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:	Ballymote Community Nursing Unit
Name of provider:	Nazareth House Management
Address of centre:	Carrownanty, Ballymote, Sligo
Type of inspection:	Unannounced
Date of inspection:	17 November 2023
Centre ID:	OSV-0000330
Fieldwork ID:	MON-0041907

About the designated centre

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

Ballymote Community Nursing Unit is registered to accommodate 32 residents who require long-term residential care or who require short term respite, convalescence, dementia or palliative care. The centre is located in a residential area a short walk from the town of Ballymote. The building is single storey and is decorated in a homely way. A large extension was added in 2019 and a refurbishment programme of the original building was completed in 2020. Accommodation is made up of 14 single and five twin rooms and two three bedded rooms which are used for short stay residents.Residents' bedroom areas are personalised and there is appropriate screening in shared bedrooms. Signage and points of interest are located throughout the building to guide residents around the centre. The centre has safe garden areas that are centrally located and cultivated with raised beds and shrubs to make them interesting for residents.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	31

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
Friday 17 November 2023	09:00hrs to 17:00hrs	Ann Wallace	Lead

What residents told us and what inspectors observed

This inspection found that recent changes in the management team and a significant turnover in staff working in the centre had impacted negatively on the continuity and the quality of care provided for residents living in the centre, however residents and their families who spoke with the inspector were largely positive about the care and services provided by the staff team in Ballymote Community Nursing Unit.

There was a calm relaxed atmosphere in the centre when the inspector arrived. The inspector was greeted by a member of the nursing team who went through appropriate security and infection prevention and control checks before the inspector was admitted to the resident areas. Following the completion of appropriate checks the inspector chatted with residents and staff whilst they waited for the person in charge to arrive in the centre.

Residents were seen starting their day and having breakfast in their bedrooms. A few residents were already up and about and one resident was waiting to be collected to go into nearby Ballymote where they attended a day care facility. Residents said that they enjoyed living in the centre and that it was a "home from home". All residents who chatted with the inspector said that they felt safe living in the centre and there was always someone to talk to if they were worried about anything.

There were 31 residents accommodated in the designated centre on the day of the inspection. Most of the residents were from the local community or nearby communities. There was a mixture of dependencies with a number of residents with maximum dependency, some of whom were non-verbal. A high number of residents needed two staff to provide their personal care and to carry out moving and handling transfers safely. There was a range of specialist equipment to support these residents including profiling beds, specialist wheelchairs and electric hoists.

The designated centre was laid out over a ground floor footprint and was divided into two units, Millbrook and Castle units. On the morning of the inspection there were three care staff and one nurse working on one unit and two care staff and a nurse working on the second unit. Care staff were still serving breakfasts along one corridor at 10.20 hours. Staff confirmed that breakfasts were served on one corridor at a time and not in line with the preferred breakfast times of residents. The trolley contained a limited menu choice of a flask of porridge, cereals with cold milk, scones and tea or coffee to drink. There was a printed menu with allergies listed on the bottom shelf of the trolley but the menu was not shared with residents on the breakfast round. Care staff told the inspector that if a resident wanted hot toast they would make it for the resident in the unit's kitchenette. The inspector discussed the limited breakfast menu choice with the chef on the day and was assured that the breakfast menu included yoghurt and fruit/juices as well as a choice of eggs/hot breakfast. However these options were not included on the menu on the breakfast

trolley and were not made available to residents on the morning of the inspection. This was a repeat finding from the previous inspection.

The inspector also observed that one nurse was still doing the morning medication round at 10.30 hours when these medications were prescribed for 08.00hours. Residents told the inspector that their daily routines were flexible depending on the day and how they were feeling. However a number of residents reported that they sometimes had to wait for staff to be available to be available in the mornings to help them get up because staff were busy with other residents. This was a repeat finding from the previous inspection.

Overall the designated centre was clean and tidy on the day of the inspection. There was only one housekeeper on duty on the day and they were working additional hours because they were also responsible for the laundry service. The rosters showed that there was only one housekeeper on duty on a number of days in November and December.

There was an activities coordinator on duty on the day. This member of staff had been recruited since the last inspection and was new to their post. Residents were seen enjoying a range of activities including music, craft work and games on the day of the inspection. A number of residents told the inspector how much they had enjoyed a traditional music session held on the previous evening. They said they had retired to bed later than usual but tired and happy. Residents said that the new activities schedule was very enjoyable and was making a difference to their quality of life in the centre. This was validated by a family member who spoke with the inspector. The activities staff was also seen visiting residents in their rooms to encourage them to join in with the afternoon sessions. One resident who had previously not left their bedroom during the day was now seen attending the afternoon session.

The next two sections present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted the quality and safety of the service being delivered.

Capacity and capability

This inspection found that management and oversight of this service was not effective, as evidenced by the findings of this report. Fundamental improvement was required in a number of areas including the assessment and care planning processes and in the day to day recording systems to achieve safe care delivery and to protect the well being of residents in this centre. As a result of the level of non compliant findings for Regulations 5 Assessment and Care Planning and Regulation 6 Health care and the impact this was having on the quality and safety of care and services provided for the residents, the provider was issued with an urgent action plan to

bring the designated centre into compliance within a time frame specified by the chief inspector.

This was an unannounced inspection carried out by an inspector of social services to review compliance with the Health Act 2007 (Care and Welfare of residents in Designated Centres for Older People) Regulations 2013, as amended. The inspector also followed up on information of concern that had been received by the Chief Inspector of Social Services and found that the concerns were substantiated.

The provider is Nazareth House Management, a national provider with a number of designated centres in Ireland. During 2023 there had been a number of changes to both the provider's senior management team and to the management team in the designated centre. The inspector acknowledges that managers and staff had been through a difficult period however more focus and effort are now required to bring the centre back into compliance with the regulations in order to ensure safer better care for residents.

The person in charge had recently returned from a period of extended leave and was settling back into the role. They had been made aware of a significant complaint that had been received about the care provided to a resident who had been recently discharged from the centre. There were no records available to show that this complaint had been followed up in line with the provider's own complaints procedure and the time frames set out in that procedure. Although information submitted following the inspection evidenced that the terms of reference for an investigation had been set out by the provider's senior management team there was no evidence, including complaints records, that this investigation had been commenced in the centre at the time of the inspection. Furthermore the issues raised in the complaint constituted a potential allegation of abuse which had not been followed up in line with the centre's own safeguarding policy and procedure. Again further information was provided following the inspection that the provider's senior management team had identified the issue as a potential safeguarding concern and had instructed that a safeguarding investigation be carried out. There was no evidence at the time of the inspection that an investigation had been commenced in line with the procedures in place to protect residents. As a result the inspector was not assured that communications between the provider's senior management team and the managers in the centre were clear and were effective in ensuring that all staff were made accountable for their areas of responsibility.

The person in charge was supported in their role by a clinical nurse manager who had also recently returned from an extended period of absence and was resuming their role in clinical audit and the supervision of the staff team. However a review of the rosters showed that the person in charge regularly worked as the second nurse on duty which left limited time to complete their management responsibilities. This was compounded by the ongoing vacancy for a second clinical nurse manager which remained vacant after six months. As a result the audit schedule had not been brought up to date and a number of the findings from this inspection in relation to assessment and care planning and the delivery of safe care for residents had not been identified and addressed.

The remainder of the staff team included staff nurses, health care assistants, housekeepers and a newly appointed activities coordinator. Catering was outsourced to an external company however all meals were freshly prepared in the centre. Maintenance was largely provided by the Health Service Executive who owned the building. The inspector spoke with staff on duty on the day and reviewed both the planned and worked rosters. Feedback from some staff confirmed that when staffing levels were reduced due to annual leave or sickness reported that some residents had to wait for staff to be available in the mornings to help them to get up. This was verified by the inspectors observations on the day. Furthermore there was only one housekeeper on duty on the day of the inspection to clean all of the centre and do the laundry for 31 residents. The inspector reviewed the staff rosters and found that the planned rosters showed that only one person was allocated to housekeeping and laundry duties on a number of days in November and December.

There were quality assurance systems in place including clear policies and procedures however this inspection found that these processes were not being implemented effectively and as a result they had failed to identify a number of non compliances with the provider's own policies and procedures leading to poor outcomes for some residents.

Furthermore the inspector reviewed minutes of the governance and management meetings and found that the management meetings were held but that there was no clear follow up of the items discussed and the actions agreed in these meetings. A review of nursing staff and health care assistant meetings found that there had only been two staff meetings in 2023. Although staff handovers were used to communicate some items from these management meetings this method of sharing information only ensured those staff attending handover received the information and did not ensure that all staff were kept informed.

Staff did have access to an ongoing training programme, however this inspection found that not all staff were up to date with their mandatory training requirements. In addition a number of staff had not attended responsive behaviours training (How residents who are living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment.) to ensure they had the appropriate knowledge to support residents who might display these behaviours.

The inspector reviewed the complaints log and found that complaints were not recorded and investigated in line with the requirements of Regulation 34; Complaints. The complaints procedure including the name of the complaints manager in the centre was not displayed in an accessible format for the residents. As a result a number of residents told the inspector that they did not know what the procedure for making a complaint was. Furthermore there were only two records of resident meetings in 2023 although the provider's policy was to hold these meetings every two months. It was not clear how the voice of residents was sought and used to inform service delivery.

Regulation 14: Persons in charge

There is a person in charge who works full time in the designated centre. The person in charge is an experienced nurse who has the required experience in older person's care and who holds a post graduate management qualification.

Judgment: Compliant

Regulation 15: Staffing

This inspection found that there was not sufficient staff on duty to meet the needs of the residents taking into account their dependencies and preferences for care and daily routines. This was evidenced by feedback from residents on the day and the inspectors findings;

- Residents were still having breakfast served at 10.30hours.
- Some residents were still waiting to get up at 11.00hrs. This is a repeat finding form the previous inspection.
- Nursing staff had not completed the medication round on one unit at 10.30 hours.
- There was only one member of staff on duty to clean the whole designated centre and do the laundry for 31 residents.

Judgment: Not compliant

Regulation 16: Training and staff development

Nine staff were overdue to attend their mandatory safeguarding training. Furthermore three new staff had not attended any mandatory safeguarding training in the designated centre.

Five Nursing staff had not attended their mandatory medication management training updates.

The rosters showed that the clinical nurse manager worked alternate weekends as the 2nd nurse on duty which took from the management hours available to provide support and supervision for staff. As a result the oversight of key clinical areas such as assessment and care planning and care delivered to residents were not robust, leading to poor outcomes for some residents.

Judgment: Not compliant

Regulation 23: Governance and management

The management and oversight of key clinical areas such as assessment and care planning and the implementation of prescribed care plans for residents were not effective leading to poor outcomes for some residents. These findings are further discussed under Regulations 5 and 6. Due the significant impact of these findings on some residents the provider was issued with an urgent action plan to come into compliance with Regulations 5 and 6 within a time frame specified by the Chief inspector.

The provider had failed to ensure that vacancies were covered in a timely manner so that staffing resources were maintained in line with the centre's statement of purpose. The following positions were vacant on the day of the inspection;

- 26 hours clinical nurse manager and one full time nurse vacancy. The clinical nurse manager post had remained vacant for six months. Although the posts had been advertised and applications received these had not been processed at the time of the inspection.

Furthermore there was no management contingency to cover two care staff long term absences. Agency staff cover was being used when available to cover short notice absences but long term absences remained uncovered until staff returned to work. This use of agency staff meant that short notice requests often went unfilled leaving the staff working in the centre to cover the roster or leave the centre without enough staff to provide safe and appropriate care for the residents.

Recent changes in the provider's senior management team did not ensure that the lines of authority and accountability were clear. As a result a recent complaint including the safeguarding concerns raised within the complaint had not been followed up as directed by the provider to ensure that the issues raised were investigated in a timely manner and any learning improvements were communicated to the relevant staff and were implemented.

The procedures that were in place to ensure residents' voices were heard and used to inform service delivery were not being implemented effectively. For example there were only two records of resident meetings held in 2023 and informal complaints/comments from residents were not being recorded and used to identify where improvements might be required.

Judgment: Not compliant

Regulation 31: Notification of incidents

One allegation of potential abuse of a resident had not been notified to the chief inspector within the required notification period. The notification was submitted following the inspection.

Judgment: Not compliant

Regulation 34: Complaints procedure

The provider had recorded one complaint since the last inspection in October 2023. The complaint had not been followed up in line with the centre's own complaints procedure. Furthermore informal complaints were not being recorded in line with the centre's complaints policy and staff who spoke with the inspector were not clear that feedback relating the tea at breakfast not being hot constituted a complaint and should have been recorded.

Judgment: Not compliant

Quality and safety

This inspection found that significant improvements were required in the current assessment and care planning procedures to ensure that the residents received safe and appropriate care in line with their assessed needs and that any clinical risks were identified and measures put into place to mitigate those risks. Furthermore, residents' care plans were not updated in line with residents' changing needs and did not contain sufficient information to guide staff to provide safe care. The failure to maintain standards in these areas had led to poor outcomes for some residents. In addition the inspection found that staff routines were not flexible and did not support resident's individual preferences for daily care and support.

The provider was in the process of implementing the actions set out in their compliance plan from the September 2023 inspection. This included the appointment of an activities coordinator in October 2023. This had brought about significant improvements in the day to day activities and entertainment available for the residents. There was now a planned schedule of activities which the coordinator regularly reviewed with residents. The schedule was displayed for residents to see. In addition the coordinator went to chat with residents in their bedrooms to let them know what was on the schedule each day and to encourage those residents who were not confident about coming to the communal rooms to join in with the activities. For those residents who spent most of their day in their rooms time was

allocated for the activities coordinator to spend with these residents in social interaction or one to one activity. This was a significant improvement form the previous inspection and residents were overwhelmingly positive about the activities that were on offer.

The inspector reviewed minutes of residents' meetings and found that these were held infrequently and where residents had provided feedback there was no record of how resident's feedback had been acted upon. Furthermore, although staff on duty were knowledgeable about individual residents preferences for daily routines and personal care the inspector found that resident's were not always offered choices in their day to day care such as menus and personal care routines.

There were arrangements in place to ensure residents were facilitated to practice their religious beliefs. There was a small oratory available for residents' use and residents who spent time in their bedrooms could watch the services from the oratory on their television.

Residents were observed meeting with their visitors and there were no restrictions on visiting in the centre. Appropriate security and infection prevention and control measures were in place for any visitors coming in to the centre.

Behavioural support care plans reviewed did not contain sufficient detail to guide staff on the interventions required to minimise responsive behaviours.

Residents had timely access to their general practitioners (GP's) and other allied health professionals such as speech and language therapy and dietetics. However the inspector found that the current lines of communication and care planning processes did not ensure that where a specialist practitioner prescribed a course of treatment that this was implemented by staff and reviewed by the resident's named nurse to ensure it was addressing the resident's needs.

The inspector observed residents being supported at mealtime in a respectful and unhurried manner. The meals were prepared on site and were nicely presented and looked appetising. Residents said that they enjoyed their meals and the snacks that were offered throughout the day. Menus were varied on a seasonal basis and were reviewed by a dietitian. However breakfast menus were not shared with the residents so that they could choose from the full menu on offer. Where residents required specialist diets these were made available. The inspector spoke with members of the catering team who were knowledgeable about individual resident's needs and preferences however, the inspector reviewed the information that was shared with the catering team for one resident and found that it had not been updated following a review by the speech and language therapist. This created a risk that the resident would be provided with the incorrect texture of diet and fluids creating a risk of aspiration or choking.

Overall, the centre was clean and well laid out for the residents. The communal rooms were spacious and corridors were wide and contained rails fixed to the walls to assist residents with their mobility. Residents were mobilising around the centre

throughout the day of the inspection and the communal areas were well used which created a sense of community and positive activity.

The provider had addressed some of the actions in relation to infection prevention and control since the September 2023 inspection and there was a new system of cleaning floors in place. Overall the centre was clean and tidy. Staff demonstrated good hand washing practices and there were were sufficient hand sanitiser dispensers throughout the centre.

Regulation 18: Food and nutrition

Residents were not made aware and offered all of the choices from the breakfast menu that were available to them. As a result residents did not know the range of breakfast items that they could choose from.

Breakfasts were served form a cold trolley. Although the porridge was kept warm in the food flask this was not heated and did not maintain the temperature of the food. Tea and coffee were served from large pots which had been heated some time earlier. Some residents were served bread or scones with their breakfast and were not offered hot toast even though this could be made in the unit's satellite kitchen.

The catering team did not have up to date information about the dietary needs of one resident following their assessment by speech and language therapist.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

The inspector reviewed a number of residents' assessments and care plans and found that staff were overly reliant on information obtained on previous admissions and as a result the standard of assessments and care planning did not ensure that all residents received safe and appropriate care in line with their current needs. This was creating significant risks and leading to poor outcomes especially for those residents who were high dependency. For example;

- Two residents had not received a pre admission assessment prior to their most recent admission to ensure the centre would be able to meet their needs. As a result one of the residents did not have access to an appropriate shower chair to facilitate them to have a shower. The resident had a personal care plan in place for regular showers but had not had a shower since their admission in October.

- A number of residents had not received a comprehensive assessment of their needs on their admission. As a result there were gaps in clinical care plans for key areas of need such as skin integrity, oral hygiene and wound care.
- One resident's assessment on admission had not identified a number of known oral health care needs even stating in one record that no care plan was required when the resident had significant oral health needs.
- Wound assessments and care plans for a number of residents had not been updated to ensure that nursing and care staff had the correct information they needed to provide safe and appropriate care. This is a repeat finding from the previous inspection.
- The nutritional care plans for two residents had not been updated to include the prescribed plan of care following specialist reviews. Furthermore the information in relation to a change of texture diets and fluids for one of the residents was not shared with the catering team which meant that the resident was not provided with the correct diet.

The inspector reviewed a sample of residents' daily care records and found that there was no clear process in place to ensure that daily care was provided in line with each resident's care plan. This had led to one resident not receiving care in line with their needs causing discomfort and distress for the resident. The records of daily care given to individual residents were not being recorded contemporaneously in either paper or electronic format and the records that were available were not well maintained. As a result the inspector was not assured that nursing staff in the centre were effectively monitoring the daily care provided for residents to ensure that this was meeting the resident's current needs. These findings relate to records of daily fluid and dietary intake, oral health care and the repositioning of those residents at risk of developing skin breakdown.

A number of care plans reviewed by the inspector were not up to date and did not reflect the resident's current care needs. There was no evidence that these care plans had been reviewed every four months as required by the regulation. This is a repeat finding from the previous inspection. Furthermore there was no evidence that where reviews were completed that this was done with the resident and/or their representative.

Judgment: Not compliant

Regulation 6: Health care

The current arrangements for the provision of clinical care for residents did not ensure that where a specialist therapist had prescribed a specific care plan that this was implemented in practice. Although the information was available in the resident's electronic care record this did not ensure that all staff were made aware of the prescribed plan of care. Furthermore there was clear evidence that nursing staff were n ot ensuring that the prescribed care was being carried out by care staff.

This had led to poor outcomes for one resident and needed to be addressed promptly by the provider.

The current arrangements for the provision and oversight of nursing care for residents did not ensure that all residents were provided with a high standard of evidence based nursing care.

Judgment: Not compliant

Regulation 7: Managing behaviour that is challenging

A number of staff had not attended training in the management of responsive behaviours (How residents who are living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment.)

Judgment: Substantially compliant

Regulation 8: Protection

The provider had failed to ensure that a potential safeguarding incident had been recorded and followed up in line with the centre's own Protection of Vulnerable Adults form Abuse policy. This allegation was investigated following the inspection.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 18: Food and nutrition	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Ballymote Community Nursing Unit OSV-0000330

Inspection ID: MON-0041907

Date of inspection: 17/11/2023

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
1. The staffing levels and skill mix were reviewed by the provider/HR/DON.
2. A successful recruitment drive is in place.
3. CNM post filled – (awaiting return of requested checks)
4. Currently 1 maintenance support staff has been employed.
5. Currently 2 nurses have been offered full time posts (awaiting return of requested checks)
6. Currently 1 nurse has commenced in post.
7. Currently 1 nurse has been offered part-time role (awaiting return of requested checks)
8. Currently 3 HCA's have been offered and accepted full time posts, to support with providing extra HCA shift in the morning. (awaiting return of requested checks)
9. Housekeeping interviews are currently on-going and we hope to offer the post to a successful applicant in January.
10. A block on respite beds is now in place which has decreased dependency levels on Millbrook unit
11. Agency staff are supporting with maintaining staffing level until the above posts are filled. The familiar agency staff member is block booked.
12. This is reflected on the off duty and allocations are completed daily by staff nurse ensuring adequate support to meet the needs of each resident in a timely manner.
13. DON/CNM provide supervision ensuring adequate support is available.
14. Laundry is supported by local launderette when needed who collect and deliver laundered items.
15. No new admissions will be accepted until staffing levels reach required levels to meet the needs of 32 residents.

This inspection found that there was not sufficient staff on duty to meet the needs of the residents taking into account their dependencies and preferences for care and daily routines. This was evidenced by feedback from residents on the day and the inspectors

findings;
16. Residents were still having breakfast served at 10.30hours:

The staffing levels were reviewed by the Registered Provider/HR/DON and a recruitment Drive was instigated with successful acceptance of the position of CNM and a Registered Nurse. This will help in effective governance and supervision to ensure residents get their Breakfast and other meals on time as per their preference. The Registered Provider will ensure that the designated centre's staffing compliment is kept under review to ensure the delivery of safe and effective care adhering to all applicable legislation and standards.

17. Some residents were still waiting to get up at 11.00hrs. This is a repeat finding form the previous inspection:

The Director of Nursing has introduced a new allocation sheet which ensures support needs relating to breakfast, washing and dressing and supervision of the residents is maintained. Oversight of the implementation is the responsibility of the Director of Nursing/CNM and will be monitored on a day to day basis by daily supervision of the DON, CNM and the clinical staff.

18. Nursing staff had not completed the medication round on one unit at 10.30 hours.

Medication Rounds are now commenced at 08.45 to ensure that the medication rounds are completed in a timely manner as per Medication Management Guidelines. The Nurse on Duty was advised to wear a Red Medication Apron so they are not disturbed on Medication Rounds.
The Nursing Staff have been instructed to refresh their Medication management Course in HSE Land.

19. There was only one member of staff on duty to clean the whole designated centre and do the laundry for 31 residents.
It will be ensured that if a Staff member is on Annual Leave, another member of staff is allocated to cover their specific duties. i.e. One allocated to Laundry and One to Housekeeping.

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
1. All staff are now up to date with all mandatory training
2. Training Needs Analysis for 2024 has been completed and dates received for training.
3. All 9 staff identified have completed Safeguarding training (new starts have also completed training)
4. All nurses have completed mandatory medication management training

5. CNM post is filled following interview, awaiting return of requested checks. 6. CNM will be on duty daily following commencement of post by new CNM. 7. Staff offered posts have been invited to attend training

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management: 1. Regulation 5 & 6 compliance plan completed and forwarded 2. Following interviews, CNM post is filled (awaiting commencement date) 3. Block booking of Agency staff in place when required 4. 3 HCA's posts offered and accepted, awaiting commence dates 5. All staff are aware of lines of authority and accountability. DON hold responsibility for reporting Notifications, in her absence this is the role of the CNM, in the unlikely event all 3 staff are not available this is maintained by CEO. 6. Residents meetings have been maintained monthly since the return of the DON and CNM. 7. A 6 monthly Residents/Relatives Satisfaction survey will be conducted to obtain feedback from the residents in relation to our service delivery. 8. Monthly meetings with residents will be held and their responses will be used to improve service delivery. 9. All complaints/comments will be recorded in VCare and resolved within stipulated time as per company policy and any identified areas for improvement will be implemented. 10. The organizational structure will be communicated to all staff members and a copy of which is now displayed at the nurses station. 11. The policy for Safeguarding of the Vulnerable Adults will be communicated and additional training in relation to the responsibility of the Clinical Team will be undertaken. The Learning Outcomes related to specific Safeguarding events will be documented, implemented and disseminated to all relevant staff. 12. Internal communication will be implemented by rolling out of an App called Altra, which will ensure that vacant shits are communicated within the team and the same is picked up promptly to ensure smooth service delivery. All efforts will be made to ensure that the Rostering is done in advance to ensure safe and effective staffing levels and in order to be proactive in filling vacant positions.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
1. Following the inspection, the Notification was forwarded promptly.
2. Notification are discussed at Governance and Management meetings
3. All Clinical Staff were educated about the importance of reporting any allegations/Event of Abuse to the Clinical Governance Team so that Notifications are sent to HIQA as per HIQA Regulations.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
1. All complaints have been reviewed and resolved except 1 as per the complaints policy. All complaints and concerns continue to be recorded in line with the complaints process and resolved within 30 days as per policy.
2. These are now maintained on V-care and audited monthly.
3. Family are aware of rationale for 1 outstanding complaint, communication is maintained between family and DON.
4. Internal investigation completed.
5. External investigator has been sourced and date received to commence investigation.
6. A new making a complaint Easi-read Pictorial document has been provided to each resident.
7. All staff will be educated regarding the Organisational complaints policy. All complaints are now being documented in VCare. The complaints are an agenda item at our monthly resident meetings.

Regulation 18: Food and nutrition	Not Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
1. New pictorial breakfast menu has been completed for each resident & is provided on the breakfast trolley.
2. Pictorial lunch menus are also available for each resident.
3. New catering equipment has been purchased to ensure that the temperature of the breakfast is maintained.
4. A review of all resident's menu has been carried out by the DON/CNM and Catering Manager to ensure all up-to-date information in relation to the resident's needs is documented and communicated to all the relevant staff members.
5. All changes to Dietary Consistency made by Dietitian and SALT will be documented

and communicated in a timely fashion
6. Residents food plans is maintained in the kitchen and Catering Manager is now involved in food reviews.
7. Audit is maintained of same
8. DON/CNM maintain responsibility of ensuring all information is updated to catering staff

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:
1. All residents prior to admission for Long Term Care will have a Pre-Admission Assessment as per company Policy. Thus, ensuring that the needs of the resident is met by the service and the appropriate Equipment is available to the Resident according to their identified needs. A comprehensive assessment using all validated assessment tools including Oral Health Assessment, Nutritional Requirement and Modified Diets and Skin Integrity will be completed within the required timeframe. A person-centred care plan will be formulated using the comprehensive assessment. Assessments and Care Plans will be updated in a timely fashion or at a minimum timeframe of 4 months.
2. The staff has been educated on the importance of documenting all aspects of care in VCare Daily Flow and the care to be given as per the Care Planning specific to the resident.
3. All care plans will be reviewed by the DON on a monthly basis or more frequently and when needed.
4. The named nurse concept remains in place within the centre.
5. Nurses meeting are held monthly with minutes provided to ensure nursing staff review and update care plans and assessments satisfactorily and are making optimum use of the v-Care system.
6. Training 1:1 sessions have been provided and remains in place for staff.
7. Comprehensive audit of resident's assessments completed 21.11.2023, all staff were updated regarding results via team meetings 22.11.2023 by DON/CNM
8. Comprehensive audit of resident's care plans completed 22.11.2023

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
1. The DON will ensure that a high standard of evidence-based nursing care is provided to all residents by using the Validated Assessment tools as per company policy. All

aspects of resident care and MDT input is documented and communicated to all relevant staff members during the Daily Handover to ensure continuity of care. The resident's progress notes and Care Plans are updated to reflect the same.
2. All mandatory Training and education will be provided to all staff on an ongoing basis and any additional training needs identified will be addressed.
3. Daily Support and Supervision will be ongoing.
4. Regular audits will be carried out to ensure that the quality of documentation is maintained
5. All recommended medical treatment and professional advice from healthcare professionals will be consistently followed.
6. Relevant care plans and documentation will be updated and communicated with staff for example, recommendations made by the dietician will be updated in the resident care plan, the kitchen folder and communicated verbally during handover times.
7. The GP will also be informed of any recommendations made.
8. Shower trolley will be delivered on 26th January.
9. On admission pre-existing wounds will be identified and resident commenced on SSKIN bundle, DON/CNM maintain oversight daily
10. SSKIN bundle training is organized for 20.02.2024
11. Wound updates are provided at Safety pause and daily handover, attended by DON/CNM
12. Oral health care is a standing item at daily safety pause, care plans are in place where required and all assessments have been reviewed and updated
13. Quarterly reviews are now to be maintained by staff nurses on V-care with oversight of this by the DON/CNM

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
1. Managing behaviour that is challenging will be in accordance with our policy. The policy will be implemented in full and overseen by the DON.
2. A Training Matrix will be maintained, outstanding training needs will be communicated to all staff.
3. Dementia care plans in place, reviewed and audited
4. Mood and behavior care plans in place, reviewed and audited.
5. Restrictive practice will only be implemented as a last resort and when absolutely necessary.

Regulation 8: Protection	Not Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: 1. Notification forwarded to HIQA 2. Internal investigation completed 3. Records maintained of same 4. External investigation commencing 5. NOK aware of above	

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.	Not Compliant	Orange	28/02/2024
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	24/11/2023
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	24/11/2023
Regulation 18(1)(b)	The person in charge shall ensure that each resident is offered choice at mealtimes.	Not Compliant	Orange	24/11/2023

Regulation 18(1)(c)(i)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are properly and safely prepared, cooked and served.	Not Compliant	Orange	24/11/2023
Regulation 18(1)(c)(iii)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional assessment in accordance with the individual care plan of the resident concerned.	Substantially Compliant	Yellow	24/11/2023
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	28/02/2023
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined	Not Compliant	Orange	24/11/2023

	management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.			
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	24/11/2023
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.	Not Compliant	Orange	24/11/2023
Regulation 34(1)(a)	The registered provider shall provide an accessible and effective procedure for dealing with complaints, which includes a review process, and shall make each resident aware of the complaints procedure as soon as is practicable after the admission	Substantially Compliant	Yellow	24/11/2023

	of the resident to the designated centre concerned.			
Regulation 34(1)(b)	The registered provider shall provide an accessible and effective procedure for dealing with complaints, which includes a review process, and shall display a copy of the complaints procedure in a prominent position in the designated centre, and where the provider has a website, on that website.	Not Compliant	Orange	24/11/2023
Regulation 34(6)(a)	The registered provider shall ensure that all complaints received, the outcomes of any investigations into complaints, any actions taken on foot of a complaint, any reviews requested and the outcomes of any reviews are fully and properly recorded and that such records are in addition to and distinct from a resident's individual care plan.	Not Compliant	Orange	24/11/2023
Regulation 34(7)(b)	The registered provider shall ensure that all staff are aware of the designated centre's complaints	Substantially Compliant	Yellow	24/11/2023

	procedures, including how to identify a complaint.			
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Not Compliant	Red	24/11/2023
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.	Not Compliant	Red	24/11/2023
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	Red	24/11/2023
Regulation 5(4)	The person in charge shall formally review, at	Not Compliant	Red	24/11/2023

	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.			
Regulation 5(5)	A care plan, or a revised care plan, prepared under this Regulation shall be available to the resident concerned and may, with the consent of that resident or where the person-in-charge considers it appropriate, be made available to his or her family.	Not Compliant	Red	24/11/2023
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 evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais	Not Compliant	Red	24/11/2023

	from time to time, for a resident.			
Regulation 6(2)(a)	The person in charge shall, in so far as is reasonably practical, make available to a resident a medical practitioner chosen by or acceptable to that resident.	Not Compliant	Red	24/11/2023
Regulation 6(2)(b)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the resident agrees to medical treatment recommended by the medical practitioner concerned, the recommended treatment.	Not Compliant	Red	24/11/2023
Regulation 6(2)(c)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the care referred to in paragraph (1) or other health care service requires additional professional expertise, access to such treatment.	Not Compliant	Red	24/11/2023
Regulation 7(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.	Substantially Compliant	Yellow	24/11/2023

Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Substantially Compliant	Yellow	24/11/2023
Regulation 8(3)	The person in charge shall investigate any incident or allegation of abuse.	Not Compliant	Orange	24/11/2023