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:	Ave Maria
Name of provider:	Cummer Care Limited
Address of centre:	Tooreen, Ballyhaunis, Mayo
Type of inspection:	Unannounced
Date of inspection:	11 August 2021
Centre ID:	OSV-0000315
Fieldwork ID:	MON-0033932

About the designated centre

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

Ave Maria Nursing Home is a purpose built single storey building, registered to provide care for 41 residents. The designated centre is family run and is located in a small country village. The centre is surrounded by mature gardens some of which are laid out with seating areas and vegetable gardens. The provider's dogs visit the centre every day and are enjoyed by the residents. All resident bedrooms are well laid out and have an en-suite bathroom facility.
The centre provides care to residents over 65 years with chronic illness, residents living with dementia and those requiring end of life care. The philosophy of care at Ave Maria Nursing Home is to create a home away from home environment, to deliver person centred care to each individual resident, in a comfortable, safe environment.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	36

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 11 August 2021	09:00hrs to 18:00hrs	Ann Wallace	Lead
Wednesday 11 August 2021	09:00hrs to 18:00hrs	Lorraine Wall	Support

What residents told us and what inspectors observed

The designated centre provided a high quality service through which the residents were able to enjoy a good quality of life and ensured that care was person centred. Managers and staff worked well together to ensure that residents were cared for in a friendly, relaxed atmosphere in which the residents felt valued and safe. This was reflected in the high levels of positive feedback which the inspectors received from residents and their visitors on the day of the inspection. The inspectors found that overall resident's rights were upheld however some of the more dependent residents spent a lot of time in their rooms with limited access to social interaction or stimulation.

The inspectors met with most of the residents throughout the day and residents were very keen to tell the inspectors that they were well cared for and that staff "couldn't do enough for us". Residents who spoke with the inspectors said that they were contented and enjoyed their life in the designated centre. Residents said that they had many friends amongst the other residents and they enjoyed the daily activities that were on offer which gave them the opportunity to meet up and socialise together. Many of the residents were from the local area and some had known each other prior to coming to live in the centre. Residents told the inspectors that they enjoyed being able to continue to live in a rural setting with views of the countryside and the day to day rural life going on around them.

Residents talked about how difficult it had been during the recent restrictions and how glad they were that things were starting to get back to normal. Residents were very grateful to managers and staff for keeping them safe during the COVID-9 pandemic and remarked how well the team had done not to have a COVID-19 outbreak in their home.

The inspectors spoke with a number of visitors who had high praise for the staff working in the centre, stating "the staff are great.", "I couldn't say anything poor about the care here.", " I am happy once he is happy." Visitors were made welcome in the centre and the inspectors saw a number of visitors meeting with residents in the garden or in the visitor's room. Staff told the inspectors how much the residents had missed their visitors during the recent COVID-19 pandemic restrictions and how they had used window visits and mobile phones and face time to help residents stay in touch with their families. Families told the inspectors that the centre had kept them informed about what was happening throughout the pandemic and that they had received photographs and messages about what staff were doing to keep the residents entertained and positive throughout this time. Everybody who spoke with the inspectors talked about the importance of residents being able to see and keep in touch with their families and their local community. It was evident that the service was valued and supported by the local community and that community links were well established.

The provider has been proactive in organising events and once the COVID-19 restrictions were lifted ensuring community participation. For example the recent visit of farm machinery to the centre, which was particularly enjoyed by the male residents of the centre. On the day of the inspection a physiotherapist visited the centre to provide a lively group session of armchair exercises. It was evident that the residents were enjoying the session and one resident told the inspectors that although they felt tired afterwards they always felt the benefit the day after these weekly sessions.

Residents told the inspectors that they were able to live their daily lives as they wished. residents chose what time to get up and retire to bed, where to spend time during the day and what activities they wished to participate in. This was reflected in the person centred approach to providing care and services in the centre. However the inspectors found that the written care plans were not always up to date and did not consistently include the needs and preferences for social care and support. However the staff knew the residents well and were familiar with their care needs and preferences for daily routines and support.

Overall residents said that they had enough to do and that their lives were becoming busy again as since COVID-19 restrictions eased the activities on offer and visits from their families and friends were increasing. However the inspectors noted that some of the more dependent residents spent a lot of time in their bedrooms with limited access to social interactions or appropriate therapies and stimulation. Staff did spend time with these residents whenever possible but this was largely task orientated, for example when care was being delivered. However staff were familiar with these residents and demonstrated genuine warmth and empathy in their interactions with the residents.

There was an open and positive culture in the centre. Residents said that they saw the providers and the person in charge most days. Staff were well trained and demonstrated responsibility and accountability for their work. Staff were clear about their responsibility to keep the residents safe and to report any concerns they might have. Residents said that they trusted the staff who they found to be kind and patient and that they felt safe and secure in their home. Residents who spoke with the inspectors said they would be able to report or concerns that they might have to a member of staff or to one of the management team.

The next two sections of the report discuss the capacity and capability of the provider to provide a safe service for the residents. The compliance with the care and welfare regulations is discussed under the relevant regulation in each section.

Capacity and capability

This was a well managed service with established management and staff teams who worked hard together to ensure that the care and services were safe and appropriate for the residents who lived in the designated centre. These findings are

mirrored in the high levels of satisfaction expressed by residents and visitors who spoke with the inspectors on the day of the inspection.

The provider is Cummer Care Ltd. which has two directors who both work in the designated centre. The provider has appointed a person in charge who commenced in their role in July 2020. The person in charge was found to have responsibility for the day to day service and was well supported by the provider. Records showed that the provider met with the person in charge regularly and that any day to day issues, incidents and complaints were managed through these meetings.

The provider had also appointed a clinical nurse manager to support the person in charge and to provide day to day supervision of nursing and care staff as well as carrying out training and clinical audits. However the inspectors found that the clinical nurse manager did not have supernumerary hours to carry out these duties as when they were rostered to work they were the nurse on duty for the whole centre.

There was a well established staff team working in the designated centre. Staff who spoke with the inspectors were clear about their role and the standards that were expected of them in their day to day work. Staff received an induction training when they commenced their role and this was followed up with mandatory updates for key areas such as safeguarding, moving and handling and fire safety. During the COVID-19 pandemic all staff had received external and internal training on infection prevention and control processes. Staff who spoke with the inspectors were knowledgeable about these areas and were clear about what they needed to do to keep the residents safe. However some improvements were required in relation to infection control practices and in relation to the times taken for fire safety evacuation practices especially the night time scenario when there are two staff on duty.

The number and skill mix of the staff was appropriate for the 36 residents accommodated in the designated centre on the day of the inspection. However at busy times and break times some call bells were not always answered promptly. There were five empty rooms at the time of the inspection and inspectors were not assured that the current staffing levels especially nursing staff would be sufficient if the centre was fully occupied. The provider had a staffing plan in place and was working to recruit additional nursing and care staff as they worked towards full occupation.

There was a comprehensive quality assurance programme in place which included audits, daily walkabouts, staff supervision, resident meetings and staff and management meetings. The provider had engaged with an external company to develop the audit programme and managers and staff were participating in training in order to implement the new programme. A number of audits had been completed in 2020 and 2021 however it was not clear how the audit findings had been communicated to the relevant staff and as a result a number of the improvement actions were still open.

Residents said that they saw the directors and the person in charge every day and that they could talk with any of them if they had any concerns. Residents said that they were listened to and felt that they could influence the service. However some residents said that they would like more opportunities to discuss and plan the menus. In addition the inspectors found that feedback form resident surveys and resident meetings had not been utilised to develop a quality improvement plan to inform how the service might be improved going forward.

Regulation 14: Persons in charge

The person in charge was a registered nurse with more than ten years experience in working with older persons in a residential setting. The person in charge held a management qualification as required by the regulations.

They were responsible for the day to day running of the service and were well known to residents and to staff and visitors.

Judgment: Compliant

Regulation 15: Staffing

The current numbers of nursing staff did not ensure that the provider would be able to cohort residents and ensure there were two nurses on duty at all times in the event of a COVID-19 outbreak.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The clinical nurse manager did not have supernumerary hours to carry out her supervision and clinical teaching role in the centre.

Judgment: Substantially compliant

Regulation 21: Records

The records of fire safety equipment checks was not complete and available on the day of the inspection.

Judgment: Substantially compliant

Regulation 22: Insurance

The provider had appropriate insurance in place which insured against injury to residents and other risks including loss or damage to a resident's property.

Judgment: Compliant

Regulation 23: Governance and management

There was a clearly defined management structure in place that identified the lines of authority and areas of responsibility. Mangers and staff were clear about the roles and the reporting structures in place. There was clear evidence that staff and managers worked well as a team to ensure that safe and appropriate care and services were provided for the residents in their care.

There was a quality assurance system in place that ensured care and services were monitored. However inspectors found that where audits had identified improvements were required these were not always acted on promptly. For example ;

1. A call bell audit carried out in October 2020 achieved 66.7% compliance and still had open take actions.

2. A housekeeping audit which had no date had achieved 56% compliance and still had open take actions.

In addition there was no clear evidence that the provider had acted on feedback received from resident surveys and resident meetings. This is discussed further under Regulation 9.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The provider had prepared a Statement of Purpose relating to the designated centre which contained the information set out in Schedule 1.

Judgment: Compliant

Regulation 31: Notification of incidents

The centre had a low incidence of incidents that required notification under Schedule 4. Those notifiable incidents that did occur were notified to the Office of the Chief Inspector within the required time frames.

Judgment: Compliant

Regulation 34: Complaints procedure

There was a clear and accessible complaints procedure which was made available to residents and their families. Residents and families knew how to make a complaint and told the inspectors that they felt able to raise any concerns they might have with the staff or the management team.

There was a low level of complaints in the centre. The inspectors reviewed the complaints records and found that complaints were managed in line with the policy and that complaints were investigated promptly. There was a record of communications between the complainant and the management team and the complainant's satisfaction with how the complaint was managed was recorded.

Judgment: Compliant

Quality and safety

The inspectors found the care and support provided to the residents of this centre to be of a good standard. As a result, residents enjoyed a good quality of life in which their rights were upheld and their independence promoted. A number of residents told inspectors that they felt safe living in the centre.

Inspectors observed that residents received a comprehensive assessment of their health, personal and social care needs on admission to the centre. However, some care plans were not updated as required and did not provide clear guidance for staff

to effectively care for all aspects of the resident's care needs, including the use of restrictive practices. In addition care plans were not person centred and did not reflect the resident's preferences for care and support.This is discussed further under Regulation 5.

Inspectors were assured that resident's medical and health care needs were being met. Residents were provided with access to health care professionals in line with their needs. Residents had good access to health care services including occupational therapy, dietetics, speech and language therapy and dental services.

Staff were respectful and courteous with the residents. Staff who spoke with the inspector showed they had the necessary knowledge and competencies required to care for residents with a variety of needs and abilities. Residents were observed to be happy and content on the day of the inspection. The inspectors reviewed a number of thank you letters and cards from residents and their families thanking staff for the care received. Staff knew the residents well and this was evident in their communication.

Residents had the opportunity to meet at regular resident's meetings and discuss their concerns. However, the inspectors found that some of the resident feedback had not been followed up.

The inspectors found that there were opportunities for residents to participate in activities, on the day of inspection. While the centre did not employ a dedicated activities coordinator, staff were proactive in ensuring that there were activities offered throughout the day. However the inspectors observed that those residents with higher levels of cognitive and physical needs spent a lot of time in their bedroom with limited social interactions and access to meaningful activities.

Residents had access to tv, radio and newspapers and were seen chatting to staff about world events.

Residents were receiving visitors inside and outside of the centre and the visiting arrangements in place were safe. Residents were very happy to have their families and friends visiting them once again.

Overall, the provider had appropriate measures in place to ensure that the residents were protected from abuse, however the inspectors found that one staff did not have the required Garda vetting in place when they started in their role. However, the provider carried out an immediate review of all staff files and provided assurances that all staff currently working in the designated centre had Garda vetting in place.

Residents reported that they felt safe within the centre. The inspector reviewed safeguarding incidents and investigations and was assured that the centre has robust processes in place and has responded appropriately to all concerns. Staff had completed training in the safeguarding of vulnerable adults and demonstrated an awareness of their role in reporting suspected abuse.

Infection Prevention and Control measures were in place. The centre had a comprehensive COVID-19 emergency preparedness plan in place. To date the centre has not experienced an outbreak of COVID-19. COVID-19 and infection prevention and control were discussed at staff and resident meetings. As a result, staff were aware of their responsibility to keep residents safe through good infection prevention and control procedures. However, some improvements were required in relation to cleaning of equipment and infection control processes which is discussed under Regulation 27.

Overall the general environment was clean and comfortable. The premises was well maintained and the layout was suitable for the residents. There were with adequate communal and dining areas and a pleasant outside seating area to the front of the building. However, there was a lack of storage space, particularly in en-suite bathrooms and in the linen storage room.

The centre had adequate means of escape along with adequate fire fighting equipment. Managers and staff were up to date with their mandatory fire safety training, however further assurances were required in relation to fire drills to ensure that residents could be adequately evacuated in the event of a fire. In addition improvements were required to ensure that all checks of fire safety equipment were maintained and made available for inspection. This is further discussed under Regulation 28.

Regulation 11: Visits

Visits were facilitated in line with the current guidance. The inspectors observed visitors in the centre on the day of the inspection.

The inspectors observed visiting areas used while restrictions were in place. These were clean with adequate hand hygiene facilities. These areas were also still available for use by those who preferred this method of visitation.

Judgment: Compliant

Regulation 17: Premises

The design and layout of the centre was suitable for the number and needs of the residents accommodated there. However, there was a lack of suitable storage in the centre.

For example:

- There was insufficient storage available in resident's en-suite bathrooms for the resident's personal hygiene products.
- Storage in the linen room required review as a number of boxes were stored on the floor.
- A bathroom in the new part of the centre was being used as a storage area.

Judgment: Substantially compliant

Regulation 26: Risk management

There was an up to date risk management policy which met the requirements of Regulation 26. There was also a comprehensive COVID-19 contingency plan in place which set out how the centre was managing those risks associated with the virus.

There was a clear process in place for reporting adverse incidents that occurred in the centre. Records showed that all incidents were followed up and any learning was communicated to the relevant staff.

There was a major incident plan in place which contained the information about procedures and contact numbers required in the event of a major incident.

Judgment: Compliant

Regulation 27: Infection control

- In some of the resident's en-suites the inspectors observed bed pans, commode trays and a used catheter bag which had not been cleaned and stored appropriately.
- Hoists and hoist slings were not on the daily cleaning schedule and there was no identification system in place to identify when a sling had been cleaned, sanitised and was ready for use or whether they were being cleaned between residents, as per infection prevention and control guidance. In addition, slings were not kept in the resident's own room and inspectors observed slings left on top of hoists after use.
- Cleaning schedules included the sanitising of frequent touch surfaces on morning and afternoon shifts. However, there was no evidence that these surfaces were cleaned on the evening or night shifts. In addition the cleaning schedules at weekend were not always completed.

- Audits of cleaning and infection prevention and control schedules had been completed, however, the inspectors found that these were not comprehensive and lacked an action plan to address issues identified.
- The inspectors found that staff clothes were hanging alongside one another in the staff changing area which created a risk of cross contamination.
- The centre used a colour coded system for mops and cloths. However, as per infection prevention and control guidance, the water was not being changed between rooms.
- Resident's bedrooms did not have foot operated bins.
- The centre only has one sluice room, requiring staff to walk some distance through the centre with used bed pans and commode trays.
- The inspectors observed that some items in the hairdressing room such as hair rollers were used as communal products. These items were removed from use on the day of the inspection because of the risk of cross contamination.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Regular fire evacuation drills were undertaken, including night time scenario drills. However, the inspectors noted that a full compartment evacuation had not been completed. The provider was asked to complete a full compartment evacuation with night time staffing levels, which they completed, however the time taken to complete the evacuation did not provide necessary assurances that all residents could be evacuated in a timely manner in the event of a fire.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

Some improvements were required in relation to the administration and storage of medicines;

- some medications were signed as given before the resident had taken the medication.
- some opened medications were not labelled with a date of opening and might have been open and in use for longer than the recommended period of time.

- lunch time medications were administered in full view of staff and other residents. Residents were not consulted as to whether they would prefer to take their medications in the privacy of their rooms.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Assessment and care plan reviews took place within a four month period for the most part, however there were not completed within the four monthly time frame outlined in Regulation 5(4). The person in charge explained that the centre was in the process of transferring all care plans into electronic format and this may have caused the delay.

The inspectors reviewed a number of resident's care plans and found that they were not person centred and did not contain the necessary information to guide care delivery.

An individual assessment or care plan was not in place for every identified need. Examples included repositioning of residents at risk of developing pressure ulcers and care interventions for personal hygiene. While the residents had repositioning charts in place, this need was not documented in the care plans reviewed by the inspectors.

A number of residents have restrictive practices in place. However, the reasons for the restrictive practice was not documented in their care plans and the inspectors found that some resident's care plans did not reference the need for the restrictive practice or indicate what interventions had been trialled previously to ensure that this was the least restrictive option.

Judgment: Substantially compliant

Regulation 6: Health care

Residents were observed to have good access to medical and healthcare professionals and were facilitated to continue under the care of their own general practitioner (GP) where possible. The person in charge confirmed that GPs were visiting the centre as required.

Judgment: Compliant

Regulation 8: Protection

The provider had taken all reasonable measures to ensure that the residents were protected from abuse. Residents reported that they felt safe within the centre. Appropriate Garda vetting was in place for all staff working in the designated centre.

The inspector reviewed safeguarding incidents and investigations and was assured that the centre has robust processes in place and has responded appropriately to all concerns.

All staff had completed training in the safeguarding of vulnerable adults and demonstrated an awareness of how to report suspected abuse when speaking with the inspectors.

Judgment: Compliant

Regulation 9: Residents' rights

Resident's meeting were held in a timely manner with a range of topics discussed. There was evidence of consultation with residents, however feedback from residents' meetings and surveys was not being used to develop and improve the service.

The inspectors found that some residents spent a lot of time in their room either due to their level of dependency or through their own choice. Staff were observed interacting with these residents in the form of task oriented care and there was little in the way of meaningful social interaction or occupation for these residents.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Ave Maria OSV-0000315

Inspection ID: MON-0033932

Date of inspection: 11/08/2021

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	Substantially Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
One Nurse has returned from Maternity leave. Ongoing job advertisements with several agencies : Unisync Healthcare provided 9 HCAs and one cleaner during the recent outbreak. We have also advertised in the local papers for staff and vacancies have also gone to various jobsites. Links made with nurses who work for different agencies during our recent outbreak and these nurses are now familiar with Nursing Home and Residents. They are available to cover shifts as necessary.

There is provision for this in the Contingency plans which are being continually reviewed and updated as plans change. We will add to our Contingency plan a further list of former staff who have volunteered to work in Ave Maria again if necessary. We will also add the links with the local Hurling Club who have volunteered to act as runners if need be and family members of various Residents (assuming they have the appropriate experience qualifications and appropriate vetting for working in Nursing Homes) who have also volunteered to help out as necessary. We plan to have the contingency plan up to date by the end of October and update it monthly thereafter.

We have employed three new Care Assistants, one of whom has completed her training awaiting her NMBI PIN.

Ave Maria Nursing Home will limit their total number of Residents to 31-33 (taking regard of dependency levels) until another nurse is sourced.

The admission process of Residents to the Ave Maria Nursing Home plays a major role in Residents future care. This takes time and care with each Resident and their NOK to ensure all aspects are covered so that we provide the best care possible. To ensure we provide the right admission culture we have created a tiered admission strategy for the centre. This strategy consists of three tiers:

Tier 1- Nursing staffing levels at 5 rostered staff nurses- admissions capped at two Residents per week and occupancy levels at 33 Residents.
Tier 2- Nursing staffing levels at six rostered staff nurses. Admissions will be increased to

3 per week and occupancy will be capped at 38.
Tier 3- Full complement of nursing staff Required, seven staff nurses-admissions will be as required and Nursing Home will run at full capacity 41 Residents.

The inspector has reviewed the provider compliance plan. This action proposed to address the regulatory non-compliance does not adequately assure the chief inspector that the action will result in compliance with the regulations.

Regulation 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
Director of Nursing has completed 3 separate sessions of Covid 19- Infection Control training (including Hand Hygiene, breaking the chain of infection and donning and doffing of PPE) with staff over the past year and has scheduled further training. DON and CNM have both completed "Train the Trainer" Course. DON has completed Infection Control link practitioner's course. Director of Nursing and Clinical Nurse Manager involved in Induction training. Schedule of Appraisals in place where staff can identify course they wish to attend and particular interests. Staff are supported to attend training with Course cost and time off work. Schedule of education and training available to all staff through Abbott nutrition. Many staff have completed courses. FEDS (feeding eating drinking and swallowing) training completed by all Nursing and care staff as well as all other mandatory training. All staff have completed additional HAS training. Policy on Responsive behaviors reviewed updated and discussed at staff meeting and daily huddles.
Following Review of processes in place to ensure Resident Autonomy, Safety and Rights in instances of Responsive behaviors' a more robust process is in place including referral to Sage advocacy, safeguarding officer, GP and any other relevant members of the MDT. The new FREDA framework to promote Fairness Respect Equality Dignity and Autonomy was discussed daily in our Huddles over a period of one month, posters were displayed and all staff completed training on HSEland.

To ensure there would be continuity of quality care for all Residents, all Residents have "Care at a glance" Care plans completed and also a short profile describing the individual Residents likes and dislikes and a brief life history of the Resident. These were drawn up by the Resident themselves with support from the named and linked staff. This ensures that in the event of a shortfall in staffing an Agency staff would be able to read the profile and "Care at a glance sheet" and would be able to deliver a Person Centred service accordingly.

Regarding CNM not having supernumerary hours, Roster has been reviewed and

supernumerary hours have been identified to carry out her role in teaching and supervision of staff. All Rosters will be produced in this way going forward. Until another nurse is employed the CNMs supernumerary hours are limited to10-12 hrs per week.

The inspector has reviewed the provider compliance plan. This action proposed to address the regulatory non-compliance does not adequately assure the chief inspector that the action will result in compliance with the regulations.

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
From the beginning of 2021, Staff nurse on duty completes daily Fire Safety and Emergency Evacuation Checks. This is also duplicated at the bottom of the daily occupancy and Roll call checklist where Fire Safety and Evacuation Checks are completed again. As our residents needs and dependencies change the personal emergency evacuation plans are updated, this is stored with all the fire documentation in the fire cupboard and is easily accessible for anyone completing an evacuation in the event of a fire, in addition we also have these printed and on the back of each of our residents individual bedroom door. In each residents individual folder there is also a completed personal emergency evacuation plan, which is reviewed monthly (or more frequently as the Residents condition dictates). All these records were completed and available on the day of inspection.
Daily fire equipment checks have been reviewed, consolidated into one document and communicated to staff and daily monitoring will continue. Monthly Audit to be completed until 2022 with follow up actions.

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Staff are continuing to familiarize themselves with our new quality assurance system, the call bell audit carried out in October 2020 still had open take actions however these actions were completed and a repeat call bell audit carried out in April 2021 received 100%, these results were available in paper form the day of inspection. The PIC has been liaising with our representative from the quality assurance system and in regards to our housekeeping audit this was a system error; a later Audit scored 80.6% but the error is now corrected and a more recent housekeeping audit had 100% compliance.

Both Audits will be completed again at the end of the month.

There is no clear evidence that feedback from Residents Surveys and Residents meetings have been acted upon.
The format of Residents meetings has been reviewed and an action focused approach is being minuted (what, by whom and when).
A full Residents survey with Actions recorded will be completed by end of October. A Relatives Survey will be completed in November 2021 with actions recorded.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Action Plan on: Insufficient storage available in Residents en-suite bathrooms for Residents Personal hygiene products. Lockers being provided for storage of Personal hygiene products by the end of October.

Action Plan on: Storage in linen room required review as a number of boxes were stored on the floor. This action has been completed and a de-clutter has happened in the linen room. There are no longer boxes on the floor and appropriate storage has been found. This action was completed on 1st October 2021.

Action Plan on: A bathroom in the new part of the centre was being used as a storage area. This room is a designated storage area. Part of our contingency planning included having a toilet and wash hand basin installed here so that this room could double as a staff toilet for our Cohort area in the event of an outbreak. We have reviewed this andwill remove the items stored here. By October 20th this room will be cleared and will be used as a Residents bathroom.

The inspector has reviewed the provider compliance plan. This action proposed to address the regulatory non-compliance does not adequately assure the chief inspector that the action will result in compliance with the regulations.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
Action plan on: In some of the Residents en-suites the inspector observed bed pans, commode trays and a used catheter bag which had not been cleaned and stored

appropriately.
It is the practice in the Nursing Home that one care assistant is allocated to collect and clean all urinals and commode bowls once all the Residents are up and organized for the day. This practice will now change so that each care assistant is responsible for removing urinals and commode trays from the rooms of the residents they get up. This was discussed at staff meeting on 5th October and information on change of practice will be reinforced at induction. This can be Audited daily by NIC and monthly on the Quality Assurance system to ensure practice is consistent.

Action plan on: Hoists and Hoist slings are not on the daily cleaning schedule and there was no identification system in place to identify when a sling had been cleaned, sanitized and was ready for use or whether they were being cleaned between Residents, as per IPC guidance. In addition, slings were not kept in the Residents own room and inspectors observed slings left on top of hoists after use.
Each Resident requiring a hoist for transfer is now being assessed for their own individual sling. The Provider has made contact with a competent person who will assess each Resident and determine if their sling is suitable. New slings will be sourced on the Occupational Therapists recommendation. We will ensure each Resident has their own individual sling which we will label with their identified room. These slings can then be stored in Residents bedrooms. While these slings were always washed and dried at night time this will now been added to cleaning schedule and signed off when the task is completed.
Regarding Hoists the Nursing Home has sourced Clinell Indicator tape and we are awaiting its arrival. This will be in place to indicate when a hoist has been sanitized.

Action Plan on: Cleaning Schedules include the sanitizing of frequent touch surfaces on morning and afternoon shifts. However, there was no evidence that these surfaces were cleaned on the evening or night shifts. In addition, the cleaning schedules at weekends were not completed.
A full review of the Infection Control Policy and cleaning schedules will be completed by mid-November and the cleaning of frequently touched surfaces will be scheduled for evening time and night time and signed when completed. The cleaning schedule at weekends will be completed and signed. This will be Audited monthly.

Action Plan on: Audits of cleaning and Infection Prevention and control schedules had been completed, however, the inspectors found that these were not comprehensive and lacked an action plan to address issues identified.
On 12th May 2021 a Cleaning and maintenance Audit was completed on the new Audit system and this scored 97.6% The only take action on this Audit was to ensure that chairs and stools were in a good state of repair. In the month of September all ripped upholstery has been identified and re-upholstered. All fabric chair coverings have been steam cleaned by an external company. The Audit will be reviewed and updated and completing the Action plan will be highlighted to staff again.

Action plan on: The Inspector found that staff clothes were hanging alongside one another in the staff changing area which created a risk of cross contamination.
At the staff meeting on 5th October this was discussed and staff agreed to either leave their jackets in their car or to place jackets inside their lockers.

Action plan on: The centre used a colour coded system for mops and cloths. However, as per infection prevention and control guidance, the water was not being changed between rooms.
Flat mop system now in place and fresh mop head and water with Acticlor plus used for each room.

Action plan on: Residents bedrooms do not have foot operated bins.
All Residents bedrooms now have foot operated bins.

Action plan on: The centre only has one sluice room, requiring staff to walk some distance through the centre with used bedpans and commode trays.
Options are being explored to determine the best solution to ensure safe and appropriate transport and disposal of waste. In the interim bedpans and urinals are emptied in the Residents ensuites, covered with a paper sleeve and transported to the sluice room for sanitizing. In the event of an outbreak all staff are aware of protocol i.e. one staff goes ahead and opens door and ensures corridor is clear. PPE is removed in the sluice room when urinal/bedpan is in the washer, and hand hygiene is performed.

Action plan on: The Inspector observed that some items in the hairdressing room such as hair rollers were used as communal products. These items were removed on the day of inspection because of the risk of cross contamination.
Residents who use hair rollers all have individual hair rollers.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
A full compartment evacuation has been completed with night duty levels of staffing on two occasions and forwarded to HIQA.
Ave Marias competent person carried out a further fire drill and forwarded same.
Review of fire drill Record sheet completed. All future fire drills and compartment evacuations to have Action section in SMART format
Monthly compartment evacuations of each compartment in rotation to be completed with night duty levels of staffing to be reviewed at the end of 2021.
The largest compartment has six bedrooms. Currently only one is occupied and this Resident is maximum dependency. This Resident does not wish to move to another room. The Nursing Home plans to review each fire compartment in regard of Residents PEEPs. The largest compartment, which has six rooms, should not have more than five Residents (whilst one remains ski sheet dependent for evacuation) unless they are mobile.
If two are ski sheet dependent there can be no more than four Residents in that compartment.
MCK fire services (Our competent person) are booked to complete a full fire safety risk Assessment and report on 18th October. His report along with a clear tested plan will be ready to submit on 25th October, one week after site visit. The report will outline actions

to be completed by the Provider to ensure safety of Residents and staff. These actions will also have a time frame for completion. MCK will carry out training for staff and complete a refresher for our Fire Marshalls. Additional staff will be added to roster during periods of absence of Providers.

All three Fire Marshalls live within 10 minutes of the Nursing Home. We also have five staff who live within ten minutes of the Nursing Home. All are willing to be available for any emergency. We have created an Emergency WhatsApp group with these eight people and in the event of a fire a group call can be made to this group and alert all that they need to attend. Members of this group are clear on their roles as fire marshalls and to supervise and maintain safety of our Residents.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
Action Plan on: Some medications are signed as given before the Resident had taken the Medication. Medication Audits have improved from the initial Audit in September 2020 to 92.2% on March 2021 with a score of 100% for the Controlled drug Audit on 26th March 2021
Observational Audits are also carried out- these show continual improvement. Medication management Policy was reviewed by Director of Nursing in November 2020 and all shortcomings were addressed. All Nursing staff have reviewed and signed off on medication management Policy. All accidents/Incidents and near misses involving Medication Management are recorded on Inselcare and reviewed and Actioned upon by DON. These accidents/incidents and near misses also feed into Medication management Policy eg. At the beginning of July of 2021 a near miss occurred with a Residents Insulin, the near miss was recorded on Insel care and reviewed by DON. Amongst the steps taken to reduce the risk of this near miss recurring was an amendment to the Medication Management Policy. This was completed on 7th July and all staff were made aware of this via verbal report and communication books. A repeat Medication Management Audit and Observational Audit is planned for October 2021 and monthly thereafter until 2022.

Action Plan on: Some opened medications were not labeled with a date of opening and might have been open and in use for longer than the recommended period of time.

Meeting on 5th October discussed this issue. All Nursing staff reminded that it is a requirement to date a medication on opening. Continued Audits and observational Audits should reflect improved practice in this area.

Action Plan on: Lunch time Medications were administered in full view of staff and other Residents. Residents were not consulted as to whether they would prefer to take their medications in the privacy of their rooms.

Each member of Nursing staff is aware of each Residents preference and have asked for their verbal consent when administering medications at meal times. In the event that the Resident is uncomfortable with this an alternative is arraigned. Many medications need to be taken with or just after food so meal times facilitates this best. Insulin is always administered in the Nurses Clinical room or the Residents bedroom to ensure privacy. By November we will have reviewed our admission paperwork and we plan to add the question regarding preference on Medication administration along with some other amendments. By November we will have amended our pre-admission Assessment and will include this question. The Pre admission Assessment informs care plans so care plans will reflect Residents preference.

The inspector has reviewed the provider compliance plan. This action proposed to address the regulatory non-compliance does not adequately assure the chief inspector that the action will result in compliance with the regulations.

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:
Action Plan: Each individual staff nurse is named staff to a number of residents, these nurses are responsible for their residents care plans, each nurse has reviewed their own residents care plans and ensured they are now person centered with all relevant information to ensure person centered quality care is delivered. A review has taken place of every residents individual needs and a care plan has been put in place to reflect each residents individual needs, for example if a resident requires repositioning regularly in bed to avoid a pressure sore, this is documented on a repositioning chart and this is now identified on the residents care plans. Care plans have also been reviewed and updated in line with restrictive practices, if a resident has a restrictive practice in situ this is reflected in the care plan and it is clearly documented why there is a need for the restrictive practice. All Residents who spend a significant amount of time in their bedrooms have participated in the development of a schedule of Activities and interactions which is tailored to their preferences. This is copied in the Residents care plans and a copy available to HCA staff. One HCA is allocated to each corridor to carry out these activities daily for any Resident in their bedroom in that particular corridor. All care plans are electronic and PIC encourages care plans to be reviewed three monthly and these will now be re audited using the new quality assurance tool.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: Action Plan: Within the Centre we have a number of residents who don't come out of their rooms daily this is depending on their health, dependency or personal preference, if a resident states that he or she doesn't want to leave their room to engage in an activity we respect their choice. It is the routine of the Centre to attend to personal hygiene needs in the morning therefore staff will only be attending these residents in the form of task orientated care first thing in the morning. In the afternoon there is a staff member allocated to activities for each corridor and this member of staff will visit the residents in their bedrooms and carry out hand massages, nail care and polish, aromatherapy or simply just interact and reminisce with them. The staff within the Centre have a good relationship with our residents and if any of the staff have any free time throughout the course of the day they will take time to interact with our residents ensuring they all individually experience meaningful interaction. For each of these residents there is now a completed care plan detailing their preferences and the activities that they like. This was completed on 10th October and was discussed at staff meeting on 5th October. This will be added to our care plan Audit.

The inspector has reviewed the provider compliance plan. This action proposed to address the regulatory non-compliance does not adequately assure the chief inspector that the action will result in compliance with the regulations.

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	31/12/2021
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	10/11/2021
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	31/10/2021
Regulation 21(1)	The registered provider shall	Substantially Compliant	Yellow	15/10/2021

	ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.			
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.	Substantially Compliant	Yellow	10/11/2021
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Substantially Compliant	Yellow	15/11/2021
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.	Substantially Compliant	Yellow	25/10/2021

Regulation 29(5)	The person in charge shall ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.	Substantially Compliant	Yellow	31/10/2021
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
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Substantially Compliant	Yellow	15/10/2021
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably	Substantially Compliant	Yellow	31/10/2021

	practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned.			