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:	An Teaghlach Uilinn Nursing Home
Name of provider:	Knegare Nursing Home Holdings Ltd
Address of centre:	Kilrainey, Moycullen, Galway
Type of inspection:	Unannounced
Date of inspection:	19 October 2022
Centre ID:	OSV-0000309
Fieldwork ID:	MON-0037870

About the designated centre

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

An Teaghlach Uilinn Nursing Home is a purpose-built designated centre for older people. Residents are accommodated in single and twin bedrooms. A variety of communal rooms are provided for residents' use, including sitting, dining and recreational facilities. The centre is located close to Moycullen village, Galway. Residents have access to a secure enclosed courtyard. The centre provides accommodation for a maximum of 75 male and female residents, over 18 years of age. The service provides care to residents with conditions that affect their physical and psychological function. Each resident's dependency needs are regularly assessed to ensure their care needs are met.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	55

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 19 October 2022	08:00hrs to 17:45hrs	Sean Ryan	Lead
Wednesday 19 October 2022	08:00hrs to 17:45hrs	Fiona Cawley	Support

What residents told us and what inspectors observed

On this inspection, residents reported that there were some improvement in the availability of familiar staff to support them with their care needs. Residents also reported that the provision of activities had improved and that the management were consulting them with regard to improving the choice of activities available to them.

Inspectors were met by the person in charge on arrival at the centre. Following an introductory meeting, inspectors walked through the centre with the person in charge and met with a number of residents in communal areas and in their bedrooms. There was a calm and relaxed atmosphere for residents in the centre. Staff were observed busily attending to residents requests for assistance with their morning care needs. Staff were observed knocking on residents' bedroom doors before entering and polite conversation was overheard between residents and staff.

Residents told the inspectors that in recent weeks, they noticed that the same staff were available to assist them and this made them feel safe and comfortable in their care. Some residents commented that at night time and weekends, staff who were not familiar with the residents care needs would attend to residents requests for assistance and residents reported that those staff were patient and asked residents how they like things to be done. One residents told inspectors that staff 'knowing your name and what you need without using a piece of paper to find it' made them feel respected and acknowledged. Residents told the inspectors that they had met with the new person in charge who checked on them most days to ensure they were satisfied with the service and gave them time to express any concerns that they may have.

Inspectors were informed that redecoration of corridors, bedrooms and communal areas was taking place on a planned and phased basis with priority been given to rooms that were currently vacant. This was evident where corridor walls had been repaired and prepped for painting. The premises was warm, spacious and comfortable for residents. Inspectors observed areas of the premises that were not adequately lit along corridors where residents' bedroom accommodation was located. Inspectors were informed that this was as a result of a recent power outage and normal lighting in the area had not returned to full function but would be repaired in the days following the inspection. Inspectors observed equipment used by residents that was not maintained in a satisfactory state of repair such as shower chairs and hoists that were heavily rusted and visibly unclean. In addition inspectors observed that store rooms did not have a defined storage purpose and were overstocked with records, mobility equipment, cleaning products and waste awaiting disposal.

On the day of inspection, the centre was nearing the end of an outbreak of COVID-19. Residents told the inspectors that they found isolation very difficult but that the shorter isolation time coupled with the efforts of the management and staff to keep

them socially engaged had made the time pass quicker. Inspectors observed that a cleaning schedule was in operation for all areas of the centre. Cleaning records were stored in each individual room and signed by staff following the area being cleaned. However, there were gaps observed in those records.

Areas of the premises occupied by residents, such as bedrooms and communal day rooms, were observed to be clean. However, some communal bathrooms, store rooms and the sluice room were not cleaned to an acceptable standard. Some staff were observed inappropriately wearing personal protective equipment in corridors. Inspectors observed that the management of clean and dirty linen and waste had not improved since the previous inspection. Clean linen was observed to be stored on trolleys alongside bags containing used linen and waste. Inspectors were informed that there was no dedicated housekeeping room in the centre and as a result cleaning equipment and supplies were being inappropriately stored in the sluice room.

Inspectors spoke with residents in their bedrooms. In the main, residents were complimentary of their bedroom accommodation and described it as 'cosy and warm'. Residents were encouraged to personalise their private bedroom space with items of personal significance such as ornaments and photographs. Residents in single bedroom accommodation confirmed that they had adequate storage for personal possessions and clothing. The majority of shared bedrooms were occupied by one resident only. Some of those rooms were not ready to accept new admissions as there was insufficient lockers, wardrobes and chairs available for two residents in those bedrooms. The person in charge was aware of those issues and confirmed that a plan was in place to address those issues prior to admitting residents to the bedrooms.

Residents were able to meet their friends and family in the privacy of their bedrooms, or sitting rooms, where appropriate. The inspector spoke with a small number of visitors. They said that they were satisfied with the care their relatives received and that that staff were kind in their interactions with their relatives.

Inspectors observed that some residents were engaged in activities in the communal day room on the ground floor. A detailed activity schedule was displayed on the notice boards for residents to view and choose activities they wished to attend.

The following sections of this report detail the findings with regards to the capacity and management of the centre and how this supports the quality and safety of the service provided to residents.

Capacity and capability

This was an unannounced risk inspection by inspectors of social services to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). Inspectors followed up

on the actions taken by the provider to address significant issues of non-compliance found on the last inspection in June 2022. Inspectors found that the provider had taken some action to implement systems to induct and orientate staff and to support staff to provided safe and effective care to residents. Further improvements were found with regard to supporting residents to access and manage their finances and in the provision of activities for residents. However, the findings of this inspection were that the provider had failed to implement their compliance plan following the previous inspection and significant action was required in the governance and management of the service provided to residents. Inspectors found ineffective management systems of monitoring and oversight resulted in repeated issues of substantial or non-compliance under;

- Regulation 5, Individual assessment and care plan,
- Regulation 6, Healthcare,
- Regulation 15, Staffing,
- Regulation 16, Training and staff development,
- Regulation 23, Governance and management,
- Regulation 27, Infection control, and,
- Regulation 34, Complaints procedure,

The previous inspection in June 2022 identified significant non-compliance in the oversight and supervision of the staffing resources to deliver safe and effective care to residents. The management systems had also failed to ensure the service provided to residents was safe and effectively monitored resulting in the quality and safety of care provided to residents being impacted on. Following that inspection, and subsequent engagement with the office of the Chief Inspector, the provider gave assurances that the necessary action would be taken to comply with the regulations and a compliance plan was submitted to that effect. The compliance plan was due to be completed in September 2022. Inspectors found that the registered provider had failed to implement their compliance plan following the previous inspection and there continued to be poor oversight and monitoring of the management systems in place to monitor and improve the quality and safety of the service provided to residents.

Knegare Nursing Homes Limited is the registered provider of the centre. The provider is involved in the operation of four other designated centres for older persons. The company is represented by one of the company directors. The organisational structure of the centre had changed since the previous inspection with the appointment of a new person in charge. On the day of inspection, the clinical management support for the person in charge was not as described in the centre's statement of purpose which detailed the management structure to include an assistant director of nursing. Inspectors found that the position of assistant director of nursing was vacant and the person in charge was supported clinically by a newly appointed clinical nurse manager. Inspectors were informed that recruitment for an assistant director of nursing and senior staff nurse was in progress. However, rosters showed that the newly appointed clinical nurse manager was working as a nurse on duty on a number of shifts and as such they were not able to carry out their clinical management role which was impacting on the clinical oversight of care, supervision of staff and their ability to support the person in

charge.

The person in charge was a suitably qualified registered nurse who had been appointed in September 2022. The person in charge worked in a supervisory capacity five days per week but attended the centre up to seven days per week to provide support and supervision to the staff.

The provider had management systems in place, such as clinical and environmental audits, to monitor the service. Inspectors reviewed completed audits that were last completed in July 2022. This included an audit of infection prevention and control measures and staff compliance with hand hygiene practices. The was evidence that quality improvement plans were developed following audit activities. A quality improvement plan had been developed following the previous inspection and detailed the actions to be implemented to address deficits in the service such as staffing, complaints management, maintenance of the premises and auditing of clinical care records. However, the progress of the quality improvement action plan could not be measured. For example, the action plan contained 11 corrective actions and there was no evidence of action taken to implement or review the status of those actions.

Risk management systems were underpinned by the centre risk management policy. The risk policy was not up to date. A review of the risk register evidenced that clinical and environmental risks were assessed, however, the risk register did not contain some of the known risks in the centre. For example, reduced management resources and the consequent impact on the oversight of the service was identified by the management as a significant risk to the service. However, the exclusion of this known risk from the centre's active risk register impacted on the centre's ability to minimise and appropriately manage risk.

Record keeping and file management systems consisted of both electronic and paper based systems. Staff personnel files contained a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2021. However, not all files contained the information specified in Schedule 2 of the regulations. Additionally, some information requested by inspectors was not accessible, or retrievable by the management team.

The provider had taken action to facilitate some staff to attend training since the previous inspection. However, there were gaps in the training records where a number of staff had commenced in their role and had not completed training pertinent to supporting the provision of safe care to residents. This included safeguarding of vulnerable people, resident manual handling techniques, fire safety and infection prevention and control.

Inspectors acknowledged that the provider had progressed to recruit some staff since the previous inspection. While the planned roster was maintained on the day of inspection, a review of the rosters evidenced challenges in maintaining planned nursing and health care staffing levels with the centres own staffing resources. Consequently, regular agency staff were employed to support the rosters as the centre continued to have multiple staff vacancies. The provider continued to admit

new residents to the centre in the absence of a stable staffing resource.

The centre had a complaints policy. The complaints procedure was prominently displayed in the centre. However, the complaints policy provided inaccurate information with regard to the personnel involved in the management of complaints and referred to the previous management personnel in the centre. A review of the complaints log found that the centre was not always managing resident complaints, in line with the centre's complaints policy.

Regulation 14: Persons in charge

The person in charge is a registered nurse and works full time in the designated centre. The person in charge was suitably qualified and experienced and met the requirements of Regulation 14.

Judgment: Compliant

Regulation 15: Staffing

Planned rosters could not be fully completed due to lack of availability of nursing and health care staff. For example, planned rosters evidenced that between 12 and 48 direct care hours were vacant on a daily basis. These gaps in the planned rosters for the coming weeks had yet to be filled and as such inspectors were not assured that the provider was able to maintain an appropriate number and skill-mix of staff.

Judgment: Substantially compliant

Regulation 16: Training and staff development

A review of staff training records indicated that a number of staff had yet to complete fire safety, safeguarding of vulnerable people and infection prevention and control training.

Staff were not appropriately supervised to carry out their duties to protect and promote the care and welfare of all residents. This was evidenced by;

- Poor supervision of staff with regard to the appropriate wearing of personal protective equipment. Staff demonstrated poor practice in relation hand hygiene and wearing of face masks.
- There was poor supervision of the housekeeping staff, the cleaning of the environment and equipment.

- There were multiple gaps in the nursing care records.

Judgment: Not compliant

Regulation 21: Records

Inspectors found that the management of records was not in line with the regulatory requirements and records were not kept in a manner that was accessible. For example;

- Staff rosters for the weeks prior to the inspection were not reflective of the roster actually worked by staff.
- Staff personnel files did not contain all the necessary information required by Schedule 2 of the regulations. For example;
    - Two staff files did not contain a satisfactory employment history.
    - One staff file did not contain two written references.
    - One staff file did not contain a record of current registration details for professional staff.

Judgment: Substantially compliant

Regulation 23: Governance and management

The registered provider did not ensure that the service had sufficient staffing resources to;

- Ensure the management structure, and support for the person in charge, was maintained in line with the centre's statement of purpose. This impacted on effective oversight of the service.
- Maintain nursing and health care staffing resources in line with the centre's statement of purpose.

Inspectors found that the registered provider had failed to take action to ensure governance and management systems were robust to ensure the service provided to residents was safe, appropriate, consistent and effectively monitored. This was evidenced by;

- The provider had failed to implement their own compliance plan, submitted by the provider, following the last inspection in July 2022 resulting in repeated non-compliances.
- Record-keeping and file management systems were not effectively monitored. For example,
    - There were gaps in the documentation required by Schedule 2 of the regulations and no action had been taken to ensure records would be

compliant with the regulatory requirements.

- The oversight of risk management systems was not robust. This was evidenced by;
    - The risk management policy had not been reviewed or updated to reflect the changes to management personnel responsible for implementing the risk management systems.
    - The centre's risk register did not contain known risks in the centre. This included risks associated with the use of the sluice room to store housekeeping equipment and the risk of cross contamination and reduced management support and management oversight.
- The monitoring and oversight systems of key areas such as infection prevention and control were not effective and did not ensure the safety and well-being of the residents.

Judgment: Not compliant

Regulation 34: Complaints procedure

Inspectors reviewed a sample of complaints that had been received since the previous inspection. Inspectors found that complaints management was not in line with regulatory requirements or the centres own complaints policy. This was evidenced by;

- The complaint records did not detail if the complaint had been resolved or if improvements were required in response to the complaint.
- A verbal complaint was not recorded in line with the requirements of the regulations.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

Inspectors found that the policies and procedures set out in Schedule 5 of the regulations were not reviewed and updated in accordance with the regulation.

Judgment: Substantially compliant

Quality and safety

The inspectors found that the interactions between residents and staff was kind and respectful throughout the inspection. Residents were satisfied with the quality of care they received and staff were observed to respond to residents requests for assistance without delay. Improvements were required in relation to care delivery, with particular regard to residents' assessments and care plans and health care. Inspectors found that non-compliance in relation to infection prevention and control impacted on residents' safety and well-being.

Residents care plans and daily nursing notes were recorded on both electronic and paper based systems. Inspectors reviewed a sample of eight residents' files and found that assessments and care plans were inconsistent and did not reflect the current care needs of the residents. Consequently, care plans did not provide guidance on the provision of safe and quality care to residents. This is discussed further under Regulation 5: Individual assessment and care plan.

Inspectors found that residents had access to medical assessments and treatment by their General Practitioners (GP) and the person in charge confirmed that GPs were visiting the centre as required. Systems were in place for residents to access a range of allied health and social care professionals through a system of referral. This included physiotherapy, speech and language therapy, dietetic services and tissue viability nursing expertise. However, while nursing documentation had been implemented following the previous inspection to monitor residents with specific care needs, such as wound care interventions, inspectors found that those records were poorly maintained.

Residents spoken with stated that they felt safe in the centre and confirmed that staff were caring and kind. All interactions by staff with residents on the day of the inspection were seen to be respectful. The centre was pension agent for three residents and adequate arrangements were in place for the management of residents' finances. There were systems in place to safeguard residents monies and goods handed in for safekeeping. A sample of records were reviewed by the inspectors and were found to be accurately recorded and audited.

While there was a cleaning schedule in place, inspectors observed that some areas of the centre were not clean and there were gaps in the cleaning records. Inspectors observed equipment used by residents that was visibly unclean, which posed a risk of cross contamination and therefore risk of infection to residents. Inspectors found that the provider had not taken action to ensure a satisfactory standard of environmental hygiene was maintained to minimise the risk of infection. Further findings in relation to poor infection prevention and control are outlined under Regulation 27, Infection control.

There were opportunities for residents to consult with management and staff on how the centre was run. Minutes of residents meetings evidenced that following the previous inspection, residents were consulted about the quality of activities and the activities scheduled was revised. Residents feedback was also sought with regard to the quality and safety of the service, the quality of the food, laundry services and the staffing. Residents had access to television, radio, newspapers and books. Internet and telephones for private usage were also readily available. There was an

activity schedule in place and there were activities provided to most residents on the day of the inspection.

Regulation 11: Visits

The registered provider had ensured that visiting arrangements were in place and were not restricted.

Judgment: Compliant

Regulation 27: Infection control

The provider did not ensure that infection prevention and control procedures were consistent with the National Standards for Infection Prevention and Control in Community Services published by the Authority. This was evidenced by:

- The centre did not have a dedicated room for the storage of cleaning equipment or preparation of cleaning chemicals. Cleaning equipment and supplies were inappropriately stored in the dirty utility which presented a risk of cross contamination
- The management of storage areas in the centre did not ensure the risk of cross contamination was minimised. For example, waste awaiting disposal was left in a storage area containing residents mobility aids, hoist slings and activities supplies. Storage areas were also visibly unclean on inspection.
- Where the cleaning schedule had been signed to confirm that an area had been cleaned, inspectors observed that in some instances the area remained visibly unclean.
- Some equipment used by residents was in a poor state of repair and not clean on inspection. For example, hoists and shower chairs had visibly rust and were not clean on inspection.
- Poor practice was observed where linen trolleys were used to transport waste bags containing used continence products, clean and dirty linen. This practice posed an infection risk to the residents.
- A number of staff demonstrated poor practice in relation to the appropriate storage of cleaning equipment and the management of waste.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

A review of the resident's assessments and care plans found that they were not compliant with the regulatory requirements. For example;

- care plans were not developed in a timely manner, in line with the assessed needs of a resident. For example, one resident did not have a care plan in place 48 hours following admission to the centre
- one resident did not have their current medical care needs integrated into their care plan. For example, a resident who required renal dialysis did not have a plan in place to guide staff in the specific needs of the resident
- a number of care plans had not been reviewed at least four monthly, in line with regulatory requirements.

Judgment: Not compliant

Regulation 6: Health care

Inspectors observed that some care practices on the day of the inspection did not reflect the assessed care needs of a number of residents. For example;

- a number of residents who required increased supervision did not have their location and whereabouts recorded in line with their care plans.
- the care records for one resident who required regular repositioning were not completed and therefore inspectors were not assured that care was provided as per the resident's assessed needs.

Judgment: Substantially compliant

Regulation 8: Protection

Inspectors followed up on the findings of the previous inspection and found that the provider had put systems in place to protect residents finances.

Judgment: Compliant

Regulation 9: Residents' rights

Staff made efforts to ensure that the residents' rights were upheld in the centre. There was an activity schedule in place. Residents were observed to be socially engaged on the day of the inspection.

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	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 27: Infection control	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for An Teaghlach Uilinn Nursing Home OSV-0000309

Inspection ID: MON-0037870

Date of inspection: 19/10/2022

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
Currently the centre has the following staffing shortages which are advertised locally, nationally and internationally on several platforms and through several job boards, government agencies and recruitment agencies. Staff members from the company attend job fairs locally, nationally and internationally. The centre has hosted open days.

Current Vacancies:
Assistant Director of Nursing x 1
Nursing Staff x 1 (due to commence on January 16th 2023)
Care Staff x 7
Catering Staff x 2 (both appointed and awaiting Garda vetting and compliance)

Agency staff used within the Nursing Home are known to the residents and are familiar with both the Nursing Home and the Managemnt Team. All agency staff are fully inducted and have been working within the centre for a period of time.

Presently the Nursing Home is waiting on Gardai Vetting for the following staff which we anticipate should start within the next 4-6 weeks.

Staff interviewed and awaiting Garda Vetting:
Care Staff x 3

Interviews are ongoing on a continuous basis with 2 planned for this week. Interviews last week resulted in 2 offers made. We are awaiting confirmation of acceptance from these candidates.

Staff are supervised by both the Person in Charge and the Clinical Nurse Manager who are evident on the floor on a daily basis. Staffing levels are reviewed daily through staff allocations and to ensure an appropriate skill mix within each area of the Nursing Home and having regard for the assessed needs of each resident.

A new Senior Nurse is due to commence in the centre in January which will strengthen and support the supervision and mentoring of staff. This Nurse will work in tandem with the CNM to ensure oversight and management of care and care provision.

The centre is striving to ensure its staffing levels are as reflected in its statement of purpose. All new staff are fully inducted and have access to appropriate training. New staff are supervised through a buddy system and their induction process overseen by the Nurses and CNM in the centre.

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
A review of the training needs has been completed by the Senior Management Team. Training has been booked and is due to take place in the coming weeks and early 2023. The Clinical Nurse Manager (CNM) has been appointed to oversee the review of the resident's care plans. Any deficits noted during audit and care plan reviews will be discussed with the staff nurses on site during staff meetings and 1;1s to ensure future compliance. Care plan training will take place with all Nursing staff to ensure they are fully aware of the care planning process and their roles and responsibilities regarding the appropriate documentation of resident's needs, abilities, choices and preferences. The centre has liaised with the training provider and external state-run bodies in relation to onsite training and support for 2023.
Staff are supervised daily on the floor either the Clinical Nurse Manager or Director of Nursing. Out of Hours audits have been conducted at weekends and evenings by both the Director of Nursing and the Clinical Director.
A Senior Nurse has been appointed and commences on the 16th of January. This will strengthen the Management Team and allow for additional supervision and support for all staff. A Nurse Tutor has also been appointed and commences on January 12th to add and additional layer of support for all clinical staff within the centre and to ensure good oversight and supervision of all staff.

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
Staff files are currently being audited to ensure full compliance. Where deficits exist, they will be attended to.
Moving forward all employees' files will be accessible to any inspector on site to review.

When the roster is released to staff a copy is maintained by the Director of Nursing and updated daily to appropriately reflect the worked rota by all staff that were either due on duty and/or attended if required to do so.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
A review of all staff files is underway to ensure compliance with Schedule 2.

The Risk Management Policy is currently under review and the Risk Register is being updated to reflect issues raised at the time of inspection. External supports have been employed to assist with review of policies and procedures.

A new Senior Nurse is due to commence in the centre in January 16th which will strengthen and support the supervision and mentoring of staff. This Nurse will work in tandem with the CNM to ensure oversight and management of care and care provision. A Nurse Tutor has also been appointed and commences on January 12th to add an additional layer of support to all clinical staff within the centre and to ensure good oversight and supervision of all staff on the floor.

Recruitment is ongoing locally, nationally and internationally. At group level two additional appointments have been made to support the centre with recruitment both locally and overseas. Five nurses have been appointed and are commencing aptitude tests on February 27th, 2023 and have been allocated to the centre to meet current deficits and any future deficits from a Nursing perspective. Health Care assistants are interviewed weekly and we currently have three confirmed staff awaiting appropriate compliance paperwork prior to commencement. The centre is working with its own recruitment agency that is dedicated to meeting the needs of the centre. Several other external Recruitment agencies have also been working with the management of the centre to ensure staffing levels are maintained and improved.

The Director of Nursing and Clinical Nurse Manager maintain appropriate induction and orientation for all new staff. Staff meetings and debriefs take place weekly to ensure good communication. Monthly care audits remain in place.

Monthly Clinical Governance meetings commenced in November 2022 with the clinical and healthcare team.
Weekly governance and management meetings take place between the Senior Management Team in the centre and the Board of Management. Daily engagement between the Director Of Nursing and the Clinical Director remains in place.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The complaints log has been reviewed by Senior Management. Where improvements had been required following a complaint these have been audited to ensure all changes have been implemented and remain in place. A complaints monitoring tool has been implemented to ensure any actions resulting from a compliant are implemented and audited. This tool also ensures auditing of consistency in any new practices resulting from the complaint and determines if they are embedded in practice or require additional training and/or resources and support.

The complaints policy is under review and changes to policy will be discussed with all staff. The complaints procedure which is displayed in reception has been updated to reflect the relevant personnel dealing with complaints in the centre.

Training on the complaints management procedure will be provided for the centre 's management team. This training will focus on the process and the documentation required to ensure appropriate action has been taken and evidenced as well as any learning shared with staff to promote improved experiences for all individuals using the service.

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
All policies are currently undergoing a complete review with Schedule 5 Policies receiving priority at this time. All amendments to policies will be communicated to all staff once completed. Any training required as a result of changes will be provided.

Regulation 27: Infection control	Not Compliant

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

A dedicated storage area for cleaning equipment has been allocated within the Nursing Home and is currently in use.
All storage areas within the Nursing Home are in the process of being redesigned with appropriate shelving in place.
A full review of all equipment on site has taken place and care equipment that required replacement has been ordered.
Post inspection the sluice room has been reviewed and items previously stored within it removed and allocated to an alternative storage area. The sluice room has been repainted and a new bed pan rack has been installed.

The system of storage for linen has been reviewed and new linen trollies have been sourced and the centre is awaiting their arrival. New waste trollies have also been ordered for the centre. When the new equipment arrives all staff will receive training on their use within the centre to ensure no cross contamination between clean and dirty waste and linen receptacles.

Refresher training regarding the use of PPE has taken place several times throughout the year with staff and again post inspection.

The IPC Committee continue to meet monthly to review all Infection related risks. Senior Management Team continue to audit compliance with cleaning regimes and practices on the floor.

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
All Nursing staff within the centre will receive care plan training and meet monthly with the CNM post monthly care plan audits to review the changes required in individual resident's needs.

The CNM has been appointed to work closely with the Nursing Staff in respect of all care plans. All new admissions will have a dedicated admitting nurse to ensure all documentation is commenced in a timely manner. Within 48 post admission the DoN will review all new resident's documentation to ensure nursing staff are meeting the regulated guidance in respect of core assessments required and care plans. Care plans are audited monthly by the senior management team. All deficits noted in the care planning process will be noted and discussed immediately with each individual nurse within the centre. Where staff require additional training and support this will be provided. All Nursing staff with the centre are to receive additional refresher training on the clinical computerised system in place within the Nursing Home. This will ensure all nursing staff are fully aware of the care planning process (assess, plan, implement and evaluate) and how to navigate and record it appropriately on the system used.

The Management Team within the centre will review care plans after significant events to ensure care plans accurately reflect the resident's life and choices and are a true reflection of the resident's current care needs, thus improving communication and providing continuity in care delivery to all residents.
The policies on care planning will be shared with all staff once reviewed and discussed at monthly meetings to ensure the process is clear and understood.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
Post inspection on-site refresher training took place with staff in relation to the records to be maintained relating to residents. Senior Management on site review these records daily to ensure they are accurately recorded and a true reflection of the situation for each resident.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Substantially Compliant	Yellow	31/01/2022
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	15/01/2022
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	15/12/2022
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre	Substantially Compliant	Yellow	31/12/2022

	and are available for inspection by the Chief Inspector.			
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Substantially Compliant	Yellow	31/12/2022
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	31/12/2022
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	31/12/2022
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	15/12/2022

Regulation 34(1)(f)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.	Substantially Compliant	Yellow	08/11/2022
Regulation 34(2)	The registered provider shall ensure that all complaints and the results of any investigations into the matters complained of and any actions taken on foot of a complaint are fully and properly recorded and that such records shall be in addition to and distinct from a resident's individual care plan.	Substantially Compliant	Yellow	08/11/2022
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the Chief Inspector may	Substantially Compliant	Yellow	08/11/2022

	require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.			
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Not Compliant	Orange	31/12/2022
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.	Not Compliant	Orange	31/12/2022
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of	Substantially Compliant	Yellow	31/12/2022

	evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.			