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:	Raheny House Nursing Home
Name of provider:	Raheny House Nursing Home Limited
Address of centre:	476 Howth Road, Raheny, Dublin 5
Type of inspection:	Unannounced
Date of inspection:	17 August 2023
Centre ID:	OSV-0000138
Fieldwork ID:	MON-0040924

About the designated centre

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

Raheny House Nursing Home is a centre in a suburban area of north Dublin providing full-time care for up to 43 adults of all levels of dependency, including people with a diagnosis of dementia. A core objective outlined within the centre's statement of purpose is 'To care for those who have entrusted themselves to us. To provide for their physical, social, emotional and spiritual needs to the best of our ability as per best practice nationally and globally'.

The centre is across two storeys and the upper floors are divided into two parts. Bedroom accommodation comprises 37 single and three twin bedrooms and a variety of communal rooms were available that were stimulating and provided opportunities for rest and recreation.

There is an oratory onsite close to a spacious dining room. A smoking room adjoins the main recreation room and an enclosed outdoor garden courtyard is accessible from the ground floor recreation room and from the conservatory.

The centre has a spacious car park and is in close proximity to local amenities and public transport routes.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	43

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
Thursday 17 August 2023	10:30hrs to 19:00hrs	Bairbre Moynihan	Lead
Thursday 17 August 2023	10:30hrs to 19:00hrs	Niall Whelton	Support

What residents told us and what inspectors observed

Inspectors greeted and chatted to a number of residents in the centre to gain an insight into their experiences of living in Raheny House Nursing Home and in more detail to five. Overall, residents were very positive about how they spent their days in the centre. Residents spoke very positively about staff and indicated that staff were caring, responsive to their needs and treated them with respect and dignity.

Inspectors arrived in the morning for an unannounced inspection to monitor ongoing regulatory compliance with the regulations and standards. In addition, the inspection had a particular focus on Regulation 28: Fire Precautions. Inspectors were greeted by a member of the administration team where inspectors signed the visitors' book. Following an introductory meeting with the person in charge, inspectors were guided on a tour of the premises. The centre had a relaxed atmosphere and residents were observed freely mobilising around the centre and to their bedrooms and chatting to other residents and staff.

Raheny House Nursing Home is registered to accommodate 43 residents with no vacancies on the day of inspection. The centre was divided over two floors containing 37 single rooms and three twin rooms. One of the twin rooms contained an en-suite bathroom. All other residents shared toilet, shower and bath facilities. In total the centre had 3 showers (one of which could only be used by mobile residents) and 3 baths (one of which was an assisted bath). Residents had personalised their rooms with personal belongings and photographs of family and friends. The majority of bed spaces contained a television. Communal space included a sitting room, oratory, recreation hall, dining room and conservatory, all of which were located on the ground floor. In addition, the centre had a dedicated hair dressing salon. 23 residents were observed in the recreation room in the morning time. Residents were seated in two rows facing the television. Two healthcare assistants were supervising residents. The registered provider had developed the garden into a mature and inviting space containing benches, chairs, tables, parasols and blooming flowers. The garden had a wheelchair accessible ramp to the upper part of the garden. Residents were observed in the garden during the day relaxing on their own or with relatives or friends. Residents had commenced a "grow garden" and had planted potatoes, tomatoes, cauliflower, strawberries and rhubarb. Access to the garden was through the conservatory and recreation room. Access to the garden was locked at all times and inspectors were informed that residents could access the garden when requested. This is discussed later in the report.

On the day of inspection, no activities co-ordinator was on duty, however, a healthcare assistant was assigned to activities for the day. The registered provider was registered for 1.58 WTE (wholetime equivalent) of activities co-ordinators with one WTE vacancy on the day of inspection. The registered provider was actively recruiting into this position. Residents were observed playing bingo in the afternoon. The activities for the week were on display on the corridor. Residents informed an inspector of an outing they had on the previous day to a local park to visit a rose

garden and then the residents went to a coffee shop afterwards. Residents spoke about how much they enjoyed the outing. Residents meeting minutes observed indicated that the registered provider is planning a trip to the national concert hall in th autumn. The priest generally attended onsite once weekly but not as regularly over the summer months. A small number of residents were observed reading newspapers in the sitting room. The registered provider had created a monthly newsletter which contained pictures of a recent barbeque in the centre and a men's only afternoon for father's day.

Residents' were consulted about the centre through residents' meetings and an annual satisfaction survey. Areas raised by residents included playing more cards as part of the activities programme. It was discussed with residents about commencing a card making group and to paint bird feeders for the garden. The chef attended the meetings to provide an update on the menu with a plan for more salads over the summer. While management stated that issues were addressed after each meeting, a small number of residents stated that they were not. No timebound action plan accompanied the meeting minutes viewed. Individual replies to the satisfaction survey were provided to an inspector. The information was not collated, however, management stated that they had addressed each of the residents' comments individually.

The evening tea-time was observed. Residents were offered a choice and residents stated that they enjoyed the addition of a pizza slice on the menu. Residents requiring modified diets were offered a choice. Tables were pre-set with table cloths. Staff were available to assist residents if required in a discreet manner. The dining room was large but it was quiet allowing residents to have a relaxed dining experience.

There were no restrictions on visiting in the centre and visitors were observed during the day of inspection. Visitors confirmed this. Visitors were complimentary about the care their loved ones received 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 inspection to assess the overall governance of Raheny House Nursing Home and to identify if actions outlined in the compliance plan from the inspection in April 2022 were completed and sustained. Overall, inspectors identified that a number of actions were implemented and sustained for example; residents' records were safely secured in metal cage above the laundry. In addition, the layout of the three twin rooms was reviewed to ensure that the space included a bed, chair and personal storage. However, repeat non compliances were identified in Regulations 23: Governance and management, 17: Premises, 27 Infection control

and 28: Fire Precautions. An additional non-compliance was identified in Regulation 9: Residents' Rights.

The registered provider of Raheny House Nursing Home is Raheny House Nursing Home Limited. The nursing home is part of a group that own and manage a number of centres in Ireland. There was a clearly defined management structure in place. The person in charge reported to a regional manager, who in turn reported to an operations manager and upwards to the chief executive officer who was also the registered provider representative. The operations manager attended onsite on the day of inspection and the feedback meeting on the day following inspection. The person in charge was supported in the role by a deputy person in charge who worked 24 out of 39 hours in a supernumery capacity, staff nurses, healthcare assistants, activities co-ordinators, catering, domestic, maintenance and gardening staff. The registered provider had a small number of vacancies at the time of inspection. In addition, a number of residents and staff identified that improvements were required in the staffing levels at night. A resident informed an inspector that they could be "waiting a while for assistance and bells are not answered promptly". This is discussed under Regulation 15: Staffing.

Staff had access to mandatory training including safeguarding, fire safety and infection control. Good compliance's were observed in safeguarding training with all staff having completed it. Staff were knowledgeable on the actions they would take if they suspected abuse. The majority of staff had completed infection control training. The registered provider had commenced staff training on end of life care. However, improvements were required, in for example; managing behaviours that challenge.

Inspectors requested the directory of residents. This was provided, was up to date and contained all the requirements of the regulation.

The annual review of quality and safety of care was completed for 2022. The review detailed clinical data for 2022, audit results and complaints. The quality improvement plan for 2023 was outlined which included refurbishment of the bedrooms, hallways, replacing old furniture and regular fire drills to support new staff. While the review contained detailed information, it did not outline how the care provided is in accordance with the national standards. Systems of communication were in place. Management stated that they aim to have one meeting a month with a staff cohort. Staff meetings and healthcare assistant meetings were taking place. Issues were discussed by management with staff. However, no timebound action plan accompanied the minutes. In addition, meeting minutes reviewed indicated that no issues were raised by staff. The operation meeting minutes were available onsite. This meeting was taking place monthly between the regional manager and the person in charge. Areas discussed included complaints and fire drills. Meeting minutes contained little detail and no actions were identified from the meeting. Incidents were recorded on an information technology system. The majority of incidents reported were falls. These were tracked and trended through a falls audit. The registered provider introduced a "red leaf programme" to identify residents who were at risk of falling. A sample of incidents were reviewed and all requiring reporting to the office of the chief inspector were

reported in line with the regulations. The registered provider had a schedule of audits in place. Audits completed included a quarterly falls audit, household cleaning audit and infection prevention and control monthly audit. Areas identified through audit in the cleaning audit remained an issue on the day of inspection. This will be discussed under the domain of Quality and Safety. On this inspection, the oversight of fire safety management systems and the processes to identify, and manage fire safety risks were ineffective to ensure the safety of residents living in the centre. This is detailed under Regulation 28: Fire Precautions.

The registered provider maintained a log of complaints. The person in charge was the nominated person to respond to complaints and an appeals person was identified, details of which were on the complaints procedure at the entrance to the centre, however, the timeline to respond to complaints was not in line with the regulation. The person in charge had completed training on complaints management. Residents had access to advocacy services, the details of which were on display in the centre.

Regulation 15: Staffing

The centres' statement of purpose states that the centre should have 6.09 WTE staff nurses. On the day of inspection the centre had 1.59 WTE staff nurse vacancy, however a staff nurse was due to commence employment on the week following inspection. The roster reviewed confirmed this. This left a gap of 0.59 WTE (wholetime equivalent). Both staff and residents reported to an inspector that there are not enough staff in the evening and at night.

- Inspectors were not assured that one registered nurse from 3pm to 8am was sufficient to meet the needs of 17 maximum dependency, 11 high dependency, 8 medium dependency and 7 low dependency residents.
- The registered provider had approx one WTE vacancy for an activities co-ordintaor. The registered provider was actively recruiting for this position at the time of inspection.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The registered provider had a training matrix in place. Gaps identified in mandatory training included:

- 6 staff had not completed hand hygiene training or the training was out of date.
- Six staff had not completed fire training or their training was out of date. Inspectors were informed following inspection that practical fire training was

scheduled for 30 August 2023.
- The training matrix provided to inspectors identified that staff completed three different trainings in dementia, challenging behaviour and responsive behaviours. Nine staff had not completed at least one of these training within the last two years or their training was out of date.

Judgment: Substantially compliant

Regulation 19: Directory of residents

The registered provider had established a directory of residents following the registration of the centre. This directory was maintained, available for review and contained all of the information specified in Schedule 3 of the regulations.

Judgment: Compliant

Regulation 23: Governance and management

The assurance systems in place in the centre required strengthening to ensure that the service provided was safe, appropriate, consistent and effectively monitored, as required under Regulation 23(c). This was evidenced by:

- Audits and meeting minutes reviewed did not contain timebound action plans.
- While the registered provider was tracking and trending falls through a falls audit, further analysis was required in order to elicit learning and devise an action plan from the trends identified.
- Identification and oversight of fire safety risks were not adequate, as detailed under Regulation 28: Fire precautions.
- Oversight of infection control required strengthening as management were unaware of a number of issues identified on inspection.
- The annual review of quality and safety of care did not outline how the care was in accordance with the national standards.

Judgment: Not compliant

Regulation 31: Notification of incidents

All incidents, as set out in Schedule 4 of the regulations were notified to the Chief Inspector of Social Services within the required timeframes.

Judgment: Compliant

Regulation 34: Complaints procedure

The complaints procedure was on display in the centre, however, it was not in line with the changes required under S.I. 628 of 2022 .

Judgment: Substantially compliant

Quality and safety

Overall, residents had a good quality of life in Raheny House Nursing Home and were supported to live their lives according to their own capabilities. Residents were supported to access health care services in line with their assessed needs and preferences. Residents had access to their own general practitioners who attended onsite and to health and social care providers as required.

The centre was originally a house and it was extended over time and required ongoing maintenance and upkeep. The registered provider reviewed the layout of the three twin rooms and the position of the curtains since the last inspection to ensure that residents could access their personal storage without having to cross over into the other resident's floor space. The corridor downstairs was painted since the last inspection and the corridor was bright with a warm colour on the walls. Inspectors were informed that there was a plan to paint the rest of the centre. In addition, improvements were identified in the inappropriate storage of residents' belongings and clean bed linen. Assistive handrails were in corridors throughout the centre. Notwithstanding this inspectors identified a number of areas requiring action with the premises. The assistant director of nursing was the infection control link nurse and had completed a one week course in a local acute hospital in infection control. Dedicated hours for carrying out this role were included in the assistant director of nursing supernumery hours. The role included carrying out infection control audits, however, enhanced oversight of premises and infection prevention and control were required by management as repeated non-compliances were identified in both regulations.

Further to fire safety risks identified at previous inspections on 08 September and 30 November 2021, the registered provider had arranged for a fire safety risk assessment. Assurances had been submitted to the Chief Inspector, that fire safety risks were addressed. This inspection included a focused review of fire safety, to follow up on the progress made. Notwithstanding the work completed, fire safety risks still persisted. The works completed included:

- construction work in attic spaces to improve the fire compartment boundaries

- enclosing the electrical panel in fire rated construction
- removal of steps at three final exits
- implementation of a system to manage key locks on fire exits
- some upgrade works to fire doors, including additional hinges and fire seals to bedroom fire doors
- a new fire door to the large day room

The fire alarm panel was located at the nurses' station with a repeater panel at the main entrance. The system was free of fault. There were records to show that the system was tested weekly as required. Monthly visual checks of the emergency lighting and weekly checks of extinguishers were also logged. The person in charge confirmed there was a suitable evacuation aid available in the room of each resident who required one. The fire doors to bedrooms did not have automatic closing devices which would close the fire doors in the event of a fire. The provider had a risk assessment in place, which indicated that fire doors were to be manually closed in the event of a fire, placing an additional burden on staff, particularly when staffing was at its' lowest level. The fire safety risk assessment, identified the absence of door closers as a high risk. The registered provider was required to identify the size and locations of confirmed fire compartment boundaries. This is further discussed under Regulation 28.

The assistant director of nursing had commenced a review of the care plans which was ongoing at the time of inspection. An inspector reviewed a sample of care plans and validated risk assessments. Overall, the standard of care planning was generally good and described holistic interventions to meet the assessed needs of residents. These were updated at four monthly intervals in line with regulations. A care plan of a newly admitted resident was reviewed and it was completed within 48 hours of admission. However, an area for action was identifed which is discussed under Regulation 5: Individual assessment and care plan. Validated assessments were regularly and routinely completed to assess various clinical risks including risk of malnutrition and falls.

Some residents had responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). Staff were knowledgeable regarding residents' behaviours and were able to describe triggers. To support this, care plans were in place which described the behaviours, triggers and the interventions to engage or redirect residents. Behavioural assessments were completed and informed an holistic approach to managing residents' responsive behaviours. Inspectors observed person-centred and discreet staff interventions during the inspection. The centre had no residents using bedrails at the time of inspection. 38 of the residents had a floor alarm and/or chair alarm mat in place. Inspectors observed staff when residents chair alarm mat alarmed and staff approached residents in a non-restrictive manner. Restraint assessments had been completed and were up to date. Inspectors observed that the two doors to access the enclosed garden were locked at all times. This is discussed under Regulation 7: Managing behaviours that challenge.

Residents generally provided positive feedback regarding life and care in the centre.

Inspectors observed staff interactions with residents and it was evident that they knew the residents well. Residents were observed moving freely within the centre. However, improvements were required to ensure the privacy and dignity of residents and in the recreation room to ensure it provided a homely atmosphere.

Regulation 17: Premises

While some refurbishment had occurred, action was required to ensure compliance with Regulation 17 and Schedule 6:

- Walls, architraves and doors were scuffed, chipped and damaged.
- The surrounds in the toilet on the "single storey corridor" were wooden, damaged and did not aide effective cleaning.
- The wall within a store room had exposed blockwork where a hole was filled and not finished. There was also plywood panels would could not be effectively cleaned.
- The carpet in the staff room was in poor condition.
- The supply and drainage pipes from an assisted bath, were exposed and partially boxed off with plywood. This could not be effectively cleaned.
- The flooring in the dining room was damaged near the kitchenette area.
- The sink in a sluice room was observed to be blocked and water trapped in the sink.
- The chair lifts were being serviced annually and not six monthly.

Judgment: Not compliant

Regulation 27: Infection control

Improvements were required in order to ensure procedures are consistent with the national standards for infection prevention control in community services. For example:

- A residents' communal toilet was blocked, the toilet removed and the contents removed from the toilet remained on the toilet floor. Furthermore, the toilet cubicle was accessible to residents. Management stated it had occurred within the last few days and were awaiting replacement of it. However, in the intervening period there was a risk to residents who went into the toilet of cross-infection.
- Oversight of equipment cleaning required strengthening. Inspectors identified multiple instances of unclean equipment. For example; a hoist and multiple floor alarm mats. The hygiene of the floor alarm mats were identified in an infection control audit but remained an issue.
- The centre had a two clinical hand hygiene sinks, which were located on the

ground floor. Furthermore, no sinks in the centre were compliant with the required specifications.
- None of the sluice rooms contained a clinical waste bin.
- A shower rail in a communal bathroom "downstairs" was rusted. This did not aide effective cleaning.
- Inspectors observed a loop mop head sitting in a bucket of unclean water. The inspectors were informed that this was used in the kitchen only. Flat mops are recommended for effective cleaning.
- A bedrail protector was observed drying over a sink that was dedicated as a hand hygiene sink. Furthermore, residents' clothes were drying at the entrance to the dirty phase of the laundering process. These practices posed a risk of cross contamination.
- The racking in the sluice room "downstairs" required review to ensure that bedpans and urinals can be inverted. In addition, bed pans were not inverted on the racking in the sluice room "upstairs".
- The cleaning schedule for soft furnishings indicated that soft furnishings in the front room and old house were cleaned twice weekly. However, the cleaning schedule did not include the chair lift which was observed to have staining. It is unclear if this was included in the steam cleaning.

Judgment: Not compliant

Regulation 28: Fire precautions

Under this regulation, the provider was required to address an immediate risk that was identified on the day of inspection. There was inappropriate storage within the electrical room, including two oxygen cylinders. A smoke detector was covered with a dust cover for work carried out four days previously. Four fire doors were observed to be propped open.

The manner in which the provider responded to the risk on the day of the inspection did provide assurance that the risk was adequately addressed.

Notwithstanding the work completed to address some of the fire safety risks in the centre, fire safety risks were identified on this inspection that impacted the safety of residents.

Improvements were required by the provider to ensure adequate precautions against the risk of fire:

- The arrangements for residents who smoke were not adequate. There was no fire blanket in the smoking room. Where residents chose to smoke outside, there was no safety equipment externally. Inspectors saw scorch marks on the seating in the smoking room. Further assurance was required regarding residents who were assessed as requiring supervision.
- There was a hoist battery being charged in a first floor corridor, introducing a

fire risk to the protected escape corridor.
- The records of the daily checks of escape routes were not documented in the fire safety register at weekends.
- A comms room had combustible storage near electrical panels.
- The closing force on some fire doors was excessive and may cause injury.

Action was required to ensure adequate means of escape:

- The means of escape for a twin room at ground floor required escaping past an office, which did not have a fire door.
- The stairs near the kitchen, was an alternative escape route from some upper floor bedrooms; it was obstructed with a cleaners' trolley.
- The width of some exit doors are less than would be expected in a nursing home, and assurance was required that exits were of adequate width to ensure safe evacuation, with any evacuation or mobility aids in use through those exits.
- The external escape routes were not provided with adequate emergency lighting to guide residents and staff towards the assembly points.

The arrangements for maintaining fire safety equipment were not adequate:

- Fire doors were not being maintained in good working order. Smoke seals were painted over, a door release device was held together with tape, some were unable to close.
- There was evidence that the fire alarm and emergency lighting systems were being serviced, however the service records were not available for review on the day of inspection. These were submitted following inspection.

The measures in place to contain fire were not adequate:

- Notwithstanding the work already completed to improve fire doors in the centre, deficits with fire doors were still impacting the containment of the fire. The fire safety risk assessment in April 2022, raised an extreme risk for the potential of smoke and fire spread and recommended a review to be carried out. There was no documented review of fire doors available to the inspectors.
- The doors to fire risk rooms were not fitted with automatic closing devices, for example the office of the person in charge.
- The doors to many fire risk rooms were not adequate fire doors, for example the kitchen, nurse office, oratory and cleaners room.
- A compartment at first floor, identified to the inspectors as two separate fire compartments, had no apparent fire door within the openings in the wall. This was identified in the fire safety risk assessment as an extreme risk.
- The wall separating the kitchen from an escape stairs did not appear to be fire rated.
- Assurance is required that the lift, which opens onto the bedroom corridors at ground floor and first floor, provides adequate containment of fire between the ground and first floor.
- Attic hatches within fire rated ceilings did not appear to be fire rated.

- Service penetrations, for wiring or pipes, through fire rated construction was not adequately sealed up to ensure adequate containment of fire.

The measures in place to detect fire were not adequate:

- The enclosures to the electrical panels did not have detection of fire.

The measures in place to safely evacuate residents and the drill practices in the centre required action:

- The escape stairs in the two storey section to the rear of the building was narrow. Staff demonstrated the evacuation aid on the stairs and there was difficulty manoeuvring it around the half landing; the stairs suitability for evacuation was not assured. Nine residents at this floor were assessed as requiring the use of a ski pad to evacuate. The operations manager, representing the provider, confirmed that when used in a drill it fits as the straps would be tightened. Further assurance was required in this regard.
- There was mixed responses from staff regarding the evacuation strategy and the extent of fire compartments. The provider had not furnished staff with correct information regarding the fire compartment boundaries.
- Considering the dependency levels of residents, the absence of simulated drills to reflect the larger compartments and the ambiguity regarding the location of fire compartment boundaries, further assurance was required that adequate resources were available to safely evacuate residents when staffing levels were at their lowest, particularly where staff have the additional burden of manually closing fire doors in the event of a fire

The fire compartments were not assured, and were being confused with fire alarm zones. The drawings, where displayed, showed fire alarm zones.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

An inspector observed two visiting care plans. Both care plans required review to reflect the current practices in the centre. Care plans were last updated during an outbreak in June which stated that residents could have one nominated visitor only.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had access to their own general practitioner. Five general practitioners attended onsite. A physiotherapist attended onsite fortnightly with no cost to the

residents. The inspectors were informed that residents were reviewed following a fall. Management stated that residents had good access to all other health and social care providers. All residents are registered for the national screening service on admission and care plans reflected this.

Wound assessments were completed on residents who had wounds. These were updated regularly and clearly guided the treatment of the residents' wounds.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Environmental restrictions in the centre required review. The two doors leading out to the external garden were locked with a keypad throughout the day of inspection. The code for the keypad was not on display and if a resident wanted to go out they had to get the assistance of staff to open the door. This practice is overly restrictive.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Action is required to ensure the registered provider is in compliance with Regulation 9: Residents' rights:

- The registered provider needs to be assured that dignity and privacy of residents is ensured at all times. For example; inspectors' observed commodes in the majority of residents' rooms. While inspectors were informed that the commodes were for residents to use at night, they remained at residents' bedsides during the day.
- Resident's in one twin room had to share a television. This meant when the privacy curtains were closed at one bedside the other resident could not view the television.
- The layout of the recreation room was institutionalised and not conducive to a social environment. For example; residents were seated in two long rows of chairs facing the television. Management stated that they had attempted to change the layout but residents changed the layout back to the rows. There was no evidence from meeting minutes reviewed that residents were consulted about the layout of the room and asked for suggestions on how to improve the layout.
- Residents' meeting minutes and the satisfaction survey did not contain time bound actions plans. For example; a resident raised an issue in two separate sets of minutes and while management stated it was actioned, this was not evidenced from meeting minutes reviewed.

• Residents highlighted the lack of showers in the centre to inspectors. The centre had three showers (one of which was contained within a bath and could only be used for mobile residents) for 43 residents. Furthermore, residents who were "upstairs" had to go downstairs to have a shower.
Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Raheny House Nursing Home OSV-0000138

Inspection ID: MON-0040924

Date of inspection: 17/08/2023

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • The center has 7 staff members on duty from 16.30 until 19.00, 5 staff members until 20.30, 4 staff members until 21.00 and 3 staff until 08.00. And activity coordinator Monday -Sunday until 18.30. Based on the examination of data collection pertaining to KPIs within the designated time window of 3:00 PM to 8:00 AM, it is evident that there are no deficiencies in the quality. Staffing levels are subject to continual evaluation in accordance with residents' care needs and a gap of 0.43 RN hours has been identified which will be closed by increasing RN hours accordingly. This will require an element of recruitment. • HCA is scheduled for additional activity shifts to compensate for the vacancy in the Activities role, which is presently undergoing an active recruitment process, therefore the vacant hours are having no effect on the residents lived experience in the home.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • Training on Challenging Behavior, Responsive Behavior, Dementia Training, and Dementia Awareness Training were initially listed in separate columns on the training matrix. However, we have now consolidated and verified this information. A total of 31 staff members have successfully completed these training modules, and we have an upcoming in-house session scheduled for October 4th to further enhance our training coverage in these areas. • The outstanding 6 staff completed the hand hygiene training. • The outstanding 6 staff have completed the Fire training as of August 30th as	

mentioned on the inspection day.

Regulation 23: Governance and management	Not Compliant

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

• We are presently conducting a comprehensive review of all audits and meeting minutes with the objective of establishing a time-bound action plan. This plan will specify the responsible individuals and include follow-up reminders. Additionally, we are in the process of implementing a new computer-based auditing system, which has demonstrated excellence in its performance.

• We have instituted the Red Leaf program to facilitate tracking and trending of incidents, apart from the falls audit. Moving forward, all falls/incidents documented in the Epic system will undergo thorough updates based on individualized case analyses conducted by a falls committee comprising staff nurse, HCA, GP, and Physiotherapist as needed. Action plans will be developed prior to the closure of each incident, and care plans will be modified in alignment with the insights gleaned from the falls committee.

• PIC has taken significant steps to enhance the thoroughness of our daily, weekly, and monthly health and safety inspections, with a specific emphasis on fire safety checks, effective immediately. These checks are being carried out by our dedicated maintenance staff and will be closely supervised by the nurse on duty. To further ensure compliance and eliminate any improper practices, PIC will conduct random spot checks.

• The center is committed to maintaining comprehensive documentation, prompt reporting, and swift resolution of any issues identified during these checks on a daily basis. Our escape routes are meticulously inspected and documented daily, with oversight from the PIC to ensure accuracy. In addition we have arranged for an external Fire Safety Engineer to conduct a thorough inspection and a review of all compartments. The registered provider, with the full support of the PIC and the Facilities Manager, is actively working to implement additional fire safety measures as outlined below under compliance with Regulation 28.

• The designated Domestic lead role has undergone revised training to enhance effectiveness. Meanwhile, the IPC lead will carry out comprehensive IPC and environmental audits until these are eventually replaced by audits conducted through computer-based auditing system. Spot checks by PIC, DPIC, Nurse on duty will also be carried out to ensure anything on a daily basis.

• An annual review of the quality and safety of care has been completed, aligning it with current standards and ensuring that updates have been incorporated.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
• Complaints policy and SOP updated in line with the changes and displayed.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• Ongoing general maintenance works around the house to address walls, architraves and doors that are chipped, scuffed, and damaged.
• The surrounds in the toilet will be refurbished to the standards.
• The hole in the storeroom is fixed and all the panels are painted.
• The carpet in the staff room will be replaced as a part of refurbishment work.
• Assisted bath is part of refurbishment program.
• The replacement of the flooring is part of the refurbishment program.
• The issue of water trapped in the sink, which was identified during the inspection, was promptly rectified on the same day as part of our routine maintenance procedures. It's important to note that this was an isolated incident, and the center has an established maintenance logbook to ensure the immediate reporting and resolution of everyday general maintenance concerns.
• The chair lift is now serviced 6 monthly. Service register updated with the new schedule.
Some areas of the nursing home are refurbished as visible during the inspection day, The refurbishment works are ongoing and expected to be completed by the end of Quarter 1 of 2024.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
• Toilet was replaced on the day with a new toilet. Reviewed the equipment cleaning schedule. The designated Domestic lead role has undergone revised training to enhance effectiveness. Meanwhile, the IPC lead will carry out comprehensive IPC and environmental audits until these are eventually replaced by audits conducted through computer-based auditing system. Spot checks by PIC, DPIC, Nurse on duty will also be carried out to ensure anything on a daily basis.
• A revised cleaning schedule has been implemented for equipment cleaning every night. This includes the hoists. Hoists are cleaned after each use with the placement of clean

stickers. Furthermore, floor alarms have been incorporated into the daily checklist. A weekly audit will be conducted by Senior heath care assistant to ensure compliance with these safety measures.
• Clinical hand washing sinks ordered and is awaiting to be replaced. 2 to be replaced upstairs and 2 downstairs as a part of refurbishment program
• A clinical waste receptacle has been positioned within the sluice room.
• A planned maintenance initiative is scheduled for the shower rail, encompassing treatment and repainting.
• PIC and DPIC will oversee and identify practices susceptible to cross-contamination. Furthermore, there will be additional training sessions provided for kitchen, laundry, and cleaning personnel. A new IPC and environmental audit protocol will be introduced to enhance these practices.
• All staff informed about the risk of cross contamination from the dirty zone to the clean zone in the laundry. All the staff completed the Infection control online training. IPC lead and the PIC will do spot checks. IPC lead will perform the comprehensive IPC and environmental audit to ensure compliance.
• An assessment of the racking within the sluice rooms has been conducted, and all staff members have been duly informed regarding the proper placement of commodes and bottles. Random compliance checks will be performed by the PIC, DPIC, and the nurse on duty.
• The cleaning schedule for soft furnishings has been updated to include the chair lift as part of the routine maintenance regimen.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• A total of three dining room fire stopper doors are scheduled for replacement.
• Within the smoking room, a fire blanket is presently in position. Residents who smoke outdoors are provided with fire extinguishers and fire blankets located adjacent to the door, along with two sand-filled buckets. Residents who smoke carry smoking aprons on their rollators, and all staff are tasked with encouraging and offering residents the use of these aprons. The two residents identified as requiring supervision are subject to a comprehensive review by both the geriatrician and GP. It's important to clarify that these residents do not require constant supervision but rather, supervision is necessary during specific periods of behavioral changes. Our staff members are trained to assess these behavioral shifts and provide supervision as needed. Under the guidance of the PIC and with the support of the MDT, the center is committed to ensuring safety and continuously evaluating the evolving needs of these residents. Additionally, any furniture showing signs of scuff marks, which may have occurred during the occupancy of the previous resident, will be promptly replaced.
• The hoist battery has been removed and safely relocated for charging.
• Records of daily escape route checks were diligently documented over the weekend in the Nurses' diary book. Subsequently, the Fire safety register book has been placed at the nurses' station, consolidating all pertinent records within.

• The comms room was cleared on the specified day. It now undergoes reinforced daily, weekly, and monthly safety checks, complemented by spot checks to ensure compliance.
• The risk register has been updated to include fire doors exhibiting resistance when closing. A comprehensive review of these doors will be conducted as part of the forthcoming refurbishment program.
• A new fire door has been ordered to replace the office door which is near the twin room 36. Automatic door closer is now fitted to the current door while awaiting the new fire door. The installation of the rest of the fire doors is an integral facet of the refurbishment program, anticipated to conclude by the end of Quarter 1 in 2024.
• All staff members have been apprised of fire safety protocols, including the imperative of maintaining clear escape routes. The cleaner's trolley is to be securely stored in the cleaners' room, with compliance subject to periodic spot checks led by the PIC and DPIC.
• Successful fire drills have been conducted when staffing levels are at the minimum level. Furthermore, another evacuation drill has been planned to further enhance our readiness.
• Emergency lighting has been implemented along external escape routes.

• A visual assessment has been conducted, revealing the need for certain remedial actions, specifically involving smoke seals and intumescent strips. The faulty door release device will be replaced. The target date set for the completion of these works is October 31, 2023. Further assessment following completion of the works will be carried out to assess compliance.

• Automatic closing devices will be installed for the 5 high-risk doors which are identified, and a risk assessment will persist until the work's completion. This also includes the office of the person in charge.

• The installation of fire doors within wall openings on the first floor compartment is an integral element of the refurbishment program.
• An assessment will be conducted to ascertain the fire rating of the kitchen partition wall.
• Certification affirming the lift's capability to adequately contain fires will be submitted.
• Fire rating will be sought for attic hatches if not previously in place.
• Service penetrations will be sealed as part of the general maintenance program.
• Fire detectors will be installed in enclosures adjacent to electrical panels.
• In addition to successful night-shift fire drills conducted when staffing levels are at their minimum, another evacuation drill is since been completed to augment our readiness by the centre’s external fire safety person. A video recording is attached to this report regarding the efficient use of the evacuation aids that are fitting along the narrow stairway. Monthly fire drills, with a particular emphasis on expansive compartments and scenarios with limited staffing, are conducted regularly. These drills not only enhance staff competence but also bolster their preparedness for emergency evacuations.
• All staff members have successfully completed fire training. The PIC and DPIC will administer tabletop drills to assess and refine staff knowledge and comprehension.
• A comprehensive review of the compartments by the centre’s external fire safety engineer will be carried out. The updated compartment drawing will be circulated among the team. The drawings will be placed on appropriate locations throughout the building. There will installation of new fire door based on the updated drawings once it is

completed. PIC will conduct table top and actual drills to assess and evaluate the staff's understanding of the updated compartment.

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
• Care plans were updated after the inspection and is now fully compliant.

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
• A comprehensive risk assessment had been established and was readily accessible for examination during the inspection. All residents who were impacted by the keypad have been outfitted with an Environmental Restraint care plan, and these plans are routinely reported to HIQA on a quarterly basis.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• All commodes were replaced with new chair commodes that serve a dual purpose – functioning as commodes during the night and seamlessly transitioning into chairs during the day. On the day of the inspection, it was evident that these commode chairs blend seamlessly into the room environment, resembling regular armchairs when not in use as commodes. To ensure the residents' privacy, they receive assistance in keeping the door or curtain closed during commode use. It's important to note that all residents express their satisfaction with having these versatile commode chairs in their rooms around the clock, and this is duly reflected in their care plans. Following the inspection, further discussions and consultations took place with both residents and their families regarding this arrangement, and all residents have expressed their contentment with retaining the commode chairs in their rooms for daytime use. These decisions have been meticulously

documented in the residents' care plans and communicated to their families. To maintain the highest standards of hygiene, all commode chairs undergo daily disinfection after each use as commodes. Additionally, they are included in our weekly steam cleaning schedule to ensure thorough and consistent cleanliness. PIC will include this in the upcoming satisfaction survey.

• The second TV is now installed in the twin room.

• We engaged in a discussion with the residents regarding the seating arrangement in the recreation room, and it was unanimously agreed to maintain the current configuration of two rows. Over the next few weeks, we will gradually reposition a few chairs to effect the desired layout change. Subsequently, residents will be surveyed once more, and the matter will be deliberated upon during the forthcoming residents' meeting.

• All the meetings’ minutes will be reviewed and have the timebound action plan.

• The installation of showers is part of refurbishment program which is scheduled to be completed by the end of quarter 1 2024

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Substantially Compliant	Yellow	01/11/2023
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	25/09/2023
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	31/03/2024
Regulation 23(c)	The registered	Not Compliant	Orange	31/10/2023

	provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.			
Regulation 23(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.	Substantially Compliant	Yellow	25/09/2023
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Not Compliant	Orange	31/03/2024
Regulation 28(1)(a)	The registered provider shall take adequate	Not Compliant	Orange	27/09/2023

	precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.			
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	11/09/2023
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	31/03/2024
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	31/03/2024
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	Substantially Compliant	Yellow	27/09/2023

	alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.			
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.	Substantially Compliant	Yellow	31/10/2023
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	31/10/2023
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.	Not Compliant	Orange	31/10/2023
Regulation 28(3)	The person in charge shall	Substantially Compliant	Yellow	27/09/2023

	ensure that the procedures to be followed in the event of fire are displayed in a prominent place in the designated centre.			
Regulation 34(2)(b)	The registered provider shall ensure that the complaints procedure provides that complaints are investigated and concluded, as soon as possible and in any case no later than 30 working days after the receipt of the complaint.	Substantially Compliant	Yellow	18/08/2023
Regulation 34(2)(e)	The registered provider shall ensure that the complaints procedure provides that a review is conducted and concluded, as soon as possible and no later than 20 working days after the receipt of the request for review.	Substantially Compliant	Yellow	18/08/2023
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and	Substantially Compliant	Yellow	18/08/2023

	where appropriate that resident's family.			
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.	Substantially Compliant	Yellow	17/08/2023
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Not Compliant	Orange	26/09/2023
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned.	Substantially Compliant	Yellow	31/10/2023