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:	Our Lady of Lourdes Care Facility
Name of provider:	Melbourne Health Care Limited
Address of centre:	Kilcummin Village, Killarney, Kerry
Type of inspection:	Announced
Date of inspection:	02 October 2024
Centre ID:	OSV-0000265
Fieldwork ID:	MON-0044204

About the designated centre

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

Our Lady of Lourdes Care Facility is a designated centre located within the rural setting of the village of Kilcummin and a short distance from the town of Killarney, Co. Kerry. It is registered to accommodate a maximum of 66 residents. It is a two-storey facility set out in three wings: Dun Beag is a dementia-focused unit accommodating 18 residents; Tus Nua on the first floor accommodating 27 residents; and Deenagh on the ground floor accommodating 21 residents. Our Lady of Lourdes Care Facility provides 24-hour nursing care to both male and female residents whose dependency range from low to maximum care needs. Long-term care, dementia care, convalescence, respite and palliative care is provided.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	65

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 2 October 2024	09:15hrs to 18:00hrs	Siobhan Bourke	Lead
Wednesday 2 October 2024	09:15hrs to 18:00hrs	Ella Ferriter	Support

What residents told us and what inspectors observed

This announced inspection took place over one day. The inspectors greeted many residents during the day and spoke, in more detail, to twelve residents, to gain an insight into their lived experience in Our lady of Lourdes Care Facility. Feedback gathered from residents was positive, and residents expressed feeling content and well cared for in the centre. One resident said "I am happy here, they are all very helpful". Another commented that they were full of "gratitude" to the staff working there. Feedback from visitors was also positive, with family members saying, they found staff "very warm and welcoming." Based on the observations of the inspectors, and from speaking with residents, it was clear that the staff were committed to providing person-centred care to residents.

Our Lady of Lourdes Facility is registered to accommodate 66 residents over two floors. The centre is set out in three units: Deenagh on the ground floor and Tus Nua and Dun Beag units are upstairs. The centre's upper floor units can be accessed by both a large lift and stairs. The centre has 46 single rooms and ten twin rooms; 33 single rooms and seven twin rooms had en-suite shower, toilet and hand wash sink and the six rooms that were not en-suite had a hand wash basin. There was an adequate number of shower and toilet facilities in the centre for residents whose rooms did not have en-suites. There was good directional signage throughout the home to guide residents and staff. The inspectors saw that codes to access the doors in the centre were displayed in residents' bedrooms, for residents who wished to use the lift or to walk around the outside of the centre.

Following an introductory meeting, the inspectors spent time meeting with residents and staff. There was a friendly and homely atmosphere in the centre. Inspectors spoke with residents in their bedrooms and communal areas in the centre. Residents described how they knew the staff well, who supported them with their care needs and this made them feel safe in their care. Inspectors observed that the person in charge was well known to residents. The inspectors saw that personal care and attention was provided in an unhurried and respectful manner during the morning to residents. Staff knocked on residents' bedroom doors before they entered. Inspectors saw that staff engaged with residents in a respectful and friendly manner and appeared knowledgeable regarding residents' preferences.

Overall, the inspectors saw that the centre was warm, homely and clean throughout. Many residents' bedrooms were personalised, with residents' family photographs and belongings and had plenty storage space. Pressure relieving specialist mattresses, falls injury prevention mats and other supportive equipment was seen in residents' bedrooms. Flooring in a number of residents' bedrooms and some of the surfaces of doors to en-suites were cracked and required repair or replacement. The inspectors saw that privacy curtains in the shared bedrooms were disposable, which took from the homely feel in bedrooms. Paintwork in a number of residents' bedrooms required attention and an area of plaster and paint on one bedroom wall was damaged. The balcony areas in residents' bedrooms had yet to be raised and

inspectors saw that exit doors to these balconies remained locked, until this work was completed. This is outlined further in the report. The person in charge outlined that a plan of renovations of the centre was being drafted, that included replacement of the centre's curtains and privacy curtains alongside other improvements.

There were a number of communal spaces in the centre for residents' use including a day space area and a dining area on the ground floor. On the first floor, there was a large dining room and a large bright day room that opened out on to a well maintained secure patio area. There was also a room known as the "coffee dock" which had comfortable seating, where residents could meet their visitors in private or use for gatherings. The older section of the home on the first floor had a smaller dining room and dayroom, which linked to the large main day room. Overall, these spaces were furnished with dressers, paintings and furniture that gave the centre a homely feel. Artwork created by residents and photos of residents participating in celebrations or activities in the centre, were displayed on the walls throughout the centre. On the first floor, the reception area had comfortable seating and the inspectors observed that residents often sat in this space during the day, watching the activity in the centre. During the walk around on the first floor, the inspectors noted that doors to access one section of the centre were closed with keypad access, which meant residents, who could mobilise with aids or independently, had to seek staff assistance, to move freely between the communal rooms and their bedrooms. The person in charge agreed to review this practice on the day of inspection.

The inspectors observed the lunchtime and evening meals on the day of inspection. The inspectors saw that there were picture menus and written menus on the first floor and residents had three choices for their main course at lunch time. Residents who required texture modified food also had a choice of main course. Both the lunch time and evening meals were well presented and appeared appetising. Residents who spoke with inspectors gave very positive feedback with regard to the quality and choice of food available to them.

Inspectors observed the resident's dining experience and saw that there were adequate staff available to assist residents with their nutritional care needs. The inspectors saw, however, that the dining experience on both floors required improvements. On the ground floor, the space available for residents in the dining area was limited to nine or ten residents, while there were over 20 residents living there. While some residents choose to eat in their bedrooms, if they did choose to eat in the dining room, there would not be enough space for them to do so. On the first floor, a number of residents in the Dun beag unit were eating in the day room at lunch time from tables placed in front of their chairs which did not promote a sociable dining experience. At the evening meal, the person in charge ensured that some of these residents were facilitated to dine in the main dining room on the first floor.

Visitors attending the centre throughout the day of the inspection were welcomed by staff. Residents and visitors were satisfied with the visiting arrangements in place. They confirmed that these arrangements were flexible. A number of visitors

who spoke with the inspectors felt that their loved ones were well cared and that they were kept up-to-date with any important changes to their care needs by staff and management.

As part of this announced inspection process, residents were provided with questionnaires to complete, to obtain their feedback on the service. In total, nine surveys were received. Overall, residents conveyed that they were happy living in the centre.

Residents' rights were promoted in the centre and residents were encouraged to maximise their independence with support from staff. Arrangements were in place for residents to meet with the management team to provide feedback on the quality of the service they received through regular residents' meetings. From a review of minutes of these meetings, it was evident that the management team acted on feedback received from residents. Residents had access to a range of media, including newspapers, telephone and TV. There was access to advocacy with contact details displayed in the centre.

A programme of activities was available to residents, which was carried out by a team of activity staff with the support of health care staff. Throughout the day of the inspection, residents were observed engaging in a number of different activities. In the morning a lively exercise class was facilitated by the activity staff on both floors. A number of residents also participated in arts and crafts. In the afternoon, a group of residents had a lively game of bingo on the ground floor, while a number of residents participated in a sing song upstairs. Those in attendance were observed to be enjoying the event.

The next two sections of the report present the findings of this inspection in relation to capacity and capability of the provider, and how this impacts on the quality and safety of the service being delivered.

Capacity and capability

This was an announced inspection, carried out over one day to monitor compliance with the Care and Welfare of Residents in Designated Centres for Older People, Regulations 2013 (as amended). Overall, findings of this inspection were, that this was a good service and a well-managed centre, where management and staff worked together to ensure residents received person centred care and support. The management team was proactive and responsive to issues as they arose and many of the findings of the previous inspection had been actioned. However, further action was required to ensure compliance as outlined under the relevant regulations.

Melbourne Healthcare Limited is the registered provider for Our Lady of Lourdes Care Facility and is registered to accommodate 66 residents. Since the previous inspection in February 2024, there had been a change of ownership of the centre in March 2024, with the departure of the previous directors and the appointment of

two new incoming company directors. One of the company directors was the nominated person representing the provider and is actively engaged in the operational management of the centre. There were clear lines of accountability with each member of the team having their role and responsibilities defined. The provider had recently appointed a director of care, quality and governance to strengthen the clinical oversight in the centre.

The director of nursing was the person in charge and was supported in her role by a clinical nurse manager grade 2, a team of nurses, health care assistants, activity staff and housekeeping staff. The centre also had a full time maintenance person and administrative assistants. There were two vacant clinical nurse manager grade 1 positions on the day of inspection, and inspectors were informed that recruitment was planned to fill these positions. Since the change of ownership, the on site management and staff team working in the centre had remained largely unchanged, providing consistency and continuity in the lives and care of residents.

From a review of the rosters and discussions with residents and staff it was found that there were an appropriate number and skill mix of staff available to meet the needs of the 65 residents living in the centre and for the size and layout of the centre. The centre had a minimum of three nurses rostered 24 hours a day and they were supported by the clinical nurse manager (CNM) who was supernumerary, four days a week. The person in charge and the CNM 2 alternated the on call rota for the centre.

A comprehensive training programme was in place for all grades of staff. Staff were facilitated to attend training appropriate to their role. Staff demonstrated an appropriate awareness of their training and their roles and responsibilities with regard to safeguarding residents from abuse, infection prevention and control, fire safety and responsive behaviours. Staff were appropriately supervised and supported in their roles by the management team.

A sample of staff personnel files were reviewed by an inspector. There was evidence that each staff member had a vetting disclosure, in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 on file, prior to commencing employment. From a sample of records reviewed, it was noted that gaps in employment were not accounted for in two files as outlined under Regulation 21 records.

There were effective communication systems in place to monitor care provided to residents. The provider had a schedule of regular management meetings in the centre to ensure oversight of the service provided.

There were systems in place to monitor the quality and safety of care provided to residents. The inspectors saw that there was a schedule of audits in place in relation to environmental hygiene and hand hygiene, and aspects of care delivery such as care planning, safeguarding, and dignity in care. The inspectors saw that action plans were developed in response to audit findings. Improvements were required to ensure better oversight of care planning and to ensure resources were available to

address the premises findings as outlined under Regulation 23 governance and management.

There was an effective complaints procedure which was displayed at the centre and staff and residents who spoke with the inspectors were aware of how to make a complaint. The arrangements for the review of accidents and incidents within the centre was robust and from a review of the incident log maintained at the centre, incidents were notified to the Chief Inspector in line with legislation.

A comprehensive annual review of the quality and safety of care provided to residents in 2023 had been prepared in consultation with residents.

There was evidence of consultation with residents in the planning and running of the centre. Regular resident meetings were held and resident surveys were completed to help inform ongoing improvements in the centre.

Regulation 14: Persons in charge

The person in charge was full time in position and had the required qualifications and experience for their role. The inspectors observed that the person was knowledgeable regarding their roles and responsibilities and residents' assessed needs.

Judgment: Compliant

Regulation 15: Staffing

On the day of inspection, there were an appropriate number and skill-mix of staff across all departments to meet the assessed needs of the 65 residents living in the centre. The inspectors observed skilled staff providing care for residents and staff were knowledgeable regarding the residents needs.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had access to training appropriate to their role. Staff had completed training in fire safety, safeguarding, managing responsive behaviours and infection prevention and control. There was an ongoing schedule of training in place, to ensure all staff

had relevant and up to date training to enable them to perform their respective roles. Staff were appropriately supervised and supported.

Judgment: Compliant

Regulation 21: Records

From a review of a sample of four staff files, an inspector saw that two files had unexplained gaps in employment history. It is a requirement of Schedule 2 of the regulations, that records contain a full employment history together with a satisfactory history of any gaps in employment. One of these staff files was corrected on the day of inspection and the provider assured inspectors that all files would be checked and actioned as required.

Judgment: Substantially compliant

Regulation 23: Governance and management

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 following:

- There was a lack of oversight of care planning documentation as further outlined and actioned under Regulation 5. Individual assessment and care plan
- The compliance plan submitted following the previous inspection with regard to premises had not been actioned in line with the required time frame.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Incidents and notification events, as set out in Schedule 4 of the regulations, were notified to the Chief Inspector of Social Services within the required time frames.

Judgment: Compliant

Regulation 34: Complaints procedure

The registered provider provided an accessible and effective procedure for dealing with complaints, which included a review process. The required time lines for the investigation into, and review of complaints was specified in the procedure. The procedure was prominently displayed in the centre.

The complaints procedure also provided details of the nominated complaints and review officer. The complaints procedure outlined how a person making a complaint could be assisted to access an independent advocacy service.

Judgment: Compliant

Quality and safety

Overall the inspectors found that residents living in Our Lady of Lourdes Care Facility were support to enjoy a good quality of life. Residents' needs were being met through good access to health care services and good opportunities for social engagement. It was evident that residents received person-centred and safe care, from a team of staff who knew their preferences. Some action was required in relation to premises, care planning and food and nutrition as outlined under the relevant regulations.

Residents' health care needs were well met. Residents had access to local General practitioner services, whereby GPs visited the centre on a regular basis, to review residents as required. There was evidence of appropriate referral to and review by health and social care professionals where required, for example, dietitian, speech and language therapist and podiatrist. A physiotherapist was on-site two days a week to assess and review residents' mobility as required. Nurses had access to expertise in tissue viability when needed. There was a low incidence of pressure ulcer formation in the centre.

The inspectors reviewed a sample of care plans and found that nursing staff completed a comprehensive assessment of residents' health, personal and social care needs on admission. Care plans were developed within 48 hours of admission as required and validated tools were used by nursing staff to inform the development of care plans. Action was required to ensure that care plans were updated when residents' needs and conditions changed as outlined under Regulation 5; Individual assessment and care plan.

There were arrangements in place to monitor residents at risk of malnutrition or dehydration. This included weekly weights, and timely referral to dietetic and speech and language services to ensure best outcomes for residents. However, action was required to ensure that where dietary recommendations were in place, that these were consistently implemented as outlined under Regulation 18; Food and nutrition.

Risk management systems were underpinned by the centre's risk management policy which detailed the systems to monitor and respond to risks that may impact on the safety and welfare of residents. A risk register had been established to include potential risks to residents' safety.

Records maintained evidenced that there was a preventive maintenance schedule of fire safety equipment and the fire alarm and emergency lighting were serviced in accordance with the recommended frequency. Daily and weekly records of checks to ensure emergency exits were free from obstruction and testing of the centre's fire alarms were maintained. Personal emergency evacuation plans were in place for each resident and updated four monthly or if a resident's condition changed. The provider ensured regular fire evacuation drills were practiced in the centre. All staff had received fire training and this took place yearly. The inspectors saw that an upgrade to the smoke detection system in the centre was in progress. However, some action was required pertaining to fire doors as outlined under Regulation 28 Fire precautions.

The provider ensured that a person was assigned as clinical lead for infection control and had completed link nurse training in infection control to assist with this role. Regular infection prevention and control meetings were held in the centre and there was good oversight of environmental and equipment hygiene. The inspectors saw that equipment and bedrooms were generally clean. Review of infection control signage was required and some staff practices regarding wearing of gloves and other findings required action, as outlined under Regulation 27 Infection control.

While the premises was warm, clean and homely, a number of findings from the previous inspection had yet to be actioned. Flooring in a number of bedrooms required repair and work had yet to be completed in the centre in relation to the balconies. This is detailed under Regulation 17; Premises.

Residents told the inspectors that staff respected them in the centre. Staff were observed to speak with residents in a kind and respectful manner and to ask for consent prior to any care interventions. The person in charge was working to promote a restraint free environment and there was close monitoring of restrictive practices such as bed rails in the centre. Inspectors saw evidence of alternatives trialled. However a number of doors in the centre had key pad locks which may impede residents freedom to move independently throughout the centre as outlined under Regulation 7 Responsive behaviours.

Regulation 11: Visits

There were no visiting restrictions in place and visitors were observed coming and going to the centre on the day of inspection. Visitors confirmed that visits were encouraged and facilitated in the centre.

Judgment: Compliant

Regulation 17: Premises

The following required action to ensure compliance with schedule 6 of the regulations and some are repeat findings

- Flooring in a number of bedrooms and ensuite bathrooms were cracked and worn and required repair or replacement.
- A number of residents' bedrooms wall-paint was marked and chipped and required action.
- A toilet seat in a resident's bedroom was stained and worn.
- Work to raise the height of the balconies from the veranda outside residents' bedrooms on the first floor, as outlined in the previous compliance plan, had yet to be undertaken by the provider.

Judgment: Not compliant

Regulation 18: Food and nutrition

Action was required in relation to food and nutrition as evidenced by the following findings;

- From a review of a sample care plans, it was noted that the dietary needs of a resident, as prescribed by a dietitian, were not consistently adhered to or recorded.
- The dining room arrangements on both floors did not facilitate all residents to experience a sociable dining experience. The inspectors saw some residents eating from tables in the day room in one of the units and the dining area on the ground floor could only accommodate half of the residents living in the unit.

Judgment: Substantially compliant

Regulation 26: Risk management

The registered provider had a risk management policy that met the requirements of the regulation. The provider had a plan in place to respond to major incidents in the centre likely to cause disruption to essential services at the centre.

Judgment: Compliant

Regulation 27: Infection control

The following required action to ensure compliance with the National Standards for infection prevention and control in community services (2018).

- The hand hygiene sink in one of the sluice rooms had yet to be replaced.
- Oversight of staff usage of disposable gloves was required, as a number of staff were observed wearing gloves when not required.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The following findings in relation to fire safety required action.

- Oxygen signage was missing from a resident's bedroom door where oxygen was in use; this was addressed by the person in charge on the day of inspection,
- The inspectors noted a number of fire doors had gaps when closed, which may allow the escape of smoke in the event of a fire. While a review of fire doors had been arranged by the provider and evidence was available that the provider was in the process of purchasing a number of new fire doors for the centre these were not in place at the time of the inspection.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

While overall, care plans were person centred, action was required to ensure assessments and care planning documentation was in line with specified regulatory requirements as evidenced by the following:

- Care plans were not consistently updated with the changing needs of residents, for example, a resident's care plan did not reflect the management of a recent infection. A resident who required medication for management of pain, did not have regular pain assessments completed.
  A resident who experienced responsive behaviour did not have this reflected in their care plan.

This may result in errors in care delivery.

Judgment: Substantially compliant

Regulation 6: Health care

Action was required to ensure that a high standard of evidence based nursing was provided at all times, as inspectors saw that observations were not consistently recorded in line with the centre's falls policy.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

The inspectors observed that some of the doors in the units on the upper floor and access to the lift were by key pad locks. These doors were observed to unnecessarily restrict residents freedom to move independently, throughout the centre.

Judgment: Substantially compliant

Regulation 8: Protection

There was an up-to-date safeguarding policy and procedure in place which was well-known amongst staff. Staff demonstrated a good awareness in relation to their role in how to keep residents' safe, and could clearly describe the reporting mechanisms should a potential safeguarding concern arise. The provider identified that the systems in place to ensure deceased residents' finances were returned to their estates in a timely manner required strengthening and had addressed this by the time of inspection.

Judgment: Compliant

Regulation 9: Residents' rights

There was evidence that residents were consulted with and participated in the organisation of the centre and this was confirmed by residents and the minutes of residents' meetings which the inspectors reviewed. Overall, residents' right to

privacy and dignity was promoted, and positive, respectful interactions were seen between staff and residents. The residents had access to individual copies of local newspapers, radios, telephones and television. Advocacy services were available to residents as required and were advertised on notice boards in the centre along with other relevant notifications and leaflets. A range of diverse and interesting activities were available for residents including one-to-one activities.
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 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Our Lady of Lourdes Care Facility OSV-0000265

Inspection ID: MON-0044204

Date of inspection: 02/10/2024

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 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: Bi-annual audits of Records is already in progress. The July audit did show gaps in some records. This was actioned and rectified at that time. On the day of inspection 2 records had gaps in CVs -1 record was amended immediately and the 2nd has since been amended. Audits of Records are scheduled for January and July. Going forward, the interview process will be more stringent and prospective employee will account for any gaps.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • Regarding oversight of care planning, commencing the 4 November 2024, a new system will be in place whereby at Nurses morning handover, the CNM2/PIC will receive updated information about each resident. The updates will be documented in a dedicated report book. The CNM2/PIC will check that any changes to a residents being/condition has been updated in appropriate care plan/s and then confirm checks by signing the report book At weekends/ Bank Holiday, this will be checked by CNM 2/PIC on the next working day. An audit of Care Plans will be scheduled alternate months and deficits actioned by PIC/ CNM 2. Care Planning and Clinical Risk Assessment education for Nurses has already commenced in October 2024. Regarding compliance plan submitted following the previous inspection in relation to premises had not been actioned in line with the required time frame.	

We have been trying to get a contractor to complete this work since we took over the nursing home in April. We are currently speaking with two different contractors in the hope that this will be completed by April 30th. The residents are currently using the other balcony area that has already had the height raised.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
1. Flooring in most of the home including all communal areas and the bedrooms plus ensuites are all being replaced. The flooring contractor will have all works completed by end of February 2025.
2. Areas that required repainting and works are all being done currently and will be completed by December 31st 2024
3. The worn toilet seat has been replaced.

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
Regarding the documentation in a care plan of prescribed treatment/care, a care planning & clinical risk assessment education for Nurses has commenced in October 2024. This will aid Nurses in understanding the significance of using the care plan efficiently to enhance a resident's life.
All care plans will be audited on alternate months starting November 2024, to ensure such information for all residents is in place in the care plans and progress notes. To further ensure compliance, PIC and CNM2 will rotate the care plan checks.

In relation to dining room space in Deenagh unit, plans are in place to have a new dining area for the lower ground when the new extension is completed. Unfortunately there is not enough space presently to extend the existing dining room, therefore, residents are now offered a 2nd meal sitting which provides choice for each resident.
With regards to Dun Beag residents taking their meals in their living room this was actioned on the day of inspection. Tus Nua dining room was reconfigured and extra tables were placed in that dining room which allowed the Dun Beag residents take their meals in Tus Nua dining room, allowing for socialisation and an improved dining experience.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
In relation to the hand hygiene sink in 1 of the sluice rooms, clinical sinks have been bought, awaiting contractor to install.

Regarding oversight of staff usage of disposable gloves, IIPCN will conduct a survey of staff knowledge regarding glove use and facilitate education accordingly. Currently, classroom style training on IPC commenced 15 October 2024 and will be completed on 15 November 2024. (4 training sessions)
PIC & CNM2 complete daily walkabouts of the facility. Various aspects are being monitored during the walkabouts, including IPC. Donning/doffing PPE and appropiate use of PPE are a feature of the Safety Pause meetings. IPC audits are completed monthly,

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
With regards to some fire doors having gaps when closed, a review of all fire doors had been completed before this inspection. Quotation has been given to the Company and awaiting sanction and a start date for works.
We have been trying to get a contractor to complete this work since we took over the nursing home in April. We are currently speaking with two different contractors in the hope that this will be completed by April 30th.

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:
Commencing the 4 November 2024, a new system will be in place whereby at Nurses morning handover, the CNM2/PIC will receive updated information about each resident. The updates will be documented in a dedicated report book. The CNM2/PIC will check that any changes to a residents being/condition has been updated in appropriate care

plan/s and then confirm checks by signing the report book At weekends/ Bank Holiday, This will be checked by CNM 2/PIC on the next working day.
Care Planning and Clinical Risk Assessment education for Nurses has commenced in October 2024. This will aid Nurses in understanding the significance of using the care plan efficiently to enhance a resident's life.
All care plans will be audited on alternate months to ensure such information for all residents is in place in the care plans and progress notes.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
The Falls Policy has been reviewed and updated with relevant information. The policy has been sent to all Nurses, has been placed on the electronic desktops at each Nurses Station and policy has been fully implemented since inspection.

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
The PIC has reviewed and risk assessed all keypad locks in the Nursing Home and has actioned some electronic keypads to be de-activated while awaiting removal. The elevator in Deenagh unit; the double doors leading to bedrooms in Tus Nua Unit; The Coffee Dock in Tus Nua; the double doors between Tus Nua and Dun Beag units.

The keypad locks will remain on the exit doors, as residents have requested that the exit doors remain locked. Codes for these keypads are displayed in all bedrooms with exception of 1 person. An electronic keypad will remain in place on both ends of the stairwell as this poses a high risk of injury to a frail resident should they fall on the stairwell.

The electronic keypad at one of the exit from Tus Nua Unit will remain in place as this leads to Veranda which requires extra works to improve safety.

Removing some of these electronic keypads will allow residents to safely access areas of the Home outside of their units while maintain their safety and promoting freedom of choice.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 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	30/04/2025
Regulation 18(1)(c)(i)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are properly and safely prepared, cooked and served.	Substantially Compliant	Yellow	04/12/2024
Regulation 18(1)(c)(iii)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which meet the dietary	Substantially Compliant	Yellow	04/12/2024

	needs of a resident as prescribed by health care or dietetic staff, based on nutritional assessment in accordance with the individual care plan of the resident concerned.			
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	04/12/2024
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.	Substantially Compliant	Yellow	04/12/2024
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	Substantially Compliant	Yellow	28/02/2025

	implemented by staff.			
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Substantially Compliant	Yellow	30/04/2025
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Substantially Compliant	Yellow	04/12/2024
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord	Substantially Compliant	Yellow	04/12/2024

	Altranais agus Cnáimhseachais from time to time, for a resident.			
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.	Substantially Compliant	Yellow	20/12/2024