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:	Roseville House Nursing Home
Name of provider:	DSPD Limited
Address of centre:	Killonan, Ballysimon, Limerick
Type of inspection:	Unannounced
Date of inspection:	02 August 2023
Centre ID:	OSV-0000427
Fieldwork ID:	MON-0041060

About the designated centre

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

Roseville House Nursing Home is a designated centre located in a rural setting a short distance from Limerick city. It is registered to accommodate a maximum of 39 residents. It is a single-storey facility set on a large mature site. Residents' bedroom accommodation is set out in two wings, the old wing, and the new wing which has two corridors. There are single, twin and one three bedded rooms, some with en suite facilities. Communal areas comprise a dining room, two day rooms and a seating area along the bright wide corridor in the new wing. Residents have access to a secure paved courtyard with garden furniture and raised flowerbeds. There are well maintained unsecured gardens around the centre. Roseville House Nursing Home provides 24-hour nursing care to both male and female residents whose dependency range from low to maximum care needs. Long-term care, convalescence care, respite and palliative care is provided.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	37

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 2 August 2023	09:00hrs to 17:30hrs	Sean Ryan	Lead

What residents told us and what inspectors observed

Resident's living in Roseville House Nursing Home gave mixed feedback about their experience of living in the centre. While residents were complimentary of the staff who provided them with care and support in a caring and respectful manner, residents expressed discontent with the quality of care they received. While residents spoke positively about the staff as individuals who made them feel safe, residents described the quality of care as being inconsistent. Residents attributed the inconsistent care to daily staffing shortages, and voiced that they often experienced delays in receiving assistance and support from staff.

The inspector was met by a clinical nurse manager on arrival at the centre. Following an introductory meeting, the inspector walked through the premises and external areas with a clinical nurse manager. The inspector was introduced to a number of residents in dining room, and in their bedrooms. The inspector met with the majority of residents during the walk around the centre, and spoke to a number of residents in detail about their experience of living in the centre. Some residents were unable to articulate their views on the quality of the service they received. The inspector observed that the comfort of those residents was checked by staff at periods during the day.

There was a busy atmosphere in the centre during the morning. Staff were busily attending to residents requests for assistance in their bedrooms, while also attempting to serve residents their breakfast, and provide supervision to residents who were observed sitting in the dining room. Housekeeping staff were observed to support the care of residents during breakfast time. A number of residents were observed sitting in in their bedrooms, waiting for staff to provide them with assistance with their morning care needs. Other residents were seen walking through the corridors requesting assistance from staff.

Residents told the inspector that they often experience prolonged wait times for assistance from staff, particularly in the morning time. Residents told the inspector that while staff 'were lovely and did their best' there 'was not enough of them to help everyone', and they attributed this to the centre being short-staffed. In recognition of this, one resident reported that on occasion they would forgo their planned shower so as not to delay other residents waiting for assistance from staff.

Residents told the inspector that they often overheard staff in the corridors talking about being short-staffed, discussing the residents that who required priority care, and the residents that could have wait until later in the morning. Two residents told the inspector that this made them feel 'anxious' because ' at times you would worry if you would be up in time for lunch'. At lunchtime, the inspector observed that some residents were still in bed. Staff informed the inspector that those residents would remain in bed as a consequence of staffing and time constraints. Staff were observed attending to the needs of residents who remained in bed throughout the day. All residents spoken with confirmed that, while they experienced long delays

waiting for assistance, staff always came to assist them, and were very apologetic about the delays the residents experienced.

The premises was warm, bright, and spacious. The centre comprised of two floors. Resident accommodation was provided on the ground floor, and the first floor was used for storage. The centre provided accommodation to 39 residents in 26 single bedrooms, five twin bedrooms, and one triple bedroom. Seven bedrooms had shower facilities within their en-suite. Communal shower and toilet facilities were located within close proximity to resident's bedroom accommodation. However, those areas were seen to be used to store resident's mobility aids, commodes, and equipment. This impacted on the accessibility of the facilities for residents. While there were some areas of the premises that had benefited from redecoration, there were numerous areas that were in a poor state of repair. Some showers were missing tiles within the shower enclosure, while wooden skirting boards were observed to be damaged in some bedrooms and en-suites. Ancillary areas were missing tiles from the walls, floors were visibly damaged, and the glass of a window was broken in another area.

Externally, residents had access to an enclosed patio garden that was appropriately furnished. However, the area was observed to be poorly maintained, and untidy, with empty plastic bottles laying on the ground. The inspector observed that construction works were in progress adjacent to the centre. This resulted in areas of the premises being cordoned off. Residents told the inspector that they could not go outside to the front garden unaccompanied, as a result of the construction works.

Residents bedrooms were personalised with items such as family photographs, colour coordinated soft furnishings, and ornaments. Residents told the inspector that they were generally happy with their bedrooms, storage, and comfortable furnishings. However, equipment such as tables were observed to be damaged, and rusted in parts. Residents confirmed that their bedrooms were cleaned daily, and that staff also cleaned their ornaments and photos. Some residents reported that the quality of the cleaning could be improved. One resident commented that although their room had been cleaned, there was a build-up of crumbs behind their bed that had not been cleaned.

While the communal areas occupied by residents were clean, there were some areas of the centre that were not cleaned to an acceptable standard. This included some bedroom and en-suites, and ancillary areas such as the sluice room, toilets, and storage areas. Some supportive equipment was observed to be visibly stained. The inspector observed that the sluice room was used to store housekeeping and maintenance equipment.

The inspector observed a number of doors that were held open with pieces of furniture which prevented the doors from closing. This may compromise the function of the doors to contain the spread of smoke and fire in the event of a fire emergency.

The dining experience was observed to be a social occasion for residents. Residents were complimentary about the food served in the centre, and confirmed that they

were always afforded choice. Residents told the inspector that they could also requested something that was not on the menu. For example, one residents had requested French toast for breakfast, and this request was facilitated. Staff were observed to engage with residents during meal times and provide discreet assistance and support to residents, if necessary. Residents in all areas had access to snacks and drinks, outside of regular mealtimes.

Throughout the inspection, residents were seen to spend their day in the dining room. Residents told the inspector that they found that day very long, and wished for more activities. While an activities schedule was in place and it detailed a schedule to include art and crafts, bird feeding, and walks, residents reported that those activities were not provided. The inspector observed residents spending extended periods of time in the dining room, and in their bedrooms with no social engagement. While residents attended a religious ceremony in the morning, and a live music event that occurred every Wednesday afternoon, there was no further activities scheduled and there was no staff member assigned to activities or social care due to staff planned and unplanned leave. This meant that the only social engagement for residents was when they were receiving direct care.

The staff were observed chatting with resident while bringing them from their bedroom to the dining room. However, these interactions were time limited as the staff were observed to be under pressure to attend to the next resident that was waiting for assistance.

Residents were provided with opportunities to express their feedback about the quality of the service during formal resident forum meetings. Residents told the inspector that they did not feel their opinion was 'valued and listened to', and consequently, some residents had ceased to attend those meetings.

The following sections of this report detail the findings in relation to the capacity and capability of the centre, and how this impacts on the quality and safety of the service provided to residents.

Capacity and capability

This unannounced risk inspection was carried out by an inspector of social services to;

- monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centre for Older People) Regulation 2013 (as amended).
- follow up on the actions taken by the provider to address non-compliant issues identified on the previous inspection of the centre in September 2022.

The findings of this inspection were that the registered provider had not fully implemented or sustained a compliance plan submitted following the previous inspection of the centre, and further action was required with regard to the

governance and management of Roseville House Nursing Home. The impact of a weak organisational structure, ineffective systems of monitoring and oversight, and inadequate staffing resources impacted on the quality and safety of the care provided to residents. This resulted in repeated issues of substantial, or non-compliance under the following regulations;

- Regulation 5: Individual assessment and care plan,
- Regulation 17: Premises,
- Regulation 16: Training and staff development,
- Regulation 23: Governance and management,
- Regulation 27: Infection control,
- Regulation 28: Fire precautions.

Additionally, the following regulations were found not to be compliant on this inspection.

- Regulation 6: Health care,
- Regulation 9: Residents' rights,
- Regulation 15: Staffing.

DSPD Limited, a company comprised of three directors, is the registered provider of Roseville House Nursing Home. The company is represented by one of the directors. The organisational structure, as described in the centre's statement of purpose, comprised of a person in charge who reported to the provider representative. Within the centre, the person in charge was supported by a clinical nurse manager, and a team of nursing, health care, administration, and support staff. On the day of inspection, the person in charge was on leave with an unknown expected return date. While a newly appointed clinical nurse manager deputised for the person in charge in their absence, the organisational structure was not clear. The inspector found that the management systems pertinent to supporting effective governance of the service such as risk management systems, and the systems to monitor and evaluate the quality of the service, were not known to the personnel responsible for the administration and oversight of the service. Consequently, assurances could not be provided that accountability and responsibility for key aspects of the service such as the oversight and management of risk, and the organisation and management of the staffing resources were robust. The absence of an effective system of governance and management negatively impacted on the registered provider's ability to recognise, respond to, and manage risk and regulatory non-compliance's in the centre, and maintain a safe and quality levels of care for residents.

The provider had not ensured that staffing resources were effectively organised and managed in the centre to ensure that care was provided to residents, in accordance with the centre's statement of purpose. A review of the staffing rosters evidenced that staffing resources were not available to cover planned and unplanned leave, or maintain planned rosters, particularly in terms of health care, activities, and administration staff. For example, a review of the rosters found multiple occasions where planned health care staff levels were not maintained. The inspector found that deficits in the health care staff rosters were supplemented by nursing staff. Additionally, the inspector observed that housekeeping staff were redirected from

cleaning duties to support the care provided to the residents. The provider was aware of the deficits in the staffing resources through daily clinical reports submitted by the nurse management. However, the provider had not assessed the risk to residents in terms of limited staffing resources, or progressed to consider alternative arrangements to ensure planned staffing levels were consistently maintained. The impact of inadequate staffing levels is discussed further under Regulation 15: Staffing.

The provider had management systems in place to monitor the quality of the service provided to residents. Key aspects of the quality of residents care was were collected in relation to falls, weight loss, nutrition, complaints, and the incidence of wounds. However, there was little evidence that this information was used to inform quality improvement initiatives. For example, while the management had identified an increase in the incidence of pressure wounds, there was no evidence that this information was used to identify contributing factors that may have led to the increase in wounds. Consequently, a quality improvement action plan could not be developed. A review of completed clinical and environmental audits found that some audits were not effectively used to identify risks and deficits in the service. For example, environmental audits assessed compliance with the quality and maintenance of the premises that included the integrity of floor coverings and wall tiles. Each completed audit achieved full compliance, with no quality improvement required, despite some floor coverings being in a poor state of repair, and wall tiles were missing or damaged in ancillary areas.

Risk management systems were guided by a risk management policy that had been reviewed in 2021. The policy detailed the systems in place to identify, record and manage risks that may impact on the safety and welfare of residents. As part of the risk management system, a risk register was maintained to record and categorise risks according to their level of risk, and priority. Despite being identified on the previous inspection, the inspector found that the risk register did not contain some of the known risk in the centre. This included the risks associated with the staffing constraints, and reduced management resources. Furthermore, while an assessment of risk had been completed in respect of ongoing construction works adjacent to the designated centre, the risk assessment did not adequately assess the potential risks and impact of those works on the care and welfare of residents living in the centre. As a result, there was no clear timeline for the works to be completed, and no effective risk management systems in place to manage any potential risk or disruption to residents during ongoing works.

Record keeping and file management systems comprised of both electronic and paper based systems. A review of staffing records found that all staff personnel files contained a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2021. However, not all files contained the information specified in Schedule 2 of the regulations. For example, some records did not contain details of relevant qualifications, or a full history of employment. Additionally, nursing care records were not consistently maintained in line with the requirements of Schedule 3 of the regulations.

A review of staff training records evidenced that all staff had up-to-date training

appropriate to their role. Staff demonstrated an awareness of their training with regard to the safeguarding of vulnerable people, and the procedure to commence in the event of a fire emergency. However, while the provider had previously committed to the provision of training for staff in relation to the nutritional assessment and monitoring of residents, and care planning, the inspector found that staff had not been facilitated to attend this training. The inspector found that the arrangements in place to supervise and support staff was not effective. For example, staff were not appropriately supervised to ensure residents received safe and quality care in line with their assessed needs.

Regulation 15: Staffing

The provider had failed to ensure that there were sufficient staffing levels in the centre to meet the assessed needs of the residents, or for the size and layout of the centre. A review of the rosters found that there was inadequate staff available to meet the health and social care needs of the residents, and to ensure residents received safe and effective care. This was evidenced by

- A review of the staffing rosters for the previous four weeks showed that there were 14 occasions where planned staffing levels had not been maintained in the health care staff roster. Additionally, long term sick leave in the administration department had not been covered.
- Residents spoken with voiced their concern with regard to staffing levels. Residents reported, and were observed, waiting long periods of time to receive assistance from staff with their care needs.
- Housekeeping staff were redirected from cleaning duties to support the provision of care to residents. This impacted on the quality of environmental hygiene observed on the day of inspection.
- Residents were required to spent their day in the dining room as a result of insufficient staff to provide supervision in other areas of the centre.
- Some residents remained in bed for the duration of the inspection, as a result of insufficient staffing to assist them to get up from bed.
- A review of the daily care records for residents found that they did not have timely access to having a bath or a shower. Staff confirmed that while residents received assistance with their personal hygiene care through bed baths, showers could not always be facilitated due to lack of staffing.
- There was insufficient staff to meet the social care needs of the residents, as detailed under Regulation 9, Resident's rights.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff were not appropriately trained to deliver effective and safe care to residents. This was evidenced by;

- Staff did not demonstrate an appropriate level of knowledge to identify and address the nutritional needs of the residents. For example, staff demonstrated a poor awareness of the assessment of residents nutritional care needs, and the pathway of care to take in response to a resident's risk of malnutrition.

The inspector found that staff supervision arrangements were not appropriate to protect and promote the care and welfare of residents. This was evidenced by poor supervision of staff to ensure;

- residents received care and support in line with their assessed care needs and care plans.
- compliance with the cleaning process in the centre, and infection prevention and control practices.
- accurate nursing care records were maintained.
- that fire safety procedures were consistently implemented by staff. For example, the inspector observed a number of instances of fire doors being held open with items of furniture, contrary to the centres own fire procedures.

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 21: Records

A review of the records in the centre found that the management of records was not in line with the regulatory requirements. For example;

- Staff personnel files did not contain all the necessary information required by Schedule 2 of the regulations. For example, three staff files did not contain evidence of relevant qualifications. Two written references were absent from one file, and one staff file did not contain a full employment history.
- Nursing records were not completed in line with the requirements of Schedule 3(4)(c). For example, a review of residents' nursing records found that nursing notes were duplicated from previous entries over a seven day period. This meant that the record was not person-centred, and did not provide assurance that the daily care needs of the residents had been met.

Judgment: Substantially compliant

Regulation 23: Governance and management

The registered provider had failed to ensure that resources in the centre were planned and managed to ensure person-centred, effective and safe services. For example;

- The registered provider had failed to ensure the service has sufficient staffing resources to maintain adequate health care staff levels to ensure consistent, safe, and quality care was provided to the residents, in line with the centre's statement of purpose.
- The number of full time nurses committed to by the providers statement of purpose, did not reflect the number of full time nurses available to deliver care.

The registered provider had not ensured there was an effective management structure in place, with clear lines of accountability and responsibility. For example, accountability and responsibility for key aspects of the service such as the oversight and management the staffing resource, and risk in the centre were unclear. Consequently, there were poor systems in place to escalate risk to the provider. This resulted in ineffective action being taken to address risks to residents.

The management systems in place to monitor the quality of the service required action to ensure the service provided to residents was safe, appropriate, consistent and effectively monitored. For example:

- Risk management systems were not effectively monitored or implemented. The centre's risk register did not contain known risks in the centre such as the risk associated with staffing constraints, limited management resources, or a comprehensive assessment of risk associated with building works adjacent to the designated centre. This meant that actions to mitigate and manage risks to residents had not been identified.
- The systems in place to monitor, evaluate, and improve the quality of the service were not effective in identifying deficits and risks in the service. For example, completed audits with regard to the premises, physical environment, and infection prevention and control reflected full compliance and did not identify aspects of the service that required quality improvement.
- There was poor oversight of record-keeping systems to ensure compliance with the regulations.
- There were ineffective systems in place to monitor and promote the well-being of residents through providing timely and appropriate referral to medical and health care services.

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 32: Notification of absence

The registered provider had failed to notify the Chief Inspector of the proposed absence of the person in charge for a continuous period of 28 days or more.

Judgment: Not compliant

Quality and safety

The inspector found that the interactions between residents and staff were kind and respectful throughout the inspection. Residents reported that the staff, and their environment, made them feel safe living in the centre. Nonetheless, the inspector found that the ineffective systems of governance and management coupled with inadequate staffing levels impacted on the quality and safety of consistent person-centred care to residents. Consequently, significant improvements were required in relation to care delivery, with particular regard to residents' assessments and care plans, health care, and resident's rights. Action was also required to ensure that the premises met the needs of the residents, and that infection prevention and control measures protected them from the risk of infection.

The inspector acknowledged that the needs of residents were known to the staff and the nursing staff. A sample of residents individual assessment's and care plans were reviewed. While all residents had a care plan and there was evidence that resident's needs had been assessed using validated assessment tools, the assessment findings were not always reflective of the residents actual care needs. Consequently, the care plans did not identify the current care needs of the residents or reflect the person-centred guidance on the current care needs of the residents.

A review of residents' records found that there was regular communication with some residents general practitioners (GP) regarding their health care needs. However, a number of residents were not provided with appropriate referral and access to medical and health care professionals, despite showing signs and symptoms of physical deterioration.

A review of the physical environment found that the provider had redecorated some areas of the premises that included some bedrooms and communal areas. However, there were numerous areas of the premises such as bedrooms, bathroom facilities, ancillary areas, and communal areas that were not maintained in a satisfactory state of repair. For example, floor tiles were damaged in toilet facilities, and wall tiles were missing or damaged in ancillary areas. Externally, the garden and enclosed courtyard were not appropriately maintained. Further findings are described under Regulation 17, Premises.

A review of the care environment found that an appropriate standard of hygiene

was maintained in the dining room, and some communal bathrooms. While there was a cleaning schedule in place, the inspector observed that some areas of the centre were not clean. For example, some bedrooms that had been documented as clean were visibly unclean on inspection. The inspector observed personal care equipment which was visibly unclean, and this posed a risk of cross contamination, and therefore risk of infection to residents. The inspector found that the inappropriate storage of equipment in ancillary areas such as the sluice room, and toilet facilities posed a risk of cross contamination. This is discussed further under Regulation 27, Infection control.

There were arrangements in place to ensure the fire detection and emergency lighting systems were serviced and maintained at regular intervals. Staff were knowledgeable with regard to the fire to commence in the event of a fire evacuation. A summary of residents Personal Emergency Evacuation Plans (PEEP) were in place for staff to access in a timely manner in the event of a fire emergency. However, those records were not kept up-to-date and referred to residents who had been discharged, as being current residents in the centre. This could cause confusion in the event of an emergency. The inspector found that further action was required in the containment and management of fire. For example, poor practice was observed whereby a significant number of doors were help open by pieces of furniture. This practice potentially compromised the function of automatic closure device on doors, in the event of a fire emergency. Further findings are described under Regulation 23, Fire precautions.

Residents were provided with opportunities to provide feedback about the quality of service on a monthly basis. Records of the meetings held evidenced that topics such as activities, staffing, and the menu were discussed. However, residents reported that the quality of the information shared with them at resident meetings did not enable them to fully participate in the organisation of the service. For example, some residents wished to be kept informed about the construction of a building adjacent to the designated centre. However, residents reported that they were not provided with this information.

Regulation 17: Premises

There were areas of the premises that were in a very poor state of repair, both internally and externally. For example,

- Equipment used by residents was in a poor state of repair. Specialised chairs were torn, and bedside tables were visibly chipped, damaged, or rusted.
- Floor coverings in some areas were not appropriately maintained. For example, the floor covering was damaged and a hole visible in the linen room. Floor coverings were lifting aware from skirting in a number of bedrooms. Skirting was also visibly damaged in residents bedrooms. This resulted in a build up of dirt and debris.
- Wall paper was visibly torn in the communal dayroom. There were water

marks evidence on the ceiling in this area.
- Tiles were damaged or missing in the sluice room, resident's en-suites, and communal toilet facilities. The glass in the sluice room window was broken.
- Storage facilities were inadequate and resulted in the inappropriate storage of resident's equipment in communal toilets. For example, mobility aids were store in a communal shower area.
- Externally, the premises was poorly maintained. A patio area was untidy as there was rubbish laying on the ground, alongside sewer rods. The paths along the front garden were not well maintained with moss and weeds growing up through them.

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 27: Infection control

The provider did not ensure that infection prevention and control procedures were consistent with the National Standards for Infection Prevention and Control (IPC) in community settings published by HIQA. This was evidenced by;

- There was no appropriately qualified infection prevention and control link practitioner in place to increase awareness of infection prevention and control issues locally.

The environment and equipment was not managed in a way that minimised the risk of transmitting a health care-associated infection. This was evidenced by;

- Cleaning chemicals and equipment was stored within the sluice room. This posed a risk of cross-contamination.
- Maintenance equipment was stored in the sluice room. A number of vases were left in a sink alongside urinals awaiting cleaning and decontamination. This practice increased the risk of cross infection.
- The equipment used for cleaning was visibly unclean on inspection.
- Storage space was limited. Wheel chairs, soiled linen receptacles and other pieces of equipment were stored within the communal bathrooms. This increased the risk of cross infection.
- Areas of the premises documented as clean were visibly unclean on inspection. This included five bedrooms occupied by residents.

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 28: Fire precautions

Action was required by the provider in order to comply with the requirements of Regulation 28: Fire precautions.

Arrangements for reviewing fire precautions in the designated centre required further action. For example,

- The provider had not reviewed fire precautions in the context of active construction works directly adjacent to two emergency exits, and their potential impact on the fire evacuation strategy.
- Residents emergency evacuations plans contained within the fire register had not been reviewed or updated to reflect residents discharged from the centre. This had the potential to delay the safe and timely evacuation of residents from the centre in the event of a fire emergency.

Arrangements for containing fire in the designated centre required further action. This was evidenced by;

- Fire doors were being kept open by means other than a hold open device, connected to the fire alarm system. This compromised the function of the door to contain the spread of smoke and fire in the event of an emergency.
- There were some areas where services such as pipes and electrics penetrated the walls and ceiling. There was a visible hole around the services in the fuse box storage area.

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

A review of a sample of resident's assessment and care plans found that they were not in line with the requirements of the regulations. For example;

- Care plans were not guided by a comprehensive assessment of the residents care needs. For example, some resident's care plans did not accurately reflect the needs of the residents and did not identify interventions in place to protect residents when identified as a high risk of falls. Additionally, a resident who had experienced significant weight loss did not have an accurate assessment of their weight completed. Consequently, staff did not have accurate information to guide the care to be provided to the residents.
- Care plans were not reviewed or updated when a resident's condition changed. For example, the care plan of a resident discharged from hospital had not been reviewed or updated following a significant increase in their

nutritional care and support needs.

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 6: Health care

The registered provider failed to ensure that all resident had appropriate access to medical and health care. This was evidenced by failure to provide;

- appropriate access to general practitioner services.
- appropriate monitoring of a resident assessed as being nutritionally at risk, in line with the recommendations of health care professionals.

The registered provider did not ensure that residents received care in line with their care plan prepared under Regulation 5. For example;

- the records for one resident who required regular repositioning were not completed at the required intervals. Therefore, the inspector was not assured that care was provided as per the resident's assessed needs.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The provider failed to provide the residents with facilities for occupation and recreation and for opportunities to participate in activities in accordance with their interests and abilities.

Residents were restricted in relation to exercising choice, such as where and how they spend their day, as a result of inadequate staffing levels to provide supervision and support. Shower and bath times where restricted to times when staff could be available, and some residents could not get up from bed as a result of staffing constraints.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 32: Notification of absence	Not compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Substantially compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Roseville House Nursing Home OSV-0000427

Inspection ID: MON-0041060

Date of inspection: 02/08/2023

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Additional Staff have been recruited. At the time of Inspection there was 4 staff taken on awaiting garda vetting. They have now commenced on the roster. We have recruited a new PIC and awaiting a start date, currently completing the Regulatory requirements. This is monitored on a daily basis by the provider with updates from the Clinical team.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: All Nurses have updated their training on MUST and are familiar with the Pathway for referral to Dietitian and SALT. Instructed CNM to supervise staff on Delivering Care and Support to Residents, On Infection Prevention and Control Practices, Maintaining Nursing Care Records and Fire Safety Procedures.	
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: Staff Files have been reviewed and updated.	

Nursing Staff have been instructed to write the report in a person centered manner at all times and not to duplicate entry's. CNM will monitor this.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Additional Staff have been recruited. At the time of Inspection there was 4 staff taken on awaiting garda vetting. They have now commenced on the roster.
Additional Nurses have been recruited and are awaiting the RCSI and NMBI process. These exams are booked in September 16/17.
We have recruited a PIC and they will be responsible for the oversight and Management of the service.
Currently the provider gets daily updates from the center from Clinical Staff. Anything that needs to be escalated to the provider is highlighted daily. The provider continues to visit the center weekly. Once the PIC commences she will escalate any issues to the provider.

Until the PIC commences employment the Provider has instructed the CNM on Risk identification and mitigation. The CNM will be supported on this by an off-site manager. Any risks that are identified will be sent to the provider on a daily basis, this will be further supported by the off site manager visiting the center weekly to assist and assess the service to ensure its appropriate consistent and safe.

The CNM will monitor and refer as appropriate to any health care professional as required. This will be further overseen by the provider and the off site manager until the PIC commences.

The Staffing levels are monitored by the provider and are in line with the SOP.

Regulation 32: Notification of absence	Not Compliant

Outline how you are going to come into compliance with Regulation 32: Notification of absence:
Notifications will be sent in a timely manner.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
A review of furniture has been carried out and any damaged items have been removed. An audit will be carried out on the premises internal and externally. An action plan will agreed following same.
A review of equipment storage has taken place and unused equipment has been removed.

Currently additional storage is not required, this is due to the fact that the premises has been decluttered and unused equipment removed. Additional storage will be in place once the extension has been constructed. There is outside storage container available for overflow.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
All staff have Infection Prevention and control training completed. They are reminded to implement this on a day to day. The CNM will oversee this.
Staff have been advised of safe and appropriate storage of items and equipment.
CNM will oversee and supervise the cleaning of equipment and rooms, daily audit now in place, will be reduced to weekly once compliance is noted.

We have spoken to the Link Practitioner programmer. They intend to run a course in October, which we will enroll a staff member. They have now reopened our Nursing Home and we will train a staff member on the next program.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Fire evacuation and procedures have been updated to reflect the ongoing works. All emergency exits are been maintained during construction and staff are aware of this.

The PEEPS are continuously updated to reflect the emergency evacuation plan.

Staff are reminded to not hold open any fire door. CNM will monitor this and ensure practice is not allowed.

All holes around services and electrics penetrating the walls and ceilings are now fire stopped using an appropriate material.

CNM will oversee and update PEEP and Fire Register as required.

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
All care plans have been reviewed and updated.
All Nursed are attending Care Planning training.
CNM will oversee the implementation of Person Centered care planning

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
System now in place to ensure GP visits will be conducted when required and at minimum 4 monthly.

Nursing staff are remained to update the records regarding repositioning. CNM will oversee this.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Any staffing issues have now been rectified. Residents can exercise their preferences as they wish. Nursing Home Staff will always facilitate the same.

Activities schedule has been updated as per resident’s wishes and choice.

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	30/10/2023
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	30/10/2023
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/10/2023
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre,	Not Compliant	Orange	30/10/2023

	provide premises which conform to the matters set out in Schedule 6.			
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Substantially Compliant	Yellow	30/10/2023
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	30/10/2023
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Not Compliant	Orange	30/10/2023
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe,	Not Compliant	Orange	30/10/2023

	appropriate, consistent and effectively monitored.			
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Not Compliant	Orange	30/10/2023
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	30/10/2023
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	30/10/2023
Regulation 32(1)	Where the person in charge of the designated centre proposes to be absent from the designated centre for a continuous period of 28 days or more, the registered provider shall give notice in writing to the Chief Inspector of the proposed absence.	Not Compliant	Orange	11/09/2023
Regulation 5(2)	The person in charge shall arrange a	Not Compliant	Orange	11/09/2023

	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.			
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Not Compliant	Orange	11/09/2023
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Not Compliant	Orange	11/09/2023
Regulation 6(1)	The registered provider shall, having regard to the care plan	Substantially Compliant	Yellow	11/09/2023

	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 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.	Substantially Compliant	Yellow	11/09/2023
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.	Substantially Compliant	Yellow	11/09/2023
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Substantially Compliant	Yellow	11/09/2023
Regulation 9(2)(b)	The registered provider shall provide for	Not Compliant	Orange	11/09/2023

	residents opportunities to participate in activities in accordance with their interests and capacities.			
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Not Compliant	Orange	11/09/2023