff were observed to speak with residents in a kind and respectful manner, and to ask for consent prior to any care interventions. Many positive respectful interactions were seen between staff and residents. Residents told the Inspector that they were offered choice in how and where they spent their day. It was evident that the management and staff in Glyntown Care Centre respected residents personal wishes. One resident told the Inspector how the staff "would go above and beyond for you here". They described how a staff member would go to the local take away every Friday to collect a special food order, which they really looked forward to. Other residents had recently been accompanied by staff to a local pub for drinks. It was evident that staff working in the centre knew the residents well, and were interested in their personal stories. Staff spoken with told the Inspector they loved working in the centre and enjoyed their time with residents. The Inspector observed that staff treated residents with respect and dignity at every interaction, throughout the day.

Overall, residents' right to privacy and dignity were respected. The residents had access to individual copies of local newspapers, radio and television. Advocacy services were available to residents as required, and details were displayed in the centre. There were numerous activities taking place throughout the day of this inspection. Residents were observed laughing and joking during activities and reported that there was always something to do in the centre. Activities residents were observed to be partaking in included a quiz, music and an exercise class with the physiotherapist. Residents had also received letters from children in the local school, and were writing back to them, with the assistance of the activities coordinator. The activities coordinator was very enthusiastic about the role and it was evident they knew residents personal preferences and abilities. Residents spoke positively in relation to the food they were served and confirmed that they had choice. The Inspector observed that residents were served with drinks and snacks throughout the day.

The next two sections of this report will present findings in relation to governance and management in the centre, and how this impacts on the quality and safety of the service being delivered.

Capacity and capability

This was a risk inspection carried out to monitor compliance with the Care and Welfare of Residents in Designated Centres for Older People, Regulations 2013, and to follow up on the non-compliance identified on the previous inspection of May, 2021. Overall, this inspection found that some improvements had been made by the registered provider, in response to the findings of the previous inspection. However, there was a requirement for increased oversight and monitoring of the service and

further improvements were required in the overall governance and management of the centre, to ensure that the service provided is safe, of good quality and appropriate to the needs of the residents. An urgent action plan was issued to the provider following this inspection, to reduce the risks identified with regards to fire precautions, which would in turn provide a safer environment for residents. The registered provider actively engaged in this process.

This had been the third inspection of Glyntown Care centre in eleven months. The last inspection of this centre had been five months previously, which identified seven regulations as non compliant. Following that inspection the provider representative and the person in charge attended a cautionary meeting with the Office of the Chief Inspector, and conveyed how the provider would address the regulatory non compliance's identified, and presented a compliance plan. The Inspector reviewed the actions from the previous inspection, and found that some improvements had been made in relation to staff training, infection control, healthcare and care planning. However, three areas identified as not compliant, namely, records, training & staff development and complaints, had not been addressed adequately by the registered provider.

The registered provider of Glyntown Care Centre is Zealandia Limited, which has two directors. Both directors are actively involved in the day to day running of the centre. One director is appointed as the person in charge and the other director is involved in the organisational management of the centre, and has a presence in the centre weekly. There was a clearly defined management structure in the centre. Lines of authority and accountability, and roles and responsibilities were understood by all staff. Care in the centre is directed through the person in charge. From a clinical perspective the person in charge is supported by a Clinical Nurse Manager, and a team of nurses, health care assistants, catering, household, and administrative staff. The provider was actively recruiting for an assistant director of nursing at the time of this inspection, due to a recent resignation.

There were systems put in place to monitor the service, since the previous inspection. A schedule of organisational audits was completed in areas such as infection prevention and control, falls, nutrition and care plans. A review of these audits found that while information was collected, correlated and action plans were formalised, these actions were not always implemented in practice, and allocated to appropriate personnel.

The staffing number and skill mix on the day of inspection was appropriate to meet the care needs of the residents. Improvements in the monitoring and provision of staff training were noted since the previous inspection. Mandatory training, as required by the regulations was in date for all staff, and a new system of monitoring staff training had been implemented, since the previous inspection. However, there was not evidence that a comprehensive induction took place for newly recruited staff, which is discussed further under regulation 16.

The previous inspection of the centre found that there were deficits in staff knowledge pertaining to assessment of wounds and pressure ulcer development. In response to this finding the registered provider had sourced additional training for

staff in these areas. The Inspector saw that new systems of monitoring residents skin integrity, fluid intake and nutrition had been introduced. However, the effectiveness of training pertaining to pressure ulcers required review, as it was found that two pressure ulcers were graded incorrectly. The oversight and monitoring of wounds by management also required improvement, which is discussed further under regulation 23.

The recruitment practices within the centre required were found not to be robust, and therefore did not safeguard residents. 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. This area had not been addressed by the registered provider following non compliance identified on the previous two inspections of this centre.

The complaints management system required significant improvement. This was a repeated area of non compliance. This inspection found that where complaints were submitted, there was not evidence that they were managed appropriately and in line with regulatory requirements, which is discussed further under regulation 24.

The Inspector followed up on unsolicited information submitted to the Office of the Chief Inspector in relation to staff training, visiting arrangements, complaints management, and infection prevention and control measures within the centre. Findings of this inspection substantiated information received with regards to complaints management, supervision of staff, and visiting arrangements, which will be discussed under the relevant regulations.

Regulation 15: Staffing

The number and skill mix of staff was appropriate to the size and lay out of the centre and the assessed needs of residents, as assessed in accordance with regulation 5. There had been unexpected absence of two healthcare assistants on the day of this inspection, however, the provider had put arrangements in place for additional staff to be rostered.

Judgment: Compliant

Regulation 16: Training and staff development

Findings of this inspection were that:

- there was not evidence of an induction procedure being carried out for newly recruited staff, which was contrary to the centres policy on recruitment. Therefore, this made it difficult to assess if all staff were appropriately supported and supervised.

- the Inspector was not assured that a newly recruited member of staff, with responsibility for risk assessing visitors for COVID-19, had been provided with the appropriate training to ensure competency for the role.
- although training had been provided in wound care for all nurses, following the previous inspection, further training was required to ensure that all staff were competent in the classification and grading of pressure ulcers.

Judgment: Not compliant

Regulation 21: Records

Significant improvements were required by the registered provider with regards to the recruitment of staff. Existing practices within the centre were not robust and did not safeguard residents. Responsibility for acquiring references was allocated to the employee, as opposed to being obtained from the registered provider. The Inspector reviewed five staff files and found:

- four files did not have references from the most recent employer.
- two files had statements of employment as opposed to references.
- one file had a gap in the employees CV.

This was a repeated area of non compliance, on the previous two inspections, and the provider had not taken the agreed actions as submitted in the compliance plan to the Chief Inspector.

Judgment: Not compliant

Regulation 23: Governance and management

A number of issues were identified with the governance and management of the centre. The governance arrangements in place did not ensure the effective delivery of a safe, appropriate and consistently monitored service. Issues pertaining to the governance arrangements included:

- there was evidence of a lack of effective systems in place to monitor staff recruitment, training and staff development, fire precautions, complaints, and infection prevention & control practices, which are all outlined further under the specific regulations.
- there was insufficient monitoring of resident wounds within the centre, which was found to be inaccurate. This information is required to ensure residents receive appropriate interventions and wound care treatment.
- The collection of information via an auditing system had been implemented since the previous inspection, however, where deficits in practices were found

to require improvements, these actions were not always implemented; for example an infection control audit had found that cleaning within the centre was not being monitored, yet this had not been addressed by management.

Judgment: Not compliant

Regulation 34: Complaints procedure

The provider had committed to implementation of a new complaints procedure following the previous inspection. However, this inspection found that this had not been implemented in practice. As per the findings of the previous inspection of this centre, complaints were not being managed in line with the centres policy and as per the regulations, evidenced by the following:

- thirteen complaints submitted since the previous inspection remained open and there was not evidence that they had been addressed with the complainant.
- complaints were not documented, as per the requirements of the regulations. They did not contain information pertaining to the investigation, outcome or satisfaction of the complainant.
- the complaints procedure displayed in the centre referenced submitting a complaint to the Health Service Executive (HSE), however, this was not appropriate as the HSE did not have responsibility for governance of the centre. This was updated on the day of this inspection.

Judgment: Not compliant

Quality and safety

Overall, this inspection found that residents living in Glyntown Care Centre were supported and encouraged to have a good quality of life. Residents rights were promoted within the centre, and there was good access to medical and nursing care. There was evidence of effective consultation with residents and their needs were being met through good access to healthcare services and opportunities for social engagement. However, the quality and safety of resident care was compromised, due to inadequate oversight of wounds within the centre, inadequate management of fire precautions, and of infection prevention and control practices.

Residents had access to appropriate medical and allied health services. There was evidence of regular medical reviews and referrals to specialist services as required. Access to geriatricians, palliative care, community mental health services, dietetics, and speech and language therapists were readily available. The provider employed a

physiotherapist who attended the centre weekly.

The Inspector noted that there were significant improvements in care planning documentation, since the previous inspection and the standard was good. Care plans described individualised and evidence-based interventions to meet the assessed needs of residents. Validated risk assessments were routinely completed to assess various clinical risks including risks of malnutrition, pressure sores and falls. These assessments informed the residents' care plans. However, some further improvements were required, which is detailed under regulation 4.

The Inspector found that the location, design and layout of the centre was generally suitable for its stated purpose and met residents' individual and collective needs in a homely way. However, some areas of the premises required attention, which is discussed further under regulation 17.

Systems were in place to promote safety and effectively manage risks. The provider was in the process of having an independent fire risk assessment of the premises carried out. Service records evidenced that the emergency lighting, fire alarm system and fire fighting equipment were serviced and fully maintained. Residents had Personal Emergency Evacuation Plans in place and these were updated regularly. Fire training was in date for all staff. Although some fire drills had been undertaken the Inspector were not assured from these drill records that the centres largest compartments of 10 residents could be evacuated in a timely manner with minimal staffing levels available during at night. An immediate action plan was issued to the provider following this inspection and further detail pertaining to fire precautions is detailed under Regulation 28.

The management and staff had been successful to date in keeping the centre COVID-19 free. The centre had a robust contingency plan in place should an outbreak of COVID-19 occur. Staff were observed to be wearing personal protective equipment correctly and adhering to good hand hygiene. However, some areas were identified as requiring improvement, in relation to infection control practices, which are outlined further under Regulation 27.

Regulation 11: Visits

Indoor visits had resumed in line with the national guidelines and there were ongoing safety procedures in place, for example, temperature checks and health questionnaires for visitors. Visits were facilitated every day including weekends. However, visiting in the centre was found to be restrictive, as time allocated for visiting had recently been reduced to 15 minutes per visit, which was contrary to national guidelines. This was reviewed and increased following the inspection. The residents and visitors the Inspector spoke with were complementary about the care in the centre and the kindness of staff.

Judgment: Substantially compliant

Regulation 13: End of life

A sample of care plans reviewed evidenced that staff had actively engaged with residents to elicit their end-of-life care wishes. Information reviewed was person centred and clearly identified the wishes of residents and family consultation.

Judgment: Compliant

Regulation 17: Premises

Some areas of the premises required to be addressed, for example:

- in some bedrooms and doorways paint was chipping.
- in some bedrooms flooring was torn and required replacement.
- some surfaces of furniture in the clinical room was chipped.
- some bathrooms did not have appropriate storage for residents personal possessions.
- the design and layout of some twin bedrooms required review as the inspector found that in some rooms bedside lockers were not situated beside beds and resident therefore could not access their personal belongings.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Systems were in place to monitor residents intake and ensure that they were provided with adequate quantities of food and drink. Residents who required modified meals were offered choices, similar to other residents and their food was attractively presented. Residents feedback was sought and used to develop menus. Residents told the Inspector they were satisfied with mealtimes and that drinks and snacks were available upon request, both day and night. There were adequate staff to supervise meals and to provide assistance to residents who could not eat independently.

Judgment: Compliant

Regulation 27: Infection control

Overall, the Inspector observed that that cleanliness of the centre had improved since the previous inspection. However, further improvements were required as it was found:

- the monitoring of cleaning was poor, this was evidenced by gaps in daily cleaning schedules. This had been found in the centres infection prevention and control audits, however, it had not been actioned. Cleaning schedules reviewed in bedrooms and bathrooms were from the month previous.
- there was one clinical room in the centre, this room was cluttered and some areas of it were visibly not clean, and there were no cleaning records available.
- although there were an appropriate amount of cleaning staff rostered to work, seven days per week, the Inspector found that the cleaning procedures required review, as bedroom and bathroom floors were being washed with hot water only. There was a lack of awareness with regards to the use of a cleaning product to ensure adequate disinfection. There was also not oversight of this process by management.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The Inspector was not assured that residents could be safely evacuated in the event of a fire, as there was not evidence that full compartment evacuations had been completed. Following the inspection, the provider was requested to carry out a fire drill for a full compartment evacuation, with night-time staffing resources, from the largest compartment. The provider actively engaged with this process and drills submitted provided the Office of the Chief Inspector with some assurances. However, further drills are required to ensure the competency of all staff.

Other areas pertaining to fire which also required to be addressed included:

- the frequency of fire drills was found to be inadequate, as there was only one fire drill in the centre in 2021.
- there were no fire zone maps displayed in the centre to indicate the closest method of escape.
- the Inspector tested fire doors in the centre and found that four doors would not fully close, therefore, their effectiveness in the event of a fire could not be assured.
- two fire doors were obstructed on the day of inspection, one externally by a wheelchair and the other internally with a mattress.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

The Inspector found that in some care plans, where the condition of a resident changed, this was not reflected in the residents care plan. For example when a residents falls risk had increased.

Judgment: Substantially compliant

Regulation 6: Health care

The last inspection of this centre found that there was a high incidence of pressure ulcer development in the centre. This inspection found that the number of pressure sores had decreased and there was evidence that where a wound occurred it was managed appropriately. For example the Inspector saw evidence of good wound care practices, which included measuring wounds, photographing wounds, complying with frequency of dressing change and referral to a tissue viability specialist if required. However, the inspector found that further training was required in the classification and grading of pressure ulcers, which was found to be inaccurate for two residents in the centre, which is actioned under regulation 16. Further oversight by the management team was also required to ensure that they were monitoring the amount of wounds within the centre, and evaluating the effectiveness of training provided, which is actioned under regulation 23.

Judgment: Compliant

Regulation 8: Protection

The Inspector was satisfied with the measures in place to safeguard residents and protect them from abuse. Safeguarding training was up to date for staff. Records evidenced that reports of suspected abuse were managed in line with the centre's policy and referrals were made to external agencies as appropriate. Residents stated that they felt safe living in the centre and all staff had a Garda Vetting disclosure on file prior to taking up employment.

Judgment: Compliant

Regulation 9: Residents' rights

Residents had facilities for occupation and recreation and opportunities to participate in activities in accordance with their interests and capacities. Residents rights were upheld and residents' dignity was respected when care was provided. Residents were consulted about their care needs and about the overall service being delivered. Resident' meetings were held monthly and there was a good level of attendance by residents. Records indicated that issues raised at these meetings were addressed promptly.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 11: Visits	Substantially compliant
Regulation 13: End of life	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Glyntown Care Centre OSV-0004921

Inspection ID: MON-0034755

Date of inspection: 08/11/2021

Introduction and instruction

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

This document is divided into two sections:

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

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

A finding of:

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

Section 1

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

Compliance plan provider’s response:

Regulation Heading	Judgment
Regulation 16: Training and staff development	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 16: Training and staff development:</p> <p>In Glyntown Care Centre a culture of learning through training and professional development is strongly promoted to ensure positive outcomes for the residents who live in our center.</p> <p>A comprehensive induction program has been completed for all newly recruited staff since inspection and any training needs have been identified. The PIC will ensure going forward that all new staff to this center will have their induction completed within their first two weeks of employment.</p> <p>The staff member who was employed in early summer to support the centers administration staff in the facilitation of visitors had induction training when he commenced employment and participated in all training conducted within the center throughout the summer. This employees name was entered onto the training matrix from commencement of employment until the monthly update on 02/11/2021, when it was removed, as it wasn’t expected that employee would return to the center due to his studies commitments. Following the recent inspection, the employee attended refresher training in mandatory training with the PIC.</p> <p>Nursing staff completed further wound care training with an external facilitator on November 16th and the Tissue Viability Nurse will provide in house training on the 17h December on appropriate wound classification and grading of pressure ulcers. Further training has been organized by the PIC with an external facilitator – Infection Prevention & Control on 24th Jan 2022 and Care Plans and Assessments in Feb 2022.</p> <p>A senior staff nurse has enrolled in the UCC Infection Prevention and Control Wound Care module commencing in Feb 2022.</p> <p>.</p> <p>The PIC is committed to providing orientation, induction, continuous training, and staff</p>	

development to ensure a rights-based approach to the care provision within this center.

Training needs analysis and evaluation comprises part of the quality improvement plan of the center's annual review.

Regulation 21: Records

Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
The system of securing and storing staff records in Glyntown Care Centre is robust and ultimately ensures the safeguarding of our residents.

Since the recent inspection a more robust system has been introduced where the PIC contacts the staff members previous employers, requests a reference, and validates it once received.

An audit of staff files has been undertaken by the administration staff. Any gaps identified have been rectified and now files are in line with regulation 21.

All staff information is securely stored in a locked cabinet in the admin office to protect the rights of the employees of this center.

All records kept in this center – residents and staff are integral to the care provided to the residents of this center.

Staff file audits forms part of our continuous quality improvement practice.

Regulation 23: Governance and management

Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

The governance and management structure in Glyntown Care Centre has clearly defined lines of authority and accountability. The PIC is supported by a CNM, a Senior nurse and a Senior HCA with supervisory qualifications. Interviews for the role of A/DON are currently being held. Staff are appropriately trained for their specific roles.

Good daily communication through staff/resident meetings and handover between all levels of staff and residents within this center enable us to provide a safe person-centered service.

A robust monitoring system of all aspects of staff recruitment is in place and the PIC with the support of the office administrator is responsible for acquiring and validating staff records. A recent audit of staff files has been completed.

Staff training in the center is an ongoing personal development process and all training whether internal or externally sourced is recorded in the electronic training matrix. The mandatory training matrix is updated and printed monthly – a traffic light system is used to quickly identify staff who are due training immediately or within 6mths or are up to date. All training certs are stored in the training folder.

Regular daily, weekly and monthly fire checks are undertaken within the centre and findings are recorded in the fire register. The PIC has committed to increase the frequency of simulated fire evacuations of residents so that staff both day and night staff are familiar with the procedure to be followed in the event of a fire in the center. The registered provider has engaged external consultants to conduct a full fire risk assessment report.

A complaints book is in place within the center, facilitating prompt accurate recording of concerns, complaints or compliments from residents or their families. The PIC reviews the complaints book twice weekly, records the information on the electronic records system, contacts the complainant and responds with timely feedback and records details of all interactions, feedback and action plans and informs the complainant of the outcome and closes the complaint if satisfied.

Complaints are an agenda item for the monthly management meetings and are discussed in a timely manner at morning handover and staff meetings.

All staff are aware of the 2018 Infection, Prevention and Control Guidelines and the 2021 Infection Prevention Control Framework. All infection prevention and control policies are up to date and signed by staff. Extensive online and in-house training in relation to infection prevention and control has been undertaken in recent months by all staff. October was a dedicated infection prevention and control focused month in our center. Residents and staff took part in various Infection Prevention and Control initiatives. Results of Infection control audits are communicated to all staff at regular meetings, SMART action plans are developed and follow up actions are undertaken and recorded. All cleaning schedules are up to date and household staff are reminded daily by the PIC and CNM of the obligation to accurately complete such documents. On the spot daily inspections of cleaning and associate documentation is undertaken by the PIC, findings are communicated to the household staff and action plan is initiated and outcomes recorded.

The registered provider has sourced external cleaning contractors and are due to commence in the center in early January 2022. Auditing of this center will be conducted by the PIC and external supervisor, findings will be communicated to the cleaning staff immediately, action plans will be initiated and outcomes will be recorded and provided to the cleaning staff. Records will be kept within the center in the audit folder.

There has been extensive focus on improving the knowledge base of staff in relation to all aspects of wound care. An external facilitator trained staff on wound documentation and wound specific care plan formulation during November. The tissue viability nurse

who reviews the wounds online will visit the center on 17th Dec and provide specific detailed education to staff on wound classification, skin integrity issues and associated documentation.

A daily wound list is generated electronically each am and is discussed at handover meeting. The PIC supervises daily dressings and documentation.

A weekly wound care check list completed by the CNM/Senior Nurse is in place and findings are discussed with the PIC and remedial actions are agreed, actioned, and documented.

A tissue viability audit is undertaken every 3 months, result is discussed with staff, SMART actions are formulated and follow up interventions/actions are implemented and documented before final sign off by the PIC. The completed audit tool is stored in the audit folder.

A comprehensive auditing system is in place for all aspects of care within the center. Communication and realistic action plans following auditing ensures a proactive approach to resident care within our center.

Audits are an item agenda for the monthly management meetings as well as all staff meetings.

Regulation 34: Complaints procedure	Not Compliant
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Outline how you are going to come into compliance with Regulation 34: Complaints procedure:

There is a culture of openness, and transparency in relation to concerns, complaints and compliments within the center.

A complaints log is in place facilitating staff to record any issues/concerns/complaints expressed by residents or family members.

The PIC reviews the log twice weekly and begins a communicative, investigative process in a timely manner with the individual to address the issues highlighted and initiate action plans. The result of the investigative process are communicated too the complainant and if satisfied with the outcome, the complaint is closed. All communication and actions and outcomes are documented in the complaints section of the electronic records system.

Complaints from residents and subsequent actions are discussed at morning handover and are an agenda item on management and staff meetings.

There is a detailed complaints procedure displayed in the reception area of the center. Details on Advocacy services are also displayed.

There is an up-to-date complaints policy in the center, all staff are aware of the appropriate procedure following receipt of a concern or a complaint and have signed the policy.

The management team evaluates the effectiveness of the center complaints procedure as an element of the continuous improvement pathway.

Regulation 11: Visits

Substantially Compliant

Outline how you are going to come into compliance with Regulation 11: Visits: Visitors are very welcome to our centre and the PIC prioritizes establishing and maintaining a professional relationship with relatives and friends of our residents.

We have always and will continue to support social interactions with residents' family and friends especially in these challenging times. Visiting guidance and national guidelines are communicated to residents during our residents' meetings. A copy of the most recent Visiting Guidance is displayed at reception for visitors to read. Any changes to current visiting protocols are communicated to relatives by the PIC and Office administrator.

All visitors to the center must comply with current National Visiting Guidelines – visiting slots must be booked with admin office prior to visits. Visiting is facilitated every day. Covid19 Declaration Form must be completed, evidence of vaccination must be produced, and infection prevention and control precautions must be adhered to. Residents can receive visits in their own room or in the library. We will always respect the residents wishes to either receive or refuse visits.

Window visits are always facilitated.

Unrestricted visiting is allowed for residents who are seriously ill or at end of life.

Visitation during these challenging times is risk rated and entered onto the centers risk register.

We consider visits an integral part of the daily life of our residents and the PIC ensures through inhouse educational sessions that all staff are aware of the FREDA principles - Fairness, Respect, Equality, Dignity and Autonomy.

Regulation 17: Premises

Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises: Glyntown Care Centre is our resident's home. It is safe, secure, and homely and residents are afforded the opportunity for rest and recreation according to their wishes.

Areas of improvement identified during the recent inspection are already listed for

upgrading on the maintenance upgrading schedule for 2022.

Our painting contractor has committed to visit the centre 3 days per month and will ensure areas identified are repainted. Residents are individually consulted regarding the color schemes of their bedrooms and residents' meetings discuss color schemes and soft furnishings for shared spaces such as the dining room, day room and library.

Resident families have been reminded to bring in personal artefacts of the residents to make their private spaces more individual and homely.

Upgrading works and refurbishments are an agenda item for monthly management meetings and projects already identified are included in the 2022 quality improvement plan.

Our aim is that residents who live in our center have a sense of ownership of their personal living space whilst balancing risk and homeliness.

Regulation 27: Infection control	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 27: Infection control:

All staff in this center are aware of and understand the most up to date infection control precautions and how our strict adherence to these policies, procedures and guidelines help us protect our residents from infections.

To further highlight and improve our adherence to these practices, the staff decided to concentrate our efforts on Infection prevention and control during the month of October. In house refresher sessions on all aspects of Infection prevention and control and associated policies were provided and all staff completed the HIQA module on the Infection Prevention and Control standards.

All cleaning schedules are up to date, household staff are reminded daily to sign the daily cleaning schedules on completion of their daily cleaning tasks. The PIC randomly inspects the schedules daily and highlights any deficits.

Infection prevention and control audits are continuing, findings are discussed with staff, SMART action plans are agreed and documented and a follow up section on the action plan is completed and closes the audit. All completed audits are stored in the audit folder.

The nurse's station/clinical area has been identified by management as requiring upgrading to comply with Infection Prevention and Control regulations and is on the maintenance schedule for early 2022.

The registered provider and PIC have engaged and employed cleaning company to provide the cleaning service to our centre. They are due to commence the contract on 04/01/2022.

Infection Prevention and Control is an agenda item for all meetings held within the center – management, staff and residents.

Visitors to the center are reminded of their responsibility to follow the most up to date Infection Prevention and Control precautions whilst visiting their loved ones. A copy of the most recent guidance document is available at reception.

The centers risk register is regularly updated by the PIC to include all infection prevention and control risks.

An infection prevention and control staff lead is assigned on a daily basis to monitor the infection control practices of the staff and is supported by the PIC.

A senior nurse has enrolled in the UCC Infection Prevention and Control module for nurses commencing in Feb 2022.

Our collective efforts in relation to Infection Prevention and Control practices have and will continue to achieve the best outcomes for the residents of our center.

Regulation 28: Fire precautions	Not Compliant
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Outline how you are going to come into compliance with Regulation 28: Fire precautions: Fire safety is one of the most important aspects of ensuring residents safety within the center. The management of this center are fully committed to ensuring fire safety checks and records are compliant with the most recent fire regulations.

Daily and weekly fire checks and periodic servicing of fire equipment are completed to ensure a safe environment for residents, visitors and staff.

An immediate action in respect of a nighttime simulated evacuation was undertaken on 11/11/2021.

Fire doors and automatic door closures have been checked. Any loose door closure device has been tightened to ensure they close effectively following activation of the fire alarm.

Under the auspices of the PIC, the frequency of simulated fire evacuations has increased to ensure that both day and night staff are aware and familiar with the procedures to be followed in the event of a fire within the center.

Fire evacuation sheets, situated under all mattresses are checked daily by staff to ensure

they are appropriately fitted.

Fire training is up to date for all staff. New staff are provided with fire safety training as soon as the external fire trainer is available following commencement of duty in the center. The induction process includes information on the location of the fire alarm panels, emergency exits, assembly points, emergency services number, Eircode for the center, fire fighting equipment, how to apply and check that a fire evacuation sheet is properly attached to the mattress, PEEPS.

The registered provider and PIC are currently reviewing the 2021 Fire Safety Handbook and have engaged with external consultants to undertake a full fire risk assessment report of our center with regard to fire safety. This commenced on 13/12/2021.

Each resident has a Personal Emergency Evacuation Plan (PEEP) which is stored in the residents bedrooms and in the emergency folder which is held in the A/DON office.

Each morning at the handover the PIC reminds staff of the absolute importance of keeping all emergency exits free from obstruction. Daily inspections of emergency exits is undertaken by the PIC.

Signage for escape routes and zone maps are being completed by an external fire consultant and are expected to be delivered to the center by Jan 2022.

Fire Hazards are identified and entered onto the risk register by the PIC.

Residents according to their level of cognition are aware of fire safety precautions through discussions at residents' meetings.

Fire safety is an ongoing agenda item on all staff and management meetings.

Regulation 5: Individual assessment and care plan	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
All residents individual care plans have been updated to reflect the resident's current status.
The PIC on a weekly basis, randomly selects a residents complete holistic care plan and reviews all the documentation to check if its person centered, up to date and reflective of the current status of the resident. The findings are communicated to all nursing staff especially to the allocated nurse of that resident. If appropriate, a time frame for corrective action is agreed and followed up by the PIC.

Staff nurses have been allocated a cohort of residents and it is their responsibility to

keep the care plans reviewed, up to date, person centered and person specific to reflect the holistic life of the resident within the center.

Training for nurses on care plan assessments, interventions and person-centered language is arranged with an external facilitator for mid Feb 2022.

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 11(2)(a)(i)	The person in charge shall ensure that in so far as is reasonably practicable, visits to a resident are not restricted, unless such a visit would, in the opinion of the person in charge, pose a risk to the resident concerned or to another resident.	Substantially Compliant	Yellow	08/11/2021
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	10/11/2021
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	08/11/2021
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to	Substantially Compliant	Yellow	28/02/2022

	the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.			
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	10/12/2021
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	01/12/2021
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Substantially Compliant	Yellow	25/11/2021
Regulation 28(1)(c)(i)	The registered provider shall	Not Compliant	Orange	31/01/2022

	make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.			
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Red	15/11/2021
Regulation 28(3)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place in the designated centre.	Not Compliant	Orange	31/01/2022
Regulation 34(1)(d)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall investigate all complaints promptly.	Not Compliant	Orange	15/11/2021
Regulation	The registered	Not Compliant	Orange	15/11/2021

34(1)(g)	provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall inform the complainant promptly of the outcome of their complaint and details of the appeals process.			
Regulation 34(1)(h)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall put in place any measures required for improvement in response to a complaint.	Not Compliant	Orange	15/11/2021
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	31/12/2021