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:	St. Dominic Savio Nursing Home
Name of provider:	Smith Hall Limited
Address of centre:	Cahilly, Liscannor, Clare
Type of inspection:	Unannounced
Date of inspection:	17 November 2022
Centre ID:	OSV-0000450
Fieldwork ID:	MON-0037825

About the designated centre

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

St. Dominic Savio nursing home is a purpose-built single-storey nursing home that provides 24-hour nursing care. It can accommodate up to 28 residents both male and female over the age of 18 years. Care is provided for people with a range of needs: low, medium, high and maximum dependency. It is located in a rural area close to the coastal village of Liscannor. It provides short and long-term care primarily to older persons. There are nurses and care assistants on duty covering day and night shifts. Accommodation is provided in both single and shared bedrooms. There are separate dining, day and visitors' rooms as well as a garden patio area available for residents use.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	27

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
Thursday 17 November 2022	10:00hrs to 18:00hrs	Fiona Cawley	Lead
Thursday 17 November 2022	10:00hrs to 18:00hrs	Sean Ryan	Support

What residents told us and what inspectors observed

The overall feedback from residents living in this centre was that they were satisfied with the care they received. Inspectors observed that staff in the centre on the day of the inspection were familiar with residents, their care needs, and their preferences.

Following an introductory meeting, inspectors completed a walk around the centre. The centre was a single-storey building and provided accommodation for 28 residents in both single and twin occupancy bedrooms. Communal areas comprised of a day room, a dining room, and a sun room. The building was well lit, warm and adequately ventilated throughout. Call bells were available throughout the centre and the inspectors observed that these were responded to in a timely manner. Corridors were sufficiently wide to accommodate residents with walking aids, and there were appropriate handrails available to assist residents to mobilise safely. There was an enclosed outdoor courtyard area, which had been upgraded since the previous inspection, to ensure it was accessible and safe for resident use.

On the day of the inspection, inspectors observed that a number of areas of the centre were poorly maintained. The flooring in the communal areas and a number of bedrooms were in a state of disrepair and a number of bedrooms required repainting. While the centre was generally clean, inspectors observed that there were areas of inconsistent levels of cleanliness. Inspectors found that there was inadequate facilities for storage in the centre on the day. Residents' equipment such as hoists and mobility aides were stored in residents' bedrooms.

Inspectors interacted with a large number of residents and spoke with a total of ten residents on the day of the inspection. Residents told inspectors that they were satisfied with life in the centre and that staff were good to them. One resident told inspectors that they were happy with the company of others in the centre as they had been very lonely at home. Another resident described how they preferred their own company and chose to spend their time in their room, where they watched TV. There were a number of residents who were unable to speak with inspectors and were therefore not able to give their views of the centre. However, these residents were observed to be content and comfortable in their surroundings. Inspectors observed that personal care and grooming was attended to a satisfactory standard. Inspectors found that the interactions between residents and staff were kind and respectful throughout the inspection.

Inspectors observed that the majority of residents spent their day between the communal day room and the dining room. A small number of residents chose to spend the day in their bedrooms. While inspectors observed that residents were provided with some opportunities to participate in recreational activities of their choice and ability, residents were also observed spending long periods of time without any social engagement. A small number of residents told inspectors that

they found the days and nights very long.

Residents had unlimited access to telephones, television, radio, newspapers and books. Friends and families were facilitated to visit residents, and inspectors observed visitors coming and going throughout the day.

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

Capacity and capability

This was an unannounced risk inspection carried out by inspectors of social services to monitor compliance with the Heath Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). Inspectors followed up on the actions taken by the provider to address areas of non-compliance found on the previous two inspections in December 2021 and July 2022. The findings of this inspection were that while some improvements were found in relation to premises and residents' rights, the provider had not completed the majority of actions included in the compliance plan submitted by the provider, to the Chief Inspector following the previous inspections. As a result, inspectors found repeat non-compliance in the following regulations;

Regulation 4: Written policies and procedures
Regulation 15: Staffing
Regulation 21: Records
Regulation 23: Governance and Management
Regulation 24: Contract for the provision of services
Regulation 34: Complaints procedure
Regulation 5: Individual assessment and care plan
Regulation 9: Residents' rights
Regulation 17: Premises

Regulation 28: Fire precautions.

In addition, inspectors found that action was required to assure compliance with the following regulations;
Regulation 6: Health care
Regulation 7: Managing behaviour that is challenging

The registered provider of St. Dominic Savio Nursing Home was Smith Hall Ltd. There were two directors of this company, both of whom were also persons participating in management and were involved in the day-to-day operational

management of the centre. In response to the regulatory non-compliance found on the last inspection in July 2022, the Chief Inspector had met with the registered provider in relation to concerns about the governance and management of the centre. At this meeting the provider committed to taking action to address the significant level of non-compliance found. The findings from this inspection were that the registered provider had failed to take appropriate action to ensure the governance systems in the centre were robust and that the service provided to residents living in the centre was safe and effective.

The person in charge of the centre was not in the centre on the day of the inspection. The director of operations, who was deputising in their absence, facilitated the inspection. While both directors attended the centre regularly, their roles and responsibilities remained poorly defined and it was not clear who held the authority and accountability for the delivery of the service. This is a repeated finding from a previous inspection.

The provider had failed to ensure that management systems were in place to ensure that the service provided was safe, appropriate, consistent and effectively monitored. For example, a review of the risk management system found that the issues identified on two previous inspections, including issues relating to governance and management and fire safety were not managed within the centre's risk register and therefore, no measures had been put in place to control the risks identified. In addition, no clinical or environmental audits or service review had taken place since the last inspection.

Inspectors reviewed the staffing rosters and found that they did not accurately reflect the staffing numbers in the centre on the day of the inspection. The roster for the day of the inspection included the person in charge, who was not on duty on the day.

Inspectors observed that the staffing levels on the day of inspection were not sufficient to meet the health and social care needs of the residents. Since the previous inspection, the provider had allocated a member of staff to provide activities to residents from Monday to Friday, 10am until 3pm. Inspectors observed that activities were provided for residents during the morning and early afternoon. However, the activities scheduled for the late afternoon were not provided for residents, and residents were observed sitting unoccupied for long periods of time. The staffing model in the centre also required the health care assistants to fulfil the laundry duties within their allocated direct care hours.

Furthermore, the staffing levels for night duty comprised of two staff members, a nurse and a health care assistant, on duty in the centre from 10pm until 8am. This staffing level was not adequate to ensure that all residents could be monitored and supported with their care needs. Following the previous inspection, the provider had committed to ensuring that there would always be an on-call arrangement in place to support the night-time staff. These arrangements for the on-call night staff were not clearly identified on staffing rosters or within a fire safety policy. Inspectors were not assured that an appropriate staffing level would be available to evacuate

residents in the event of an emergency, in a timely manner.

A review of the policies and procedures in the centre found that there were a number of policies that were out of date. In addition, there were a number of policies that were not available for inspectors to review.

Inspectors followed up on the action taken by the provider in relation to the contracts for the provision of services following significant non-compliance identified on the previous inspection. A review of contracts found that not all residents had a signed contract in place. All contracts reviewed had the fees for the service identified, and also included a number of additional charges such as payments for activity programmes, pressure areas support equipment, and laundering of personal clothes. However, inspectors found that the contracts did not include all additional charges that residents were required to pay. This will be discussed further under Regulation 24: Contract for the provision of services.

A review of the complaints records found that the process for managing complaints was not in line with regulatory requirements. This is a repeat non-compliance.

Regulation 15: Staffing

The number and skill mix of staff was not appropriate having regard to the assessed needs of the residents. For example:

- there was inadequate staff to meet the social needs of the residents. For example, there was no facility to support residents with occupation or activity in the afternoon.
- the staff roster did not identify staff allocated to work in the laundry. Care staff were required to work in the laundry which reduced the number of hours available for direct care of residents.
- the staffing levels at night did not provide assurance that residents could be monitored effectively.
- the staffing levels at night did not provide assurance that residents could be safely evacuated in the event of an emergency.

This is a repeat non-compliance.

Judgment: Not compliant

Regulation 16: Training and staff development

Inspectors found that staff had access to, and had completed training, appropriate to their roles.

Judgment: Compliant

Regulation 23: Governance and management

The provider had failed to ensure that the designated centre had sufficient resources to ensure effective delivery of care. For example, the staffing in place on the day of the inspection was not in line with the staffing detailed in the statement of purpose for the designated centre. The statement of purpose included an assistant director of nursing and 13 registered nurses. There was no assistant director of nursing working in the centre and there were eight registered nurses on the staff roster.

Inspectors found that the organisational structure in the centre on the day of the inspection did not provide assurance that the provider had a clearly defined management structure that identified clear lines of authority and accountability.

The management systems in place were ineffective and therefore, did not ensure that the service provided to residents was safe, appropriate, consistent and effectively monitored. This was evidenced by;

- there was no system of monitoring or oversight in place. There was no evidence that any audits had taken place since the previous inspection and there was no quality improvement system in place.
- the risk management systems were ineffective. Risks identified on the last three inspections were not identified and managed within the centre's risk register. For example, the risk in relation to fire safety was not appropriately managed.

The compliance plan responses from two previous inspection findings had not been fully implemented.

This is a repeat non-compliance.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

The provider failed to ensure that contracts for the provision of services were in place in line with regulatory requirements. For example;

- there were only 23 out of 27 contracts available for inspectors to review which were signed by residents or their representative
- charges incurred by residents for the use of rooms for chiropody and hairdressing were not included in contracts signed by residents or their

representative.

This is a repeat non-compliance.

Judgment: Not compliant

Regulation 34: Complaints procedure

The centre's complaints management policy and procedure did not include all the requirements of Regulation 34. For example;

- there was no person appointed to ensure all complaints were appropriately managed
- the policy did not include an appeals process
- complaints reviewed by inspectors did not include an investigation.

This is a repeat non compliance.

Judgment: Not compliant

Regulation 4: Written policies and procedures

A number of policies required by Schedule 5 of the regulations were in not place in line with regulatory requirements. For example;

- Fire safety
- Management of behaviour that is challenging
- The use of restraint

The following policies were out of date;

- Admissions
- Staff training and development
- Communication
- End of life

This is a repeat non-compliance.

Judgment: Not compliant

Quality and safety

Residents reported their satisfaction with the care provided and felt safe living in the centre. However, the poor governance arrangements in the centre impacted on the quality and the safety of residents' care. The actions proposed by the provider to bring the centre into full compliance with the regulations had not been completed and non-compliant issues found with Regulation 17: Premises and Regulation 28: Fire precautions continued to impact resident safety. Action was also required to comply with Regulation 5: Individual assessment and care plan, Regulation 7: Managing behaviour that is challenging and Regulation 9: Residents' rights. The findings of this inspection reflect poor oversight of the service resulting in non-compliance across aspects of both the care delivery and care environment.

A review of fire precautions evidenced that the provider had taken some action to address issues of non-compliance found on the previous inspection. This included replacing the key lock at the front door and ensuring areas such as the electrical panel room was easily accessed by staff through a key pad. Nonetheless, inspectors found that the provider did not have a fire safety policy and therefore it was not possible to assess the providers systems to manage fire risks in the centre. The provider had completed a review of the integrity of fire doors in the centre since the previous inspection. However, the provider did not have a clear time-bound action plan of works completed to date, and there was no time line for the works to be completed. Furthermore, there was no risk management system in place to manage any potential risk to residents while awaiting the outstanding works to be completed. Further findings are detailed under Regulation 28, Fire precautions.

Following the previous inspection, the provider submitted a compliance plan to address deficits with the premises with regard to maintenance, storage, redecoration and the provision of additional showering facilities for residents. This plan was due for completion by September 2022. Inspectors acknowledged that while some redecoration and maintenance works had been completed, the provider had not taken action to manage inappropriate storage of equipment, redecoration of residents' bedrooms or to install additional shower facilities as detailed in the providers compliance plan.

There was adequate supplies of personal protective equipment available to staff and wall mounted hand sanitisers were placed throughout the centre and at the point of care. The provider had installed three dedicated hand wash basins since the previous inspection. Areas occupied by residents, such as communal day rooms, were clean on inspection.

A review of six resident files identified some gaps in residents’ assessments and care plan records, where information pertinent to guiding person-centred care was not evident. Inspectors found that a number of care plan reviews had not been consistently completed in line with the requirements of the regulation.

A review of residents' records found that there was regular communication with residents' general practitioners (GP) regarding their health care needs. Arrangements were in place for residents to access the services of a number of

allied health and social care professionals.

Restraint records reviewed indicated a low incidence of bed rail usage in the centre. However, inspectors found that the documentation relating to the use of bed rails was not in line with the national policy for the use of restraint.

Resident's did not have consistent access to activities. A member of staff was assigned to provide activities daily and inspectors observed small group sessions in the day room. However, residents were observed to spend long period of time in the afternoon with limited social engagement and no meaningful activities.

Regulation 11: Visits

The registered provider had arrangements in place to facilitate residents to receive visitors in either their private accommodation or in a designated visiting area. Visits to residents were not restricted.

Judgment: Compliant

Regulation 17: Premises

There were areas of the premises that were not maintained in a satisfactory state of repair and action was required to comply with the requirements of Schedule 6 of the regulations. For example;

- there was inadequate showering facilities available for residents. This was identified on the previous two inspections.
- the floor covering in the day room, dining room and some bedrooms was worn and uneven in parts, posing both an infection control risk and tripping hazard to residents.
- there was inappropriate storage facilities in the centre. For example, hoists, mobility aids and specialised seating were stored in residents bedrooms.
- a number of bedrooms had damaged paintwork on the walls, where paint was visibly chipped and damaged.
- the floor in one bedroom was visibly damaged and the wall had holes where electrical sockets had been removed. Inspectors acknowledged that the provider took action to address this issue during the inspection.
- equipment used by residents, such as shower chairs and commodes, were in a poor state of repair and could not be cleaned effectively
- store rooms, communal bathrooms and some bedrooms were not cleaned to an acceptable standard.

This is a repeat non-compliance.

Judgment: Not compliant

Regulation 28: Fire precautions

At the time of inspection, the registered provider had not taken adequate precautions to ensure that residents were protected from the risk of fire. In addition, fire precautions were not being adequately reviewed. For example;

- while there was a system in place to check all fire escape routes daily, these checks were not consistently recorded
- a fire exit in the day room continued to be obstructed by a resident's chair and this was not identified in the daily fire safety checks
- a staff room and external storage area were used to store oxygen cylinders inappropriately.
- there were holes and service penetrations through ceilings in the heat distribution and electrical switch room. This reduced the ability of the walls to effectively contain a fire.
- fire doors appeared damaged
- the fire evacuation procedures displayed in the centre did not detail the arrangements in place for the timely evacuation of residents in the event of a fire emergency when staffing was at minimum levels
- inspectors reviewed records of simulated fire evacuation drills and were not assured that adequate arrangements had been made for evacuating residents from the centre in a timely manner with the staff and equipment resources available. Records did not detail the correct number of residents in a zone or the requirement to call management for assistance at night time to effect a safe and timely evacuation of residents.

This is a repeat non-compliance.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

A review of the residents' assessments and care plans found that care plans had not been reviewed following a change in a residents health status or assessed need as required under Regulation 5. For example, a resident's care plan did not contain information regarding their nutritional needs. They were assessed as a high risk of malnutrition with continued weight loss and interventions recommended by a dietitian were not integrated into the resident's care plan and, consequently, were

not known to staff.

Inspectors found that a number of care plans were not revised in consultation with the resident and, where appropriate, their representatives, as required by the regulations.

This is a repeat non-compliance.

Judgment: Not compliant

Regulation 6: Health care

Residents had access to medical assessments and treatment by their General Practitioners (GP).

Residents also had access to a range of allied health care professionals such as dietitian, speech and language therapy, tissue viability nurse, psychiatry of old age and palliative care.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

There was a number of residents using bedrails at the time of the inspection. However, inspectors found that the management of bedrails was not in line with national guidelines for a restraint free environment. For example;

- there was no multi-disciplinary assessment of risk prior to initiating the use of bedrails for a number of residents
- some records did not evidence if the least restrictive alternatives were trialled prior to initiating the use of bedrails
- residents, or their relatives, were not consulted regarding the use of bedrails
- risk assessments were not reviewed and updated at regular intervals or when the resident's condition changed. For example, some assessments had not been reviewed since 2021.

Judgment: Substantially compliant

Regulation 9: Residents' rights

While there were activities provided to the residents on the day of the inspection,

residents were observed spending long periods with no provision activity especially in the afternoon. This is a repeat non-compliance.
Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Not compliant
Regulation 34: Complaints procedure	Not compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for St. Dominic Savio Nursing Home OSV-0000450

Inspection ID: MON-0037825

Date of inspection: 17/11/2022

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: ***This compliance plan response from the registered provider did not adequately assure the office of the Chief Inspector that the actions will result in compliance with the regulations.*** We have a desiginated activities cordinator Monday to Friday 10am to 3pm. From 3pm to 5pm we have a designated staff member providing meaningful activities and scoical care 7 days a week. All activities are overseen and cordinated by a person participation in management. We have added an additional 18 hours a week onto housekeeping roster. The extra hours will facilitate laundry duties now being undertaken by housekeeping staff. We constently review our roster and respond to changes in our dependancy levels. Our key performance indicators demonstrate that our current staffing levels are meeting the care needs of all our residents. Our new roster now clearly identifies who is on call over night. Feedback received from night staff, indicated that staffing levels where sufficient to effectively monitor the residents' care needs. In the event of an acute escalation of care needs a member of staff is rostered as "night duty on call".	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Following the inspection, a new member of staff joined our team as a person participation in management to assist and support the person in charge. We also added 18 additional hours per week to our housekeeping roster. These measures will enhance	

the safety and care of our residents. There are clear lines of reporting and responsibility outlined in the Statement of Purpose and Function. Operationally, following the inspection, we have reviewed our Statement of Purpose and updated our staffing details. Our Statement of Purpose is now displayed in our entrance foyer which includes our updated organisation structure chart which identifies clear lines of authority and accountability. We now have an additional person participaton in management to assist and support the person in charge. St. Dominic Savio has recently joined an external co-operative that specialises in supporting family run nursing homes. This will assist and support us with strengthening our governance and management structure. An audit plan has been created and these audits are carried out monthly by the clinical management team and the findings are discussed at the monthly governance meetings. The person participating in managment and person in charge meet weekly to review our key performance indicator and to ensure quality improvement plans, as a result of our audits, are followed up and closed out. The risk register is currently being fully reviewed and all risks are being re-assessed including fire and appropriate controls are being put in place. Once complete, the risk register will be reviewed monthly by the PIC and PPIM and all risks will be discussed at the monthly governance meetings. An information booklet on Fire has been created and shared with all staff to clearly show the fire safety plan in St. Dominic Savio. This booklet will also be issued to all staff on induction as part of their fire training. All of the above will be fully complete and implemented by the 31/1/2023.

Regulation 24: Contract for the provision of services	Not Compliant

Outline how you are going to come into compliance with Regulation 24: Contract for the provision of services:
We have updated and revised all our contracts of care. This new contract clearly identifies all possible charges that can be incurred and the prices for these services. All residents have been issued with the contract of care so that all residents are using the same contract of care and ensuring that all residents have a signed contract of care. Going forward, admissions will not take place until there is a signed contract of care in place. We aim to have all signed contracts of care returned and in place by the 31/3/2023

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The complaints policy and procedure has been reviewed to include a designated person

to ensure all complaints are appropriately managed and this person is the person in charge. The policy also includes an appeals person, and this is the registered provider representative. The complaints policy also includes a complaints reviewer so as to ensure the policy is reflective of the recent changes to the Health Act in relation to complaints. The complaints reviewer is a person participation in management. The complaints procedure is clearly displayed in the entrance foyer and has also been included in the statement of purpose and function. All of the above have been completed.

Regulation 4: Written policies and procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
A Centre specific fire safety policy that is in line with the regulations is now in place, and this will be shared with all staff and is part of our fire training and drills. A Management of behaviour that is challenging policy in line with the regulations and that is Centre specific is now in place and will be circulated and shared with all staff. The use of restraint policy that is in line with the regulations and is Centre specific is now in place and will be circulated and shared with all staff. We have also implemented a restrictive practice information booklet for residents, staff and families/nominated persons. The purpose of these booklets are to educate our residents, staff and families on restrictive practice and to commence our preparation for restrictive practice thematic inspections that will be carried out in 2023. The following policies are all being reviewed and updated to ensure they are in line with current best practice and will be shared with all staff once complete. • Admissions • Staff training and development • Communication • End of life This will be complete by 31/1/2023. An audit systems will be implemented to ensure that all policies are reviewed, audited and updated annually. This will be in place by the 30/4/2023. We have information booklets on end of life care for our residents and families/nominated persons as this was a finding from the National Residents Experience Survey that residents would have liked more information around end of life care and their choices in relation to this care. These booklets can be made available as required.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Additional showering facilities have been added to the facility and should be operational in 2 weeks. These changes have been included on our floor plans and in our Statement of Purpose and Function. The floor covering in the day room, dining room and bedrooms where it was identified as damaged has been replaced. A review of our equipment and

storage has taken place, one hoist is now stored in a designated hoist parking area and the second hoist is sored in a suitable location. Maintenance personnel are on site regularly painting and fixing any areas that require maintenance as soon as they are noted. The PPIM and PIC carry out a weekly audit of the facility where they check for any damaged areas, the cleanliness of the facility, storage of equipment, condition of equipments such as commodes and shower chairs and fire escape routes. On the day of the inspection two pieces of equipment were noted to be in need of replacement and they were immediately replaced on the day of inspection. Any damaged equipment will be replaced if found to be defective during the weekly audit.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
A fire register is in place which includes a record of daily, weekly, monthly and quarterly checks. All fire escape routes are checked three times daily and this is documented by the staff nurse on duty and audited by the PIC weekly. The daily fire escape route checks ensures that there is no obstruction of any fire escape route. A re-education of all staff is taking place and this will also feature in our annual mandatory fire training of all staff and is addressed in our fire drills every second month. The PIC and PPIM will also carry out spot checks of fire escape routes at different times so as to ensure compliance. This is included in the weekly facility audit carried out by a person particapation in management. All oxygen cylinders are now stored externally in a well ventilated upright position and are secured with a chain. All holes and service penetrations in ceilings in the electrical switch room have been repaired. All of the above are complete. A full review of our fire doors has been carried out by a competent person and we are awaiting the report. It is hoped we should have this report before the 31/01/2023. The on-call names and phone numbers that are to be contacted in the event of an emergency at night have been added to the fire evacuation procedures displayed on the floors. This is complete. A full review of resident numbers in each compartment has been carried out as part of the fire policy review. It clearly identifies the number of residents and their dependency in each compartment. This helps to ensure a swift and safe evacuation of residents in the event of an emergency.

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:
As part of our monthly key perforamane indicators, nutrition and resident’s weights are

being monitored monthly. Any resident at risk of malnutrition and continued weight loss will be weighed weekly and will be reviewed by the GP and dietician. All residents' care plans that are at risk of malnutrition have been fully reviewed and all recommendations from the dietician have been implemented. It would normally be usual practice to ensure that all care plans are revised in consultation with residents and, where approprite, their representatives. Following our inspection, a full review of all care plans is being undertaken by the PPIM and PIC and all care plans will be revised in consultation with the residents and, where appropriate, their representatives. This will be monitored as part of our monthly audits and discussed at our monthly governance meetings.

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:
An updated bedrail assessment is being implemented for all residents. This risk assessment clearly includes input with the multi-disciplinary team and all alternatives tried prior to bedrails being used. The risk assessment also includes involvement and consultation with the residents and, where appropriate, their relatives. This risk assessment will be reviewed as required and at a minimum of four months. The updated bedrail risk assessment and all residents restrictive practice care plans will be updated to include all alternatives used prior to the use of any bedrails. Our new restrictive practice information booklet will also be made available to all residents and their relatives to help educate them on the use of restrictive practices. Restrictive practice will be one of our monthly key performance indicaator audits and will be discussed and reviewed at our monthly governance meetings.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Our activity programme is being reviewed and staff are allocated to provide and to assist realidents with meaningful activity and occupation throughout the day. Further activity training will also be provided to staff in 2023. This training will be complete by 31/3/2023.

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	04/01/2023
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	17/01/2023
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the	Not Compliant	Orange	31/01/2023

	effective delivery of care in accordance with the statement of purpose.			
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	31/01/2023
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	31/01/2023
Regulation 24(1)	The registered provider shall agree in writing with each resident, on the admission of that resident to the designated centre concerned, the terms, including terms relating to the bedroom to be provided to the resident and the number of other occupants (if any) of that bedroom, on which that	Not Compliant	Orange	31/03/2023

	resident shall reside in that centre.			
Regulation 24(2)(d)	The agreement referred to in paragraph (1) shall relate to the care and welfare of the resident in the designated centre concerned and include details of any other service of which the resident may choose to avail but which is not included in the Nursing Homes Support Scheme or to which the resident is not entitled under any other health entitlement.	Substantially Compliant	Yellow	31/03/2023
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	04/01/2023
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	31/01/2022
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the	Substantially Compliant	Yellow	04/01/2023

	designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.			
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	04/01/2023
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.	Not Compliant	Orange	04/01/2023
Regulation 28(3)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place in the designated centre.	Not Compliant	Orange	04/01/2023
Regulation 34(1)(d)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall investigate all	Not Compliant	Orange	04/01/2023

	complaints promptly.			
Regulation 34(1)(g)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall inform the complainant promptly of the outcome of their complaint and details of the appeals process.	Not Compliant	Orange	04/01/2023
Regulation 34(3)(a)	The registered provider shall nominate a person, other than the person nominated in paragraph (1)(c), to be available in a designated centre to ensure that all complaints are appropriately responded to.	Not Compliant	Orange	04/01/2023
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.	Not Compliant	Orange	31/01/2023
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the Chief Inspector may require but in any event at intervals	Not Compliant	Orange	30/04/2023

	not exceeding 3 years and, where necessary, review and update them in accordance with best practice.			
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Substantially Compliant	Yellow	31/03/2023
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	Orange	31/03/2023
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of	Substantially Compliant	Yellow	31/03/2023

	Health from time to time.			
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Substantially Compliant	Yellow	31/03/2023