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:	Wygram Nursing Home
Name of provider:	Wygram Nursing Home Limited
Address of centre:	Davitt Road, Wexford Town, Wexford
Type of inspection:	Short Notice Announced
Date of inspection:	08 November 2023
Centre ID:	OSV-0000756
Fieldwork ID:	MON-0041426

About the designated centre

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

The centre is a purpose built three storey facility that opened in 2015 and is located in Wexford town. The centre is registered to accommodate 71 residents. Residential accommodation is provided across three floors and consists of the following: The ground floor has 10 single ensuite bedrooms and one twin ensuite bedroom. The first floor has 25 single ensuite bedrooms and three twin ensuite bedrooms. The second floor contains 24 single ensuite bedrooms and two twin ensuite bedrooms. There are two passenger lifts to each floor. Each of the three floors had a central core area which was fitted out with couches and armchairs and there is also a communal day room on the second floor. The ground floor also has a large sitting room which includes an oratory in one section, the main section of this room has direct access to an enclosed garden area. There is a separate visitors room with overnight facilities which families have the opportunity to use for privacy or if their loved one is unwell. There is one dining room on the ground floor that is large enough to accommodate all residents. The dining room has dividers that can be pushed back so the room can be used for a number of functions at the same time, for example activities. The main kitchen area is adjacent to the dining room. There are two smaller galley style kitchens on both the first and second floors. A number of bedrooms on the first and second floors have balcony areas which residents can also access. There is also a community resource building on site known as Davitt House which is a focal point for social, educational and religious activities. The provider is a limited company called Wygram Nursing Home Limited. The centre provides care and support for both female and male adults over the age of 18 years requiring long-term, respite or convalescent care with low, medium, high and maximum dependency levels. The range of needs include the general care of the older person, residents with dementia and or a cognitive impairment. The centres stated aim is to meet the needs of residents by providing them with the highest level of person centered care in an environment that is safe, friendly and homely. Pre-admission assessments are completed to assess a potential resident's needs and whenever possible residents will be involved in the decision to live in the centre. The centre currently employs approximately 87 staff and there is 24-hour care and support provided by registered nursing and healthcare assistant staff with the support of housekeeping, catering, administration, laundry and maintenance staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	71

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 8 November 2023	09:00hrs to 19:00hrs	Mary Veale	Lead
Wednesday 8 November 2023	09:00hrs to 19:00hrs	Aisling Coffey	Support

What residents told us and what inspectors observed

This was an announced inspection which took place over one day. Based on the inspectors' observations and discussions with residents and staff, Wygram Nursing Home was a nice place to live. There was a welcoming and homely atmosphere in the centre. The inspectors spoke with one visitor and seven residents living in the centre. All were very complimentary in their feedback and expressed satisfaction with the standard of care provided. Residents' rights and dignity were supported and promoted by kind and competent staff. Residents appeared to enjoy a good quality of life and had many opportunities for social engagement and meaningful activities.

On arrival the inspectors were greeted by a member of the housekeeping team. The inspectors were met by the person in charge, registered provider representative, the director of quality, safety and risk manager and the assistant director of nursing. Following an introductory meeting, the inspectors were accompanied on a tour of the premises by the person in charge and assistant director of nursing. The inspectors greeted, spoke with, and observed residents in communal areas and in their bedrooms.

The centre was clean to a high standard and the atmosphere was calm and relaxed. The centre was a large and spacious three-storey building with 59 single bedrooms and six twin rooms. All of the bedrooms were en-suite with a shower, toilet and wash hand basin. Residents' bedrooms were clean, tidy and had ample personal storage space. Bedrooms were personalised containing family photographs, art pieces and personal belongings. Pressure relieving specialist mattresses, cushions and fall prevention equipment were seen in some of the residents' bedrooms. Bedrooms on the east and west sides on the first and second floors had access to their own private balcony area. Residents on the ground floor could access the garden from their bedrooms.

Overall, the inspectors observed that the premises was laid out to meet the needs of the residents. There were appropriate handrails and grab rails available in the bathroom areas, and along the corridors, to maintain residents' safety. The building was well lit, warm and adequately ventilated throughout. There was a choice of communal spaces. For example; the ground floor had a large dining room, garden view sitting room with an adjoining oratory which was available to all residents across the three floors and was accessible via a passenger lift. There was a visitor's room on the ground floor which was not accessible for residents on the day of inspection, this is discussed further in this report under Regulation 23: governance and management. There were three large circular areas on each floor with ample armchairs and fireplaces adjacent to the lift areas on all floors. The second floor had a hairdressing room and a conservatory room with balcony area.

Residents had access to an enclosed garden area to the rear of the building on the ground floor and a large open garden at the front of the building. The gardens had level walkways, comfortable seating and sensory flower beds. Inspectors were told

that the garden areas were used by residents and staff when the weather allowed.There was a designated outdoor smoking area for residents who chose to smoke in the rear garden.

The inspectors observed the residents spending their day moving freely through the centre from their bedrooms to the communal spaces. Residents were observed engaging in a positive manner with staff and fellow residents throughout the day. It was evident that residents had good relationships with staff and residents had built up friendships with each other. There were many occasions throughout the day in which the inspectors observed laughter and banter between staff and residents.

Residents looked well cared for and had their hair and clothing done in accordance to their own preferences. Residents' stated that the staff were kind and caring, that they were well looked after and they were happy in the centre. Residents said they felt safe and trusted staff. Residents told the inspector that staff were always available to assist with their personal care.

Residents' enjoyed home cooked meals and stated that there was always a choice of meals and the quality of food was very good. The daily menu was displayed on the tables in the dining room and outside the entrance door to the dining room. There was a choice of two options available for the main meal. Water dispensers were available for residents on all floors. The meal time experience was quiet and was not rushed. Staff were observed to be respectful and discreetly assisted the residents during the meal times. The inspectors observed that the dinning room at lunch time. The dining room was observed to be at full capacity on the day of inspection and with the exception of the conservatory room on the second floor, all other communal spaces in the centre were observed to be utilised as a dining space for residents at lunch time.

The centre provided a laundry service for residents. Residents whom the inspectors spoke with on the day of inspection were happy with the laundry service and there were no reports of items of clothing missing.

The centre's resident information booklet and weekly activities programme was displayed at the lift area on all floors. All of the 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, radios and televisions. Some residents told the inspectors that they could leave the centre to go into the town if they wished. Wygram Nursing Home was conveniently located close to the centre of Wexford town. The inspectors observed residents reading newspapers, watching television, listening to the radio, and engaging in conversation. Residents were observed to enjoy friendships with peers throughout the day. On the day of inspection, residents were observed attending a sensory activity and a rosary session in the morning, and a live music event in the afternoon. Residents' views and opinions were sought through resident meetings and satisfaction surveys and they felt they could approach any member of staff if they had any issue or problem to be solved.

Visits and outings were encouraged and practical precautions were in place to

manage any associated risks. Visitors were seen coming and going over the course of the inspection. Visits took place in communal areas and residents' bedrooms where appropriate. There was no booking system for visits and the residents whom the inspectors spoke with confirmed that their relatives and friends could visit anytime. The visitor whom the inspectors spoke with was complimentary of the staff and the care that their family members received. The visitor knew the person in charge and had no hesitation to contact the person in charge if they had any cause of concern.

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 announced inspection to monitor the provider's compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and to follow up on the findings of the previous inspection of May 2023. Improvements were found in infection prevention control and fire safety since the last inspection. On this inspection, the inspectors found that actions were required by the registered provider to address Regulation 23: governance and management and areas of Regulation 5: individual assessment and care planning, Regulation 16: staff training and development, Regulation 31: notification of incidents, and Regulation 34: complaints procedure. The inspectors also followed up on notifications submitted to the Chief Inspector of Social Services since the previous inspection.

The registered provider had made changes to the footprint of the centre contrary to condition 01 of the registration for Wygram Nursing Home and had not informed the office of the Chief Inspector of Social Services. On the day of inspection, the inspectors observed that the visitor’s room was in use as an office space. The provider was requested to convert the space back to the visitor’s room as outlined in the floor plans under which the centre was registered.

Wygram Nursing Home Limited is the registered provider of Wygram Nursing Home. The company is part of the Virtue Integrated Care Group. The person in charge worked full time and was supported by an assistant director of nursing, a clinical nurse manager, a senior nurse, a team of nurses and healthcare assistants, activities co-ordinators, housekeeping, laundry, catering, administration and maintenance staff. At the time of inspection the director of operations was seconded as a person in charge to another centre in the group and the quality, safety and risk manager was providing support to the person in charge. The management structure within the centre was clear and staff were all aware of their roles and responsibilities. Out of hours on call for emergencies was provided on a rotational basis by the person in charge and the assistant director of nursing.

There were sufficient staff on duty to meet the needs of residents living in the centre on the day of inspection. The centre had a well-established staff team who were supported to perform their respective roles and were knowledgeable of the needs of older persons in their care and respectful of their wishes and preferences.

There was an ongoing schedule of training in the centre and management had good oversight of mandatory training needs. An extensive suite of mandatory training was available to all staff in the centre and training was up to date. There was a high level of staff attendance at training in areas such as cardio-pulmonary resuscitation (CPR), manual handling, dementia awareness, and infection prevention and control. Staff with whom the inspector spoke with, were knowledgeable regarding fire evacuation procedures and safeguarding procedures. However; further improvements were required to ensure staff were appropriately supervised which is discussed further in this report under Regualtion16: training and staff development.

Management systems in place to monitor the centre's quality and safety required review. The centre had an extensive suite of meetings such as quality, risk and safety meetings, governance meetings, head of department meetings, nurses meetings, health care assistant meetings, and catering staff meetings. Meetings took place weekly, monthly and quarterly in the centre. There was evidence of a weekly key performance indicator (KPI) report between the person in charge, the registered provider representative & quality safety and risk manager weekly. The centre had a number of committees, for example; a health and safety committee, safeguarding committee, nutrition, falls and restrictive practice committee. There was evidence of an ongoing schedule of audits in areas including falls, restrictive practice, fire safety, wound care and infection prevention and control. These audits found areas to improve the quality and safety of care and these improvements were being implemented. The centre had implemented a number of quality improvement projects in 2023, for example; a values engagement project for residents and staff, and a safeguarding self-assessment tool. The annual review for 2022 was completed in line with the national standards. It set out the improvements completed in 2022 and improvement plans for 2023. Improvement were required in tracking of incidents to monitor and improve the quality and safety of care. This is discussed further under Regulation 23; governance and management.

The inspectors followed up on incidents that were notified to the Chief Inspector of Social Services and found that incidents were not submitted within three working days and were not managed in accordance with the centre's policies. This is discussed further in this report under Regulation 23: governance and management, and Regulation 31: notification of incidents.

Overall electronic and paper based records were well maintained. Requested records were made available to the inspectors throughout the day of inspection and records were appropriately maintained, safe and accessible. Staff records, as set out in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), were available to inspectors. Improvements were required to ensure that full employment histories and references were in place. This will be addressed in this report under Regulation

21: records.

There was a complaints management policy within the centre and a complaints procedure displayed on all floors at the lift area. A sample of complaints management records were reviewed. Inspectors observed complaints had been assessed and managed promptly and that improvements and recommendations arising from the complaint had been communicated to staff members to improve the overall quality of care and resident experience. Residents said they were aware they could raise a complaint with any member of staff or the person in charge. Actions were required to align the complaints procedure with SI 628 of 2022 - Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) (Amendment) Regulations. This will be addressed in this report under Regulation 34:complaints procedure.

Regulation 15: Staffing

Staffing was found to be sufficient to meet the needs of the residents on the day of the inspection. The registered provider ensured that the number and skill-mix of staff was appropriate to meet the needs of the residents. There were two registered nurses at a minimum in the centre day and night.

Judgment: Compliant

Regulation 16: Training and staff development

Actions were required in training and staff development: For example:

- The induction checklist for one staff member did not have confirmation that this employee had read the centre's policies.
- The induction checklist and performance review for one staff member did not have confirmation that this employee had completed safeguarding training during induction. This is a mandatory requirement outlined in the centre's adult safeguarding policy. There was no further evidence available on the day of inspection that this employee had completed safeguarding training as part of their induction.
- Clinical supervision arrangements for one employee were not documented following a safeguarding incident to ensure measures were in place to protect residents from abuse.

Judgment: Substantially compliant

Regulation 19: Directory of residents

The registered provider had established and maintained a directory of residents which included all the information as specified in Schedule 3 of the regulations.

Judgment: Compliant

Regulation 21: Records

A review of three personnel files found evidence of the staff member's identity and Garda Síochána (police) vetting disclosures. However, the personnel files did not contain all of the documentation required under Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) to ensure safe and effective recruitment practices. For example:

- Two personnel files did not contain full employment histories.
- Disciplinary records were not on one file.
- One file did not have two references, while on a second file it was unclear if there was a reference from the most recent employer as the file lacked a complete employment history.

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

The management systems to ensure that the service provided was safe, appropriate, consistent and effectively monitored, as required under Regulation 23(c), were not sufficiently robust. This was evidenced by:

- The system for assessment of residents post a fall required review as a number of fall incidents involving residents were not managed in accordance with the centre's policies.

- The registered provider had made changes to the footprint of the centre without informing the Office of the Chief Inspector.
- The system for the management of staff induction and performance review required improvement. Further assurance was required to ensure that a staff member had completed safeguarding training as part of their induction and appropriate clinical supervision arrangements for the employee were in place on night duty to ensure measures were in place to protect residents from abuse.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

Residents had a written contract and statement of terms and conditions agreed with the registered provider of the centre. The written contract outlined the room the resident occupied and additional charges, if any.

Judgment: 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 30: Volunteers

The provider informed the inspectors that there were no volunteers attending the centre at the time of inspection.

Judgment: Compliant

Regulation 31: Notification of incidents

A review of residents' nursing notes found that one incident as set out in schedule 4

of the regulations was not notified to the Chief Inspector within the required time frames.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The complaints procedure and policy included the details of the persons involved in the complaints procedure. These persons had received suitable training to deal with complaints. The complaints procedure outlined how a person making a complaint could be assisted to access an independent advocacy service. Improvements were required to ensure that both the complaints policy and complaints procedure referred to the newly established role of review officer, as specified within SI 628 of 2022 - Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) (Amendment) Regulations, which came into effect on 01 March 2023.

Judgment: Substantially compliant

Quality and safety

The findings of this inspection evidenced that the management and staff strived to provide a good quality of life for the residents living in Wygram Nursing Home. Residents' health, social care and spiritual needs were well catered for. Improvements were required in relation to Regulation 5: individual assessment and care planning.

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, a psychiatric team, nurse specialists and palliative home care services. A range of allied health professionals were accessible to residents as required and in accordance with their assessed needs, for example, physiotherapist, speech and language therapist, dietician and chiropodist. Residents had access to a mobile x-ray service in the home. Residents had access to local dental and optician services. Residents who were eligible for national screening programmes were also supported and encouraged to access these.

The premises were clean and pleasantly decorated throughout. Attention had been given to supporting residents with a cognitive impairment to orientate themselves within their environment. Doors to the dining areas and bathrooms were brightly coloured to distinguish them from other doors. Doors also contained both text and pictorial signage to indicate their use. Other tools were used, such as boards

displaying the day, date, season and expected weather. There was a traditional green post box at the entrance to the centre where residents could post cards and letters to loved ones.

Improvements were found in infection prevention and control since the previous inspection. Shower chairs containing visible rust had been replaced or repaired. The centre's storage areas were clean, and free of clutter and organised. Staff were observed to have good hygiene practices and correct use of personal protective equipment (PPE). Alcohol hand gel was available throughout the centre. Sufficient housekeeping resources were in place on the day of inspection. Intensive cleaning schedules and a regular weekly cleaning programme were available in the centre. The centre had a cleaning schedule for curtains. The centre used a tagging system to identify equipment that had been cleaned. Although the laundry area was small, used laundry was segregated in line with best practice guidelines. The centre used the corridor outside the laundry to create a work way flow for dirty to clean laundry which prevented a risk of cross contamination. There was evidence that infection prevention control (IPC) and COVID-19 were agenda items on the minutes of the centres staff meetings and management meetings. The centre had a quarterly IPC audit schedule which included, auditing of the laundry, the equipment, the environment, and hand hygiene. There were up to date IPC policies which included COVID 19 and multi-drug resistant organism (MDRO) infections. The centre had an antimicrobial stewardship register and the person in charge had good oversight of antibiotic usage. The centre had a lead IPC nurse and all staff had training in IPC and specific training regarding the prevention and management of COVID-19, correct use of PPE and hand hygiene.

Improvements were found in fire safety following the previous inspection. There were effective systems in place for the maintenance of the fire detection, alarm systems, and emergency lighting. All doors to bedrooms and compartment doors had automated closing devices. All emergency lighting was checked on the day of inspection and were found to be in working order. Fire training had been completed by all staff. There was evidence that fire drills took place quarterly in the centre. There was evidence of fire drills taking place in each compartment and a night time drill taking place in the centre's largest compartment. Fire drill records were detailed containing the number of residents evacuated, how long the evacuation took, and learning identified to inform future drills. There was a system for daily and weekly checking, of means of escape, fire safety equipment, and fire doors. All fire safety equipment service records were up to date. All escape routes were assessable, free from obstructions and the assembly point was accessible. The centre had an L1 fire alarm system. Each resident had a personal emergency evacuation plan (PEEP) in place which was up to date and included supervision at the evacuation area. Fire evacuation maps were displayed in the centre. Staff spoken with were familiar with the centre's evacuation procedure. There was evidence that fire safety was on the agenda at meetings in the centre. On the day of the inspection there were six residents who smoked. The outdoor designated smoking area had a call bell linked to the centre's call bell system, a fire extinguisher, a fire apron and a fire retardant ash tray.

Residents with communication difficulties were supported to communicate their

needs and preferences. There was evidence of residents with specialist communication requirements being facilitated to communicate through specialist means such as pictorial systems. Staff consulted with were also knowledgeable of residents' non-verbal cues. These cues were also documented in care plans viewed by the inspectors. Inspectors noted residents with sensory needs had been referred for specialist support to enable their communication and participation. Evidence of speech and language therapy, optician and audiology interventions were seen on residents' files.

The inspectors viewed a sample of residents' electronic nursing notes. From a review of a sample of care plans, inspectors found that validated assessment tools were completed by nursing staff, which informed the development of care plans. However, actions were required to ensure the delivery of safe, quality care, which will be outlined under Regulation 5.

A policy and procedures were in place for the prevention, detection and response to allegations or suspicions of abuse. The person in charge had received training in the assessment and responding to allegations of abuse. Staff spoken to were aware of the categories of abuse and the procedure for reporting concerns within the centre. The residents spoken with stated that they felt safe in the centre. The registered provider was the pension agent for one resident and provided transparent records to inspectors.

Management and staff promoted and respected the rights and choices of residents in the centre. Residents had access to books, televisions, radios, national and local newspapers. Dedicated activity staff implemented a varied and interesting schedule of activities seven days a week. Activity staff spoken with were aware of resident interests and capabilities and offered different activities to cater to resident needs. The activities schedule was displayed in the bedrooms seen by inspectors and at the lift areas to promote participation among residents and visitors. Roman Catholic Mass was celebrated weekly in the centre, and religious leaders of other denominations were facilitated to visit. Advertisements for independent advocacy services were observed throughout the centre. Residents were supported and encouraged to maintain links with their families and the wider community through visits and trips out when possible.

Regulation 10: Communication difficulties

The registered provider ensured that residents with communication difficulties were supported to communicate freely. There was evidence of specialist communication requirements documented in care plans. Staff spoken to were also knowledgeable of these specialist requirements.

Judgment: Compliant

Regulation 17: Premises

The registered provider had made changes to the footprint of the centre contrary to condition 01 of the registration for Wygram Nursing Home and had not informed the office of the Chief Inspector of Social Services. On the day of inspection, the inspectors observed that the visitor's room was in use as an office space. The provider was requested to convert the space back to the visitor's room as outlined in the floor plans under which the centre was registered.

Judgment: Not compliant

Regulation 27: Infection control

The registered provider was implementing procedures in line with best practice for infection control. Effective housekeeping procedures were in place to provide a safe environment for residents and staff.

Judgment: Compliant

Regulation 28: Fire precautions

The provider had good oversight of fire safety. Annual training was provided and systems were in place to ensure fire safety was monitored and fire detection and alarms were effective in line with the regulations. Bedroom doors had automatic free swing closing devices so that residents who liked their door open could do so safely. Evacuation drills were regularly practiced based on lowest staffing levels in the centre's largest compartment.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Six resident care plans were reviewed on inspection. Actions were required to ensure these care plans facilitated safe, quality resident care:

- While pre-admission assessments had taken place for all six residents, one contained significant gaps and was undated and unsigned, while a second pre-admission assessment was not dated, so it was unclear when it had occurred.

- While there was evidence of assessment and care planning within 48 hours of the resident's admission in four files, this could not be verified on two files, and records indicated that in one instance, the assessment and care plan was completed before the resident's admission while the second was completed three years after their admission.
- It was not possible to verify that care plan reviews took place at intervals not exceeding four months as the electronic system used for care planning in the centre only allowed the user to review care plans in the past six months.
- Three care plans did not document if the resident or their family had been consulted about the most recent care plan revision. This was a repeat finding from the 24 May 2023 inspection.
- There were discrepancies noted in two of the care plans where a resident was documented as having "good hearing" or "no issues with hearing", but had a hearing impairment and required the support of hearing aids. In a third resident's care plan, it was noted that the resident was to be referred for hearing services, but no evidence of this referral or follow-up was available.

Judgment: Substantially compliant

Regulation 6: Health care

There were good standards of evidence-based healthcare provided in this centre. Five general practitioners attended the centre and were available to residents. Residents who required specialist healthcare services, such as speech and language therapy, physiotherapy and chiropody, could access these services in the centre

Judgment: Compliant

Regulation 8: Protection

Measures were in place to protect residents from abuse, including staff training and an up-to-date policy. Allegations of abuse were investigated in line with the centre's policy. The registered provider was a pension agent for one resident, and there were clear and transparent records available to the inspectors.

Judgment: Compliant

Regulation 9: Residents' rights

Residents’ rights and choice were promoted and respected within the confines of the

centre. Activities were provided in accordance with the needs' and preference of residents and there were daily opportunities for residents to participate in group or individual activities. Facilities promoted privacy and service provision was directed by the needs of the residents.
Judgment: 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	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 30: Volunteers	Compliant
Regulation 31: Notification of incidents	Substantially compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 17: Premises	Not compliant
Regulation 27: Infection control	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Wygram Nursing Home OSV-0000756

Inspection ID: MON-0041426

Date of inspection: 08/11/2023

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • The Director of Nursing & HR have reviewed the induction checklist and confirmation of policies being read at time of induction is in place for all employees. • The Director of Nursing & HR have reviewed the induction checklist, this includes all mandatory training including safeguarding training listed on same. The Director of Nursing has appointed 2 staff members to attend the designated officer, Safeguarding training, same booked for the 30th of January 2024. This will facilitate Staff members to receive 1:1 training inhouse as part of their induction. • The Director of Nursing has implemented a formal documentation process for clinical supervision arrangements after such incidents to ensure the ongoing safety and well-being of our residents. A Clinical Supervision Diary has now been implemented, this will include daily feedback to the staff members and shared learning, this is a systematic diary system to record staff check-ins and check-outs during duty hours. This will enhance our ability to monitor and track staff activities, ensuring greater accountability and adherence to protocols.	
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: A review of three personnel files found evidence of the staff member's identity and Garda Síochána (police) vetting disclosures. However, the personnel files did not contain all of the documentation required under Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) to ensure safe and effective recruitment practices. For example:	

• The Director of Nursing and HR are currently reviewing all staff files – all gaps will be identified and corrected.
• The company is currently introducing an new electric monitoring system where no staff member will be permitted to start until compliant with the regulations.
• Disciplinary records will be stored on personal files once due process completed.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• The Assistant Director of Nursing will review all falls within the 48 hour time line to ensure compliance – The Director of nursing will have clinical oversight of same.

• The Changes to the footprint of the centre has been reversed in line with our current Statement of Purpose.

• To address the concerns regarding the management of staff induction and performance review, the induction forms and performance review documents have been reviewed and changes made to address the improvements required. These changes will include a confirmation section for reading policies and attending safeguarding training during induction. 2 Staff members are booked to attend the designated officer training in safeguarding on the 30th of January 2024.
• A review of our Clinical Supervision has been completed and there is a plan in place to strengthen our clinical supervision. This will be a priority to ensure the safety and well-being of our residents.

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
A review of residents' nursing notes found that one incident as set out in schedule 4 of the regulations was not notified to the Chief Inspector within the required time frames.
Internal Review:

• Upon discovering the oversight, we immediately initiated an internal review to understand the reasons for the delayed notification. Our investigation revealed a procedural lapse in our reporting mechanisms.
• We have taken corrective action to address the specific incident, ensuring that the

required notification has been submitted to the Chief Inspector. We understand the critical nature of reporting incidents promptly and apologize for any inconvenience caused.

Regulation 34: Complaints procedure	Substantially Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: The Director of Nursing has completed a review of both the complaints policy and the complaints procedure. Updates have been made to ensure both refer to the newly established role of review officer, as specified within SI 628 of 2022 - Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) (Amendment) Regulations, which came into effect on 01 March 2023.	
Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: In response to this observation, the provider has taken immediate corrective action. The office space has been formally reverted to its original function as the visitor's room.	
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: • The Director of Nursing commenced her role on the 29th of August 2023 and she is the designated preadmissions officer – a review of all pre assessments completed by her are compliant with the regulations and assurance given that this will continue to be the case. In the case where she is not available to attend same the ADON will complete and the assessment will be reviewed by the DON. All admissions will be audited within 48 hours and any gaps addressed. • The Director of Nursing introduced a holistic careplanning approach in 2023 – this involved the review of all careplans, same were addressed to streamline the careplanning process to ensure compliance with timeline of 48hours post admission. The introduction	

of the post admission audit will ensure compliance with same going forward.
• This is currently been addressed by the electronic sysytem providor. However to ensure compliance with this the Director of Nursing will introduce a quartlerly Audit of Careplans, to address any gaps and a quality improvement plan initiatiated and actioned.
• As part of the 48 hour Audit post admission, all preassessment documentation will be reviewed to ensure that all needs of the Resident are identified, referrals made, and care planned for

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 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	20/12/2023
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.	Not Compliant	Orange	20/12/2023
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	20/12/2023
Regulation 23(c)	The registered	Not Compliant		20/12/2023

	provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.		Orange	
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.	Substantially Compliant	Yellow	20/12/2023
Regulation 34(2)(d)	The registered provider shall ensure that the complaints procedure provides for the nomination of a review officer to review, at the request of a complainant, the decision referred to at paragraph (c).	Substantially Compliant	Yellow	20/12/2023
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident	Substantially Compliant	Yellow	31/01/2024

	concerned and where appropriate that resident's family.			