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

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| Name of designated centre: | St. Francis' Nursing Home |
| Name of provider: | St Francis Nursing Home (Mount Oliver) Company limited by Guarantee |
| Address of centre: | Mount Oliver, Dundalk, Louth |
| Type of inspection: | Unannounced |
| Date of inspection: | 22 June 2021 |
| Centre ID: | OSV-0000168 |
| Fieldwork ID: | MON-0032433 |

## About the designated centre

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

St Francis Nursing Home is a purpose built nursing home which accommodates a maximum of 25 female residents over the age of 65 years. The centre cares for their religious Sisters and also female residents from the community. The Nursing Home provides 24 hour nursing and residential care to those with medium, high and maximum dependencies. The centre is situated on extensive grounds, 3.2 km North of Dundalk. On the same site as the Mount Oliver Convent the centre has a separate entrance. The accommodation is laid out along two corridors; La Verna and Kevina. All bedrooms are single and have ensuite facilities. There are multiple rooms strategically situated throughout the centre for resident use. The centre also has an enclosed garden for private use. St Francis Nursing Home is a not-for-profit charity set up by the Franciscan Missionary Sisters for Africa.

**The following information outlines some additional data on this centre.**

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| Number of residents on the date of inspection: | 21 |

## 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 |
|---|---|---|---|
| Tuesday 22 June 2021 | 09:35hrs to 16:45hrs | Sheila McKevitt | Lead |
| Tuesday 22 June 2021 | 09:35hrs to 16:45hrs | Nikhil Sureshkumar | Support |

## What residents told us and what inspectors observed

The inspectors observed that residents living in the designated centre were content and relaxed and that staff provided discreet assistance and ensured resident's needs were met. All residents, staff and visitors who communicated with the inspectors on the day reported a high level of satisfaction with the care and services provided in the centre. However, the inspectors found that the governance and management arrangements required to be strengthened to ensure the service was safe, consistent, and appropriately monitored for the benefit of the residents living there and and that any areas identified for improvement were timely acted on.

The centre was well-maintained with spacious corridors which were clean, bright and well ventilated. Lengthy corridors had seating arrangements for residents and seating areas were decorated with wall drawings of trees, flowers, and views of country side.

Staff said the walls throughout the corridors were decorated with the support of an art teacher. Inspectors saw the wall art included a murial of a letter box which mimicked an actual letter box. Residents were found to be enjoying the wall art in the sitting area while having morning refreshments served by staff. Residents said they had access to indoor courtyards that were well-maintained with flowering plants and foliage.

There were several medium and small sized communal rooms around the centre. Inspectors were told that these rooms were used for family meetings and also to support families of residents approaching end of life. There were two tea point rooms where residents and relatives could help themselves to refreshments. There was a dedicated prayer room which had seating spaced adequately for residents to pray. The staff identified it as an area where residents use to come and meet together for tea before COVID -19 but currently not in use for this purpose due to COVID-19 precautions.

The bedrooms were spacious, clean and with sufficient storage space for personal belongings. The name of the resident was displayed at the bedroom door along their room number. Personal emergency evacuation plan for each resident was available in their room together with manual handling assessments. The corridors were compartmentalised with suitable fire doors.

The provider had good arrangements in place for residents to receive visitors in private spaces that had been arranged for this purpose. Visits were pre-arranged and only happened by appointment to ensure residents' safety was maintained. Each visitor was seen to be met by a designated staff member who instructed and supervised the visitor on the precautions to be taken including temperature check, mask-wearing, social distancing and hand washing. Visitors and residents reported that they were satisfied with the measures in place and understood that it was to

maintain their safety.

Residents were found to be enjoying the activities in the activities room which was sufficiently staffed at the time of inspection. Staff spoken with were knowledgeable about the residents, their food and fluid consistency including residents' special dietary needs. Inspectors observed staff engaging with residents in a kind and sensitive manner. Residents appeared well-dressed and well-groomed. Residents who spoke with the inspectors said "I like the food, and it's great here". One resident has mentioned that "I miss my own food, but they are trying to make my food, but I am happy here". There was an ambiance of calmness in the centre. One resident told inspectors they had access to a lot of space in the grounds of the facility and they enjoyed using it for walks.

Staff said the management were supportive. Staff were knowledgeable about responding to safeguarding issues, concerns and complaints. Staff said that sometimes certain food (turnips) were not presented in an appetising manner for residents and despite raising several concerns about it, the issues had not been rectified.

Inspectors spent time observing residents' dining experience and noted that residents appeared relaxed and were enjoying their food. Those who required assistance with their meals were assisted by staff who sat with them and who provided discreet support which was patient, kind and dignified. The food was freshly cooked on site and was noted to be wholesome and nutritious. Inspectors observed that uneaten shredded turnip had been left on residents' plates in the dining room.

Sluice facilities were found to be purpose-built and well-maintained. However, inspectors observed practices where worktops in the sluice rooms were used for storing clean items. Also, some unused yellow bins were stored outside the sluice room and a toilet area. This cluster of yellow bins were found to be obstructing access to the toilet and hand wash area. The person in charge had these two issues rectified prior to the end of the inspection. Housekeeping rooms were inspected and were seen to be clean, and had lever operated taps on the wash hand sinks, however these were not compliant with relevant guidance for wash hand sinks.

Hoist and specialised chairs stored in an equipment storage area appeared to be well-maintained. Laundry facility was spacious and had two hand wash facilities. There were sufficient number of washing machines and a drier available in the laundry area. There were dedicated areas identified for segregating dirty linen. Staff who spoke with the inspectors were knowledgeable of the laundry process. There was a hot room available next to the laundry area for drying wool, and delicate clothing.

The next two sections of this report will summarise the findings of the inspection and discuss the levels of compliance found under each regulation.

## Capacity and capability

Overall the governance of this centre was weak. The centre had not come into compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). Inspectors found that the compliance plans identified on the last inspection in September 2019 had not been addressed in full and further areas of non compliance were identified on this inspection, which included policies and procedures, staffing, training and development, governance and management, infection prevention and control and fire precautions.

In January 2021 the Chief Inspector had been notified of an outbreak of COVID-19 which affected 15 staff and 13 residents, and where five residents who contracted COVID-19 had sadly died. This was an unannounced inspection to monitor the provider's compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older people) Regulations 2013 and to assess their contingency arrangements in the event of another outbreak in the centre.

The registered provider was St. Francis Nursing Home (Mount Oliver) Company limited by Guarantee. The governance team consisted of the provider representative and the newly appointed person in charge. The newly appointed person in charge was only one week in post. Although the lines of accountability were reflected in the statement of purpose, it was evident during this inspection that they did not have clarity on their roles and responsibilities. Neither the provider representative or the newly appointed person in charge appeared to have clear knowledge or oversight of all aspects of the service provided. The lack of oversight resulted in non-compliances identified during this inspection.

The communication between the provider representative and person in charge was mainly verbal in format since the beginning of the pandemic. The inspectors were informed that this was due to the restrictions imposed by public guidelines. However, it had not changed since the easing of restrictions. The absence of a structured channel of communication had led to the further deterioration in the level of compliance. The new person in charge stated that they had requested weekly meetings with the provider representative, but these had not been scheduled to date.

Staffing levels on the day of this inspection was adequate to meet the needs of the 21 residents during the day and night. However, there was not enough qualified nursing staff employed to work in the centre. This was brought to the fore during the COVID-19 outbreak in January 2021. At this time the Health Service Executive (HSE) supported the centre by providing them with the assistance of registered general nurses and health care assistants. However, since then, the number of qualified staff on the roster had reduced further. Therefore, agency staff were being used to cover annual leave and the person in charge was often the only staff nurse on duty. The negative impact of this was that the person in charge did not have protected time to carry duties of a person in charge as outlined in the Health Act

2007 (Care and Welfare of Residents in Designated Centres for Older people) Regulations 2013.

The staff had access to training. For example, a number of staff had completed training in the auditing of clinical practices since the last inspection. However, the oversight of training was poor. It was not clear who had overall responsibility for the training of staff. The system in place had failed to identify the fact that a number of staff had not completed some mandatory training.

There was a comprehensive clinical risk register of all accidents and incidents that took place in the centre and appropriate action taken in the review of residents following a fall. There was a general risk register in place, however it required further review to ensure it reflected the current risks in the centre and that it was consistently updated whenever a new risk or hazard was identified so that there was a clear record of the control measures that were put in place to mitigate the risk.

Clinical staff demonstrated a positive attitude to their work and were clear about their roles and responsibilities and the standards that were expected of them. Staff had access to support and supervision in their work which helped to ensure that there was an established staff team and that staff morale was good. However, it was not clear who was supervising the maintenance team.

Communication with staff occurred regularly on a formal and informal basis. All staff who spoke with the inspectors confirmed that they felt supported, and that they could raise issues readily with the person in charge and felt their views would usually be listened to but were not always acted upon.

Staff were observed adhering to infection prevention and control practices such as the uniform policy, monitoring staff temperatures arriving and during the working day, good hand hygiene practices and social distancing measures at break times.

Policies and procedures were in place as set out in Schedule 5, however they had not been updated within the last three years and none of them reflected COVID-19 specific information. For example the policy on temporary absence and discharge of residents had not been updated with the current public health measures in respect of isolating residents on admission. There was a distinct Management of COVID-19 policy in place that addressed all other relevant areas.

## Regulation 14: Persons in charge

A new person in charge had commenced on 14 June 2021. Some of the documents submitted pertaining to the person in charge role were incomplete. The provider representative informed the inspectors that updated documents had been submitted on the morning of inspection.

The person in charge confirmed she was working full-time, was a registered general nurse, had three out of six years experience in the management of older persons

and had a post registration management qualification.

Judgment: Compliant

## Regulation 15: Staffing

There were not enough registered nurses employed to work in the centre. There were just over four whole time equivalent registered nurses employed to work in the centre. Of these, three were working full-time hours and two nurses were working part-time hours. The role of the person in charge had been filled by the senior staff nurse and the senior staff nurse post remained vacant. Inspectors were informed that a new clinical nurse manager's post was advertised. However when further information was requested, the position advertised for was of a staff nurse. It had not been filled to date.

Judgment: Not compliant

## Regulation 16: Training and staff development

It appeared that staff had access to a programme of ongoing mandatory training, which was submitted after the inspection. However, evidence of the training completed by the catering team was not provided to inspectors. In addition, there were some gaps in the training completed by other staff, the gaps were mainly in infection prevention and control, hand hygiene and breaking the chain of infection.

Judgment: Substantially compliant

## Regulation 19: Directory of residents

The hard copy residents directory was reviewed and overall it was found to contain the required information outlined in part 3 of Schedule 3.

Judgment: Compliant

## Regulation 23: Governance and management

The governance of this centre was not effective.

The oversight of practices was weak. There were no established systems in place to ensure all clinical and non clinical practices were being monitored by the provider and person in charge. The lack of oversight in areas such as training and staff development, staffing levels, keeping records up-to-date had lead to a deterioration in this centre's level of compliance.

Inspectors found that the monitoring and oversight of these areas did not ensure that where issues were identified that these were addressed in a timely manner or followed up by the responsible person. For example, the issues in relation to emergency lighting, which were brought to the attention of the provider on the inspection of November 2019 had not been addressed. Also, the lack of succession planning for upcoming vacant posts was a concern.

While a risk register was in place, it was not a live document and it was not updated with identified risks and hazards to ensure appropriate mitigating controls were put in place.

There was no evidence of any formal communication between the provider representative and the person in charge. Therefore, it was not evident if the provider representative was actively involved in the management of the centre or if they were supporting the person in charge.

The annual review completed for 2020 was provided on request to the inspector. A full review of the quality and safety of care delivered to residents was not included. There was no evidence that residents or their families were consulted about the review and it was not made available to residents.

Judgment: Not compliant

## Regulation 31: Notification of incidents

All notifications that are required to be submitted to the Chief Inspector had been submitted and no notifiable incidents noted during the review of incidents in the electronic records.

Judgment: Compliant

## Regulation 34: Complaints procedure

There was a complaints policy in the centre and complaint procedure was on display at various notice boards in the centre. The complaints policy and procedure identified the person to deal with the complaints and complaint overseer. It also outlined the complaints process and how the outcome of the complaint should be communicated to the complainant. It also included an appeals process, should the

complainant be dissatisfied with the outcome of the complaints process and there was a mention of advocacy services which shall be made available in the centre. The residents spoken with have said that "if I have any concerns I shall tell the staff". However, there were no open or closed complaints available to review during inspection.

Judgment: Compliant

## Regulation 4: Written policies and procedures

The policies and procedures outlined in Schedule 5 of the regulations were available for review. They had not been updated within the last three years. They were all last reviewed in May 2018 and the process of reviewing them had not begun.

The inspectors found that a number of these policies did not reflect practices in the centre. For example, the visiting policy did not include the current visiting options available to relatives/visitors, and it did not refer to face-to-face visiting arrangements in place. The fire safety policy was not reflected in practice, as identified on the day.

The system for logging complaints referred to in the complaints policy was not reflective of the actual practice. The staff spoken with confirmed that they did not log the complaints into the electronic record system as stated in the complaints policy.They said they informed the complaints officer who entered the compliant into the electronic record system. This information provided was not reflective of the complaints policy which was last updated on the May 2018.

Judgment: Not compliant

## Quality and safety

Inspectors found that residents received a service which met their needs. However improvements were required in respect of residents' care plans, fire safety precautions and infection control measures.

Residents had access to medical care and additional treatment and expertise from varied allied health professionals. Residents were closely monitored for signs and symptoms of COVID-19, and clinical observations were recorded twice daily.

Each resident's care needs were comprehensively assessed. Care plans were developed to reflect the resident's assessed need, however they did not always include sufficient detail to guide care and inform staff about each resident's care needs. There was evidence that residents were consulted with in respect of their

care planning arrangements.

Residents reported feeling safe in the centre and friends visiting residents confirmed that their loved ones were treated with respect and dignity. Staff had attended safeguarding training.

Visiting restrictions had been eased in the centre in line with Public Health advice and current guidance (Health Protection and Surveillance Centre, *Guidance on Visits to Long Term Residential Care Facilities*). Visiting was facilitated in residents' bedrooms and in a number of designated areas, each of which were observed to be appropriate to accommodate social distancing. Visits were by appointment only and were accommodated seven days per week.

Overall the building was clean and comfortable and the premises were laid out to meet the needs of the residents.

The fire alarm and fire extinguishers were serviced as required and records were available for review. Fire drills and fire training had been completed on several occasions with all staff, and all had received this mandatory training within the past year. However the frequency of checks for the emergency lighting in the centre and the frequency of fire drills carried out with staff to ensure they had the skills for evacuating the residents in the event of fire required review. Both these issues were identified on the last inspection of November 2019 and had not been addressed.

In addition, the risk register also required to be further developed as it did not identify all risks in the designated centre, as judged under Regulation 23.

There was evidence of appropriate preparedness should the centre experience a second outbreak of COVID-19. A comprehensive contingency plan had been put into place to minimise the risk of residents or staff contracting a COVID-19 infection. Systems were in place to test staff and residents who presented or reported symptoms of COVID-19. This plan supported early recognition and containment of suspected cases of COVID-19.

Overall the general environment and residents' bedrooms, communal areas, toilets and bathrooms, and sluice facilities inspected appeared clean. Daily cleaning checklists for resident rooms (environment and equipment) were up to date. The housekeeping manager completed monthly spot checks of random rooms, both private bedrooms and communal rooms in the centre. The laundry facility visited had restricted access and showed separation of dirty and clean activities with good clear directional flow.

The observations made by inspectors showed staff followed good hand hygiene techniques using alcohol hand gel. Furthermore staff adherence to 'Bare Below Elbow' initiatives (ensuring hands and forearms are free of jewellery, sleeves are above the elbow, nails are natural, short and unvarnished and skin is intact) was evident. Hand hygiene and personal protective equipment (PPE) advisory posters were displayed and alcohol hand rub gel was available throughout. Face protection masks were worn by all health care workers at the time of this inspection.

## Regulation 11: Visits

Satisfactory arrangements were in place for residents to receive visitors in private.

The provider had developed a visiting protocol to minimise any risk of COVID-19 to the residents, staff and visitors. Visiting was restricted in line with Public Health guidance (Health Protection and Surveillance Centre, *Guidance on Visits to Long Term Residential Care Facilities*).

Judgment: Compliant

## Regulation 20: Information for residents

A guide was prepared and available to residents. It included a summary of the services and facilities available to them. It included the complaints procedure, the arrangements for visits and had been updated to include information in relation to the additional fees that may be charged.

Judgment: Compliant

## Regulation 26: Risk management

A risk management policy and risk register was in place and maintained. A process for hazard identification and assessment of identified risks relating to residents and to the centre were recorded and subject to review. Risks identified were outlined and the plan in place to control these risks was clear. However, this had not been consistently updated and the oversight of risk management in the centre required to be strengthened as outlined under Regulation 23.

Judgment: Compliant

## Regulation 27: Infection control

While the inspectors observed numerous examples of good practices and adherence to the National Standards in Infection prevention and control in community services, the inspection identified additional opportunities for further improvement in relation to the following:

- There was an infection prevention and control policy to guide practices in the centre. However inspectors found that the COVID-19 policy named the outgoing person in charge as the clinical lead.
- the design of clinical hand wash sinks inspected were not in line with best practice and relevant guidance.
- enhanced oversight of storage practices to ensure effective segregation of clean and dirty processes was required; for example storing clean items on the sluice worktops.

Judgment: Substantially compliant

## Regulation 28: Fire precautions

A repeated finding in relation to fire safety precautions required a more proactive approach to the management of risk and fire in the designated centre. For example;

- The emergency lighting checks had been carried out and had a certificate of annual inspection. Although there was evidence that testing had been completed by a competent emergency lighting contractor within the past year, there was no evidence that emergency lights were inspected and tested on a quarterly basis as required.
- There had only been one fire drill completed in 2020 and one to date in 2021. The frequency of these needed to be increased to ensure staff were 100% competent in the procedure to follow in the event of an evacuation, particularly at night when their were just two staff on duty.

Judgment: Substantially compliant

## Regulation 5: Individual assessment and care plan

The sample of records reviewed showed that overall residents' care plans and assessments were in place to reflect resident's assessed needs. However, inspectors found that some care plans were not comprehensively updated post assessment by a member of the allied healthcare team. These care plans did not include enough specific detail to ensure the resident received the care required to meet the specific need. For example;

- One resident had been reviewed by a nutritionist in March 2021 and the resident's care plan had not been updated to include the recommendations made by the nutritionist.
- Another resident had gained a significant amount of weight over a short period of time and there was no evidence that the residents GP had been informed of this weight gain and no evidence that the frequency of weighting

this resident was reviewed by the nursing staff.

Judgment: Substantially compliant

## Regulation 6: Health care

Residents had access to medical and allied heath care services. Residents' general practitioners (GPs) made site visits on a regular basis. Residents had access to Old Age Psychiatry Services, gerontologist and additional expertise such as diabetic specialists, physiotherapist, occupational therapist and chiropody .

There was evidence that nurses engaged in continuous professional development, completed medication management courses and were informed of current best practice in relation to infection prevention and control as well as the management of residents with suspected or confirmed COVID-19.

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 14: Persons in charge | Compliant |
| Regulation 15: Staffing | Not 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 | Compliant |
| Regulation 4: Written policies and procedures | Not compliant |
| **Quality and safety** | |
| Regulation 11: Visits | Compliant |
| Regulation 20: Information for residents | Compliant |
| Regulation 26: Risk management | Compliant |
| Regulation 27: Infection control | Substantially compliant |
| Regulation 28: Fire precautions | Substantially compliant |
| Regulation 5: Individual assessment and care plan | Substantially compliant |
| Regulation 6: Health care | Compliant |

# Compliance Plan for St. Francis' Nursing Home OSV-0000168

## Inspection ID: MON-0032433

## Date of inspection: 22/06/2021

**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 15: Staffing | Not Compliant |
| Outline how you are going to come into compliance with Regulation 15: Staffing:<br>A new CNM/Deputy Person in Charge has been recruited and will commence employment when all statutory requirements have been met. This will bring the number of whole time equivalent registered nurses employed to 5.1.<br><br>Two bank nurses have been recruited and will commence work by 10th August 2021. | |
| Regulation 16: Training and staff development | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 16: Training and staff development:<br>The Staff Training Plan and Matrix were analyzed to account for the gaps in training. Oversight of staff progress in On-line learning has been given to Administrator and Audit for Staff Training Records is on the Audit schedule in conjunction with appraisals.<br><br>The relevant Catering Staff Training records are included on the Matrix with Nursing Home Staff records.<br><br>Certificates for on-line courses were obtained. Certificates/Courses no longer available on HSeLanD were replaced using Temporary HSeLanD Version. Breaking the Chain of Infection has been replaced by 2 Amric Basics of Infection Prevention and Control.<br><br>At present most staff members have completed on-line trainings (Hand Hygiene, Breaking the Chain of Infection, Infection Prevention and Control, Safeguarding) and gaps have been filled. | |

The Administrator will meet with individuals who have not completed the prescribed on-line courses to support their efforts to successfully complete the on-line learning within the next 3 weeks.
Fire Safety Training will take place on 4 August. The earliest booking available for SafePass Training (external) for the Maintenance staff is in September.

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| Regulation 23: Governance and management | Not Compliant |

Outline how you are going to come into compliance with Regulation 23: Governance and management:
St Francis Nursing Home CLG is a registered charity and Fund Raising is ongoing.

The Home's Management System has been reviewed and weaknesses highlighted during the Inspection have been analysed and are being addressed.

Management Meetings will be planned and documented and held on a regular basis. Planned and documented meetings will also be held with Nurses, HCAs, Housekeeping, Administration and Maintenance.

Data collected through observation, communication and audits will be analysed and action taken to lead to quality improvement in our service.

A comprehensive yearly plan and a Schedule of Audits has been drafted. Outcomes of audits will be analysed by the PIC and Registered Provider and issues arising will be addressed in a timely fashion.

A Risk Register will be left in a place accessible to all staff so that identified hazards/risks can be documented in a timely way and solutions suggested. The Risk Register will be monitored by the Nurse on duty and the PIC to ensure appropriate action is taken.

The 2020 Annual Review is being edited to include materials from audits and the Improvement Plan we had in place for 2021.

Residents' and relatives' questionnaires are currently being processed. The views of residents and relatives will be included in our 2021 Annual Review.

Copies of the Annual Review will be left at the Reception Desk

Additional registered nurses have been recruited since the inspection.

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| Regulation 4: Written policies and procedures | Not Compliant |

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
Written Policies and Procedures are under review being prioritized according to changing regulations and guidance eg, Covid 19, and the date of the last review.

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|---|---|
| Regulation 27: Infection control | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 27: Infection control:
The name of our former PIC has been removed from our Covid-19 Policy and replaced with the name Patricia Datta, our current PIC.

Designated clinical hand wash sinks will be fitted with longer tap handles as per relevant guidance.

Appropriate IPC signage displayed in the sluice rooms to remind staff about appropriate storage of equipment. Information regarding the separation of clean and dirty objects and materials will be disseminated to all staff via their immediate supervisors.

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| Regulation 28: Fire precautions | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Annual Emergency Lighting inspection and testing was completed by competent emergency lighting contractor on 2 June 2021 and documented. The same contractor has been booked to undertake the next quarterly inspection and each quarterly/annual inspection and testing thereafter.

Fire drills/evacuations will take place at least twice a year and more often if required, with each member of staff participating at least once a year. Night evacuation drills will be included. Participation by staff is mandatory.

A fire drill at night with on duty night staff participating has been scheduled for 5th August 2021.

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| 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:

Following the Inspection, a teaching session was conducted with all staff nurses to illustrate the gaps highlighted by the inspectors. Using the EpicCare system, the PIC illustrated to all staff how residents' care plans should be formulated and updated, inclusive of input from the residents or their significant representative. It was emphasized that care plans are living documents which must reflect problems identified, care given and personal preferences of the residents.

Auditing of care plans is included in the Clinical Audit Schedule. The PIC/Deputy PIC will review at least 5 care plans monthly. In addition, the PIC will do spot checks on care plans when significant changes occur in a resident's condition/care needs and communicate to staff nurses if updating is incomplete.

## 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 |
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| 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. | Not Compliant | Orange | 10/08/2021 |
| Regulation 16(1)(b) | The person in charge shall ensure that staff are appropriately supervised. | Substantially Compliant | Yellow | 02/09/2021 |
| Regulation 23(a) | The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose. | Not Compliant | Orange | 04/10/2021 |
| Regulation 23(c) | The registered | Not Compliant | Orange | 30/10/2021 |

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| | 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. | Not Compliant | Orange | 30/08/2021 |
| Regulation 23(e) | The registered provider shall ensure that the review referred to in subparagraph (d) is prepared in consultation with residents and their families. | Not Compliant | Orange | 30/01/2022 |
| Regulation 23(f) | The registered provider shall ensure that a copy of the review referred to in subparagraph (d) is made available to residents and, if requested, to the | Substantially Compliant | Yellow | 01/10/2021 |

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| | Chief Inspector. | | | |
| 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 | 30/11/2021 |
| Regulation 28(1)(c)(iii) | The registered provider shall make adequate arrangements for testing fire equipment. | Substantially Compliant | Yellow | 01/09/2021 |
| Regulation 28(1)(d) | The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire. | Substantially Compliant | Yellow | 16/08/2021 |

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| Regulation 04(1) | The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5. | Substantially Compliant | Yellow | 15/12/2021 |
| Regulation 04(3) | The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice. | Not Compliant | Orange | 15/12/2021 |
| 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 | 31/10/2021 |