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. Gladys Nursing Home
Name of provider:	Willoway Nursing Home Limited
Address of centre:	53 Lower Kimmage Road, Harold's Cross, Dublin 6w
Type of inspection:	Unannounced
Date of inspection:	07 February 2023
Centre ID:	OSV-0000686
Fieldwork ID:	MON-0038506

About the designated centre

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

St. Glady's Nursing Home is located in a suburb of Dublin and close to local shops, bus routes and social amenities such as parks. It is a period building which has been developed to each side of the original building. It is registered to provide care for up to 51 residents. There are 21 single rooms, and 15 sharing rooms. Some of the bedrooms are en-suite and there are accessible bathrooms and toilets throughout the centre. The centre provides care of the elderly, but can also support residents under retirement age. The service is provided to residents with low, medium, high and maximum dependency. They focus on meeting residents needs in relation to care of the elderly, Alzheimer's, dementia or psychiatric needs.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	49

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
Tuesday 7 February 2023	08:50hrs to 18:30hrs	Mary Veale	Lead
Tuesday 7 February 2023	08:50hrs to 18:30hrs	Frank Barrett	Support

What residents told us and what inspectors observed

This was a pleasant centre where residents for the most part enjoyed a good quality of life and were supported to be independent. Resident's rights and dignity was supported and promoted by kind and competent staff. Care was led by the needs and preferences of the residents who were mostly happy and well cared for in the centre. The overall feedback from residents was of satisfaction with the care and service provided. Residents' whom the inspectors spoke with were positive about their experience of living in St Gladys Nursing Home. The inspectors greeted the majority of the residents on the day of inspection and spoke at length with seven residents. The inspectors spent time observing residents daily lives and care practices in order to gain insight into the experience of those living there.

On arrival the inspectors were met by a member of the nursing staff and were guided through the centre's infection control procedure before entering the building. The inspectors were greeted by the chief operations officer. Following an introductory meeting with the person in charge, the inspectors were accompanied on a tour of the premises. The centre is registered to accommodate 51 residents and there were 49 residents living in the centre on the day of inspection. At the time of inspection the centre could accommodate 50 residents due the configuration of bedroom 2 on the first floor. Room 2 had an external fire exit door which was a fire evacuation route to a secure garden area. The occupancy of this room was reduced to one resident to ensure that the fire exit door was not obstructed. The inspectors spoke with and observed residents' in communal areas and in their bedrooms. The inspectors noted that the centre was busy on the day of inspection, residents were being assisted by staff with their care needs and visitors were attending the centre.

The centre was a two storey building with five separate wings referred to as Mount Argus, Kimmage Lower, Kimmage Upper, Harolds Cross Lower and Harolds Cross Upper. Access to each floor was by stairs or lift. The centre was warm. The communal areas were located on the ground floor which included a visitor's room, three day rooms, and a dining room. The laundry, a storage area, and staff changing facilities were located within cabins at the the rear of the building. The resident's bedroom accommodation comprised of 21 single rooms and 15 twin rooms with shared bathrooms or en-suite facilities. Bedrooms were personalised and decorated in accordance with the resident's wishes. Many of the residents' bedrooms had fresh jugs of water. Lockable locker storage space was available for all residents. Personal storage space comprised of a double or single wardrobes and drawers. The inspectors observed that the personal storage space for residents in some twin rooms was not included in the resident's bedroom floor space, this is discussed further in this report. Pressure reliving specialist mattresses, low to floor beds and other supportive equipment was seen in residents' bedrooms.

The centres reception and communal rooms had been carefully and beautifully decorated and the décor was sympathetic to the age of the building. The original building had retained many of its period features, for example, high ceilings and

staircase. The dining room and day rooms to the front of the building had large windows where residents were seen throughout the day of inspection enjoying the street view. The day rooms to the rear of the building looked out on to courtyard gardens. The day rooms had large televisions, shelves containing books, and one had a piano. The dining room was conveniently located beside the kitchen on the ground floor. All day room spaces on the ground floor were busy from mid-morning time on the day of inspection. Residents were seen to have their meals, engage in activities and some had visitors in the same day space through out the day of inspection.

Some corridors and storage areas in the centre were cluttered. This will be discussed further in the quality and safety section of the report. Corridor and bed room areas were found to be clean and flooring had been installed in the dining room, two day rooms, a stairwell and a communal bathroom prior to the previous inspection. There were assistive handrails in all corridor areas. The inspectors observed appropriate seating in all communal areas. There was an on-going schedule of works taking place to upgrade the premises. Alcohol hand gels were available throughout the centre to promote good hand hygiene practices.

Residents had access to two courtyard gardens and access to both courtyard garden areas was from the centres day rooms at the back of the building. Garden areas were easily accessible with level footpaths for residents to safely walk around. The courtyards had looped walkways allowing residents and their families to fully enjoy the outdoor space. The garden areas were attractive and well maintained with mature scrubs and seating areas.

The inspectors observed the lunch time and evening meals in the dining room and the three day rooms on the ground floor. Breakfast was serviced to residents in their bedrooms in the morning and all other meals were served in the centres communal rooms in the afternoon and evening on the day of inspection. The lunch time meal served in the dining room was a social occasion, with some residents chatting and nice exchanges of conversation between staff and residents. Residents who required assistance with eating and drinking were seen to be assisted discreetly and independence was promoted where possible. Food was served directly from the kitchen and was warm, and appetising. There was a choice of main meal and desert on the day of inspection. All residents whom the inspectors spoke with were complementary of the home cooked food, the choice of meals offered and said that snacks were available at any time.

The majority of residents' spoken with said they were very happy with the activities programme in the centre and some preferred their own company but were not bored as they had access to newspapers, books, televisions, Wi-Fi, and visits from friends and family. The activities programme was displayed in the centre and residents' had a choice of attending activities each day. For residents who could not attend group activities, one to one activities were provided. Over the inspection day, residents were observed partaking in a current affairs activity, and a bowling activity. The inspectors observed staff and residents having good humoured banter during the activities and observed the staff chatting with residents about their personal interests and family members. Mass took place monthly in the centre and a

Eucharist minister offered communion to residents every Wednesday. The inspectors observed many residents walking around the centre. The inspector observed residents reading newspapers, watching television, listening to music, and engaging in conversation. Books and board games were available to residents. There were pictures displayed of residents on day trips to nearby attractions and residents artwork was displayed in residents bedrooms. The hairdresser attended the centre weekly.

A number of residents were living with a cognitive impairment and were unable to fully express their opinions to the inspectors. However, these residents appeared to be content, appropriately dressed and well-groomed.

Visitors who spoke with the inspectors were complimentary of the care and attention received by their loved ones. Visitors spoken with said that sometimes access to communicate with staff was difficult but that staff communication with their loved ones was excellent. Residents who could express their opinion were complimentary of the staff and said that staff were always quick to answer their call bells

The centre provided a laundry service for residents. All residents' whom the inspectors spoke with on the day of inspection were happy with the laundry service and there was one report of an item of clothing missing.

The next two sections of this report will present findings in relation to governance and management in the centre, and how this impacts on the quality and safety of the service being delivered.

Capacity and capability

This was an unannounced inspection carried out to monitor ongoing compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) 2013 as amended. The inspectors found that overall this was a well-managed centre where the residents were supported and facilitated to have a good quality of life. The provider had progressed some areas of the compliance plan following the inspection carried out in January 2022 and improvements were found in Regulation 5: individual assessment and care plan, and Regulation 23: governance and management. The centre had an inspection in November 2022 which focused specifically on Regulation 27: infection control. As this was a recent inspection, the inspectors did not follow up on this specific compliance plan, to allow the provider time to progress its plan to come into compliance with Regulation 27: infection prevention and control. On this inspection, the inspectors found that actions was required by the registered provider to address Regulation 17: premises. Actions were required to come into compliance in areas of Regulation 9: residents rights, Regulation 11:visits, Regulation 12: personal possessions, Regulation 16: training and staff development, Regulation 21: Records, Regulation 24: contract for provision of services, and Regulation 28: fire precautions.

The registered provider had applied to renew the registration of St Glady's Nursing Home. The application was timely made, appropriate fee's were paid and prescribed documentation was submitted to support the application to renew registration.

Willoway Nursing Home limited is the registered provider for St Glady's Nursing Home. The company had two directors, one of whom was the registered provider representative. The person in charge worked full time and was supported by a clinical nurse manager, a team of nurses and healthcare assistants, activities co-ordinators, housekeeping, laundry, catering, administration and maintenance staff. The management structure within the centre was clear and staff were all aware of their roles and responsibilities. The person in charge was supported by a chief operations manager and by shared group departments, for example, human resources. There were sufficient staff on duty to meet the needs of residents living in the centre on the day of inspection.

Staff had completed training in safe guarding, fire safety, infection prevention control and manual handling. There was an ongoing schedule of training in place to ensure all staff had relevant and up to date training to enable them to perform their respective roles. Staff with whom the inspectors spoke with, were knowledgeable regarding fire evacuation procedures and safe guarding procedures. Improvements were required in staff training and development which is discussed further in the report.

There were effective systems in place to monitor the quality and safety of care which resulted in appropriate and consistent management of risks and quality. There was evidence of a comprehensive and ongoing schedule of audits in the centre, for example; care plans, infection prevention and control, medication management and falls. Audits were objective and identified improvements. Records of governance and local staff meetings showed evident of actions required from audits completed which provided a structure to drive improvement. There were regular governance meeting and staff meeting taking place in the centre and agenda items included key performance indicators (KPI' s), training, fire safety, and COVID-19 planning. It was evident that the centre was continually striving to identify improvements and learning was identified on feedback from resident's satisfaction surveys, post falls analysis, complaints and audits. The annual review for 2022 was submitted following the inspection. It set out the improvements completed in 2022 and improvement plans for 2023.

The provider supported four residents to manage their pension and this was done in line with the department of social protection guidelines. Procedures were in place for the management of residents' monies and locked storage was provided for residents' valuables.

A sample of resident's contract for the provision of services were viewed on inspection. Improvements required to the contracts of care are discussed further under Regulation 24: contact of service provision.

Records and documentation, both manual and electronic were well presented, organised and supported effective care and management systems in the centre.

Requested records were made available to the inspectors throughout the day of inspection and records were appropriately maintained, safe and accessible. Improvements were required in staff records and this is discussed further under Regulation 21: records.

Incidents and reports as set out in schedule 4 of the regulations were notified to the Chief Inspector within the required time frames. The inspector followed up on incidents that were notified and found these were managed in accordance with the centre's policies.

There was a complaints procedure displayed in the reception area of the centre. There was a nominated person who dealt with complaints and a nominated person to oversee the management of complaints. A record of complaints received in 2022 was viewed. There was evident that the complaints were effectively managed and the outcomes of the complaint and complainants satisfaction was recorded.

Registration Regulation 4: Application for registration or renewal of registration

All documents requested for renewal of registration were submitted in a timely manner.

Judgment: Compliant

Registration Regulation 8: Annual fee payable by the registered provider of a designated centre for older people

All the requested fees were received.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge worked full time in the centre and displayed good knowledge of the residents' needs and had good oversight of the service. The person in charge was well known to residents and their families.

Judgment: Compliant

Regulation 15: Staffing

Staffing was found to be sufficient to meet the needs of the residents on the day of the inspection.

Judgment: Compliant

Regulation 16: Training and staff development

Not all staff had access to appropriate training to support them to perform their respective roles. For example, 22 staff required training in the management of behaviour that is challenging, and in line with the centres mandatory training requirements.

Judgment: Substantially compliant

Regulation 21: Records

Improvements were required with staff records. In a sample of four staff files viewed, two of the files did not have a satisfactory history of gaps in employment in line with schedule 2 requirements.

Judgment: Substantially compliant

Regulation 22: Insurance

There was a valid contract of insurance against injury to residents and additional liabilities.

Judgment: Compliant

Regulation 23: Governance and management

Management systems were effectively monitoring quality and safety in the centre. Clinical audits were routinely completed and scheduled, for example, falls, medication management, and quality of care and these audits informed ongoing quality and safety improvements in the centre. There was a proactive management approach in the centre which was evident by the ongoing action plans in place to

improve safety and quality of care.

Judgment: Compliant

Regulation 24: Contract for the provision of services

Contract of provisions required review as one contract of provisions did not reflect the current bedroom accommodation for the resident .

Judgment: Substantially compliant

Regulation 3: Statement of purpose

Amendments were made to the centre's statement of purpose during the inspection. The statement now contained all of the information set out in schedule 1 of the regulations and in accordance with the guidance.

Judgment: Compliant

Regulation 31: Notification of incidents

Incidents and reports as set out in schedule 4 of the regulations were notified to the Chief Inspector within the required time frames. The inspectors followed up on incidents that were notified and found these were managed in accordance with the centre’s policies.

Judgment: Compliant

Regulation 34: Complaints procedure

The inspector reviewed the complaints log and found the records contained adequate details of complaints and investigations undertaken. A record of the complainants’ level of satisfaction was included.

Judgment: Compliant

Quality and safety

Overall, residents and visitors expressed satisfaction with the care provided in the centre. Improvements had been noted in the area of individual assessment and care planning since the inspection carried out in January 2022. On this inspection actions was required by the provider to comply with Regulation 17: premises. Actions were also required by the provider to comply in the areas of Regulation 5: care planning and individual assessment, Regulation 9: residents rights, Regulation 11: visits, Regulations12: personal possessions, and Regulation 28: fire safety.

Visiting had almost returned to pre-pandemic visiting arrangements in the centre. There were ongoing safety procedures in place. For example, temperature checks and health questionnaires. Residents could receive visitors in their bedrooms, the centres communal areas and outside in the gardens. Their was a booking system in place for visiting.

Residents were supported to access appropriate health care services in accordance with their assessed need and preference. General Practitioners (GP's) attended the centre and residents had regular medical reviews. Residents had access to a consultant geriatrician, psychiatric services, nurse specialists, palliative home care services and a mobile x-ray service. A range of allied health professionals were accessible to residents as required; for example, physiotherapist, speech and language therapist, dietician and chiropodist. Residents had access to dental and optician services. Residents who were eligible for national screening programmes were also supported and encouraged to access these.

The centre had arrangements in place to protect residents from abuse. The centre had a safeguarding policy to guide staff on the management of allegations of abuse. Safeguarding training had been provided to all staff in the centre and staff were familiar with the types and signs of abuse and with the procedures for reporting concerns. All staff spoken with would have no hesitation in reporting any concern regarding residents' safety or welfare to the centre's management team. The provider assured the inspectors that all staff had valid Garda vetting disclosures in place and that volunteers were not attending the centre.

The centre acted as a pension agent for four of the residents. Resident's had access to and control over their monies. Residents who were unable to manage their finances were assisted by a care representative or family member. Laundry was provided in the centre for residents and some residents chose to have their clothing laundered at home. Further improvements in relation to the residents' personal possessions are discussed further under Regulation 12.

70% of residents living in St Glady's Nursing home on the day of inspection had symptoms of dementia or a confirmed diagnosis of dementia. There was policy in place to inform staff in the management of responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort with their social or physical environment) and restrictive practices in the centre.

Residents' had access to psychiatry of later life. For resident's with identified responsive behaviours, nursing staff had identified the trigger causing the responsive behaviour using a validated antecedent- behaviour- consequence (ABC) tool. There was a clear care plan for the management of resident's responsive behaviour. It was evident that the care plans were being implemented. There were ten residents who used bed rails as a restrictive device. Risk assessments were completed, and the use of restrictive practice was reviewed regularly. Less restrictive alternatives to bed rails were in use such as sensor mats and low beds. The front door to the centre was locked. The intention was to provide a secure environment, and not to restrict movement . Residents' were seen assisted by visitors to leave the centre to use the gardens at the rear of the building during the day and visitors were accessed the centre using a door bell.

There was a good standard of care planning in the centre. In samples of care plans viewed residents' needs were comprehensively assessed by validated risk assessment tools. Care plans were person centred and routinely reviewed. The person in charge was facilitating care planning training at the time of inspection to support nursing staff in developing person centred care planning. However; from the sample of nursing notes viewed it was not evident that four monthly reviews of care plans with residents had taken place.

The centre was clean, and apart from a lack of storage the centre was general tidy. Alcohol gel was available, and observed in convenient locations throughout the building. Staff were observed to have good hygiene practices and correct use of PPE. There was evidence of infection prevention control (IPC) meetings with agenda items such as COVID-19 and actions required from specific IPC audits. The centre had an IPC policy which included COVID-19 management.

The centre had a risk management policy that contained actions and measures to control specified risks and which met the criteria set out in regulation 26. The centre’s risk register contained information about active risks and control measures to mitigate these risks. The risk registered contained site specific risks such as risks associated with absconding, risks associated with fire safety and staff shortages.

Residents rights, and choices were respected. Residents were actively involved in the organisation of the service. Regular resident meetings and informal feedback from residents informed the organisation of the service. The centre promoted the residents independence and their rights. The residents had access to a SAGE advocate. The advocacy service details and activities planner were displayed in the centre. Residents has access to daily national newspapers, books, televisions, and radio’s. Satisfaction surveys showed high rates of satisfaction with all aspects of the service. Roman Catholic and Church of Ireland clergy visited residents’ in the centre regularly. A Eucharistic minister offered communion to residents weekly. Residents were offered choice in their meals but were limited in their options to have their meals in the dining room. On the day of inspection, all the residents had their breakfast in their bedrooms. Some residents had their meal in the dining room but most Residents had their diner and evening meals in communal spaces were they also partook in activities and visits from family. The premises in particular the communal rooms and shared bedrooms was having an impact on the residents

rights. This is discussed further under Regulation 9.

It was observed by inspectors throughout the inspection, that ongoing storage issues, and a lack of storage space, was impacting of the safe delivery of services at the designated centre. For example, linen trollies were found to be stored in toilet and shower rooms. Inspectors found a large storage shed used by the designated centre, to the rear of the building, inside of which inspectors found building materials, and tools stored with clinical items such as face masks, incontinence wear, and clean bed linen. Inspectors found that a number of call bells were not working or were missing, this is discussed further under Regulation 17: premises.

Inspectors reviewed the arrangements in place at the centre to protect residents from the risk of fire. Inspectors found that the lack of storage space was impacting on the fire safety of the building. Due to these storage issues, some evacuation routes both internally and externally were found to be partially obstructed..

Improvements were also required in relation to arrangements for residents who smoke. It was found that residents were assisted to an external smoking shed. Inspectors found that there was no call bell at the location.

On reviewing the fire safety systems in place in the centre inspectors found that the fire detection and alarm system for the centre was lacking detection in some areas These areas were identified on a fire safety risk assessment carried out at the centre. The emergency lighting system and evacuation signage was also deficient in some areas. There was a lack of external emergency lighting on escape routes This was noted on recent quarterly maintenance checks, but had not been actioned.

Inspectors found that containment in the event of a fire was impacted by some doors not closing completely on release of the door holder, The Staff entrance door to the kitchen was found to remain open when released, and some large gaps were found around the perimeter of fire doors. This is detailed further under Regulation 28.

Inspectors reviewed the records relating to staff training in fire safety. It was found that there was a good system in place to identify issues through weekly workarounds and checks of escape routes. Staff training in fire safety was scheduled for staff who did not have up-to-date training, however, on reviewing the training, it was found that six staff rostered for duty in the following week were not on the training schedule.

Overall, while improvements were required to fire safety arrangements, Inspectors found that staff knowledge of the procedures, and policies relating to fire safety was good. The centre had completed a substantial amount of upgrade works in the recent past, which would improve the overall fire safety of the centre. The provider had put a plan in place to address the remaining issues, and had implemented culture of proactive fire safety in the designated centre.

Regulation 11: Visits

Indoor visiting had not resumed in line with the most up to date guidance for residential care centres. For example:

- Visitors were required to book a visit in advance.

Judgment: Substantially compliant

Regulation 12: Personal possessions

Actions were required to reconfigure the layout of some of the multi-occupancy twin rooms as some residents were unable to maintain control over their clothes. For example:

- Wardrobes were located outside the residents floor space in rooms 3, 4, 30, and 31. As wardrobes were located out side the residents floor space, residents had to exit their private floor space or enter another residents private space to access their clothing.
- Residents in room 37 shared a wardrobe.
- There was no area to hang clothes in the wardrobe in room 27.

Judgment: Substantially compliant

Regulation 17: Premises

Actions were required by the registered provider to provide a premises which conform to the matters set out in Schedule 6. For example:

- There was a lack of storage in the designated centre resulting in excessive and inappropriate storage in toilets and shower rooms. The storage shed at the rear of the centre, was not arranged in a suitable manner with many items stored on the floor.
- A cabinet on the first floor was damaged, and drawers were unable to be opened.
- A cabinet under the sink in the shared toilet between bedrooms 9 and 10 made from medium density fibreboard (MDF) was damaged.
- A review of call bells was required as a significant number of call bells were missing or damaged residents bedrooms. Call bells were missing from bedrooms 5, 6, 7, 8, 9, 14, 15, 18, 19, 20, 22, 24, 25, 30, 31, 32, 33,34, and 35. Call bells were missing from shared toilets between bedrooms 9 and 10, and bedrooms 30 and 31, the toilet opposite room 22 , and the smoking

shed.
- Day space 4 on the floor plans for the centre was not communal space. On the day of inspection this space was observed as corridor area which provided an evacuation route for residents. This area stored manual handling equipment and had two sets of drawers for the storage of bed linen.

Judgment: Substantially compliant

Regulation 26: Risk management

There was good oversight of risk in the centre. Arrangements were in place to guide staff on the identification and management of risks. The centre's had a risk management policy which contained appropriate guidance on identification and management of risks.

Judgment: Compliant

Regulation 28: Fire precautions

The registered provider did not take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment for example:

- An electrical distribution board was found on the ground floor escape stairwell in "Wing A" which did not have a fire rated cover.
- Inappropriate storage of combustible materials in the storage container.
- There was no call bell provided in the smoking shed.

The registered provider did not take appropriate measures to provide adequate means of escape, including emergency lighting for example:

- Emergency lighting was not provided or not working on external escape routes.
- Items were found to be stored on escape corridors for example, a large cabinet and a hoist charging on first floor corridor.
- Laundry bins were left in an evacuation route at the side of the building, and a hoist was found on the escape corridor near room 35. There was also a large cabinet in the same hallway, as well as unused mobility aids, which were impacting on the escape route in the event of a fire.
- Assembly point signage could not be found on the day of inspection. Inspectors spoke with staff who showed inspectors where they had been advised to gather in the event of an evacuation, however, it was pointed out to the provider that signage was not in place to direct residents or visitor to the assembly points in the event of a fire. The provider stated on the day of

inspection, that recent refurbishment works, including painting of garden walls may have resulted in the existing signage being removed.

The registered provider did not provide adequate arrangements for detecting, containing and extinguishing fires for example:

- There were gaps in the fire detection system for example, no fire detection in the laundry, external storage shed, kitchen store room,or staff toilet.
- Containment of fire was compromised by fire doors not closing completely for example: compartment door near room 17, kitchen staff entrance door, and under stairs door at reception.
- There were a number of doors which were damaged or had excessive gaps around the perimeter when closed for example; cross hallway doors at day room ground floor.
- No access available to fire extinguisher in storage shed.

The registered provider had not made arrangements for all staff of the designated centre, to receive suitable training in fire prevention and emergency procedures, including evacuation procedures.

- Six staff rostered for duty at the designated centre in the week following the inspection did not have up-to-date fire safety training, and were not on the providers schedule of staff training.
- The most recent fire drill available on the day of inspection was from the previous June. No simulated night time drill information was available on the day of inspection.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Care plan reviews were comprehensively completed on a four monthly basis to ensure care was appropriate to the resident's changing needs however it was not always documented if the resident or their care representative were involved in the reviews in line with the regulations.

Judgment: Substantially compliant

Regulation 6: Health care

There were good standards of evidence based health care provided in this centre. GP's routinely attended the centre and were available to residents. Allied health professionals also supported the residents on site where possible and remotely when appropriate. There was evidence of ongoing referral and review by allied health

professional as appropriate.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

There was a centre-specific policy and procedure in place for the management of behaviour that is challenging. A validated antecedent- behaviour- consequence (ABC) tool, and care plan supported the resident with responsive behaviour. The use of restraint in the centre was used in accordance with the national policy. Alternatives measures to restraint were tried, and consent was obtained when restraint was in use. Records confirmed that staff carried out regular safety checks when bed rails were in use.

Judgment: Compliant

Regulation 8: Protection

Measures were in place to protect residents from abuse including staff training and an up to date policy. Staff were aware of the signs of abuse and of the procedures for reporting concerns.

Judgment: Compliant

Regulation 9: Residents' rights

Actions were required by the provider to review the facilities for occupation and recreation. For example:

- Residents were offered choice in their meals but had limited options to eat meals in the dinning room. Not all resident had an opportunity to have their meals in the dinning room.
- The day spaces were some residents spend a large part of their day was impacting on some residents choice of recreational activities. For example on the day of inspection, some residents in day space 2 had limited access to the television as one resident was utilising the television to stream music. Day spaces 1 and 3 were observed to be noisy with some residents watching television, partaking in activities and having visits from family and friends in the same space simultaneously.

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	
Registration Regulation 4: Application for registration or renewal of registration	Compliant
Registration Regulation 8: Annual fee payable by the registered provider of a designated centre for older people	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Compliant
Regulation 24: Contract for the provision of services	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Substantially compliant
Regulation 12: Personal possessions	Substantially compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for St. Gladys Nursing Home OSV-0000686

Inspection ID: MON-0038506

Date of inspection: 07/02/2023

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: All staff have been asked to complete training in managing behaviors that challenge, this will be supported through both online and in person training sessions. This will be completed for all staff by May 31st 2023.	
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: A review was undertaken of the four staff files which required clarification on gaps in employment record, and clarification documented on any gaps in employment history, with a further review of all staff files in the center to be completed by May 14th 2023.	
Regulation 24: Contract for the provision of services	Substantially Compliant
Outline how you are going to come into compliance with Regulation 24: Contract for the provision of services: Contracts are being updated to correctly reflect the bedroom numbers for each resident in the home. This will be completed by May 14th 2023.	

Regulation 11: Visits	Substantially Compliant
Outline how you are going to come into compliance with Regulation 11: Visits: Communication was issued to all families to assure them that booking was not required for visits in the center. One resident's family member did inform the staff of their intention to visit due to the resident's mobility issues and the need for assistance and transfer of the resident on her special chair to her room during the visit. This was the only instance in which notification of intention to visit was requested from a family member and was not related to visiting restrictions.	
Regulation 12: Personal possessions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 12: Personal possessions: Reconfiguration and necessary structural and upgrade work has been commenced in the home to address any room where there was challenges for residents in accessing private space and belongings. This should be completed by May 31st.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: Laundry facilities in the centre has been decommissioned by March 31st 2023, and this is to be retrofitted to become additional storage for the centre. This is due for completion by May 31st 2023. The cabinet on the first floor has been replaced. This was completed in March 2023. Call bells have been addressed in all rooms as laid out in the report with call bells repaired or replaced. These were completed March 2023. Ongoing monitoring of call bells has also been introduced through daily checks by staff, with same being recorded on the electronic documentation system. Audits are completed on these records as part of call bell audits completed as well as regular spot checks completed by the management team.	

Call bells/ pull cords are in place in all bathrooms/ en suites in the facility. These were completed in March 2023.

A call bell will be installed in the smoking area, this will be completed by May 31st 2023.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: A risk assessment will be completed around the location and design of the electrical distribution boards. Fire certification for the building was issued based on the current placement and design of the electrical distribution boards in line with the current valid fire certificate.

Inappropriate storage of combustible materials within the storage container was moved on the day of inspection. Ongoing monitoring and surveillance is in place in the home, with the installation of increased storage space and the reduction of stock levels within the home also contributing to the prevention of the reoccurrence. This will be completed by May 31st 2023.

There was a fire blanket in place in the smoking shed on the day of inspection, furthermore a fire extinguisher within 10m of the smoking area which is in line with IS3217 standards for fire detection.

External exit lights will be reviewed and risk assessed any required action undertaken to address. This will be completed by July 31st 2023.

Assembly point signage has been replaced and is clearly displayed within the centre. This was completed in March 2023.

Detection will be installed in those areas requiring additional fire detection based on a risk assessment and based on IS3217 standards for fire detection. This will be completed by June 30th 2023.

Thorough checks are in place on all fire doors in the centre. Due to underfloor heating there can be minor movements of the doors, but the ongoing checks identify these minor changes and are adjusted on an ongoing basis. The fire door in the kitchen was affected by the use of a fan in the kitchen, resulting in negative pressure pulling the door. This has been addressed in March 2023 and ongoing monitoring of same is in place to prevent this occurring.

Fire drill information from November 2022 was provided to the inspector after the inspection and ongoing drills are scheduled and will be completed going forward on a monthly basis.

Regulation 5: Individual assessment and care plan	Substantially Compliant

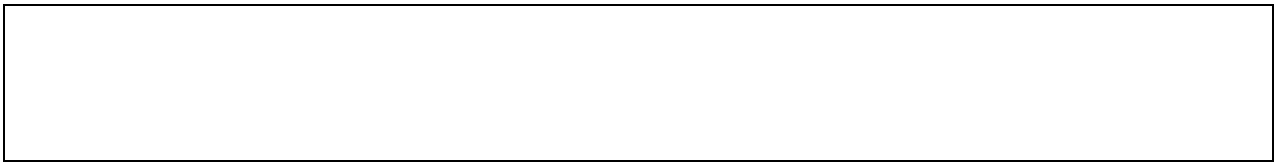
Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
In order to come into compliance with Regulation 5, amendments were made to the documentation of family/ resident involvement in the care planning process to ensure that their involvement is clearly documented on our electronic documentation system. This was introduced and updated for all residents in March 2023 with ongoing review through audit in place in the center.

Adherence to this process will be monitored through audit of care planning and assessment processes in the home, by the management team, in line with the center's audit schedule. Any findings or required quality improvements will be clearly communicated to staff in the center. This will be completed by May 31st 2023 with ongoing review in place.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
A review was undertaken of menus in the center, and a change of menus completed in April 2023, in line with resident feedback and preferences.
The introduction of increased dining times to facilitate all residents in the dining room will be introduced in the center, with two lunch sittings being offered to residents in line with their own preference. Ongoing review of this will be managed by the management team, with frequent feedback from residents considered and supported in resident meetings in the center. This will be completed by April 31st 2023.

A review of activities provided in the centre will be undertaken in line with the assessments utilized for each resident around meaningful activities and their own personal preferences. If a resident would prefer to undertake activities in the privacy of their own room this will be supported by the team in the center. Similarly, residents who choose to stay in the communal spaces will be supported to participate in activities of their choosing, and with the involvement of their family members if they wish. Feedback from all residents and their families is supported through regular resident and family meetings. This will be completed by April 31st 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 11(1)	The registered provider shall make arrangements for a resident to receive visitors.	Substantially Compliant	Yellow	31/05/2023
Regulation 12(a)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that a resident uses and retains control over his or her clothes.	Substantially Compliant	Yellow	31/05/2023
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	31/05/2023
Regulation 17(2)	The registered provider shall, having regard to the needs of the	Not Compliant	Orange	31/05/2023

	residents of a particular designated centre, 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	14/05/2023
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 resident shall reside in that centre.	Substantially Compliant	Yellow	14/05/2023
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building	Not Compliant	Orange	30/06/2023

	services, and suitable bedding and furnishings.			
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Substantially Compliant	Yellow	31/07/2023
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.	Substantially Compliant	Yellow	30/06/2023
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	30/06/2023
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where	Substantially Compliant	Yellow	30/06/2023

	necessary in the event of fire, of all persons in the designated centre and safe placement of residents.			
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	31/05/2023
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Substantially Compliant	Yellow	30/04/2023
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Substantially Compliant	Yellow	30/04/2023