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Moycullen Nursing Home, OSV-0000365, 09 March 2022

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Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	Moycullen Nursing Home
Name of provider:	Mowlam Healthcare Services Unlimited Company
Address of centre:	Ballinahalla, Moycullen, Galway
Type of inspection:	Unannounced
Date of inspection:	09 March 2022
Centre ID:	OSV-0000365
Fieldwork ID:	MON-0036077

About the designated centre

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

Moycullen Nursing Home is a purpose built facility located in Ballinahalla, Moycullen, Co Galway. The centre admits and provides care for residents of varying degrees of dependency from low to maximum. The nursing home is single storey in design and accommodates up to 53 residents. Residents are accommodated in 47 single bedrooms and 3 double bedrooms. Resident living space is made up of a large sitting room and a large dining room. In addition, the centre has a smaller lounge, a visitors room and an oratory. Residents also have access to an enclosed courtyard and gardens. The provider employs a staff team consisting of registered nurses, social care workers, care assistants, housekeeping and catering staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	45

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 9 March 2022	09:30hrs to 18:30hrs	Claire McGinley	Lead
Wednesday 9 March 2022	09:30hrs to 18:30hrs	Una Fitzgerald	Support

What residents told us and what inspectors observed

This was an unannounced inspection. On arrival, the person in charge guided the inspectors through the infection prevention and control measures necessary on entering the designated centre. At the time of inspection there were no resident within this centre with COVID-19.

Inspectors spoke with ten residents and also spent time in communal areas observing resident and staff interaction. The feedback from the residents was that the place was 'fine' that 'the food was good' and 'the staff were helpful'. The general feedback from residents was one of satisfaction with the care and the service provided.

The centre was registered to accommodate 53 residents.There were 45 residents accommodated in the centre on the day of inspection. The centre was a single-storey building with single and double occupancy accommodation. Inspectors found that parts of the premises were found to be unclean.

Inspectors observed a number of residents that were poorly presented. Residents who required support with their personal hygiene had not been appropriately attended to. Six residents were observed wearing clothes that were heavily soiled or wet, and shoes that had ingrained food debris and dirt.

Inspectors observed the lunch time dining experience. The daily menu was displayed in the dining room and was accessible to residents. The dining room was supervised by a member of staff at all times. Meals were facilitated in the residents bedroom and the dining room. Inspectors observed staff facilitating and assisting with meals in a respectful and dignified manner. Meals appeared to be appetising and well portioned.

Inspectors observed that the communal sitting room was occupied by the residents with a staff member in attendance. An activities schedule for residents was in place and staff were seen to support activities, in line with the plan on the day of inspection.

Inspectors were informed that four single occupancy bedrooms were currently closed due to a leak. Inspectors observed this area and identified that repair works to these bedrooms had commenced, however some of the resident's personal belongings, toiletries and assessment documentation remained in the rooms. Inspectors observed soiled incontinence wear, out of date food items, worn and damaged mattresses, and furniture that was visibly unclean had been left in these bedrooms while repair works took place. The repair work required access to pipes and required excavation of some areas of the wall and flooring. Inspectors observed visible holes in bedrooms that posed a risk to residents. The area had not been secured adequately at the time of inspection and residents were observed accessing the area without supervision. A risk assessment was not in place for the works being

carried out and there was no plan in place to protect residents.

On the day of inspection, the inspectors observed that not all residents had access to a call bell. The inspectors confirmed with the person in charge that there was no identified reason as to why these residents could not have access to a call bell. This meant that when the resident required assistance, they were reliant on calling staff walking up and down the corridors.

Capacity and capability

This was an unannounced risk inspection to monitor the designated centre's compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) 2013 as amended. Inspectors also followed up on the action taken to address the findings of the previous inspection on 17 November 2020.

As part of this inspection, inspectors also reviewed unsolicited information received by the Chief Inspector in relation to care standards and staffing and found it to be partially substantiated.

The findings of this inspection was that

- governance and management of the centre required improvement
- staff were inadequately supervised,
- action was required to ensure that the residents living environment was safe and in a good state of repair,
- resident's rights were not respected and upheld.
- the assessment and care planning process were not appropriately reviewed and updated.

The registered provider of this centre is Mowlam Healthcare Services Unlimited Company. This provider has a number of designated centres in Ireland. The provider had a clear management structure in place that identified the lines of authority and responsibility. The centre was supported by a regional management structure that included a director of care and a regional manager. The person in charge of the centre was supported by the regional manager and had access to the facilities available within the Mowlam Healthcare Group.

Within the centre, the person in charge was supported by an assistant director of nursing, a team of nurses and care staff, a social care practitioner, activities coordinators, catering, housekeeping, laundry, and administration. Individual roles were clearly set out and managers and staff were aware of their individual responsibilities and lines of reporting. Residents were familiar with the organisational structure in the centre and told inspectors that they knew who to speak with if they had a concern or a complaint.

On the day of inspection, there were thirty residents assessed as having maximum dependency care needs, nine with high dependency care needs and six with medium dependency care needs. Inspectors were informed that there was a deficit of six health care assistants and a maintenance person from the roster. The numbers of staff available to cover all the required hours did not reflect the staffing levels committed to in the centre's statement of purpose. Inspectors acknowledge that there was an ongoing recruitment process to replace staff.

There were systems in place to review the safety and quality of the services provided for residents. These included clinical audits, quality and safety reviews and reviews of serious incidents and complaints. However, the quality improvement plans for some of these audits and reviews had not been completed and therefore, the issues identified had not been addressed.

Inspectors found that the level of care supervision was not adequate to ensure an appropriate standard of care was delivered to each resident. While there appeared to be adequate levels of staff and senior nursing staff on duty on the day of the inspection, the standard of personal care received by residents was poor and had not been identified and addressed by the supervising staff. In addition, a review of staff training records found significant gaps in staff training records, such as, fire safety and infection prevention and control. These findings are detailed under Regulation 16: Staff training and development.

Inspectors found that complaints and concerns were well managed. Inspectors reviewed the complaints log and found that the records contained details on the nature of each complaint, investigation carried out and follow up communication with the resident and family, as required. There was evidence that the outcome of complaints was documented and this included the complainant's level of satisfaction. The complaints procedure was displayed at the main entrance. Residents reported feeling comfortable speaking to any staff member if they had a concern.

Registration Regulation 4: Application for registration or renewal of registration

An application for renewal of registration was received by the Chief Inspector within the required time frame. The application met the registration regulatory requirements.

Judgment: Compliant

Regulation 15: Staffing

Inspectors found that the level of staffing on the day of the inspection was adequate to meet the assessed needs of the residents and for the size and layout of the building. The deficit in the availability of staff to ensure that the centre could be

safely rostered is addressed under Regulation 23: Governance and management. The inadequate supervision of staff is addressed under Regulation 16,Staff training and development.

Judgment: Compliant

Regulation 16: Training and staff development

A review of staff training records found significant gaps in fire safety update training and training in the management of responsive behaviours.

Staff were found to be poorly supervised. The standard of personal care observed on the day of the inspection was very poor. This issue was not identified by the senior nurses on duty and therefore no action had been taken to ensure care was delivered to an acceptable standard.

Judgment: Not compliant

Regulation 21: Records

All records requested during inspection were made readily available to the inspectors in a timely manner. A review of staff records showed that staff were recruited and inducted in accordance with the centre's policy and procedure. A sample of staff files was reviewed and those examined were compliant with the regulations, and contained all the items listed in Schedule 2. An Garda Siochana (police) vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 were available in the designated centre for each member of staff.

Judgment: Compliant

Regulation 23: Governance and management

Inspectors found that the provider did not have adequate resources in place to ensure the effective delivery of care. For example, there was inadequate levels of health care assistants available to ensure that the centre could be appropriately staffed.

Inspectors found that management systems were not in place to ensure that the service provided was safe, appropriate and effectively monitored. This was evidenced by;

- poor risk management systems. For example, the risks associated with ongoing repair work had not been identified or managed in line with the centre's own policy.
- internal audit completed in relation to infection prevention and control had identified areas of risk and improvement, however, inspectors found that no action had been taken to address these issues.
- poor monitoring of care standards evidenced by unsatisfactory levels of basic care delivery such as personal hygiene needs.
- poor oversight in relation to maintenance and upkeep of the designated centre.

The annual review of the quality and safety of care delivered to residents for 2021 was not available.

Judgment: Not compliant

Regulation 3: Statement of purpose

A detailed statement of purpose was available to staff, residents and relatives. The statement of purpose contained the required details as set out in Schedule 1 of the regulations.

Judgment: Compliant

Regulation 31: Notification of incidents

An alleged safeguarding incident reviewed by inspectors had not been notified to the Chief Inspector as required under regulation 31.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

Inspectors reviewed the complaints log and found that complaints were managed in line with the centre's policy and the requirements under Regulation 34.

Judgment: Compliant

Regulation 4: Written policies and procedures

The centre had policies and procedures in place, in line with Schedule 5 of the regulations. Policies were reviewed within intervals not exceeding three years.

Judgment: Compliant

Quality and safety

Inspectors found that the provision of quality care was poor. Supervision and oversight of care deliver and documentation required improvement. Furthermore, inspectors observed that parts of the premises were poorly maintained and in a poor state of repair. Inspectors also found that Regulation 28, Fire precautions was not compliant. The detail is outlined further in the report.

There was an electronic documentation system in place. Residents had a comprehensive nursing assessment completed on admission and a care plan was developed for each resident. Inspectors reviewed a sample of resident records and found that the care plans were not always person-centered and did not always contain the information required to guide the care. For example; nutritional requirements.

Residents had access to a general practitioner (GP) and health and social care professionals. Where residents require further allied health and specialist expertise and this was facilitated through a system of referral. For example, residents with known responsive behaviours as a result of an underlying dementia diagnosis were reviewed by psychiatry of later life services. Inspectors found that there was a positive culture in the centre towards promoting a restraint-free environment. Overall, inspectors found that the person in charge was clear in their understanding of the risks of restrictive practices and their potential impact on residents.

Residents' lives had been significantly impacted by the COVID-19 pandemic and consequent restrictions. Inspectors observed that staff adhered to guidance in relation to hand hygiene and in wearing PPE in line with the national guidelines. Staff reported that the training they had received had been of a good standard and they were able to implement it in practice. The management team were committed to ensuring all reasonable measures were in place to prevent the spread of the COVID-19 virus in the centre. This included

- a temperature and COVID-19 symptom check on arrival to the centre, alcohol hand sanitizers were available throughout the centre
- appropriate signage was in place to prompt all staff and residents to perform frequent hand hygiene

- individual resident slings for manual handling purposes

However, inspectors found that further monitoring and oversight of the cleaning procedure was required. The inspectors observed many areas of the premises that were not cleaned to an acceptable standard and dust, dirt and grime was evident throughout the building. Further findings are discussed under Regulation 27: Infection control.

The centre had completed an internal fire audit in November 2021 and as a result, had taken actions in relation to fire safety in the centre. Quarterly servicing had been completed and there was an annual certificate for the service of fire fighting equipment. Records documented the fire drill scenarios created and how staff responded. The majority of staff spoken with were knowledgeable on what actions to take in the event of the fire alarm being activated. Each resident had a completed personal emergency evacuation plan (PEEP) in place to guide staff. However, the residents that had transferred out of their bedroom as a result of the leak did not have their PEEP moved with them. This put the residents at greater risk in the event of an emergency. Further development of the fire drills was required to provide assurances that the largest compartment could be safely evacuated within acceptable time frames.

The premises in general was in a poor state of repair. Inspectors observed significant facility wide issues that required maintenance and repair in bedrooms, bathrooms and along corridors. The findings are detailed under Regulation 17: Premises.

There were appropriate handrails and grab-rails available in the bathrooms and along the corridors to support residents moving freely through the centre and maintain their safety. Access to outdoor garden space was accessible to residents. Residents were supported to maintain personal relationships with family and friends.

Inspectors found that some residents were not provided with a call bell system. This posed a risk that their needs would not be met in a timely manner.

Regulation 11: Visits

The centre was facilitating visiting in line with the current COVID-19 Health Protection and Surveillance Centre (HPSC) guidance on visits to long term residential care facilities.

Judgment: Compliant

Regulation 17: Premises

On the day of inspection one section of the centre was undergoing repair work due to a leak. Excluding this part of the centre, inspectors found that multiple parts the premises were not clean and were in a poor state of repair. This was evidenced by;

- the paint on the resident's bedroom walls was peeling and damaged.
- there was insufficient storage for supportive equipments such as hoists/walking frames. For example; resident communal bathrooms were used as a storage area for equipment. This use of the resident bathrooms was inappropriate but also made the bathroom uninviting for residents.
- one of the resident's communal bathrooms was unclean and malodourous.
- resident bedroom doors were badly marked
- there was a hole in the wall of a residents bedroom where the plaster had been removed.

Judgment: Not compliant

Regulation 26: Risk management

The risk policy contained all of the requirements set out under Regulation 26(1). The system of risk identification and management required improvement. This is actioned under Regulation 23: Governance and management.

Judgment: Compliant

Regulation 27: Infection control

A number of issues were identified which were not consistent with effective infection prevention and control measure during the course of the inspection.

This is evidenced by

- Individual resident chair coverings were ripped and torn and in need of repair.
- Shower chairs that were heavily rusted and required replacement.
- resident equipment was not cleaned appropriately.
- bathroom flooring was lifting and in many cases was in a poor state. There were gaps between the concrete and the floor coverings that were a reservoir for bacteria and also a trip hazard for residents.
- beds and armchairs in the centre were worn in parts and this had an effect on the ability to clean to the standards required.

Judgment: Not compliant

Regulation 28: Fire precautions

A range of simulated fire drills had taken place. However, the drills did not provide assurance that the largest compartment in the centre could be safely evacuated with night time staffing levels in a timely manner, in the event of an emergency.

Inspectors were informed that weekly fire door checks had been completed. The documentation was not available for review. Multiple doors released by inspectors on the walkabout had gaps when the doors shut. For example; inspectors had a clear view through the gaps. Therefore, the gaps compromised the fire doors function of containing smoke.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Inspectors reviewed care plan documentation in place and found that some care plans were not consistently updated with the most relevant detail specific to the care needs of the residents. Inspectors were told very specific detail about residents with responsive behaviours and specific detail about residents with weight loss concerns. Staff told inspectors what management strategies were in place to support the residents. However, on review of the care plans this detail was not contained in the documentation that guides the care.

Judgment: Substantially compliant

Regulation 6: Health care

Residents were provided with unrestricted access to a general practitioner. Residents had access to allied health care professionals such as physiotherapy, occupation therapy, dietitian services and tissue viability expertise.

Judgment: Compliant

Regulation 9: Residents' rights

The registered provider had failed to ensure that resident's rights and dignity were

consistently upheld. This was evidenced by;

- Some residents did not have access to a call bell. This meant that that the residents were reliant on staff walking up and down the corridor or on their own ability to call out for assistance as was observed on the day of inspection.
- There was inadequate privacy screening in one twin bedroom.

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
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Moycullen Nursing Home OSV-0000365

Inspection ID: MON-0036077

Date of inspection: 09/03/2022

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
• We will ensure that all staff receive the required mandatory training as part of their induction, including, but not limited to: Moving & Handling of People, Behavioural & Psychological Symptoms of Dementia (BPSD)/Responsive Behaviours, Safeguarding and Protection of residents, Fire Safety, Infection Prevention & Control, Medication Competency Assessment, A Human-Rights Based Approach to Care. All outstanding mandatory training and education programmes, and refresher updates have been delivered or are scheduled for all staff to bring the training records up to date.
• Fire safety training has taken place as scheduled. This included annual fire safety refresher updates for staff in post for more than a year, and fire safety and evacuation training for the 2 new staff members.
• All staff have received education in Behavioural & Psychological Symptoms of Dementia as part of induction, which is included as pat of the Care of Residents with Dementia education.
• Staff training and development needs will continue to be discussed during the probationary period, performance appraisal and clinical supervision meetings, where staff are given the opportunity to identify any areas of training they feel would benefit them. Targeted education and training will also be facilitated if there are observed staff skills deficits based on individual training needs analysis.
• The nursing home will continue to actively promote a Human Rights-Based Approach to care. All residents receive a high standard of personal care in accordance with their preferences. There is a small number of residents in the home who have a cognitive impairment, yet have expressed a preference to maintain their independence as far as possible, including at mealtimes. These residents occasionally require encouragement or assistance to change soiled clothing or attend to hygiene after meals, and the staff will continue to approach this with sensitivity and care, with due respect to the individual residents' choice to be autonomous with activities of daily living and with consideration to avoid escalation of responsive behaviours.
• The Assistant Director of Nursing will provide supervision and guidance to staff on duty

and was working on a supernumerary basis on the day of inspection.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

• All residents in the nursing home will be assessed prior to admission to ensure that their care needs can be safely met in the nursing home.
• The PIC and ADON will continue to supervise workflow and care practices to ensure that staff are facilitated to provide high quality, safe and effective care to all the residents.
• The staffing roster will continue to be produced in advance and there are appropriate deputising arrangements for the PIC. All members of the nursing home management team can be contacted out of hours, and staff on duty are aware of all contact details.
• We are actively recruiting staff staff. We have recruited healthcare assistants from outside of the EU and several of the currently vacant HCA positions will be filled with these staff. This will enhance the local and national recruitment programme. The overseas HCAs are qualified nurses that are unregistered in Ireland.
• Staffing within the home will be carefully and consistently monitored by the PIC to ensure that there are always enough suitably qualified staff available to meet each resident’s assessed care needs.
• During periods when staff are unavailable to work due to sickness leave, or when a post is vacant, the PIC will make every effort to realign the rosters so that another staff member can cover the shift(s), but if that is not possible, agency staff are booked to replace the absent staff member and to ensure that there are always sufficient numbers of suitably qualified staff available to meet the residents’ assessed care needs.
• The PIC will continue to ensure that there are effective channels of communication for all staff in the home by holding and attending regular communication meetings, mid shift Safety Pauses and handover meetings, and will give staff an opportunity to provide feedback on any residents who may have a change in their needs or health status.
• The management of risk associated with ongoing works was being managed as well as possible considering that the repair works required had occurred the day before the inspection, and it had not been possible to anticipate the needs for these works. As soon as the leak was discovered, all necessary actions were taken to provide repairs urgently, and these works were in progress during the inspection. The works were completed safely and comprehensively.
• There is an audit schedule in place and action plans and quality improvements from recent audits are recorded in an audit folder in the home. Following a fire safety audit in November 2021, there have been significant improvements, including evidence of the fire evacuation drill scenarios and staff response to these. The knowledge and awareness of staff regarding how to respond to a fire safety emergency have improved, and all residents have a record of their Personal Emergency Evacuation Plan to guide staff.
• The PIC and ADON will provide clinical oversight to ensure that all residents’

assessments and care plans have been completed and are individualised and person-centred. They will ensure that the assessment informs the plan of care and considers the residents’ current medical, health and lifestyle status, including Behavioural & Psychological Symptoms of Dementia (BPSD) or responsive behaviours.
• There are a small number of residents who wish to be independent and autonomous in all activities of daily living, although they are known to have cognitive impairment. On occasions, they may have food-stained clothing or require attention to personal hygiene after meals. As part of our commitment to promoting a human rights-based approach to care, the staff will continue to respect the residents’ choice to remain independent at mealtimes; staff will encourage residents to attend to hygiene at a time that will avoid escalation of responsive behaviours.
• The Annual Review of the quality and safety of care delivered to residents for 2021 has been completed.

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
• The PIC is aware of her requirement to notify incidents within the required regulatory framework and will notify such incidents accordingly.
• The Healthcare Manager will monitor compliance with the submission of required notifications to the Authority.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• A painting contractor has been engaged and all painting works will be completed by the end of May. These works will also address the repair of plaster on the wall of a resident’s room and the door that was marked.
• A deep clean of the entire nursing home has been carried out, which included cleaning of all bedrooms, bathrooms and communal areas of the home. Storage areas have been decluttered and all equipment is stored appropriately, communal areas are free from clutter and equipment.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
• The individual resident chair observed to have been torn and in need of repair is the personal property of an individual resident. The chair has been sent for reupholstering and repair. The chair will be returned to the home by the end of May. A rental chair has been provided in the interim.
• There was one shower chair with rust on the frame, which has been disposed of and a replacement is now in situ.
• Resident equipment was cleaned as part of the deep clean of the home. There is an equipment cleaning schedule in place and the PIC will monitor compliance with this.
• A flooring contractor has been engaged to repair and replace all areas of damaged and worn flooring. This work is expected to be completed by the end of May.
• All beds and armchairs have been checked for wear and tear and there are now no worn beds or armchairs in the nursing home. All beds and furniture are in good order and all furniture, including beds and armchairs were cleaned as part of the deep clean of the nursing home. There is a cleaning schedule in place and the PIC will monitor compliance with this.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• The PIC will ensure that all staff have participated in a fire drill so that they have the knowledge and skills to safely evacuate residents in the event of a fire.
• A night-time simulated drill will be conducted in the large compartment on a weekly basis; it will be timed, and the methods used to evacuate residents and the level of assistance required will be described in the drill evaluation record.
• Records of fire door checks will be maintained and available for inspection. The gaps that were observed on inspection are being repaired and this work will be completed by 20/05/2022.

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 PIC will ensure that all residents’ care plans are individualised and contain relevant, person-centred information. The care plans will take account of all aspects of residents’

physical and mental health, personal and social care needs and any supports required to meet those needs, as identified by initial and ongoing assessment and review.
• The PIC and ADON will provide clinical oversight of these assessments and care plans. They will conduct regular documentation audits and reviews to ensure that the residents' care records are person-centred, sufficiently detailed, and that they are updated to accurately reflect the current assessed care needs of each resident and suitably outline the required nursing and care interventions.
• We will continue to devise, discuss and implement care plans in consultation with residents and/or relatives and the care plans will be sufficiently comprehensive to direct care; all information contained in the assessment will inform the individualised plan of care.
• The PIC and ADON will ensure that the resident assessment informs the plan of care and considers each resident's current medical, health and lifestyle status, including Behavioural & Psychological Symptoms of Dementia (BPSD) or responsive behaviours. If responsive behaviours are a presenting issue, an Antecedent, Behaviour & Consequence (ABC) chart will be completed for 3 days to assess the patterns of responsive behaviours, identify triggers and determine appropriate de-escalation techniques.
• Care plans will be reviewed at intervals not less than 4 monthly, or as indicated by the resident's condition or circumstances.
• The PIC will ensure that reviews are completed to monitor the effectiveness of the residents' support and treatment provision.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• We will continue to actively promote a human rights-based approach in relation to the care and welfare of all residents, including those with a cognitive impairment. For example, residents are facilitated, monitored and supported in the home to live as independently and safely as possible. Their rights are always respected, and the PIC will implement a risk-balancing approach to ensure that individual rights, choices and decisions are upheld.
• We will continue to consult regularly with residents and their families to ensure that we respect their choices and preferences. We will continue to provide assistance with all aspects of care as required.
• All residents have been consulted regarding Activities, and their choices, preferences, likes/dislikes are documented. The PIC will ensure that the activity schedule continues to reflect resident's choices and preferences.
• All staff members will continue to engage respectfully with the residents in the nursing home, bearing in mind their preference in relation to managing their own lives autonomously. For those with cognitive impairment, if this results in stained clothing or a need to address hygiene after meals, staff will approach each individual resident in accordance with their behavioural management care plan.
• All residents who can use a call bell have access to a call bell. There are call bells available in every room, but there are some residents who are unable to use a call bell,

even if they had access to one. We have implemented measures to check on these residents very regularly and to ensure supervision of all care provided. These residents are not relying on having to wait for a staff member to attend, there are intentional checks carried out at regular intervals.
• We will review the twin room and ensure that the privacy screening maintains the privacy and dignity of each resident in the room, while ensuring that each resident can access or exit the room without impacting on the privacy of the other.

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)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Yellow	31/05/2022
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	31/05/2022
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	31/05/2022
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with	Not Compliant	Orange	31/05/2022

	the statement of purpose.			
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	31/05/2022
Regulation 23(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.	Not Compliant	Yellow	31/05/2022
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Not Compliant	Orange	31/05/2022

Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	31/05/2022
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	31/05/2022
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	31/05/2022
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	Substantially Compliant	Yellow	31/05/2022

	the resident concerned and where appropriate that resident's family.			
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	31/05/2022